

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G470	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/14/2015
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NAME OF PROVIDER OR SUPPLIER BI-COUNTY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 466 BALTIMORE ST BERNE, IN 46711
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W 0000 Bldg. 00	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: August 12, 13 and 14, 2015.</p> <p>Facility number: 000984 Provider number: 15G470 AIM number: 100244870</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000	<p>Baltimore Recertification & Licensure Survey Plan of Correction Survey Event ID SCRJ11 September 2015</p> <p>W104- Governing Body The governing body of Bi-County Services, Inc. (BCS) will exercise general policy, budget and operating direction over the agency.</p> <p>This standard was not met as we did not provide operating direction for staff regarding utilization of CPR/life safety measures should they discover an individual consumer(s) who show no signs of pulse, respirations and are unresponsive at time of discovery. This Plan of Correction includes the agency's new protocol to address the failure of providing staff with operating directions related to unresponsiveness and theneed for CPR/life safety measures for the consumers entrusted to our care. The CPR/Life Safety Measures Protocol for Consumer(s) Found Unresponsive was developed with input from BCS nursing staff, a physician, Human Resources Manager, American Red Cross CPR instructor used by BCS, other Supervised Group Living (SGL) providers and BCS</p>	
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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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			<p>program administrative team and management. We believe thatthe protocol developed meets the criteria of health/safety interventions upon discovery of any consumer(s) who might be found unresponsive and can be revised as needed to address ethical concerns related to Out of Hospital DNR's, Advanced Directives, etc. There has been no question of negligence raised by local authorities at the scene, coroner or the Mortality Review Committee (MRC) regarding consumer #8 and his not having CPR instituted at time his body was found, which was cold and rigid at the time of discovery.</p> <p>1. Corrective action and follow-up specific to Consumer #8, as well as the Baltimore group home in general:</p> <p>1.A CPR/Life Safety Measures Protocol for Consumer(s) Found Unresponsive has been developed for staff to have guidelines/operating direction in the possible situation of a consumer being found unresponsive, without respirations or pulse. All Residential Management Team (RMT) members, medical department, administrative programming staff, Baltimore staff and all staff working with Baltimore consumers across all settings will be trained on the protocol by 9/13/15.</p> <p>2. The Protocol also includes the</p>		

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			<p>process of investigation of circumstances of the death of a consumer where neglect &/or other allegations of violation of consumer rights is in question, as well as notification of death of a consumer through the BDDS Incident Reporting process and the MRC. All pertinent staff (management and administrative teams) involved in the IR process will be trained on the protocol's investigation process by 9/13/15.</p> <p>3. All staff working with all BCS residential group home consumers will be trained on the protocol by 9/13/15.</p> <p>4. The protocol will be available for staff to utilize/follow if needed in each SGL home and at Day Services (DS) & workshop settings by 9/13/15.</p> <p>5. Monitoring of corrective action will be done by management & administrative teams in conjunction with review by the BCS Human Rights Committee.</p> <p>Person's Responsible: RMT's, QAM, Residential Administrator, Medical Department and Program Director.</p> <p>Completion Date: 9/13/15 W154-Staff Treatment of Clients The facility must have evidence that all alleged violations are</p>	

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			<p>thoroughly investigated.</p> <p>BCS was found to have failed in investigating the circumstances of the death of a consumer and the lack of staff utilization of CPR/life saving measures at the time the consumer was found. The consumer was cold, rigid, had no pulse or respirations and was unresponsive. The staff person on duty at the time of discovery believed that the consumer was dead and had been dead for a period of time. It is true that BCS did not investigate the circumstances of lack of CPR/life saving measures by staff on duty at the time of death.</p> <p>As a result of this citation, we believe that it is important that the investigation component be a part of the CPR/Life Safety Measures Protocol for Consumer(s) Found Unconscious.</p> <p>We believe that the corrective action identified in the W104 tag meets the criteria for our POC related to this W154 tag.</p> <p>Please reference W104 A.1-5 for our corrective action related to the W154 standard cited. Corrective action will be completed by 9/13/15 with the Program Director, Program Administrative Team and Residential Management Teams responsible for POC implementation.</p>		

