

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2015
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NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: August 18, 21 and 28, 2015.</p> <p>Provider number: 15G656 Facility number: 001193 AIM number: 100446910</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/8/15.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 2 additional clients (#4 and #5), the governing body failed to exercise general policy and operating direction over the facility to ensure a full and complete accounting of clients #1's, #2's and #3's financial records.</p>	W 0104	104 Now and in the future, all staff will be trained and retrained at least annually on financial and abuse neglect policies. Please see W140, W149, W153, W154 and W155. The Lead Home Manager, QIDP, Financial Department, and Home Manager will ensure these trainings occur.	09/21/2015

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>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to ensure all allegations of abuse/neglect were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law, to ensure all allegations of abuse/neglect were thoroughly investigated and to ensure the facility removed a staff from duty after an allegation of abuse was made for clients #1, #2, #3, #4 and #5.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The governing body failed to exercise general policy and operating direction over the facility to ensure a full and complete accounting of the clients' personal finances for clients #1, #2 and #3. Please see W140. 2. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented its policy and procedures to ensure all allegations of abuse/neglect were reported immediately to the administrator and to the BDDS and APS according to state law and to ensure all 			

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	<p>allegations of abuse/neglect were thoroughly investigated and to ensure the facility implemented corrective actions to prevent recurrence of the abuse for clients #1, #2, #3, #4 and #5. Please see W149.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure the staff immediately reported all allegations of abuse to the administrator and to the BDDS and APS according to state law for clients #1, #2, #3, #4 and #5. Please see W153.</p> <p>4. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse were thoroughly investigated for clients #1, #2, #3, #4 and #5. Please see W154.</p> <p>5. The governing body failed to exercise general policy and operating direction over the facility to ensure a staff was immediately removed from client contact when an allegation of abuse was made involving client #4. Please see W155.</p> <p>9-3-1(a)</p>			

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W 0140 Bldg. 00	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to provide a full and complete accounting of the clients' personal finances.</p> <p>Findings include:</p> <p>Client #1's, #2's and #3's COHRs (Cash On Hand Records) were reviewed on 8/21/15 at 3 PM with the LHM (Lead Home Manager).</p> <p>The clients' COHRs indicated October 2014 through April 2015 documented on one sheet of paper.</p> <p>Client #1's COHRs indicated no receipts for the following purchases: 11/13/14 for \$16.01 01/07/15 for \$6.20 03/06/15 for \$3.52 03/22/15 for \$5.35 03/22/15 for \$15.31 03/26/15 for \$5.87 04/11/15 for \$12.39 05/05/15 for \$9.80.</p>	W 0140	<p>140</p> <p>Now and in the future, all staff will be trained and retrained on how to assure there is a full and complete accounting of client's personal funds per the JRDS Policy on Funds of Persons Served. Staff will also ensure all receipts are completed and entered at the end of each shift. The Home Manager, weekly will review each account, and assure all clients' accounts balance and have completed receipts. The JRDS Fiscal Department, Home Manager and Lead Home Manager are responsible.</p>	09/21/2015

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	<p>Client #2's COHRs indicated no receipts for the following purchases: 11/01/14 for \$5.98 04/11/15 for \$13.14 04/29/15 for \$8.00.</p> <p>Client #3's COHRs indicated no receipts for the following purchases: 11/07/14 for \$9.02 11/21/14 for \$6.42 11/21/14 for \$12.54 01/05/15 for \$10.06 03/21/15 for \$6.72 03/22/15 for \$6.29 03/28/15 for \$5.93 04/12/15 for \$13.03 04/29/15 for \$8.00.</p> <p>During interview with the LHM on 8/21/15 at 3 PM, the LHM: __ Indicated there were some issues with the previous HM (Home Manager) as the HM failed to maintain the clients' COHRs. __ Indicated no evidence of money missing in the home. __ Indicated the previous home manager's employment was terminated and the home now has a new HM.</p> <p>During telephone interview with the Accounting Technician (AT) on 8/26/15 at 1 PM, the AT:</p>			

