

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/28/2012
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NAME OF PROVIDER OR SUPPLIER  CDC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 204 RILEY RD DELPHI, IN 46923
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W0000	<p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>Dates of Survey: September 24, 25, 26, 27 and 28, 2012.</p> <p>Facility Number: 000827 Provider Number: 15G308 AIMS Number: 100235060</p> <p>Surveyor: Kathy Wanner, Medical Surveyor III.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 10/4/12 by Tim Shebel, 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 and interview, the governing body failed to maintain operating direction over the facility by failing to repair the cracked front sidewalk where 4 of 5 clients living in the home (clients #1, #2, #3 and #5) entered and exited the home daily.</p> <p>Findings include:</p> <p>Observations were conducted at the home where clients #1, #2, #3 and #5 live on 9/26/12 from 5:33 A.M. until 7:20 A.M.. At 7:15 A.M. clients #1, #2, #3 and #5 exited the home by the front door and traversed down the front sidewalk to board the transit to transport them to work. The front sidewalk had a horizontal crack across the width of the sidewalk. One portion of the cracked sidewalk was raised 3/4" to 1" (three fourth of an inch up to one inch). Client #1 and client #2 utilized roller-walkers to ambulate to the transit via the cracked sidewalk. Client #5 was assisted in walking along the uneven sidewalk by Direct Care Staff (DCS) #3.</p> <p>Client #1's record was reviewed on 9/26/12 at 1:04 P.M.. Client #1's</p>	W0104	<p>In response to tag 104 a work order was put into the Maintenance department to repair the sidewalk to the front entrance of the house on 9-27-2012. Maintenance had the repair completed by October 15, 2012. Monitoring of any environmental along with the health and safety of home will be done by Health &amp; Safety Specialist on a monthly basis. Monitoring will be done by completing a checklist of issues to look for any issues</p>	10/15/2012			

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	<p>Individual Support Plan (ISP) dated 5/23/12 indicated she utilized a walker at workshop and when outside.</p> <p>Client #2's record was reviewed on 9/26/12 at 1:45 P.M.. Client #2's ISP indicated he had a diagnosis of, but not limited to Cerebral Palsy. Client #2 had a Fall Risk plan dated 12/11. An internal report dated 8/14/12 indicated "[Client #2] went home this past weekend with dad. Dad reported [client #2] fell on sidewalk crack. There was no indication if this was the sidewalk at the group home or another sidewalk.</p> <p>Client #3's record was reviewed on 9/26/12 at 2:08 P.M.. Client #3's ISP indicated she utilized a roller walker whenever she was outside of her bedroom. Client #3 had a fall risk plan dated 5/3/12.</p> <p>Client #5's record was reviewed on 9/26/12 at 2:38 P.M.. Client #3's Physician Order (PO) dated 9/12/12 indicated client #5 was legally blind.</p> <p>The Residential Manager (RM) was interviewed on 9/26/12 at 7:18 A.M.. When asked about the clients walking on the uneven sidewalk the RM stated, "They seem to just walk right over it without problems, I've tripped on it though."</p>						

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	<p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 9/26/12 at 2:40 P.M.. When asked about the cracked front sidewalk at the group home. The QMRP indicated it needed to be repaired.</p> <p>The Health and Safety Specialist (HSS) was interviewed on 9/26/12 at 2:45 P.M.. The HSS stated, "I will put in a work order for them to repair the sidewalk."</p> <p>9-3-1(a)</p>			