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W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview, the governing body failed to exercise general policy and operating direction over the facility by failing to provide facility staff with a policy regarding utilization of CPR/life safety measures regarding 1 of 1 client (client #8) who showed no signs of life (unresponsive, no pulse, no respirations, and was cold to the touch).</p> <p>Findings include:</p> <p>Facility records were reviewed on 8/12/15 at 3:03 P.M. including the following Bureau of Developmental Disabilities Services (BDDS) reports.</p> <p>- A BDDS report dated 1/21/15 at 6:00 A.M. indicated "[Client #8] was discharged from [mental/behavioral health hospital #1] on 1/20/15 and returned home about 3:10 P.M. He was responsive and appeared to have a good affect. [Client #8] was discharged with many medication changes. [Client #8] has (sic) sleep apnea (breathing stops during sleep) and has a history of CPAP (continuous positive airway pressure) machine refusal. [Client #8] has (sic)</p>	W 0104	<p>Baltimore Recertification & Licensure Survey Plan of Correction</p> <p>Survey Event ID SCRJ11</p> <p>September 2015</p> <p>W104- Governing Body</p> <p>The governing body of Bi-CountyServices, Inc. (BCS) will exercise general policy, budget and operating direction over the agency.</p> <p>This standard was not met as we did not provide operating direction for staff regarding utilization of CPR/life safety measures should they discover an individual consumer(s) who show no signs of pulse, respirations and are unresponsive at time of discovery. This Plan of Correction includes the agency's new protocol to address the failure of providing staff with operating directions related to unresponsiveness and theneed for CPR/life safety measures for the consumers entrusted to our care. The CPR/Life Safety Measures Protocol for Consumer(s) Found Unresponsive was developed with input from BCS nursing staff, a physician, Human Resources Manager, American Red Cross CPR instructor used by BCS,</p>	09/13/2015			

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	<p>diabetes and seizure disorder. Staff saw him after 10:00 P.M. and gave him a haircut at night per his request. Staff tried to rouse him for morning routine and found him unresponsive, no pulse, no vitals, and called 911. Police arrived and the Sheriff pronounced [client #8] dead early after 6:00 A.M. The Corner (sic) could not readily find the cause of death and requested an autopsy to be performed at [Hospital #2]. As of this writing, the COD (cause of death) is not yet determined. [Name of Facility] will follow directions and answer questions by all state personnel, police, hospital, coroner's office. Police blocked [client #8's] bedroom door with police tape to seal off the room pending the investigation and completion of the autopsy. Family was notified within minutes of [client #8] being found. Family has arranged for burial services. [Name of Facility] has started a mortality review. [Name of Facility] will submit COD documentation and autopsy reports when received."</p> <p>The Narrative: Details-Death section of the BDDS report indicated: "... 5. Circumstances immediately following the death or discovery of the death, 'Staff called 911 after discovering of body. [Client #8] was found to have no pulse, no vitals at time of discovery.' 6.</p>		<p>other Supervised Group Living (SGL) providers and BCS program administrative team and management. We believe that the protocol developed meets the criteria of health/safety interventions upon discovery of any consumer(s) who might be found unresponsive and can be revised as needed to address ethical concerns related to Out of Hospital DNR's, Advanced Directives, etc. There has been no question of negligence raised by local authorities at the scene, coroner or the Mortality Review Committee (MRC) regarding consumer #8 and his not having CPR instituted at time his body was found, which was cold and rigid at the time of discovery.</p> <p>1. Corrective action and follow-up specific to Consumer #8, as well as the Baltimore group home in general: 1.A CPR/Life Safety Measures Protocol for Consumer(s) Found Unresponsive has been developed for staff to have guidelines/operating direction in the possible situation of a consumer being found unresponsive, without respirations or pulse. All Residential Management Team (RMT) members, medical department, administrative programming staff, Baltimore staff and all staff working with Baltimore consumers across all settings will be trained on the</p>				

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W 0154	<p>Describe all life-saving measures... that were attempted at time of death.... '911 was called, no documentation of CPR performed.' 7. If no life-saving measures were taken, please explain why not.... 'There is no known reason why CPR was not used, possibly panic / anxiety from sudden discovery'. "</p> <p>An interview was conducted with the Program Director (PD) on 8/13/15 at 2:05 P.M. When asked if the governing body had a policy in place to assist staff to know what they are to do when/if they discover someone unresponsive, with no pulse, no vitals. The PD stated, "No, we don't have a policy in place at this time."</p> <p>9-3-1(a)</p> <p>483.420(d)(3)</p>		<p>protocol by 9/13/15.</p> <p>2.The Protocol also includes the processof investigation of circumstances of the death of a consumer where neglect&/or other allegations of violation of consumer rights is in question, aswell as notification of death of a consumer through the BDDS Incident Reportingprocess and the MRC. All pertinent staff(management and administrative teams) involved in the IR process will be trained on the protocol's investigation process by 9/13/15.</p> <p>3.All staff working with all BCSresidential group home consumers will be trained on the protocol by9/13/15.</p> <p>4.The protocol will be available forstaff to utilize/follow if needed in each SGL home and at Day Services (DS)& workshop settings by 9/13/15.</p> <p>5.Monitoring of corrective action will bedone by management & administrative teams in conjunction with review by theBCS Human Rights Committee.</p> <p>Person's Responsible: RMT's, QAM, Residential Administrator,Medical Department and Program Director.</p> <p>Completion Date: 9/13/15</p>		

