

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 10/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CDC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960
---	---

(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
W000000	<p>This visit was an extended recertification and state licensure survey.</p> <p>Dates of Survey: October 7, 8, 9, 10, 21 and 23, 2013.</p> <p>Facility number: 000684 Provider number: 15G148 AIM number: 100243120</p> <p>Surveyor: Amber Bloss, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 11/5/13 by Chris Greeney, QIDP and Ruth Shackelford, QIDP.</p>	W000000		

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.

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 10/23/2013	
NAME OF PROVIDER OR SUPPLIER CDC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960			
(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			
W000104	<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 observation and interview, for 6 of 6 clients (clients #1, #2, #3, #4, #5, and #6) who resided in the home, the governing body failed to exercise operating direction over the group home to ensure maintenance was completed for the interior of the home in regards to missing light fixture bulbs and covers, a rusty bathroom vent, a broken switch plate, linoleum edging in disrepair, a broken door frame, wall and door disrepair, and stained carpeting.</p> <p>Findings include:</p> <p>During group home observations on 10/7/13 between 4:30 PM and 7:11 PM and on 10/8/13 between 6:15 AM and 7:43 AM, the interior of the group home was observed. Client #1's bedroom closet door was scuffed with red marks. Client #1's bedroom ceiling fan and light was missing the light cover. The men's bathroom had a rusty vent on the wall next to the toilet. The light fixture above the sink in the men's bathroom was a three light bulb fixture which was missing the middle bulb and cover. The men's bathroom plastic switch plate had a corner broken off leaving exposed sharp edges. In the kitchen, the edging between the linoleum and carpet had two corners broken off near the refrigerator and near the stove. The kitchen area carpet had dark stains beneath and around the kitchen dining table. The sliding glass door in the kitchen had a broken section of wood trim at the bottom where Clients #1, #2, #3, #4, #5, and #6 would walk over.</p> <p>During an interview on 10/10/13 at 11:49 AM, the</p>	W000104	As for tag 104 a maintenance check list has been drafted for maintenance issues to be checked in the group home monthly. All issues listed in the deficiency has been completed on 11-13-2013. Monitoring of the checklist will be done monthly by Group Home Supervisor. Addendum: A checklist will be done weekly by group home staff member if any issue found to be deficient staff will turn into Maintenance Department on the appropriate form for issue to be addressed. Monitoring of issues will be done by GHS weekly by reviewing the checklist that staff have completed. Also to ensure that the home is maintained for health and safety the house inspection checklist will include all areas of the home. Checklist to be implemented upon completion and approval of the inspection form no later than 12-6-2013.	11/13/2013			

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 10/23/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER CDC INC	STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960
---	---

(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>QIDP (Qualified Intellectual Disabilities Professional) indicated there was a maintenance work order submitted for the broken door trim on 5/6/13 but the work order was never completed. The QIDP indicated no other work orders were submitted for the above concerns. The QIDP indicated residential staff clean the carpets themselves. The QIDP indicated there were maintenance issues at the home.</p> <p>9-3-1(a)</p>			

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 10/23/2013	
NAME OF PROVIDER OR SUPPLIER CDC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960			
(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			
W000149	<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 record review and interview, the facility failed to implement written policies and procedures that prohibit neglect in regards to ensuring the facility's staff were initially trained to properly secure a wheelchair in the van for 1 of 6 clients residing in the home (Client #3).</p> <p>Based on interview and record review for 1 of 12 allegations of neglect and/or abuse reviewed, the facility failed to implement written policies and procedures that ensure allegations of abuse are investigated for 1 of 6 clients residing in the home (Client #4).</p> <p>Findings include:</p> <p>1. On 10/8/13 at 12:43 PM, the Bureau of Developmental Disabilities Services (BDDS) reports from 10/8/12 to 10/8/13 were reviewed. A BDDS report dated 8/11/13 indicated "staff was transporting consumers from Special Olympics. A vehicle pulled in front of the bus and staff needed to brake hard. Staff was able to avoid concluding (sic) into the other vehicle. Staff noticed that [Client #3]'s wheelchair had moved. [Client #3] had hit the back of her head causing about 1 inch red mark on her left shoulder (no longer visible)." The report indicated Client #3 went to the emergency room for evaluation and obtained a negative CT scan. The report indicated the "supervisor had the staff buckle the wheelchair to ensure that staff had the consumer correctly belted in. Staff was able to correctly belt the wheelchair in. All staff will be trained in appropriate</p>	W000149	As for tag 149 part 1 all group home staff has been retrained and a risk plan has been developed and implemented. Monitoring to ensure staff are following risk plan and training will be done monthly by qualified supervisor staff. As for tag 149 part2 all QIDP's will have been returned by 11-22-2013 on investigation and agency policies for abuse and neglect. Monitoring that allegations of abuse and neglect will be investigated will be done by QIDP as internal incident reports are received. Addendum: Staff will ensure that client #3 is transported correctly by following guidelines in the training book which is on the transit. For clients that have mobility issues will be assessed and a risk plan will be developed for appropriate transportation and use of approved appropriate transportation devices. To ensure the safety of all clients when transporting. Answer to addendum question one,; a training book has been developed with instructions and pictures of how to appropriately secure clients in wheelchairs on the transits. Answer to question 2. Qualified Supervisory staff (QSS) will do a visual check of all staff to	11/13/2013			

