

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/26/2012
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NAME OF PROVIDER OR SUPPLIER  QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: March 12, 13, 14, 16 and 26, 2012</p> <p>Facility Number: 000939 Provider Number: 15425 AIM Number: 100368660</p> <p>Surveyor: Jo Anna Scott, Medical Surveyor III.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on March 30, 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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W0137	<p>483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing.</p> <p>Based on observation and interview for 1 of 7 clients living in the home (client #6), the facility failed to ensure client #6 had access to his eyeglasses when he wasn't wearing them.</p> <p>Findings include:</p> <p>During the observation period on 3/13/12 from 7:00 AM to 8:50 AM, client #6 was asked if he wanted his eyeglasses. Staff unlocked the cabinet door in the medication room and offered the glasses to client #6. Client #6 put the glasses on for a few minutes and then gave them back to staff #4. Staff #4 locked the glasses back in the cabinet.</p> <p>Interview with client #6 on 3/13/12 at 7:50 AM indicated the eyeglasses were new and they kept the glasses in the medication room to keep them safe.</p> <p>Interview with staff #2, Administrator, on 3/3/12 at 11:30 AM indicated the glasses were kept locked in the cabinet to ensure they didn't get lost or broken.</p> <p>9-3-2(a)</p>	W0137	<p>All clients will be asked not to keep any items in the med room/locked areas without a signed "rights restriction" if he or she still desires to keep the item in that location. A personal lock box will be offered as an alternative as applicable. The Home Manager will implement.</p> <p>To prevent further occurrence the IDT will monitor monthly.</p>	04/25/2012			

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W0237	<p>483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives.</p> <p>Based on record review and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4), the facility failed to ensure their training goals for Purchasing were documented.</p> <p>Findings include:</p> <p>The record review for client #1 was conducted on 3/13/12 at 1:00 PM. The Individual Habilitation Plan dated 11/15/11 indicated client #1 had a formal training objective of purchasing. Review of the data tracking sheets indicated there was no data collection in February and March, 2012</p> <p>The record review for client #2 was conducted on 3/13/12 at 3:59 PM. The Individual Habilitation Plan dated 2/1/12 indicated client #2 had a formal training objective of purchasing. Review of the data tracking sheets indicated there was no data collected in February and March, 2012.</p> <p>The record review for client #3 was</p>	W0237	<p>The purchasing goal was being implemented in the Day Program frequently. The in home program goals will be revised to address money skills applicable to in home training as well as community purchasing goals so as to promote more frequent data collected in the home setting.</p> <p>To prevent further occurrence the program coordinator and home manager will monitor this monthly.</p> <p>Monitored by IDT</p>	04/25/2012	

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	<p>conducted on 3/13/12 at 12:00 PM. The Individual Habilitation Plan dated 9/4/11 indicated client #3 had a formal training objective of purchasing. Review of data tracking sheets indicated there was no data collected in February and March, 2012.</p> <p>The record review for client #4 was conducted on 3/13/12 at 2:40 PM. The Individual Habilitation Plan dated 5/1/11 indicated client #4 had a formal training objective of purchasing. Review of data tracking sheets indicated there was no data collected in February and March, 2012.</p> <p>Interview with staff #4, Administrator, on 3/16/12 at 2:00 PM indicated the data was not collected in the home because the clients made purchases at the day program. Interview with staff #2, Administrator, on 3/16/12 indicated the clients did go shopping while in the home and would have an opportunity to have data collected while in the home in the evenings and on weekends.</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.</p> <p>Based on observation of 2 of 18 doses of medication administered and record review for 2 of 4 sampled clients (clients #2 and #4), the facility failed to ensure the medications were administered according to the physician's orders.</p> <p>Findings include:</p> <p>During the morning observation period on 3/13/12 from 7:00 AM to 8:55 AM, the medication administration was started at 7:30 AM. Client #2 came to the medication room at 7:30 AM and took the Veramyst nasal spray for congestion and sprayed 1 spray in each nostril. Staff #5 continued with giving the rest of client #2 his medication.</p> <p>Client #4 received her medication at 7:50 AM. Panoxyl for acne was applied to client #4's face.</p> <p>Review of the Physician's Orders dated 3/1/12 through 3/31/12 was conducted on 3/13/12 at 8:55 AM. The Physician's Order indicated client #2 was to receive two sprays in each nostril of the Veramyst and client #4 was to apply the Panoxyl in the shower.</p>	W0368	<p>All staff in the home have been retrained on medication administration as it relates to client self administration and topical application.</p> <p>To prevent further occurrence the home manger will conduct routine med observations with directed care staff and have quarterly trainings.</p> <p>The nurse and home manager will implement and monitor monthly.</p>	04/25/2012			

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	<p>Interview with Staff #2, Administrator, on 3/13/12 at 4:00 PM indicated the nursing staff reviewed the physician's orders and the medication should have been administered as stated on the physician's orders.</p> <p>9-3-6(a)</p>			