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Bldg. 00	<p>STAFF TREATMENT OF CLIENTS</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed to thoroughly investigate the circumstances of the death of a client and the lack of staff utilization of CPR/life saving measures regarding 1 of 1 client (client #8) who showed no signs of life (unresponsive, no pulse, no respirations, and was cold to the touch).</p> <p>Findings include:</p> <p>Facility records were reviewed on 8/12/15 at 3:03 P.M. including the following Bureau of Developmental Disabilities Services (BDDS) reports.</p> <p>- A BDDS report dated 1/21/15 at 6:00 A.M. indicated "[Client #8] was discharged from [mental/behavioral health hospital #1] on 1/20/15 and returned home about 3:10 P.M. He was responsive and appeared to have a good affect. [Client #8] was discharged with many medication changes. [Client #8] has (sic) sleep apnea (breathing stops during sleep) and has a history of CPAP (continuous positive airway pressure) machine refusal. [Client #8] has (sic) diabetes and seizure disorder. Staff saw him after 10:00 P.M. and gave him a haircut at night per his request. Staff tried</p>	W 0154	<p>W154-Staff Treatment of Clients</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>BCS was found to have failed in investigating the circumstances of the death of a consumer and the lack of staff utilization of CPR/life saving measures at the time the consumer was found. The consumer was cold, rigid, had no pulse or respirations and was unresponsive. The staff person on duty at the time of discovery believed that the consumer was dead and had been dead for a period of time. It is true that BCS did not investigate the circumstances of lack of CPR/life saving measures by staff on duty at the time of death.</p> <p>As a result of this citation, we believe that it is important that the investigation component be a part of the CPR/Life Safety Measures Protocol for Consumer(s) Found Unconscious.</p> <p>We believe that the corrective action identified in the W104 tag meets the criteria for our POC related to this W154 tag.</p> <p>Please reference W104 A.1-5 for</p>	09/13/2015			

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	<p>to rouse him for morning routine and found him unresponsive, no pulse, no vitals, and called 911. Police arrived and the Sheriff pronounced [client #8] dead early after 6:00 A.M. The Corner (sic) could not readily find the cause of death and requested an autopsy to be performed at [Hospital #2]. As of this writing, the COD (cause of death) is not yet determined. [Name of Facility] will follow directions and answer questions by all state personnel, police, hospital, coroner's office. Police blocked [client #8's] bedroom door with police tape to seal off the room pending the investigation and completion of the autopsy. Family was notified within minutes of [client #8] being found. Family has arranged for burial services. [Name of Facility] has started a mortality review. [Name of Facility] will submit COD documentation and autopsy reports when received."</p> <p>The Narrative: Details-Death section of the BDDS report indicated: "... 5. Circumstances immediately following the death or discovery of the death, 'Staff called 911 after discovering of body. [Client #8] was found to have no pulse, no vitals at time of discovery.' 6. Describe all life-saving measures... that were attempted at time of death.... '911 was called, no documentation of CPR</p>		<p>our corrective action related to the W154 standard cited. Corrective action will be completed by 9/13/15 with the Program Director, Program Administrative Team and Residential Management Teams responsible for POC implementation.</p>	

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	<p>performed.' 7. If no life-saving measures were taken, please explain why not.... 'There is no known reason why CPR was not used, possibly panic/anxiety from sudden discovery'. "</p> <p>Client #8's Certificate of Death dated 1/27/15 was reviewed on 8/12/15 at 3:03 P.M. It indicated the "Immediate Cause (Final Disease or Condition Resulting in Death) A. Seizure Disorder" and the Manner of Death "Natural."</p> <p>An interview was conducted with the Program Director (PD) on 8/13/15 at 2:11 P.M. The PD stated, "The 911 dispatcher had not directed the staff to begin CPR for [client #8]." The PD indicated staff had found client #8 after his body was already cold to the touch. The PD stated: "[Client #8] had no required bed checks or special seizure protocols for during the night. He did not like to even have anyone knock on his bedroom door. He kept and used his VNS (Vagal nerve stimulator) independently." The PD indicated staff did bed checks on each of the clients in the home on an hourly basis. This was done very discreetly for client #8 due to his wishes for privacy. Staff would just quietly open his door and look into his room to assure he was in bed. When asked if the facility had completed an internal investigation</p>			

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	<p>regarding the death of client #8. The PD indicated they had not completed an internal investigation. The PD stated "The autopsy indicated his death was from his seizure disorder, and he had died of natural causes."</p> <p>9-3-2(a)</p>				