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W 0149 Bldg. 00	<p>__ Indicated the previous HM failed to maintain the clients' COHRs.</p> <p>__ Indicated no further receipts were available for review.</p> <p>__ Indicated the previous HM failed to turn in the clients' receipts after making purchases.</p> <p>__ Indicated the clients' COHRs were to be reconciled once a month.</p> <p>__ Indicated the clients' records were not being reconciled monthly.</p> <p>9-3-2(a)</p> <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 3 of 3 sampled clients (#1, #2, and #3) and 2 additional clients (#4 and #5), the facility failed to implement its policy and procedures to ensure all allegations of abuse/neglect were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law and to ensure all allegations of abuse/neglect were thoroughly investigated for clients</p>	W 0149	149 Now and in the future, all allegations of abuse/neglect will be reported immediately to the administrator; to BDDS and APS within 24 hours of the incident. Investigation of the allegations of incidents of abuse/neglect will be investigated by JRDS within 5 days of the alleged incidents or knowledge of, per our attached policy. Staff have been trained and will be retrained at least annually. All investigations are routinely reviewed by members of the JRDS Quality Review Team. Home Manager, QIDP and Lead Home Manager are responsible.	09/21/2015

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	<p>#1, #2, #3, #4 and #5 and to ensure a staff was removed from duty after an allegation of abuse was made for clients #1, #2, #3, #4 and #5.</p> <p>Findings include:</p> <p>The facility reportable and investigative records were reviewed on 8/18/15 at 1 PM.</p> <p>1. The 8/4/15 BDDS report indicated on 8/3/15 staff #5 left client #4 in the bathroom with the lights off and the door shut while client #4 was having a behavior and hitting himself. Client #4 was discovered by the HM (Home Manager). The 8/4/15 investigative record indicated staff #5 was suspended pending the investigation.</p> <p>The 8/4/15 investigative record indicated interviews with staff #1, #2, #3, #4, #5 and #6 conducted by the LHM (Lead Home Manager), the Senior Director of Services (SDS/ Administrator) and the HM on 8/4/15 between 12 PM and 5 PM. The record indicated: __Staff #2 indicated she had not read client #4's behavior plan. __Staff #2 was asked if it was protocol to put client #4 in the bathroom with the lights out and to shut the door, staff #2 stated, "I did it over the weekend."</p>			

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	<p>__Staff #2 indicated client #1 had bruises on her legs that looked like finger prints.</p> <p>__Staff #2 indicated when staff #5 asked staff #2 what she should do with client #4, staff #2 stated, "I (staff #2) told her (staff #5) if you turn the lights off and close the door it calms him (client #4) down a lot. I always stay by the door so I can hear him. Staff walked away and when I went back to see how his behavior was going, he was sitting on the toilet with the door open and the lights on."</p> <p>__Staff #3 indicated staff #2 yelled at client #5 because she was wet and told her she was not a baby and indicated staff #2 stated, "Watch she'll (client #5) start crying."</p> <p>__Staff #3 indicated the previous Monday or Tuesday morning, client #5 had "flinched" while staff #3 was assisting client #5 with her personal hygiene and stated, "I'm not a threat. Don't know why she (client #5) would flinch?"</p> <p>__Staff #3 indicated on Friday while working with staff #4, staff #4 had placed her hand over client #1's mouth and nose to prevent client #1 from drinking from staff #6's drink.</p> <p>__Staff #3 indicated staff used foul language in the home around all of the clients (clients #1, #2, #3, #4 and #5).</p> <p>__Staff #5 stated, "That was the first time I (staff #5) did something or saw</p>			

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	<p>something that didn't feel right, [staff #2] told me this is what to do." __Staff #6 indicated staff #2, #5 and herself were working the night of the incident and stated, "[Staff #2] said turn the lights off and shut the door." Staff #6 told the HM and the HM went to the bathroom and turned the lights on for client #4.</p> <p>The investigative report indicated a note from the SDS dated 8/5/15. The note indicated "[Staff #5] has been employed by JRDS since July 14, 2015 and has only been working in the [name of street of the group home] since July 22, 2015. As a new staff, she relied on other staff to guide her regarding the care of the individuals who live in this home. It has been determined that she had been given incorrect information or possibly misunderstood the directions given by a more seasoned staff. After investigation of the incident, it has been determined the client was in the bathroom for 45 to 60 seconds prior to intervention by the Home Manager; the staff was not trained well on the different behavior plans; and seasoned staff may have been trained incorrectly by former Home Managers. It has also been determined that all staff at the [name of street of the group home] needs (sic) retraining on the JRDS Abuse Neglect, Exploitation Policy, the JRDS</p>			