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W0249	<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 staff failed to follow the fall risk plan for 1 of 3 sampled clients (client #3) which resulted in client #3 falling.</p> <p>Findings include:</p> <p>Facility records were reviewed on 9/25/12 at 12:12 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the past year. The BDDS reports indicated the following:</p> <p>A BDDS report dated 2/21/12 for 2/21/12 at 4:05 P.M. indicated "Group Home Staff (GHS) [name of staff] #3 woke [client #3] up for the day. [Client #3] sat up on the side of her bed. GHS #3 left [client #3] bedroom to retrieve bathing items needed. GHS #3 returned ten minutes later and found [client #3] sitting on the floor. [Client #3] informed GHS #3 that she fell to the floor. GHS #3 did not observe any injuries or bruises on [client #3] from the fall. [Client #3] does have a risk plan which GHS #3 did not follow. GHS #3</p>	W0249	In response to tag 249 Staff were retrained on risk plan on 5-7-2012. Plan was reviewed and updated 6-22-2012. Updated again on 10-4-2012 staff will be retrained on the plan as of 10-18-2012 during a staff meeting.. The gait belt has since been placed on a hook outside the shower. Monitoring of the use of the gait belt will be done on an at least weekly basis by Group Home Supervisor or designee	10/15/2012			

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	<p>did admit to not following risk plan. GHS #3 was counseled and retrained on [client #3's] risk plan. GHS #3 will be suspended without pay."</p> <p>A follow-up BDDS report dated 2/28/12 indicated GHS #3 was suspended immediately. The staff admitted to failing to follow the risk plan in place for [client #3], which substantiated the incident .... The group home supervisor and other random CDC staff make quality inspections at random times to ensure that consumers are free of abuse. GHS #3 and all staff were retrained on the risk plan for the consumer (client #3) ...."</p> <p>The facility tracking system to monitor for trends and patterns was reviewed on 9/25/12 at 1:59 P.M.. The tracking system indicated on 2/22/12 client #3 had developed "1-1/2" x 4" (one and one half inch by four inch) oblong bruise on her right front calf." Indicated this was from her fall on 2/21/12.</p> <p>An Internal Incident Report dated 6/27/12 at 3:20 A.M. indicated "Staff was helping [client #3] with a shower. [Client #3] slipped off chair and fell on her buttocks. There is no bruising at this time." The Qualified Mental Retardation Professional (QMRP) noted on the report "Gait belt positioning of belt moved to</p>						

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	<p>ensure access of gait belt without taking eyes of (sic) gait belt and consumer."</p> <p>Client #3's record was reviewed on 9/26/12 at 2:08 P.M.. Client #3's Individual Support Plan (ISP) dated 4/24/12 indicated client #3 had a history of frequent falls. Client #3' record indicated she had a physical therapy evaluation on 11/9/11 with an order to utilize a gait belt to get in/out of shower. Client #3's record indicated she had a fall risk plan up-dated on 5/30/12. The fall risk plan indicated "[Client #3] will use the gait belt for transfers in and out of the shower...staff will ensure they remain closer than arms reach of [client #3]....Staff will remain with [client #3] when she awakens after any period of sleep until [client #3] appears awake, is mobile, and does not appear to have any signs of instability."</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 9/26/12 at 2:40 P.M.. When asked about client #3's falls the QMRP indicated client #3 often refuses to use her walker, and is non-compliant with staff. The QMRP indicated staff did not follow the risk plan for client #3 when she fell in the shower or when she fell off the side of her bed.</p> <p>9-3-4(a)</p>				

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W0268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility day program staff failed to promote growth, independence and dignity for 2 of 3 sampled clients (clients #2 and #3).</p> <p>Findings include:</p> <p>Observations were conducted at the facility owned and operated day services program on 9/25/12 from 12:40 P.M. until 1:50 P.M.. Client #2 was in his classroom. There were two other peers in the classroom. One of the peers was seated in her wheelchair. Client #2 was seated on a recliner with his legs down. There was a visible incontinence protector placed on the seat of his chair. The classroom had three other unoccupied chairs in the classroom which had incontinence protectors on the seat. Client #3 was in her classroom with a ratio of 2 staff to 8 other peers. Client #3 had a 4" (four inch) circular stain on the back of her tan slacks. The stain had a brown color around the circumference of the stain and a brown nickel sized area in the center of the stain. Client #3 walked to and from the table to the magazine cabinet, stood by the table and talked with</p>	W0268	In response to tag 268 Day Services staff will be trained on client dignity on 10-16-2012. Geri pads in the classroom have been covered with material to keep the dignity of clients. Monitoring of client dignity will be done by Day Services Coordinator, QDDP-D, QMRP, or designee. Direct care staff has been trained and are responsible to report and correct any issues upon seeing.	10/15/2012			

