

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G308	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 05/02/2012
NAME OF PROVIDER OR SUPPLIER CDC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 204 RILEY RD DELPHI, IN 46923		
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W0000	<p>This visit was for the investigation of complaint #IN00106887.</p> <p>COMPLAINT #IN00106887 SUBSTANTIATED, Federal and state deficiencies related to the allegations are cited at W122, W149, and W154.</p> <p>Dates of Survey: April 30, May 1, and 2, 2012</p> <p>Facility number: 000827 Provider number: 15G308 AIM number: 100235060</p> <p>Surveyor: Tracy Brumbaugh, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on May 7, 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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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, record review and interview, the Condition of Participation: Client Protections, was not met as the facility neglected to implement their abuse/neglect policy/procedure resulting in systemic abuse/neglect and neglected to ensure allegations were thoroughly investigated for 1 of 4 clients (client F) who lived in the home.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Please refer to W149. The facility failed to ensure staff did not use the table in garage as a place for client F to eat his supper when he refused to eat and to ensure staff did not take client F's wallet to encourage him to eat and failed to implement the facility's abuse/neglect policy which indicated abuse, neglect or mistreatment was prohibited. 2. Please refer to W154. The facility failed to thoroughly investigate an allegation of abuse/neglect for 1 of 4 clients (client F) who lived in the home. <p>This federal tag relates to complaint #IN00106887.</p>	W0122	In response to tag W122 as of 5-2-2012 the card table and chairs have been removed from the garage. Group Home supervisor or designee will complete QI during meal times implemented on 5-2-2012 and will continue to do the QI checks. Investigation training has been reviewed and staff to be retrained on this on 5-29-2012.	05/24/2012	

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	9-3-2(a)				

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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 observation, record review and interview, the facility failed to implement its Abuse/Neglect policy to ensure 1 of 4 clients (client F) who lived in the home, was not made to eat his supper in the garage or have his wallet taken away due to not wanting to eat his supper.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 5-1-12 at 10:30 a.m. A review of incident reports from 4-1-12 until 5-1-12 indicated a Bureau of Developmental Services reports (BDDS) report dated 4-10-12 for client F indicated his wallet had been taken away and he was made to sit in the garage if he did not eat.</p> <p>On 4-30-12 from 3:30 p.m. until 7:00 p.m. an observation at the home of clients A, B, C, and F was conducted. At 3:45 p.m. a table and four chairs was in the garage of clients A, B, C, and F. At 5:30 p.m. an interview with client F indicated he had sat in the garage when he was bad and wouldn't eat. At 6:05 p.m. an interview with client A indicated client F did have to go to the garage when he wouldn't eat. Client A pointed to the</p>	W0149	To ensure internal incident reports are being reviewed and seen all internal incident reports go thru a signature cycle and then are locked in a cabinet with limited staff access. The key to the cabinet is kept by the Health and Safety Specialist and the Adult Services Manager, staff needing access to an incident need to contact either H&S or the Adult Services Manger to access the report.	05/24/2012			

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	<p>garage and indicated client F went out there but she didn't have to because she was good. At 6:15 p.m. client F pointed to the garage and indicated if he was bad he ate out there. Client F also indicated his wallet had been taken away but he had it back now. At 6:30 p.m. client B indicated client F had cried and used foul language when his wallet had been taken away because he wouldn't eat. At 6:35 p.m. client C indicated client F had sat in the garage to eat. Client C pointed to the garage then pointed at client F and stated his name. At 6:50 p.m. client B indicated client F had been to the garage because he wouldn't eat.</p> <p>On 5-2-12 a confidential interview via phone indicated clients A and B had reported that client F had to eat in the garage and his wallet had been taken away to ensure he would eat his food. The confidential interview indicated reports were filed but the reports have disappeared and the garage at client F's home is not climate controlled.</p> <p>On 5-1-12 at 12:15 p.m. a review of the facility's internal investigation dated 4-11-12 indicated the investigation had taken place by telephone and at the day program site. Client F was interviewed in an office at his day program. The investigation indicated client F talked</p>				