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	<p>Behavior Management Policy, and client specific behavior management. This training will occur within the next two weeks or before."</p> <p>__The facility records failed to indicate the allegations of abuse made during the interviews conducted by the LHM, SDS and the HM on 8/4/15 were reported to BDDS and/or APS and were investigated.</p> <p>__The facility records failed to indicate immediate appropriate action was taken in regard to the allegations of abuse of clients #1, #2, #3, #4 and #5.</p> <p>__The facility records indicated staff #2 ended her employment with JRDS on 8/11/15.</p> <p>During telephone interview with the Administrator (ADM) on 8/28/15 at 10 AM, the ADM:</p> <p>__Indicated the allegations of abuse made during the investigation of the 8/3/15 incident were not reported to BDDS and/or APS and were not investigated.</p> <p>__Indicated she missed recognizing the allegations when the investigation was being conducted.</p> <p>__Indicated the facility was to report all allegations of abuse immediately to the administrator and to BDDS and APS within 24 hours of knowledge of the abuse.</p> <p>__Indicated upon knowledge of an</p>			

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	<p>allegation of abuse the facility was to suspend all staff implicated in the allegation.</p> <p>__ Indicated staff #2 was not suspended after admitting to leaving client #4 in the bathroom with the lights out and the door shut and/or advising a co-worker to do the same.</p> <p>__ Indicated staff #2 ended her employment with JRDS on 8/11/15.</p> <p>__ Indicated all staff were retrained in recognizing and reporting abuse and neglect and were retrained on each client's specific program plans.</p> <p>2. The 3/16/15 BDDS report indicated on 3/15/15 client #5 slapped client #4 in the chest. The 3/15/15 investigative record indicated four clients and two staff were in the home. The record indicated two staff statements and no client interviews. The facility records indicated the facility failed to conduct a thorough investigation.</p> <p>The 4/16/15 Bureau of Developmental Disabilities Services (BDDS) report indicated on 4/15/15 client #5 slapped client #2 twice on the chest. The facility records indicated the facility failed to conduct an investigation.</p> <p>During interview with the ADM on 8/18/15 at 1 PM, the ADM:</p>			

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	<p>__ Indicated the facility was to report all allegations of abuse immediately to the administrator and to BDDS and APS within 24 hours of knowledge of the abuse.</p> <p>__ Indicated all clients and all staff present at the time of the incident should be interviewed.</p> <p>__ Indicated all allegations of abuse were to be thoroughly investigated.</p> <p>Review of the revised facility policy "Individual Protection Policy" of 5/12 on 8/18/15 at 2 PM indicated "JRDS [Jay-Randolph Developmental Services] personnel are required to preserve an individual's rights, dignity, health, and safety. As such JRDS prohibits the abuse, neglect, exploitation, mistreatment of an individual served or the violation of the individual's rights." The policy defines abuse to be the "use of unreasonable physical force such as spanking, pinching, shoving, shaking and other punitive acts.... actions, verbal statements or commands, or other procedure that result in a detrimental outcome for the individual involved (i.e. tone of voice, derogatory statement, facial expressions, isolation, demeaning gestures, name calling, and other damaging acts.)." The policy indicated "Individuals served must not be subjected to abuse by anyone, including, but not limited to, JRDS staff,</p>			

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W 0153 Bldg. 00	<p>other consumers, consultants or volunteers, staff of other agencies serving the individual, family members or legal guardians, friends, or other individuals." The facility policy indicated the staff were to report abuse/neglect/mistreatment immediately to the Executive Director or a designee and then the Program Head or designee would initiate an investigation.</p> <p>9-3-2(a)</p> <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 8 allegations of abuse reviewed, the facility failed to ensure the staff immediately reported all allegations of abuse to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients #1, #2, #3, #4 and #5.</p>	W 0153	<p>153 Now and in the future, all allegations of abuse/neglect will be reported immediately to the administrator; to BDDS and APS within 24 hours of the incident. Staff have been trained or retrained on the JRDS attached Incident Reporting policy and will be retrained at least annually. All reportable incidents are routinely reviewed by member of the JRDS Quality Review Team. Home Manager, QDP and Home Lead</p>	09/21/2015

