

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G648	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/03/2012
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NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 108 ALTRA DR CLARKSVILLE, IN 47129
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W0000	<p>This visit was for a post certification revisit (PCR) to the fundamental recertification and state licensure survey completed on May 11, 2012.</p> <p>Survey Dates: July 2 and 3, 2012</p> <p>Facility Number: 001160 Provider Number: 15G648 AIM Number: 100240260</p> <p>Surveyor: Dotty Walton, Medical Surveyor III.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/11/12 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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W0149	<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.</p> <p>Based on record review and interview for 1 of 1 reportable incidents (client #2), the facility failed to ensure direct contact staff did not leave client #2 alone in the facility van during a day trip.</p> <p>Findings include:</p> <p>Review of a reportable incident on 7/02/12 at 1:00 PM indicated a report dated 6/19/12 regarding a a day trip to a volunteer site (horse stable) on 6/18/12. The report indicated staff #6 had taken client #2 along with some of her peers to the site and client #2 refused to get out of the facility van. The report indicated staff #6 decided to let client #2 stay in the van to eat her 10:00 AM "snack that is required for her diabetes." The report indicated staff #6 stated she was in "close proximity to the van and she had [client #2] in her sight to monitor for 10 minutes while the other clients volunteered." The report indicated when they returned to the van, staff #6 discovered client #2 had gotten into a peer's lunch and eaten spaghetti. Client #2's blood glucose was checked and it was "295 and it required insulin administration." Review of a 6/26/12 Human Resources note by</p>	W0149	<p>QCS immediately suspended the responsible employee pending the completion of an investigation. The investigation substantiated the claim of neglect on the part of the staff person. The employee was severely reprimanded and offered significant retraining in another more supervised position within the company. The staff person is no longer employed by QCS. These disciplinary and investigatory actions are in compliance with QCS policy and mandated guidelines. The client suffered no ill effects from the incident and the client's medical protocol was followed. All other Day Options employees were retrained as well to prevent any recurrence of this type of incident on July 5, 2012. The Day Options manager will monitor for compliance.</p>	07/20/2012	

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	<p>Human Resources Manager/HRM #7 on 7/2/12 at 7:30 PM indicated the investigation concluded "leaving [client #2] unattended in the van was a very poor decision staff made on her own, by not calling the program manager to ask for assistance."</p> <p>Review of the facility's January 2012 "Abuse/Neglect/Mistreatment Understanding Policy" on 7/02/12 at 3:45 PM indicated the agency prohibited neglect of clients and defined Neglect:</p> <p>"Neglect is an employee NOT doing something required by law, rules, program plan or other policy, which can cause injury or place the client at risk. ...An example would be...leaving a client alone and unattended"</p> <p>Interview with HRM #7 on 7/2/12 at 1:30 PM indicated staff #6 should have called for instructions and should not have left client #2 in the van unattended on a hot day (according to the local radio station it was 90 degrees Fahrenheit the morning of 6/18/12).</p> <p>Interview with Administrator #1 on 7/2/12 at 4:00 PM indicated staff #6 had not followed policy by leaving client #2 unattended in the facility van on 6/18/12.</p>						

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	9-3-2(a)			

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client #1), the facility failed to ensure direct contact staff reported and documented an unusual behavior (stealing food from the trash container) to the supervisory/administrative staff.</p> <p>Findings include:</p> <p>Review of client #1's record on 7/02/12 at 1:35 PM indicated an Individual Habilitation Plan/IHP with accompanying Behavior Support Plan dated January 2012. The record review indicated the client had a behavior plan to address AWOL behavior (leaving the facility without permission). The review indicated a 6/08/12 behavior data sheet for AWOL wherein staff #5 documented client #1 "stole pizza from trash can." The staff had not documented how this happened, if the client had eaten any of the pizza or if the supervisor/administrator had been notified for their input. The record review indicated client #1 had a "safe dining skills" goal to have appropriate amounts of food on utensil, sit utensil</p>	W0189	<p>The group home staff will be retrained in appropriate program implementation and redirection of this client. A new targeted behavior (Noncompliance / grabbing objects) will be added to his BSP. Staff will also be retrained in reporting all unusual or significant behaviors.</p> <p>The home manager will monitor for compliance.</p>	07/20/2012			

