

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G148	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/20/2012
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NAME OF PROVIDER OR SUPPLIER CDC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK 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 18, 19 and 20, 2012.</p> <p>Facility Number: 000684 Provider Number: 15G148 AIMS Number: 100243120</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 9/27/12 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 for 21 of 23 BDDS (Bureau of Developmental Disabilities Services) reports regarding client protection, the facility neglected to implement the facility's policy and procedure and neglected to prevent client to client aggression for 3 of 3 sampled clients (clients #1, #2 and #3) and 3 additional clients (clients #4, #5 and #6), neglected to report alleged incidents of abuse immediately (client #5), neglected to provide appropriate supervision to the clients (clients #1, #2, #3, #4, #5, and #6) and neglected to prevent client exploitation/mistreatment (clients #4 and #5).</p> <p>Findings include:</p> <p>On 09/18/12 at 12:30 PM the facility's BDDS Reports were reviewed from 10/05/11 through 09/17/12 and indicated the following:</p> <p>11/21/11: "QDDP (Qualified Developmental Disability Professional) was conducting staff meeting on 11/21/11. Staff was being retrained on reporting all abuse and neglect situations</p>	W0149	In Response to Tag 149 CDC Resources has updated their Abuse and Neglect Policy for he 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. Group Home Coordinator has implemented an Abuse and Neglect form so that staff can report any incident with reprisal from co-workers. Forms are given to staff at any staff meeting and are available at anytime to fill out. Forms are reviewed by Coordinator at time of receiving. Client #3 has been moved to another bedroom to ensure the safety of the clients. Group Home Supervisors and Assistants have implemented doing a midnight Quality Inspections monthly; along with the midnight shift calling other group home staff working at another group home every two hours to check on staff to ensure that no staff is sleeping	10/05/2012			

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	<p>immediately. [Staff #10] stated that she was aware of an incident that should have been reported immediately. [Staff #10] spoke with the group home supervisor in private. [Staff #10] stated that when [client #5] arrived to the group home from a visit with his mother [name], [client #5] stated that his mother had slapped him across the face and stated that his mother told him to 'get the f--- out of her house.' [Client #5] did not have any visible marks at the time of his report to staff. QDDP spoke with [client #5] on 11/22/11. [Client #5] stated that he had a good visit with his mother...".</p> <p>12/31/11: "...staff walked into the room and saw [client #3] swing his fist and hit [client #2] on the left side of the head causing [client #2's] glasses to be knocked off his face... Staff failed to follow [client #3's] BSP (Behavior Support Plan) as written in this incident."</p> <p>01/21/12: "Neglect was substantiated in this incident...The relief staff states that when she arrived [staff #15] was asleep in the chair...[staff #15] stated she had not realized that she had fallen asleep. The consumers are to be staffed 24-7 (24 hours a day/7 days a week...".</p> <p>01/31/12: "...[client #1] was nagging [client #2] about pop money. [Client #2]</p>		<p>on duty. All staff will be retrained on all the Behavior Support Plans for the home on October 16, 2012. Client #2's Behavior Support Plan has been updated and will be trained on October 16, 2012 also. Day Service staff will be retrained on ISP training on October 16, 2012; to ensure all know what an ISP is for and how to keep clients safe. Day Service has revised the classroom to put a divider in the room to keep clients safe. A divider screen has been placed in the break room to keep the clients apart to ensure safety of all. Group home staff have implemented a daily counting of all PRN's. Counts are done at the beginning of the shift. Staff was retrained on Abuse and Neglect to address the incident of kissing Client #2's forehead.</p>		

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	<p>yelled 'no' and [client #2] hit [client #1] with an open hand on [client #1's] forearm...[Client #2] just started to receive behavioral services...".</p> <p>03/22/12: "...While [client #3] turned and walked away [client #1] hit [client #3] on the back twice...it was also noted that on 03/21/12 [client #1] was not administered his Alprazolam 0.5 mg 1 tab[let] QID (four times daily) 9pm medication (for anxiety)...[Client #1] has a behavior plan that addresses physical aggression that staff did not follow properly...".</p> <p>04/02/12: "Office staff saw that [client #5] was walking in the hallway without staff supervision...Investigation concluded that there was mis-communication from day service coordinator and day service staff...".</p> <p>04/03/12: "...[client #3] walked over to [day service client #1] and punched her in the arm...Day service staff will assess the classroom and meet to discuss changes that could be implemented...".</p> <p>05/01/12: "...[client #3] reached across the staff and hit [day service client #1] on the back of the head...On this day staff attempted to co-mingle the group...Day service coordinator stated a plan would be developed to ensure that the two</p>						