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	<p>Findings include:</p> <p>The facility reportable and investigative records were reviewed on 8/18/15 at 1 PM.</p> <p>The 8/4/15 BDDS report indicated on 8/3/15 staff #5 left client #4 in the bathroom with the lights off and the door shut while client #4 was having a behavior and hitting himself. Client #4 was discovered by the HM (Home Manager). The 8/4/15 investigative record indicated staff #5 was suspended pending the investigation.</p> <p>The 8/4/15 investigative record indicated interviews with staff #1, #2, #3, #4, #5 and #6 conducted by the LHM (Lead Home Manager), the Senior Director of Services (SDS/ Administrator) and the HM on 8/4/15 between 12 PM and 5 PM. The record indicated: __Staff #2 indicated she had not read client #4's behavior plan. __Staff #2 was asked if it was protocol to put client #4 in the bathroom with the lights out and to shut the door, staff #2 stated, "I did it over the weekend." __Staff #2 indicated client #1 had bruises on her legs that looked like finger prints. __Staff #2 indicated when staff #5 asked staff #2 what she should do with client #4, staff #2 stated, "I (staff #2) told her</p>		Manager responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2015
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NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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	<p>(staff #5) if you turn the lights off and close the door it calms him (client #4) down a lot. I always stay by the door so I can hear him. Staff walked away and when I went back to see how his behavior was going, he was sitting on the toilet with the door open and the lights on." __Staff #3 indicated staff #2 yelled at client #5 because she was wet and told her she was not a baby and indicated staff #2 stated, "Watch she'll (client #5) start crying." __Staff #3 indicated the previous Monday or Tuesday morning, client #5 had "flinched" while staff #3 was assisting client #5 with her personal hygiene and stated, "I'm not a threat. Don't know why she (client #5) would flinch?" __Staff #3 indicated on Friday while working with staff #4, staff #4 had placed her hand over client #1's mouth and nose to prevent client #1 from drinking from staff #6's drink. __Staff #3 indicated staff used foul language in the home around all of the clients (clients #1, #2, #3, #4 and #5). __Staff #5 stated, "That was the first time I (staff #5) did something or saw something that didn't feel right, [staff #2] told me this is what to do." __Staff #6 indicated staff #2, #5 and herself were working the night of the incident and stated, "[Staff #2] said turn</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/28/2015
NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371		
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W 0154	<p>the lights off and shut the door." Staff #6 told the HM and the HM went to the bathroom and turned the lights on for client #4.</p> <p>The facility records failed to indicate the allegations of abuse made during the interviews conducted by the LHM, SDS and the HM on 8/4/15 were reported to BDDS and/or APS.</p> <p>During telephone interview with the Administrator (ADM) on 8/28/15 at 10 AM, the ADM: ___ Indicated the allegations of abuse made during the investigation of the 8/3/15 incident were not reported to BDDS and/or APS. ___ Indicated she missed recognizing the allegations when the investigation was being conducted. ___ Indicated the facility was to report all allegations of abuse immediately to the administrator and to BDDS and APS within 24 hours of knowledge of the abuse.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2015
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NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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Bldg. 00	<p>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 3 of 8 allegations of abuse, the facility failed to ensure all allegations of abuse were thoroughly investigated for clients #1, #2, #3, #4 and #5.</p> <p>Findings include:</p> <p>The facility reportable and investigative records were reviewed on 8/18/15 at 1 PM.</p> <p>1. The 8/4/15 investigative record indicated staff interviews conducted by the LHM (Lead Home Manager), the Senior Director of Services (SDS/ Administrator) and the HM on 8/4/15 between 12 PM and 5 PM. The record indicated during the investigation the following allegations were made: __Staff #2 indicated client #1 had bruises on her legs that looked like finger prints. __Staff #3 indicated staff #2 yelled at client #5 because she was wet and told her she was not a baby and indicated staff #2 stated, "Watch she'll (client #5) start crying." __Staff #3 indicated the previous Monday or Tuesday morning, client #5 had "flinched" while staff #3 was assisting client #5 with her personal</p>	W 0154	<p>154</p> <p>Now and in the future, an investigation of the allegations of incidents of abuse/neglect will be investigated by JRDS within 5 days of the alleged incidents or knowledge of, per our attached policy. Staff have been trained and will be retrained at least annually. All investigations are reviewed by members of the JRDS Quality Review Team. Home Manager, QIDP and Lead Home Manager are responsible.</p>	09/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/28/2015
NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>hygiene and stated, "I'm not a threat. Don't know why she (client #5) would flinch?"</p> <p>__ Staff #3 indicated on Friday while working with staff #4, staff #4 had placed her hand over client #1's mouth and nose to prevent client #1 from drinking from staff #6's drink.</p> <p>__ Staff #3 indicated staff used foul language in the home around all of the clients (clients #1, #2, #3, #4 and #5).</p> <p>The facility records failed to indicate the allegations of abuse made during the interviews conducted by the LHM, SDS and the HM on 8/4/15 were investigated.</p> <p>During telephone interview with the Administrator (ADM) on 8/28/15 at 10 AM, the ADM:</p> <p>__ Indicated the allegations of abuse made during the investigation of the 8/3/15 incident were not investigated.</p> <p>__ Indicated she missed recognizing the allegations when the investigation was being conducted.</p> <p>__ Indicated upon knowledge of an allegation of abuse the facility was to initiate an investigation.</p> <p>2. The 3/16/15 BDDS report indicated on 3/15/15 client #5 slapped client #4 in the chest. The 3/15/15 investigative record indicated four clients and two staff were</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2015
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NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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W 0155 Bldg. 00	<p>in the home. The record indicated two staff statements and no client interviews. The facility records indicated the facility failed to conduct a thorough investigation.</p> <p>The 4/16/15 Bureau of Developmental Disabilities Services (BDDS) report indicated on 4/15/15 client #5 slapped client #2 twice on the chest. The facility records indicated the facility failed to conduct an investigation.</p> <p>During interview with the ADM on 8/18/15 at 1 PM, the ADM: ___ Indicated all allegations of abuse were to be thoroughly investigated. ___ Indicated all clients and all staff present at the time of the incident should be interviewed.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on 1 of 8 allegations of abuse reviewed, the facility failed to ensure a staff was immediately removed from client contact when an allegation of abuse was made involving client #4.</p>	W 0155	<p>155</p> <p>Now and in the future, JRDS will immediately remove a staff from client contact when an allegation of abuse/neglect has been reported</p>	09/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2015
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NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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	<p>Findings include:</p> <p>The facility reportable and investigative records were reviewed on 8/18/15 at 1 PM.</p> <p>The 8/4/15 BDDS report indicated on 8/3/15 staff #5 left client #4 in the bathroom with the lights off and the door shut while client #4 was having a behavior and hitting himself. Client #4 was discovered by the HM (Home Manager). The 8/4/15 investigative record indicated staff #5 was suspended pending the investigation.</p> <p>The 8/4/15 investigative record indicated staff interviews conducted by the LHM (Lead Home Manager), the Senior Director of Services (SDS/ Administrator) and the HM on 8/4/15 between 12 PM and 5 PM. The record indicated: ___ "Home Manager, [name of home manager] reported that she had found [client #4] in the bathroom with the lights out and the door shut. Newly hired DSP (Direct Support Professional), [staff #5] was in the area and said, 'He's (client #4) having a behavior. Is this what I am supposed to do? This is what I was told to do.'" ___ Staff #2 had instructed staff #5 to put</p>		<p>concerningthat staff. JRDS staff were trained andwill be retrained at least annually on the Policy and Procedures forInvestigations. When an investigation isnecessary the Department Head will ensure that all procedures are followed aswritten in the policy.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2015
