

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G101		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/20/2012	
NAME OF PROVIDER OR SUPPLIER CDC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2906 N 400 E MONTICELLO, IN 47960			
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W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of survey: September 17, 18, 19 and 20, 2012.</p> <p>Facility Number: 000639 Provider Number: 15G101 AIMS Number: 100234030</p> <p>Surveyor: Claudia Ramirez, RN/Public Health Nurse Surveyor III/QMRP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed September 26, 2012 by Dotty Walton, 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. Based on record review, and interview the facility neglected to implement the facility's policy and procedure related to abuse and neglect. The facility neglected to protect 2 of 2 sampled clients (clients #1 and #2) and 2 additional clients (clients #3 and #4) for 10 of 22 incidents reviewed, from aggressive behaviors and failed to supervise client #4 and left her in a vehicle for 3 hours in the winter month.</p> <p>Findings include:</p> <p>On 09/17/12 at 1:30 PM the facility's BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed from 10/01/11 through 09/16/12 and indicated the following:</p> <p>11/04/11: "...[client #1] got up fast and went towards [client #3] and pulled her hair...Staff should be aware of [client #1's] actions at all times and continue with BSP (Behavior Support Plan)."</p> <p>11/29/12: "Staff #1 received call from Staff #2 stating that Staff #2 was saying rude remarks towards [client #1] after [client #1] had a bowel movement in her pants..."</p>	W0149	In response to Tag W149 CDC Resources has updated their Abuse and Neglect Policy for the agency and has passed CDC Resources Board of Directors on 06-06-2012. CDC Resources has also updated their training for Abuse and Neglect Curriculum. Group Home staff will be trained on the updated Curriculum on October 16, 2012 during a staff In Service training will be done by the Group Home coordinator and Group home Assistant Coordinator. Also during this training the Clients ISP will be reviewed and re-trained on. All staff was retrained on the Behavior Support Plan of Client #1 on October 2, 2012. CDC Resources has implemented a one to one ratio at the group home during waking hours for client #1 as part of the Behavior Support Plan.	10/05/2012	

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	<p>Follow-up BDDS report dated 12/16/12 indicated, "the allegations are substantiated in this incident. Staff admitted to the allegation during the investigation. Staff was terminated as a result of this incident...".</p> <p>12/06/12: "[Client #1] was heading for the bathroom when [client #4] came through the living room door. [Client #4] pushed [client #1] with her walker...Staff will, as much as possible, keep [client #4] and [client #1] at least arms distance from one another."</p> <p>01/28/12: "[Client #1] was standing in the kitchen at the sink...[Client #4] pushed her walker into [client #1]...staff discussed with [client #4] the inappropriateness of her actions."</p> <p>02/12/12: "...[Client #1] with no precursor or warning grabbed [client #3's] hair...Group home Coordinator implemented 1-1 (1 staff to 1 client ratio) staff for [client #1]...".</p> <p>02/13/12: "...[Client #2] hit [client #1] on the back...to keep [client #2] and [client #1] on opposite sides of the dining room table."</p> <p>02/24/12: "...[Client #1] pulled [client #3's] hair. [Client #3] hit [client #1] for</p>						

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	<p>pulling hair...Staff failed to be proactive in this incident...".</p> <p>03/04/12: "This writer received a call from witness stating that a group home consumer was left in the vehicle for about three hours while staff went shopping. This writer went to grocery store and met with group home staff coming out of the grocery store. Staff had two other consumers helping with groceries. I observed consumer [client #4] in the passenger side of the vehicle. [Staff #13] admitted that [client #4] was left in the vehicle while she and the other two consumers went in to shop for groceries. [Client #4] was seat belted in vehicle seat. I opened the door to speak to [client #4]. [Client #4] stated she was ok and that she did not want to go into the store. I touched [client #4's] faced and hands and they did not seem cold. [Staff #13] stated that she left group home about 10:15 AM. Staff was immediately suspended...".</p> <p>Follow-up BDDS report dated 03/12/12 indicated, "Neglect was substantiated in this incident. [Staff #13] stated that she did leave [client #4] in the car for up to three hours without supervision. [Staff #13] stated that [client #4] was an adult and felt as if [client #4] should have the choice to remain in the car if she wanted to stay there...[Staff #13] was terminated as a result of this incident...".</p>				

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	<p>03/17/12: "...Female peer [client #3] went to pick up ball and [client #4] pushed [client #3] down to the couch...Staff will encourage [client #3] to keep safe distance from [client #4]."</p> <p>07/03/12: "...[client #1] came up to [client #2] and pinched [client #2] on her left arm...[client #1] went into living room and pinched [client #4] on right leg...Staff failed to follow the behavior plan of the consumer in this incident and prevent the incident from occurring and reoccurring...".</p> <p>On 09/19/12 at 1:15 PM, a review of the facility's 06/26/12 Policy on Abuse and Neglect indicated, "All forms of abuse, neglect, exploitation and mistreatment and violation of any rights of an individual are prohibited including...Intentionally touching another person in a rude, insolent or angry manner...verbal abuse, including screaming, swearing, name calling, belittling, or other verbal activity...failure to provide appropriate supervision, care or training...".</p> <p>On 09/19/12 at 1:30 PM an interview with the QDDP-D (Qualified Developmental Disability Professional-Designee) was conducted.</p>			