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	<p>consumers remained in different area (sic) when attending class...".</p> <p>05/07/12: "...[client #5] went to give [client #2] a handshake. [Client #2] reacted by scratching [client #5's] arm...Staff ensure that the consumers remain at least an arms length away from each other...".</p> <p>05/15/12: "...[Client #1] told [client #2] to put his glasses back on. [Client #2] got mad and reached over and grabbed [client #1's] hand and scratched [client #1's] hand...Staff will continue to follow and monitor [client #2's] BSP."</p> <p>05/24/12: "...Group home assistant checked the PRN's (medications as needed) for expiration dates and noticed that [client #4] was missing one box of Sudafed (Pseudoephedrine for sinus/allergies; may be used to make illegal drugs). The last count of the PRN's was 04/17/12. The box contained contained (sic) 24 tablets of 30 mg (milligram). No staff was suspended, this is a result of a prior staff that was terminated after failing a drug test (drug test was random and administered on 04/23/12)...The staff in question was [staff #13]...all staff working in that group home is (sic) scheduled to take a random drug test tomorrow 05/24/12...The police</p>						

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	<p>were notified...The police stated that the staff [staff #13] was well known to them."</p> <p>05/24/12: "...Group home assistant checked the PRN's for expiration dates and noticed that [client #5] was missing three boxes of Sudafed. The last count of the PRN's was 04/17/12. Two of the boxes contained 24 tabs of 30 mg in each. The other box had about 12 tablets. No staff was suspended, this is a result of a prior staff that was terminated after failing a drug test (drug test was random and administered on 04/23/12)...The staff in question was [staff #13]...all staff working in that group home is (sic) scheduled to take a random drug test tomorrow 05/24/12...The police were notified...The police stated that the staff [staff #13] was well known to them."</p> <p>06/07/12: "...[client #3] swung his lunch box hitting [client #2] in his face with the lunch box...[client #3] should board the van last after the other consumers have taken their seats. Staff will continue to follow BSP...".</p> <p>06/11/12: "...[Staff #9] stated she knocked on the front door of the group home (where clients #1, #2, #3, #4, #5 and #6 lived) three times and no-one answered. [Staff #9] stated that she walked down the sidewalk to the living</p>						

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	<p>room window because it was opened. [Staff #9] wrote that she saw [staff #8] sitting in a chair in the living room sleeping...[Staff #9] stated that she called to [staff #8] but he did not wake up, so she called the house phone, which did wake him...The investigation concluded that the incident was substantiated as the staff admitted to falling asleep...".</p> <p>06/15/12: "...[client #3] was sitting on the bus. [Client #2] boarded the bus and slapped [client #3] on the forearm...Staff will continue to follow [client #2's] and [client #3's] BSP...".</p> <p>06/18/12: "...[client #2] started yelling and hit [client #1] on his right arm and side of his body. [Client #1] hit [client #2] on his left arm...It is recommended that consumers [client #2] and [client #1] be kept out of (sic) arms length from each other as much as possible."</p> <p>07/03/12: "Staff 1 was in the bathroom assisting [client #5] with changing his colostomy bag. Accused staff [staff #14] come into observes (sic) at this time. [Staff #14] started kissing [client #5] on his neck and face and rubbing his face. Staff #1 redirected the staff (staff #14) and stated that the actions were inappropriate and as staff, they are not to do this. [Client #5] went to his room, and</p>						