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 10/23/2013	
NAME OF PROVIDER OR SUPPLIER CDC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960			
(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>buckling procedure to ensure that [Client #3] is buckled appropriately."</p> <p>The follow up BDDS report dated 8/16/13 indicated "a review was completed on the wheelchair and the seatbelt placement on the wheelchair. The transportation coordinator identified that the training that was completed was not correct. The placement of the lap belt was incorrect. The transportation coordinator retrained the trainer, developed a picture book with appropriate placement of seatbelt placement, and developed a tape indicator on the wheelchair and seatbelts to ensure that appropriate placement of the seatbelts. All staff that transports [Client #3] was (sic) retrained on the appropriate way to seatbelt [Client #3]'s wheelchair on the vehicle."</p> <p>During an interview on 10/10/13 at 11:49 AM, the QIDP (Qualified Intellectual Disabilities Professional) indicated each bus is different on where the wheelchair tie downs hook. The QIDP indicated the training the trainer had provided was found to be incorrect for the method required for the van in which Client #3 was injured during transport.</p> <p>2. The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on 10/8/13 at 12:43 PM. An internal incident report dated 10/5/13 indicated staff "heard [Client #5] and [Client #4] yelling (sic) as staff was running to living room staff seen (sic) [Client #5] and [Client #4] holding each other by the shirt." The report indicated "staff separated [Client #5] and [Client #4]." The incident report for Client #5 indicated he had "no reaction." The incident report for Client #4 indicated he "said [Client #5] hit him" and indicated Client #4 was checked for injury and there were "no marks at this time."</p>		<p>ensure that staff are following the procedure properly, this is the initial monitoring after this is completed then staff will be monitored by QSS weekly by visual checks. Question 3. Training was the same as annual training, but included specific role playing on abuse, neglect, and exploitation of clients. Question 4. the internal incident reports for allegation of ANE will have a second follow-up by the Social Service Coordinator and Health & Safety Specialist to ensure compliance of staff. The monitoring will be done with all internal incident reports upon receiving for ANE.</p>				

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 10/23/2013
NAME OF PROVIDER OR SUPPLIER CDC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960		
(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>During an interview on 10/21/13 at 10:45 AM, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #4's allegation of abuse was not investigated. The QIDP indicated Client #4's allegation should have been investigated.</p> <p>On 10/8/13 at 10:30 AM, the facility's "Policy on Abuse and Neglect" dated March 26, 2013 was received from the Health and Safety Specialist. The facility policy on abuse indicated "all forms of abuse, neglect...are prohibited..." which included physical abuse and neglect such as "failure to provide appropriate supervision, care or training." The facility policy indicated incidents of potential abuse and/or neglect will be thoroughly investigated and "the summary and recommendation of the investigation" will be sent to "relevant parties" for follow up.</p> <p>9-3-2(a)</p>				

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 10/23/2013
NAME OF PROVIDER OR SUPPLIER CDC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960		
(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	