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	<p>The QDDP-D indicated the agency had many staff issues in the past year which resulted in many new staff. She indicated clients should not be aggressive to each other and needed to be protected. She further indicated staff should not leave clients unattended in a vehicle. She indicated staff neglected to follow the abuse/neglect policy and procedure.</p> <p>9-3-2(a)</p>				

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review, and interview for 8 of 8 BDDS (Bureau of Developmental Disabilities Services) reports regarding client aggression, the facility neglected to initiate and document immediate corrective action to prevent incidents of client abuse to clients #1, #2, #3 and #4 by failing to supervise clients #1, #2, #3 and #4.</p> <p>Findings include:</p> <p>On 09/17/12 at 1:30 PM the facility's BDDS Reports were reviewed from 10/01/11 through 09/16/12 and indicated the following:</p> <p>11/04/11: "...[client #1] got up fast and went towards [client #3] and pulled her hair...Staff should be aware of [client #1's] actions at all times and continue with BSP (Behavior Support Plan)." No record of documented effective corrective action was available for review.</p> <p>12/06/12: "[Client #1] was heading for the bathroom when [client #4] came through the living room door. [Client #4] pushed [client #1] with her walker...Staff will, as much as possible, keep [client #4] and [client #1] at least arms distance from</p>	W0157	In response to Tag 157 All staff was retrained on the Behavior Support Plan of Client #1 on October 2, 2012. CDC Resources has implemented a one to one ratio at the group home during waking hours for client #1 as part of the Behavior Support Plan. CDC Resources has updated their Abuse and Neglect Policy for the agency and has passed CDC Resources Board of Directors on 06-06-2012. CDC Resources has also updated their training for Abuse and Neglect Curriculum. Group Home staff will be trained on the updated Curriculum on October 16, 2012 during a staff In Service training will be done by the Group Home coordinator and Group home Assistant Coordinator. Also during this training the Clients ISP will be reviewed and re-trained on.	10/05/2012			

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	<p>one another." No record of documented effective corrective action was available for review.</p> <p>01/28/12: "[Client #1] was standing in the kitchen at the sink...[Client #4] pushed her walker into [client #1]...staff discussed with [client #4] the inappropriateness of her actions." No record of documented effective corrective action was available for review.</p> <p>02/12/12: "...[Client #1] with no precursor or warning grabbed [client #3's] hair...Group home Coordinator implemented 1-1 (1 staff to 1 client ratio) staff for [client #1]...". No record of documented effective corrective action was available for review.</p> <p>02/13/12: "...[Client #2] hit [client #1] on the back...to keep [client #2] and [client #1] on opposite sides of the dining room table." No record of documented effective corrective action was available for review.</p> <p>02/24/12: "...[Client #1] pulled [client #3's] hair. [Client #3] hit [client #1] for pulling hair...Staff failed to be proactive in this incident...". No record of documented effective corrective action was available for review.</p>			

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	<p>03/17/12: "...Female peer [client #3] went to pick up ball and [client #4] pushed [client #3] down to the couch...Staff will encourage [client #3] to keep safe distance from [client #4]." No record of documented effective corrective action was available for review.</p> <p>07/03/12: "...[client #1] came up to [client #2] and pinched [client #2] on her left arm...[client #1] went into living room and pinched [client #4] on right leg...Staff failed to follow the behavior plan of the consumer in this incident and prevent the incident from occurring and reoccurring...". No record of documented effective corrective action was available for review.</p> <p>On 09/19/12 at 1:30 PM an interview with the QDDP-D (Qualified Developmental Disability Professional-Designee) was conducted. The QDDP-D indicated the agency neglected to document effective corrective action for the BDDS incidents.</p> <p>9-3-2(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, the facility failed for 1 of 2 sampled clients (client #1) to implement client #1's behavior plan as written.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 09/18/12 from 6:45 AM until 8:01 AM.</p> <p>At 6:52 AM client #1 hit staff #1 and was verbally prompted to go to her room. Client #1 refused to go to her room and sat down in a chair by the medication administration area. Staff #1 asked staff #2, "can I do it here?" (time out for client #1) Staff #1 looked at the clock and client #1 hit staff #1. Staff #1 said, "please don't hit." At 6:56 AM, client #1 got up to wash her hands and got a plate for food and sat at the dining room table and knocked loudly on the table with her hands 9 times. Staff #1 stated to client #1, "we don't throw spit" and staff #1 prompted her to go to her room. Client</p>	W0249	In response to Tag 249 Behavior Specialist has been notified of the need to update Client #2's Behavior Support Plan. Behavior Support Plan will be updated by	10/05/2012			