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	<p>staff [staff #14] went into his room and started rubbing [client #5's] feet. Staff was suspended pending an investigation...".</p> <p>07/18/12: A BDDS follow-up report indicated, "The reporting staff told different stories...It is believed the two staff involved has a personal conflict with each other...In this incident, both staff admitted that the practice of the consumer was to have staff kiss him on the forehead and/or to the head as a comfort for the consumer to sleep...staff no longer works for the agency...".</p> <p>07/15/12: "...[client #2] hit [client #3] on his right arm...staff will continue to follow both [client #2's] and [client #3's] BSPs."</p> <p>07/21/12: "...[Client #2] started yelling... [client #2] got up beside [client #5] and hit him in the stomach. [Client #5] reacted by throwing his plate...[Client #2] has had an increase of aggression...".</p> <p>08/28/12: "...[client #3] started moving his arms and [client #5] reacted by hitting [client #3] in the face. [Client #3] retaliated instantly by hitting [client #5's] back...[Client #3] is being served one to one during waking house at the group home due to increase aggression issues."</p>						

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	<p>09/12/12: "...Staff heard [client #1] (roommate of [client #5]) state 'ouch.' [Client #1] stated that [client #5] hit him hit (sic) fist on the forehead...[Client #5] continues to have behavior challenges and continues to live in an imaginary world...".</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...Exploitation/Mistreatment: Exploitation involves taking unethical advantage of someone for one's own benefit...Mistreatment consists of any deliberate misplacement, exploitation or wrongful temporary or permanent use of an individual's belongings or money, personal identity or personal services...".</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 had</p>						

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	<p>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 be stealing client medications, or asleep on duty and clients should feel safe in their homes. She indicated staff neglected to follow the abuse/neglect policy and procedure.</p> <p>9-3-2(a)</p>			

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 23 BDDS (Bureau of Developmental Disabilities Services) reports reviewed regarding alleged client abuse (client #5), the facility neglected to report the alleged client abuse immediately to the Administrator.</p> <p>Findings include:</p> <p>On 09/18/12 at 12:30 PM the facility's BDDS Reports were reviewed from 10/05/11 through 09/17/12 and indicated the following dated report:</p> <p>11/21/11: "QDDP (Qualified Developmental Disability Professional) was conducting staff meeting on 11/21/11. Staff was being retrained on reporting all abuse and neglect situations immediately. [Staff #10] stated that she was aware of an incident that should have been reported immediately. [Staff #10] spoke with the group home supervisor in private. [Staff #10] stated that when [client #5] arrived to the group home from a visit with his mother [name],</p>	W0153	In response to Tag 153 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. Group Home Coordinator has implemented an Abuse and Neglect form so that staff can report any incident with reprisal from co-workers. Forms are given to staff at any staff meeting and are available at anytime to fill out. Forms are reviewed by Coordinator at time of receiving. All staff will be retrained on all the Behavior Support Plans for the home on October 16, 2012. Client #2's Behavior Support Plan has been updated and will be trained on October 16, 2012 also.	10/05/2012	

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	<p>[client #5] stated that his mother had slapped him across the face and stated that his mother told him to 'get the f--- out of her house.' [Client #5] did not have any visible marks at the time of his report to staff. QDDP spoke with [client #5] on 11/22/11. [Client #5] stated that he had a good visit with his mother...".</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 did not follow the policy/procedure and failed to report the 11/21/11 incident immediately to the Administrator.</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 14 of 23 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 to client abuse, failing to supervise clients #1, #2, #3 and #5 and to prevent physical aggression to consumers/clients at the agency's workshop.</p> <p>Findings include:</p> <p>On 09/18/12 at 12:30 PM the facility's BDDS Reports were reviewed from 10/05/11 through 09/17/12 and indicated the following:</p> <p>12/31/11: "...staff walked into the room and saw [client #3] swing his fist and hit [client #2] on the left side of the head causing [client #2's] glasses to be knocked off his face... Staff failed to follow [client #3's] BSP (Behavior Support Plan) as written in this incident." No record of documented effective corrective action was available for review.</p> <p>01/31/12: "...[client #1] was nagging [client #2] about pop money. [Client #2]</p>	W0157	<p>In response to Tag 157 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. Group Home Coordinator has implemented an Abuse and Neglect form so that staff can report any incident with reprisal from co-workers. Forms are given to staff at any staff meeting and are available at anytime to fill out. Forms are reviewed by Coordinator at time of receiving. All staff will be retrained on all the Behavior Support Plans for the home on October 16, 2012. Client #2's Behavior Support Plan has been updated and will be trained on October 16, 2012 also.</p>	10/05/2012			