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 10/23/2013	
NAME OF PROVIDER OR SUPPLIER CDC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960			
(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			
W000153	<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.</p> <p>Based on interview and record review for 1 of 12 allegations of neglect and/or abuse reviewed, the facility failed to report an allegation of possible abuse to the Division of Disability, Aging and Rehabilitative Services (DDARS)/BDDS (Bureau of Developmental Disabilities Services) per 460 IAC 9-3-1 (b) (5) and to Adult Protective Services (APS) per IC 12-10-3 for 1 of 6 clients residing in the home (Client #4).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on 10/8/13 at 12:43 PM. An internal incident report dated 10/5/13 indicated staff "heard [Client #5] and [Client #4] yelling (sic) as staff was running to living room staff seen (sic) [Client #5] and [Client #4] holding each other by the shirt." The report indicated "staff separated [Client #5] and [Client #4]." The incident report for Client #5 indicated he had "no reaction." The incident report for Client #4 indicated he "said [Client #5] hit him" and indicated Client #4 was checked for injury and there were "no marks at this time."</p> <p>During an interview on 10/21/13 at 10:45 AM, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #4's allegation of abuse was not reported to BDDS. The QIDP indicated Client #4's allegation should have been</p>	W000153	As for tag 153 all group home staff has been retrained and a risk plan has been developed and implemented. Monitoring to ensure staff are following riskplan and training will be done monthly by qualified supervisor staff.Addendum:the internal incident reports for allegation of ANE will have a second follow-up by the Social Service Coordinator and Health & Safety Specialist to ensure compliance of staff. The monitoring will be done with all internal incident reports upon receiving for ANE.Monitoring of staff will be done bi-weekly by QSS to ensure the safety of clients and that staff are following risk plans.	11/22/2013			

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 10/23/2013
NAME OF PROVIDER OR SUPPLIER CDC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960		
(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	
	reported to BDDS. 9-3-2(a)				

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 10/23/2013
NAME OF PROVIDER OR SUPPLIER CDC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960		
(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	
W000154	<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 record review and interview, the facility failed to investigate 1 of 12 allegations of abuse affecting 1 of 6 clients residing in the group home (Client #4).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) and reports of injury were reviewed on 10/8/13 at 12:43 PM. An internal incident report dated 10/5/13 indicated staff "heard [Client #5] and [Client #4] yelling as staff was running to living room staff seen (sic) [Client #5] and [Client #4] holding each other by the shirt." The report indicated "staff separated [Client #5] and [Client #4]." The incident report for Client #5 indicated he had "no reaction." The incident report for Client #4 indicated he "said [Client #5] hit him" and indicated Client #4 was checked for injury and there were "no marks at this time."</p> <p>During an interview on 10/21/13 at 10:45 AM, the QIDP (Qualified Intellectual Disabilities Professional) indicated Client #4's allegation of abuse was not investigated. The QIDP indicated Client #4's allegation should have been investigated.</p> <p>9-3-2(a)</p>	W000154	As for tag 154 all QIDP's will have been returned by 11-22-2013 on investigation and agency policies for abuse and neglect. Monitoring that allegations of abuse and neglect will be investigated will be done by QIDP as internal incident reports are received. Addendum: Agency has hired a internal investigator to ensure all allegations of abuse, neglect, misconduct and exploitation are investigated upon QIDP knowledge. All clients will meet with staff once weekly to ensure there are no issues as of 11-22-2013. Review of clients house meeting notes will be monitored and done by QSS on a weekly basis.	11/22/2013	

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 10/23/2013
NAME OF PROVIDER OR SUPPLIER CDC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960		
(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	

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 10/23/2013	
NAME OF PROVIDER OR SUPPLIER CDC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960			
(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			
W000189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on interview and record review, the facility failed to train staff to properly secure a wheelchair in a van to ensure safety of 1 of 3 sampled clients (Client #3).</p> <p>Findings include:</p> <p>On 10/8/13 at 12:43 PM, the Bureau of Developmental Disabilities Services (BDDS) reports from 10/8/12 to 10/8/13 were reviewed. A BDDS report dated 8/11/13 indicated "staff was transporting consumers from Special Olympics. A vehicle pulled in front of the bus and staff needed to brake hard. Staff was able to avoid concluding (sic) into the other vehicle. Staff noticed that [Client #3]'s wheelchair had moved. [Client #3] had hit the back of her head causing about 1 inch red mark on her left shoulder (no longer visible)." The report indicated Client #3 went to the emergency room for evaluation and obtained a negative CT scan. The report indicated the "supervisor had the staff buckle the wheelchair to ensure that staff had the consumer correctly belted in. Staff was able to</p>	W000189	As for tag 189 all group home staff has been retrained and a risk plan has been developed and implemented. Monitoring to ensure staff are following riskplan and training will be done monthly by qualified supervisor staff. Addendum: Staff will ensure that client #3 is transported correctly by following guidelines in the training book which is on the transit. For clients that have mobility issues will be assessed and a risk plan will be developed for appropriate transportation and use of approved appropriate transportation devices. To ensure the safety of all clients when transporting. Answer to addendum question one; a training book has been developed with instructions and pictures of how to appropriately secure clients in wheelchairs on the transits. Answer to question 2. Qualified Supervisory staff (QSS) will do a visual check of all staff to ensure that staff are following the procedure properly, this is the initial monitoring after this is completed then staff will be monitored by QSS weekly by visual checks. Question 3. Training was the same as annual training, but included specific role	11/22/2013			