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	<p>others. At 1:30 P.M. client #3 was asked to use the restroom. DPS #2 gave client #3 an incontinence pad to replace the one in her panties. Client #3 was not asked to change her panties or her slacks.</p> <p>Day Program Staff (DPS) #1 was interviewed on 9/25/12 at 1:15 P.M.. When asked about the incontinence protectors on the chairs. DPS #1 stated, "No, [client #2] doesn't normally wet himself, the protectors are there just in case someone wets."</p> <p>DPS #2 was interviewed on 9/25/12 at 1:48 P.M.. When asked about client #3's stained slacks DPS #2 stated, " Everyday it is the same thing. She (client #3) says we don't like her anyways, so why clean-up. She doesn't want to clean-up. I told her she would need to change her pad now, but will need to have her clothes changed before she leaves."</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 9/26/12 at 2:40 P.M.. The QMRP stated, "[Client #3] should have been changed immediately." The QMRP indicated she was not sure why client #2's classroom used the incontinence protectors on the chairs. The QMRP indicated that it was dignified for client #3 to have remained in her stained slacks. The QMRP indicated it</p>				

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	<p>was not dignified to have incontinence protectors visible through-out client #2's classroom.</p> <p>The Health and Safety Specialist (HSS) was interviewed on 9/26/12 at 2:45 P.M.. The HSS indicated she thought they used the protectors on the chairs because the chairs were cloth and not scotch guarded.</p> <p>9-3-4(a)</p>				

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed to ensure all medications were administered in compliance with the physician's orders for 1 of 3 sampled clients (client #1).</p> <p>Findings include:</p> <p>Facility records were reviewed on 9/25/12 at 12:12 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports for the past year. The BDDS reports indicated the following:</p> <p>A BDDS report dated 9/6/12 for 9/5/12 at 5:00 P.M. indicated "Staff administered a housemate's (client #3's) medication to [client #1]. [Client #1] was administered Cabapentin (sic) (anti-convulsant) Cap (capsule) 400 mg (milligrams), Lisinopril (anti-hypertensive) 2.5 mg, Trospium CL (urinary incontinence) tab (tablet) 20 mg. The pharmacy and agency nurse was (sic) notified immediately. Staff was instructed to watch for dizziness, light-headedness, and to check blood pressure every shift. Staff monitored [client #1] every two hours. The physician was notified and no additional recommendations were given at the time of this writing. [Client #1]</p>	W0368	In response to tag 368 the med area at the group home has been moved to ensure privacy. This was completed 9-10-2012. Supervised med passes are done monthly on random staff at the group home by the Group Home Supervisor, Group Assistant, Group Home Coordinator, and or Group Home Assistant Coordinator		

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	<p>exhibited no side effects as a result of this medication error. Staff took blood pressure every shift as recommended-within normal range for [client #1] through out night and morning. Coordinator spoke with the staff making the error. Staff stated that a housemate (client #3) was with them when preparing meds (medications); however the staff asked the consumer to wash their (client #3's) hands and [client #1] walked in and started talking to the administering staff. Staff administered the medication to [client #1] at that time. The root cause appears to be the result of the medication area not being in a private area of the home, which allowed too many distractions during medication administration. The medication area will be moved and arranged to ensure a more private area for medication administration by 9/10/2012."</p> <p>The Residential Manager (RM) was interviewed on 9/26/12 at 6:38 A.M.. When asked about the new location for medication administration the RM stated, "It is more one-on-one, and more private, less distractions."</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 9/26/12 at 2:40 P.M.. When asked about client #1 receiving the wrong medication</p>						

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	<p>the QMRP stated, "Yes, she was given [client #3's] medication. It happened fairly recently. It was serious for her (client #1) to be given someone else's medication." The QMRP indicated client #1 had not received medications according to her physician's orders.</p> <p>9-3-6(a)</p>				