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	<p>yelled 'no' and [client #2] hit [client #1] with an open hand on [client #1's] forearm...[Client #2] just started to receive behavioral services...". No record of documented effective corrective action was available for review.</p> <p>03/22/12: "...While [client #3] turned and walked away [client #1] hit [client #3] on the back twice...it was also noted that on 03/21/12 [client #1] was not administered his Alprazolam 0.5 mg 1 tab[let] QID (four times daily) 9pm medication (for anxiety)...[Client #1] has a behavior plan that addresses physical aggression that staff did not follow properly...". No record of documented effective corrective action was available for review.</p> <p>04/03/12: "...[client #3] walked over to [day service client #1] and punched her in the arm...Day service staff will assess the classroom and meet to discuss changes that could be implemented...". No record of documented effective corrective action was available for review.</p> <p>05/01/12: "...[client #3] reached across the staff and hit [day service client #1] on the back of the head...On this day staff attempted to co-mingle the group...Day service coordinator stated a plan would be developed to ensure that the two consumers remained in different area (sic)</p>						

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	<p>when attending class...". No record of documented effective corrective action was available for review.</p> <p>05/07/12: "...[client #5] went to give [client #2] a handshake. [Client #2] reacted by scratching [client #5's] arm...Staff ensure that the consumers remain at least an arms length away from each other...". No record of documented effective corrective action was available for review.</p> <p>05/15/12: "...[Client #1] told [client #2] to put his glasses back on. [Client #2] got mad and reached over and grabbed [client #1's] hand and scratched [client #1's] hand...Staff will continue to follow and monitor [client #2's] BSP." No record of documented effective corrective action was available for review.</p> <p>06/07/12: "...[client #3] swung his lunch box hitting [client #2] in his face with the lunch box...[client #3] should board the van last after the other consumers have taken their seats. Staff will continue to follow BSP...". No record of documented effective corrective action was available for review.</p> <p>06/15/12: "...[client #3] was sitting on the bus. [Client #2] boarded the bus and slapped [client #3] on the forearm...Staff</p>						

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	<p>will continue to follow [client #2's] and [client #3's] BSP...". No record of documented effective corrective action was available for review.</p> <p>06/18/12: "...[client #2] started yelling and hit [client #1] on his right arm and side of his body. [Client #1] hit [client #2] on his left arm...It is recommended that consumers [client #2] and [client #1] be kept out of (sic) arms length from each other as much as possible." No record of documented effective corrective action was available for review.</p> <p>07/15/12: "...[client #2] hit [client #3] on his right arm...staff will continue to follow both [client #2's] and [client #3's] BSP's." No record of documented effective corrective action was available for review.</p> <p>07/21/12: "...[Client #2] started yelling... [client #2] got up beside [client #5] and hit him in the stomach. [Client #5] reacted by throwing his plate...[Client #2] has had an increase of aggression...". No record of documented effective corrective action was available for review.</p> <p>08/28/12: "...[client #3] started moving his arms and [client #5] reacted by hitting [client #3] in the face. [Client #3] retaliated instantly by hitting [client #5's]</p>						

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	<p>back...[Client #3] is being served one to one during waking house at the group home due to increase aggression issues." No record of documented effective corrective action was available for review.</p> <p>09/12/12: "...Staff heard [client #1] (roommate of [client #5]) state 'ouch.' [Client #1] stated that [client #5] hit him hit (sic) fist on the forehead...[Client #5] continues to have behavior challenges and continues to live in an imaginary world...". 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 implement and document effective corrective action for the BDDS incidents.</p> <p>9-3-2(a)</p>				