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	<p>about Easter and indicated he had his wallet that nobody had taken it. Other clients in client F's home had been questioned and the report indicated clients appeared to be confused. When clients were asked where client F sat to eat they pointed to his chair in the day program class room. The investigation failed to indicate any of the clients had been interviewed in their own home to decrease the confusion of what was being asked. The investigation indicated several staff had reported clients F's wallet had been taken before as a way to get him to eat but they had all been retrained on not to do that anymore.</p> <p>On 5-1-12 at 12:05 p.m. a review of the facility's abuse/neglect policy dated 2-22-11 indicated all clients would be free from abuse, neglect, or mistreatment and incidents involved with the violation of an individuals rights would be investigated.</p> <p>On 5-1-12 at 12:45 p.m. an interview with the Qualified Mental Retardation Professional (QMRP) indicated the abuse/neglect policy should be implemented and staff should not take away wallets or make clients eat in the garage. The QMRP indicated staff had been retrained on the abuse/neglect policy and behavior support plans.</p>						

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on observation, record review and interview, the facility failed to ensure a thorough investigation was completed for an allegation for 1 of 4 clients (client F) who lived in the home, to ensure he wallet wasn't taken away from him and he wasn't made to eat at the table in the garage for refusing to eat.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 5-1-12 at 10:30 a.m. A review of incident reports from 4-1-12 until 5-1-12 indicated a Bureau of Developmental Disabilities Services reports (BDDS) report dated 4-10-12 for client F indicated his wallet had been taken away and he was made to sit in the garage if he did not eat.</p> <p>On 4-30-12 from 3:30 p.m. until 7:00 p.m. an observation at the home of clients A, B, C, and F was conducted. At 3:45 p.m. a table and four chairs was in the garage of clients A, B, C, and F. At 5:30 p.m. an interview with client F indicated he had sat in the garage when he was bad and wouldn't eat. At 6:05 p.m. an interview with client A indicated client F did have to go to the garage when he wouldn't eat. Client A pointed to the</p>	W0154	In response to tag W154 as of 5-2-2012 the card table and chairs have been removed from the garage. Group Home supervisor or designee will complete QI during meal times implemented on 5-2-2012 and will continue to do the QI checks. Investigation training has been reviewed and staff to be retrain ed on this on 5-29-2012.	05/24/2012			

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	<p>garage and indicated client F went out there but she didn't have to because she was good. At 6:15 p.m. client F pointed to the garage and indicated if he was bad he ate out there. Client F also indicated his wallet had been taken away but he had it back now. At 6:30 p.m. client B indicated client F had cried and used foul language when his wallet had been taken away because he wouldn't eat. At 6:35 p.m. client C indicated client F had sat in the garage to eat. Client C pointed to the garage then pointed at client F and stated his name. At 6:50 p.m. client B indicated client F had been to the garage because he wouldn't eat.</p> <p>On 5-2-12 a confidential interview via phone indicated clients A and B had reported that client F had to eat in the garage and his wallet had been taken away to ensure he would eat his food. The confidential interview indicated reports were filed but the reports have disappeared and the garage at client F's home is not climate controlled.</p> <p>On 5-1-12 at 12:15 p.m. a review of the facility's internal investigation dated 4-11-12 indicated the investigation had taken place by telephone and at the day program cite. Client F was interviewed in an office at his day program. The investigation indicated client F talked</p>				

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	<p>about Easter and indicated he had his wallet that nobody had taken it. Other clients in client F's home had been questioned and the report indicated clients appeared to be confused. When clients were asked where client F sat to eat they pointed to his chair in the day program class room. The investigation failed to indicate any of the clients had been interviewed in their own home to decrease the confusion of what was being asked. The investigation indicated several staff had reported clients F's wallet had been taken before as a way to get him to eat but they had all been retrained on not to do that anymore.</p> <p>On 5-2-12 at 12:50 p.m. an interview with the Qualified Mental Retardation Professional (QMRP) indicated the investigation did take place at the day program site and via phone. She indicated the clients were asked where client F sat and they pointed to his seat in his class room. The QMRP indicated no clients were asked at their home where the allegation happened at.</p> <p>This federal tag relates to complaint #IN00106887.</p> <p>9-3-2(a)</p>						

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