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	<p>#1 refused to get up and then got up and sat in the chair by the medication administration area. Client #1 was verbally prompted 44 times to go to her room from 7:05 AM until 7:25 AM. During the prompting time frame, client #1 slapped at staff and pushed staff in the stomach. Staff #1 stated, "gonna have to do it here, she's not gonna move." Staff #2 stated, "I don't know if it counts or not."</p> <p>At 7:25 AM staff #1 and staff #2 were interviewed. Both staff indicated they were not sure what to do when client #1 would not go to her room.</p> <p>Client #1's records were reviewed on 09/18/12 at 11:00 AM. Client #1's ISP (Individual Support Plan) dated 06/19/12 contained a Behavior Support Plan (BSP) dated 12/20/11. The BSP indicated client #1's behavior included, "physical aggression: i.e. pinching, hitting, slapping, or other physical contact directed towards another person with the intent of causing harm." The BSP indicated when client #1 displayed the behaviors staff should intervene the following way: "If [client #1] is physically aggressive toward another peer or adult she will immediately be asked to remove her self to a quiet area. The quiet area is area (sic) away from peers that will</p>						

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	<p>allow [client #1] the time to gain her composure. The quiet area in the home could be [client #1's] room, or any other area that is away from her roommates...Once in the quiet area staff will use peripheral vision to maintain visual contact with [client #1]...The staff must present themselves as the gentle brick wall (staff will stand with hands crossed in front of body with head down). If [client #1] attempts to leave the quiet area, staff will use their body to not allow [client #1] to leave the area...Staff must not react to any behavior that [client #3] may show! While [client #1] is in the quiet area, staff will remain quiet. Maintaining the peripheral vision/gentle brick wall pose. No Talking! [Client #1] will remain in the quiet area until she is quiet and sitting in the chair. The criteria for [client #1] being able to start the count is, sitting and quiet. Staff may say "Sit" or "Quiet." When using those words staff will speak lower and softer. Staff will/may also use hand signals to prompt [client #1]. Sit is point to the chair. Quiet is bringing an open thumb and fingers together quickly. When [client #1] is quiet and sitting in the chair, staff will use a time piece to measure 2 minutes. If [client #1] yells, pounds, or stands up during the 2 minutes then the 2 minutes will start over. Staff may need to repeat above steps many, many times.</p>			

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	<p>Once [client #1] is sitting and quiet for 2 minutes she will then be able to leave the quiet area. Once out of the quiet area [client #1] may return to the previous activity or staff can give [client #1] choices to what she may do..."</p> <p>An interview was conducted on 09/18/12 at 7:55 AM with the Group Home Supervisor (GHS). She indicated staff #1 and #2 did not follow the BSP as written and failed to implement it correctly with client #1.</p> <p>On 09/19/12 at 1:30 PM an interview with the QDDP-D (Qualified Developmental Disability Professional-Designee) was conducted. The QDDP-D indicated staff should follow the BSP as written.</p> <p>9-3-4(a)</p>				

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W0460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review and interview, the facility failed for 1 of 2 sample clients (client #2) who was on a modified diet to follow diet orders.</p> <p>Findings include:</p> <p>On 09/17/12 from 4:15 PM until 6:15 PM observations at the group home were completed. At 4:50 PM staff #3 cut up fresh onions, green peppers and celery and added it to a bowl containing beans for the four bean salad. At 5:55 PM client #2's served food from the serving bowls onto her plate. One of the dishes served was a four bean salad which contained raw onions, green peppers and celery. Client #2 ate the serving of the four bean salad with the raw vegetables. Staff #3 asked client #2 if she liked the bean salad and she replied, "sure was good."</p> <p>On 09/18/12 from 6:45 AM until 8:01 AM observations at the group home were completed. At 7:07 AM client #2 poured herself cereal and stated, "I like Cheerios." She poured milk on the cereal and consumed the contents.</p>	W0460	In response to Tag 460 All staff was retrained on the Dining Risk Plan for Client 2on October 2, 2012.	10/05/2012			

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	<p>Client #2's records were reviewed on 09/18/12 at 11:52 AM. Client #2's record contained a dietary Quarterly Nutritional Review dated 04/27/12. The review indicated client #2 was on a mechanical soft diet. Client #2's 05/16/12 Risk Plan for Choking indicated, "The following foods should be avoided while on either a soft or mechanical soft diet...cereal...raw or hard vegetables...".</p> <p>On 09/19/12 at 1:30 PM an interview with the QDDP-D (Qualified Developmental Disability Professional-Designee) was conducted. The QDDP-D indicated client #2 should not have eaten the cereal or eaten raw vegetables and other alternatives should have been offered.</p> <p>9-3-8(a)</p>				