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	<p>down after bites and take a drink after bites of food. The IHP indicated client #1 had a plan dated 12/11 for choking risk but there was no plan for taking food from the trash can.</p> <p>Interview with staff #1 on 7/02/12 at 4:00 PM indicated she had to call (on the afternoon of 7/02/12) staff #5 to find out what had transpired with client #1 on 6/08/12. Staff #5 had not notified the administration about this unusual occurrence (this was the first time client #1 had taken food from the trash) either by incident report or phone call. Staff #1's interview with staff #5 indicated client #1 had left the facility, gone outside to the trash can and taken a pizza box out of the trash can which contained some slices of pizza. The interview indicated staff #5 was "right behind" client #1 but was unable to keep him from taking bites of the pizza, which was said to have been in the trash can "a couple of hours." The interview indicated the client was at risk for choking due to eating food in large bites. The interview indicated staff should have documented/reported the whole episode so the administrators could address the behavior.</p> <p>9-3-3(a)</p>						

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W0248	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (client #3), the facility failed to ensure the client's falls risk plan was available to all staff.</p> <p>Findings include:</p> <p>During observations at the facility from 11:30 AM until 2:00 PM on 7/02/12, client #3 walked on the tips of his toes and did not appear to be aware of uneven surfaces.</p> <p>Review (7/02/12 at 1:11 PM) of client #3's record for use in the group home and the day program book indicated client #3 had a history of falling in the community and the facility. He had sustained lacerations, scratches and bruises and was prone to falls when traversing uneven surfaces. The facility book contained a falls risk program dated 01/2012 for client #3.</p> <p>Review of client #3's day program (facility owned/operated) record on 7/02/12 at 1:20 PM indicated no falls risk</p>	W0248	This document was inadvertently removed with end of month paperwork. All risk plans will now be copied onto colored paper to avoid confusion and mistaken filing. The Day Options manager will monitor for compliance.	07/20/2012			

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	<p>plan/methodology.</p> <p>Interview with staff #6 on 7/02/12 at 1:24 PM indicated no falls risk plan for client #3 in the day program book. Interview with staff #1 at 4:00 PM on 7/02/12 indicated client #3's falls risk plan was supposed to be in the day program book, he had been falling at home and day program and he should have a falls program in his book.</p> <p>This deficiency was cited on 5/11/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(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 observation, record review and interview for 1 of 3 sampled clients (client #1), the facility failed to implement client #1's training objectives during formal and informal opportunities.</p> <p>Findings include:</p> <p>During observations at the facility from 11:30 AM until 2:00 PM on 7/02/12, client #1 exhibited the behaviors of invading staff and visitor's personal space and grabbed their arms/hands repeatedly. Staff did not effectively redirect client #1's behaviors. During the noon meal, client #1 took large bites of his sandwich, did not set it down between bites and ate rapidly. Staff did not consistently monitor/redirect his eating.</p> <p>Review of client #1's record on 7/02/12 at 1:35 PM indicated an Individual Habilitation Plan/IHP dated January 2012. The record review indicated the client had a behavior plan to address touching others</p>	W0249	<p>The group home staff will be retrained in appropriate program implementation and redirection of this client. A new targeted behavior (Noncompliance / grabbing objects) will be added to his BSP. Staff will also be retrained in reporting all unusual or significant behaviors.</p> <p>The home manager will monitor for compliance.</p>	07/20/2012			

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	<p>inappropriately and a "safe dining skills" goal to have appropriate amounts of food on utensil, sit utensil down after bites and take a drink after bites of food. The IHP indicated client #1 had a risk plan dated 12/11 for choking risk.</p> <p>Interview with staff #1 on 7/02/12 at 4:00 PM indicated client #1's IHP goals should be reinforced.</p> <p>This deficiency was cited on 5/11/12. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</p>			