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W0248	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN</p> <p>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 record review and interview, the facility failed for 2 of 3 sampled clients (clients #1 and #3) by not ensuring their current ISPs (Individual Support Plan) and (BSPs) Behavior Support Plans were at the group home for staff to review.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. A record review on 09/19/12 at 7:10 AM, of client #1's records at the group home was conducted. The records contained client #1's BSP dated 11/05/10. There was not an ISP for client #1 in the home. Client #1's records were reviewed on 09/19/12 at 10:00 AM. Client #1's record indicated the current ISP was dated 07/25/12. The record also indicated the current BSP was dated 08/09/11. 2. A record review on 09/19/12 at 7:10 AM, of client #3's records at the group home was conducted. The records contained client #3's BSP dated 08/11/11. There was not an ISP for client #3 in the home. 	W0248	In response to Tag 248 Group Home Assistant Coordinator has implemented a monthly check of the group home books to ensure that the books are up to date with the current ISP, Behavior Support Plans, and any risk plan of the clients.	10/05/2012			

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	<p>Client #3's records were reviewed on 09/19/12 at 11:05 AM. Client #3's record indicated the current ISP as dated 06/12/12. The record also indicated the current BSP was dated 05/07/12.</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 whatever records were in the clients' binders was the only information the staff had.</p> <p>9-3-4(a)</p>			

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W0368	<p>483.460(k)(1) DRUG ADMINISTRATION 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 for 3 of 3 sampled clients (clients #1, #2 and #3) and 3 additional clients (clients #4, #5 and #6) who take medications prescribed by the physician, to administer medications as ordered.</p> <p>Findings include:</p> <p>On 09/18/12 at 12:30 PM the facility's BDDS Reports were reviewed from 10/05/11 through 09/17/12 and indicated the following medication errors:</p> <p>11/13/11: "Group home staff [staff #5] gave [client #6] an extra dose of medication. Extra medication given was Ferrous (iron) and Fish oil (supplement)...".</p> <p>11/20/11: "Staff [staff #5] did not administer [client #3] his 6:00 am medication Levothyroxine (for thyroid) 1 tab[let] 75mcg (microgram) QD (daily)...".</p> <p>11/27/11: "Group home staff working this morning found [client #5's] 9pm medication Desmopressin (hormone/reduces urine production) 1mg</p>	W0368	In response to Tag 368 Group Home Assistant coordinator has revised the med pass area at the group home to ensure that the clients have privacy during med passes. Group Home Coordinator has implemented a supervised med pass of staff monthly. Group Home Coordinator, Assistant Coordinator, Group Home Supervisors and Group Home Assistants will do random supervised med passes each month by randomly picking a time and staff to supervise during a med pass. A Random supervised med pass has been implemented to be done at each staff meeting also.	10/05/2012			

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	<p>(milligram) tab given at bedtime on the floor...".</p> <p>03/04/12: "[Client #3] was not administered Hydrocodon[e] (for pain) 1 tab 7.5/500 (milligrams) by mouth TID (three times daily) at 2:00pm dose time...".</p> <p>03/13/12: "Group home staff arrived to workshop to transport [client #1] to a dentist appointment. At the dentist appointment, staff realized that they had forgotten to take [client #1's] Alprazolam (for anxiety) .5 mg for administration at 11:00 am. [Client #1] did not receive his 11:00 am dose...".</p> <p>03/16/12: "Staff [#9] did not administer medication Ferrous Sulf[ate] (iron) 1 tab 325 mg BID (twice daily) to [client #6]. Staff over looked medication card...".</p> <p>03/21/12: "Staff forgot to give [client #1] his 9:00 pm dose of Alprazolam 0.5 mg tab that is prescribed QID (four times daily)...".</p> <p>03/24/12: "[Client #3] is prescribed 1 tab of Oyster shell/D Tab 500 mg BID (supplement) (7am, 9pm). Staff administered 1 tab of Oyster shell/D Tab 500 mg to [client #3] at 9am which resulted in [client #5] receiving the</p>			