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NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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	<p>client #4 in the bathroom, turn the lights out and shut the door.</p> <p>__Staff #6 indicated staff #2, staff #5 and herself were working the night of the incident and stated, "[Staff #2] said turn the lights off and shut the door."</p> <p>__Staff #2 was asked if it was protocol to put client #4 in the bathroom with the lights out and to shut the door, staff #2 stated, "I did it over the weekend."</p> <p>__Staff #2 indicated when staff #5 asked staff #2 what she should do with client #4, staff #2 stated, "I (staff #2) told her (staff #5) if you turn the lights off and close the door it calms him (client #4) down a lot. I always stay by the door so I can hear him.</p> <p>The facility records indicated the investigation of abuse for client #4 on 8/3/15 was completed on 8/13/15. The investigative record indicated the allegation of abuse was substantiated. The facility records indicated staff #2 was not suspended in regard to the allegation of abuse of client #4.</p> <p>During telephone interview with the Administrator (ADM) on 8/28/15 at 10 AM, the ADM:</p> <p>__Indicated upon knowledge of an allegation of abuse the facility was to suspend all staff implicated in the allegation.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2015
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NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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W 0249 Bldg. 00	<p>__ Indicated staff #2 was not suspended during the investigation of the abuse of client #4.</p> <p>__ Indicated staff #2 ended her employment voluntarily with JRDS on 8/11/15.</p> <p>9-3-2(a)</p> <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, interview and record review for 2 of 3 sample clients (#1 and #3), the facility failed to ensure the staff implemented the clients' ISP (Individualized Support Plan) training objectives in regard to dining when formal and informal training opportunities existed and to ensure the staff followed client #1's BSP (Behavior Support Plan) in regard to thumb sucking.</p>	W 0249	<p>249</p> <p><i>Now and in the future all clients will receive continuous activetreatment programming consistent with his/her needs. All staff will be trained and retrained tofollow the written guidelines in the BMP and continuous active treatment. Documentationwill be completed at all opportunities to ensure formal and informal ISPIimplementation occur. The Home Manager, Lead Home Manager and QIDP willroutinely observe to ensure all</i></p>	09/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2015
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NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Findings include:</p> <p>Observations were conducted at the group home on 8/18/15 between 3:30 PM and 5:30 PM and on 8/21/15 between 5:30 AM and 7:30 AM.</p> <p>During the AM and PM observation periods the following was observed: __ Client #1 was often seen sucking her thumb. __ Staff would sometimes ask client #1 to stop sucking her thumb. __ The staff did not provide client #1 with an object to hold when observed sucking her thumb.</p> <p>During the AM and the PM observation periods the following was observed: __ Clients #1 and #3 were served mashed potatoes, broccoli, crumbled beef, bread and crushed pineapple for their evening meal on 8/18/15. __ Clients #1 and #3 were served oatmeal, waffles, toast, cottage cheese and juice for their morning meal on 8/21/15. __ Client #1's food was softened to a mechanical soft consistency. __ Client #3's food was placed in a blender and pureed. __ The staff utilized buffet style dining for the evening meal and a family style for the morning meal. __ During both observation periods</p>		<p>active treatment is being completed on a formal and informal basis including implementation of BMP training strategies.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2015
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NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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	<p>clients #1 and #3 began eating their food as soon as they sat down at the table and food was on their plate, ate their food at a fast pace while taking large bites and did not take a drink between bites of food.</p> <p>__ During both observation periods the staff did not sit with the clients as soon as they began eating and/or supervise clients #1 and #3 throughout the entire meal.</p> <p>Client #1's record was reviewed on 8/21/15 at 10 AM.</p> <p>Client #1's BSP dated 10/24/14 indicated: __ Client #1 had targeted behaviors of, not all inclusive, excessive eating, obsessing about food, PICA (eating non food items) and sucking on her thumb. __ Staff were to monitor client #1 at all times. __ When client #1 was sucking her thumb the staff were to provide client #1 with items she could hold, play with or squeeze to replace the thumb sucking and provide stimulation. __ "Staff will attempt to, at least, ask [client #1] to take her thumb out of her mouth at least one time per quarter hour."</p> <p>Client #1's CMP (Choking Management Plan) dated 11/2/12 indicated "Encourage [client #1] to take small bites with sips of fluid every 2 bites. Encourage [client #1] to put down small spoon between bites</p>			

