

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G424	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/18/2013
NAME OF PROVIDER OR SUPPLIER REHABILITATION CENTER DEVELOPMENTAL SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 1999 BELL RD CHANDLER, IN 47610		
(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 recertification and state licensure survey.</p> <p>Dates of Survey: July 10, 11, 15, 16 and 18, 2013</p> <p>Provider Number: 15G424 Aims Number: 100239680 Facility Number: 000938</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed July 25, 2013 by Dotty Walton, 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.

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview the facility failed, for 1 of 4 sampled clients (#4), to ensure the qualified intellectual disabilities professional (QIDP) coordinated client #4's treatment program in regards to her use of a wheelchair alarm.</p> <p>Findings include:</p> <p>Observations were done on 7/10/13 from 3:28p.m. to 5:27p.m. and on 7/11/13 from 6:05a.m. to 7:43a.m. at the group home. Throughout the observations, client #4 was in a wheelchair without a chair alarm being used.</p> <p>Record review for client #4 was done on 7/15/13 at 2:18p.m. Client #4's 8/3/12 individual program plan indicated client #4 was to have a wheelchair alarm to alert staff if client #4 attempted to get out of her wheelchair. The program indicated client #4 at times would have an unsteady gait and falls in the past.</p> <p>Professional staff #2 was interviewed on 7/15/13 at 2:36p.m. Staff #2 indicated client #4 was supposed to have a</p>	W000159	<p>An IDT was held on 7-23-2013 in regard to client # 4's wheelchair alarm. The wheelchair alarm was only utilized on a PRN basis when it was first put in place to ensure the client did not get up if her balance was unsteady. However, after obtaining the alarm, the client did not attempt to get up, so the alarm was never utilized. Therefore, the alarm should have been discontinued from her programming at the time the alarm was no longer utilized; however, the paperwork did not get updated. IDT agreed on 7-23-2013, that the alarm is no longer needed for client # 4 and all of the corresponding paperwork has been updated to reflect this change.</p> <p>Systemically and preventatively, all QMRP's have been retrained in regard to ensuring client programming changes are discussed and implemented timely through the IDT process, and also that all paperwork is updated accordingly at the time of the change.</p>	08/17/2013			

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	wheelchair alarm on her wheelchair. Staff #2 indicated client #4 did not currently have a wheelchair alarm. Staff #2 indicated a client in another group home had borrowed client #4's wheelchair alarm around 3 weeks ago. Staff #2 indicated client #4's alarm had not been replaced. 9-3-3(a)			

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W000383	<p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview the facility failed, for 7 of 7 clients residing in the group home (#1, #2, #3, #4, #5, #6, #7), to ensure the keys to the drug storage cabinet were inaccessible to unauthorized people.</p> <p>Findings include:</p> <p>An observation at the group home was done on 7/10/13 from 3:10p.m. to 5:27p.m. At 3:52p.m., the medication room door was open and unattended by facility staff. The medication room was located next to the dining room and accessible to all clients (#1, #2, #3, #4, #5, #6, #7) and staff. There was a key left in the lock of a cabinet door in the medication room, visible from outside the room. At 4:08p.m., staff #4 opened the cabinet with the keys left in the door. The cabinet contained clients #5 and #7's medications.</p> <p>Staff #4 was interviewed on 7/10/13 at 4:08p.m. Staff #4 indicated they do not usually leave the keys in the medication cabinet lock. Interview of professional staff #1 on 7/10/13 at 5:10p.m. indicated the medication keys should not be left in the medication cabinet door when the</p>	W000383	<p>RCDS medication administration policy specifically outlines that staff are to keep the med keys with them at all times or in a safe location. This policy has not been an issue prior to this occurrence. Therefore, all professional staff and Residential Assistants in all of our group homes have been retrained on the policy of ensuring that the med keys are kept with them or in a safe location. This retraining will prevent future occurrence.</p> <p>Preventatively, routine observations will be done at Bell Group Home by the group home manager and/or coordinator at least one time per week for four weeks to ensure that the med key is being placed in a safe location between medication passes. Systemically, the group home managers and coordinators conduct random medication administration observations within the homes. Managers and coordinators will begin monitoring safe placement of the med keys on a routine basis as they are conducting their observations of staff passing client medications.</p>	08/17/2013			

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	medication room was unattended. 9-3-6(a)				