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	<p>medication TID (three times a day)...".</p> <p>03/26/12: "[Client #1] is prescribed xanax (for anxiety) give 1 tab orally 4 times daily 6 am, 11 am, 4 pm and 9 pm. Staff did not administer the 9 pm dose...".</p> <p>03/26/12: "[Client #3] is prescribed Hydroco/APAP tab 7.5 (milligrams) for lortab (for pain). Give 1 tab PO (by mouth) BID at 7am, 2pm, 9pm. Staff working administered the medication at 7pm and a peer re-administered at 9pm... [Client #3] received 1 extra dose of the medication...".</p> <p>04/04/12: "On 04/05/12, staff went to administered (sic) [client #6's] Pot-Cl-microtab 20 mg (Potassium Chloride/electrolyte) at 7pm and noticed that on 04/04/12 staff had not administered her 7 pm dose...".</p> <p>04/05/12: "Staff went to administer [client #3's] 2 pm medication at day service on 04/05/12. Staff noticed that the medication was listed on the MAR (Medication Administration Record) incorrectly as a PRN (as needed) and not as a routine medication. [Client #3] is prescribed hydroco/APAP 7.5-500 (milligrams) for Lortab give 1 tab by mouth TID; it was incorrectly listed in the day service MAR as Lortab give 1 tab by</p>						

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	<p>mouth as needed for pain. Staff noticed that [client #3] had not received his Lortab give 1 tab by mouth at 2pm on 04/02/12, 04/03/12 and 04/04/12..."</p> <p>04/13/12: "Staff rechecking medications found that [client #4] at 7 am on 04/13/12 received her Simvastin (sic) 20 mg (for cholesterol) one tab by PO (by mouth) every evening..."</p> <p>05/17/12: "Group home staff [staff #20] did not administer to [client #2] his 7:00 am medications consisting of: Centrum 1 tab QD (vitamin), Dilantin 5-half tab 50 mg each (total 125 mg) QAM (every AM) (for seizures), Sertraline 1 tab 50 mg QD (behaviors), Calcium/D 600-400 1 tab BID (bones). Double checking staff [staff #5] did not notice that the medications were not administered..."</p> <p>06/16/12: "Group home staff [staff #3] administered [client #6's] was (sic) another consumers medication. Medicine administered was Oyster Shell 500, Certa-vite senior tab (vitamin), Baclofen 10 mg (muscle relaxant), Hydrocodone 7.5/500..."</p> <p>07/27/12: "Group home staff [staff #11] did not administer to [client #3] his 2:00 pm medication of Hydrocodone 7.5-500 1 tab TID. Staff making the error noticed</p>						

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	<p>the error at the next medication time of 9:00 pm...".</p> <p>08/19/12: "[Client #3] missed one dose of Lamitrine 25 mg 1 tab PO QD (seizures). Staff failed to follow medication administration...".</p> <p>08/19/12: "[Client #2] missed one dose of Seroquel 25 mg 1 tab at bedtime (bipolar). Staff failed to follow medication administration...".</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 medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders. She further indicated many of the staff in the home had been recently terminated or had resigned. She indicated staff had been retrained each time an error occurred.</p> <p>9-3-6(a)</p>				

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W9999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>460 IAC 9-3-2 Resident Protections</p> <p>(c) The residential provider shall demonstrate that its employee practices assure that no staff person would be employed where there is:</p> <p>(1) evidence of abuse or fraud in any setting;</p> <p>(3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles (BMV) record a criminal history check as authorized in IC 5-2-5-5, and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>This State Rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed for 1 of 1 newly hired employees with a felony drug conviction,</p>	W9999	In response to Tag 9999 CDC Resources Human Resource Team have implemented a double check system in which two team members will double check all background checks prior to informing the Coordinator that the potential employee is alright to hire.	10/05/2012	

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	<p>to not hire the employee.</p> <p>Findings include:</p> <p>Staff #13's employee records were reviewed on 09/19/12 at 9:50 AM. A review of the records indicated staff #13 was hired on 01/12/12. Staff #13's BMV record indicated she had a felony B conviction for "poss[ession] of contr[olled] sub[stance]" with the offense date of 04/02/02. Staff #13 indicated on her application for employment she had never pleaded "guilty" or "no contest" to or been convicted of a crime.</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 #13 should "never" have been hired with a felony conviction and this was the same person who allegedly had taken the Sudafed (allergy medication) from two of the clients' medications.</p> <p>9-3-2(c)(3)</p>				

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