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NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>and to take a small drink. Consider small presentation of food items as [client #1] is not compliant when 1:1 (one staff to one client supervision) is not available. Cueing does not work without 1:1."</p> <p>Client #1's ISP (Individualized Support Plan) dated 10/24/14 indicated client #1 was at risk for choking and had an objective to improve her dining skills. The methodology to the objective indicated "[Client #1] tends to eat too fast. Staff will need to sit beside her (client #1) and monitor during mealtime. Staff will encourage [client #1] to put her spoon down between bites of food. Staff are to also encourage [client #1] to drink liquids after she takes at least 3 bites of food. Don't seat [client #1] at the table until her plate is ready and staff is ready to sit with her. After both of you are seated, give her the spoon. Lay it on her plate and she will take it from there. Training will be done at all opportunities...."</p> <p>Client #3's record was reviewed on 8/21/15 at 12 PM.</p> <p>Client #3's CMP dated 11/2/12 indicated "Encourage [client #3] to take small bites and sips of fluid between bites. Alternate solids and liquids. Consider small presentation in order to slow client's rate</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2015
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NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>of intake as compliance with cueing is minimal 1:1. Encourage [client #3] to sit up straight. Supervision and assistance during all oral intakes to reduce risk for coughing/choking while eating."</p> <p>Client #3's ISP dated 11/17/14 indicated client #3 was at risk for choking and had an objective to improve his dining skills. The methodology to the objective indicated "[Client #3] tends to eat too fast. Staff will need to sit beside him (client #3) and monitor during mealtime. Staff will encourage [client #3] to put his spoon down between bites of food. Staff are to also encourage [client #3] to drink liquids after he takes at least 3 bites of food. Don't seat [client #3] at the table until his plate is ready and staff is ready to sit with him. After both of you are seated, give him the spoon. Lay it on his plate and he will take it from there. Training will be done at all opportunities...."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/21/15 at 3:30 PM, the QIDP: ___ Indicated the staff were always to provide the clients training in family style dining at every available opportunity. ___ Indicated the staff were to be sitting with clients #1 and #3 and not assisting</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/28/2015
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NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES	STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371
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W 0322 Bldg. 00	<p>other clients.</p> <p>___ Indicated the staff were to supervise clients #1 and #3 while eating their meals and prompt the clients to take small bites of food and small sips of liquids between bites.</p> <p>___ Indicated whenever client #1 was observed sucking her thumb the staff were to provide client #1 with a choice of items she could hold, play with or squeeze to replace the thumb sucking and to provide stimulation.</p> <p>9-3-4(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain preventive and general medical care.</p> <p>Based on record review and interview for 2 of 3 sampled clients (#2 and #3), the facility failed to ensure the clients were provided annual cancer screening in regard to a PSA (Prostate Specific Antigen) to test for prostate cancer.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 8/21/15 at 11 AM. Client #2's record indicated client #2 was over the age of 50. Client #2's record indicated no annual PSA testing.</p>	W 0322	<p>322</p> <p>Now and in the future, all staff will be trained andretrained at least annually to ensure all clients are provided annual PSAcancer screenings, if required. Theattached form will be used to ensure all preventive and general medical care iscurrent. The Home Manager and DSPs willensure all pertinent appointment datesare documented on the form. The HomeManager and Nurse will monthly assure the appointments are completed timely orwill schedule them, as ordered, to</p>	09/21/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 08/28/2015
NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371		
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W 0327 Bldg. 00	<p>Client #3's record was reviewed on 8/21/15 at 12 PM. Client #3's record indicated client #3 was over the age of 50. Client #3's record indicated no annual PSA testing.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/21/15 at 3:30 PM, the QIDP: ___ Indicated she spoke with the facility's LPN about client #2's and client #3's annual PSA test. ___ Stated the LPN had "overlooked it" and client #2 and client #3 will be scheduled for a PSA test.</p> <p>9-3-6(a)</p> <p>483.460(a)(3)(iv) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure client #1 received an</p>	W 0327	<p>be within the required timeline.</p> <p>327 Now and in the future, all staff will be trained and retrained at least annually to ensure all clients are</p>	09/21/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G656	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/28/2015
NAME OF PROVIDER OR SUPPLIER JAY-RANDOLPH DEVELOPMENTAL SERVICES			STREET ADDRESS, CITY, STATE, ZIP CODE 227 E UNION ST PORTLAND, IN 47371		
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	<p>annual TB (Tuberculosis) testing and/or screening.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/21/15 at 10 AM. Client #1's record indicated no annual TB testing and/or screening.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/21/15 at 3:30 PM, the QIDP:</p> <p>__ Indicated she had spoken with the facility's LPN about client #1's TB testing.</p> <p>__ Stated the LPN had "overlooked it" and client #1 was "overdue" for her annual TB test.</p> <p>9-3-6(a)</p>		<p>provided annual tuberculosis testing and/or screening. The attached form will be used to ensure the annual TB test is current. The Home Manager and DSPs will ensure the annual TB test date is documented on the form. Also the results of the test will be placed in the individual's Medical file. The Home Manager and Nurse will monthly assure the TB tests and /or screenings are completed timely or will schedule them, as ordered, to be within the required timeline.</p>		