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 10/23/2013
NAME OF PROVIDER OR SUPPLIER CDC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960		
(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>correctly belt the wheelchair in. All staff will be trained in appropriate buckling procedure to ensure that [Client #3] is buckled appropriately."</p> <p>The follow up BDDS report dated 8/16/13 indicated "a review was completed on the wheelchair and the seatbelt placement on the wheelchair. The transportation coordinator identified that the training that was completed was not correct. The placement of the lap belt was incorrect. The transportation coordinator retrained the trainer, developed a picture book with appropriate placement of seatbelt placement, and developed a tape indicator on the wheelchair and seatbelts to ensure that appropriate placement of the seatbelts. All staff that transports [Client #3] was (sic) retrained on the appropriate way to seatbelt [Client #3]'s wheelchair on the vehicle."</p> <p>During an interview on 10/10/13 at 11:49 AM, the QIDP (Qualified Intellectual Disabilities Professional) indicated each bus is different on where the wheelchair tie downs hook. The QIDP indicated the training the trainer had provided was found to be incorrect for the method required for the van in which Client #3 was injured during transport. During another interview on 10/10/13 at 3:03 PM, the QIDP indicated the House</p>		<p>playing on abuse, neglect, and exploitation of clients. Question 4. the internal incident reports for allegation of ANE will have a second follow-up by the Social Service Coordinator and Health & Safety Specialist to ensure compliance of staff. The monitoring will be done with all internal incident reports upon receiving for ANE.</p>		

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 10/23/2013
NAME OF PROVIDER OR SUPPLIER CDC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960		
(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	
	Supervisor was responsible for retraining the staff but no documentation could be found to indicate training had been completed and who had been trained. 9-3-3(a)				

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 10/23/2013	
NAME OF PROVIDER OR SUPPLIER CDC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960			
(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			
W000249	<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 upon observation, interview and record review, the facility failed to ensure the Behavior Management Program was implemented as written for 1 of 3 sampled clients (Client #1).</p> <p>Findings include:</p> <p>On 10/7/13 between 4:30 PM and 7:11 PM, group home observations were conducted. At 4:45 PM, a voice monitor could be heard in the kitchen area which also served as the medication administration area, staff office area, and contained a small dining room table for clients to sit. The monitor was on the desk and could be heard throughout the room. At 5:04 PM, the Residential Manager (RM) indicated the monitor was for Client #1's BSP (Behavior Support Plan) and was kept in Client #1's bedroom which he shared with Client #4. The monitor could be heard in the kitchen throughout the observation.</p> <p>On 10/8/13 between 6:15 AM and 7:43 AM, group home observations were conducted. The monitor could be heard as being on throughout the observation period which the sounds of opening and shutting door, conversations with staff, and Client #1 talking to himself. During an interview at 6:17 AM, DSP (Direct Support Professional) #1 indicated the monitor in the kitchen area was for Client #1. DSP #1 stated it was on because</p>	W000249	As for tag 249 clarification for client 1's Behavior Support plan in regards to the issue of the monitor will be done by 11-22-13. Monitoring to ensure BSP is being followed will be done by Group Home supervisor monthly by Quality Inspections .Addendum: all clients who have an identified need for a restrictive measure will have HRC approved plan with a detailed plan of action prior to implementation and staff training. Monitoring of plans will be done by Behavior Management Committee monthly or as a new plan is needed.	11/22/2013			

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 10/23/2013	
NAME OF PROVIDER OR SUPPLIER CDC INC				STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960			
(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>Client #1 "terrorizes his room (throws items to floor) and to be sure there is no yelling between roommates which is [Client #4]."</p> <p>On 10/9/13 at 1:17 PM, record review indicated Client #1's diagnoses included, but were not limited to, mood disorder, moderate intellectual disabilities, and possible Fragile X syndrome. Client #1's ISP (Individual Support Plan) dated 7/16/13 indicated Client #1 "needs on going behavior management in order to address physical aggression and socially inappropriate behavior."</p> <p>Record review indicated Client #1 had a BSP (Behavior Support Plan) dated 3/5/13 indicated target behaviors of physical aggression and false allegations. The BSP indicated "due to the recent increase in false allegations toward others, staff need to ensure that when interacting with [Client #1] that another staff member needs to be present in order to verify the conversation/interaction." Client #1's BSP indicated the protocol for use of monitoring device was "when [Client #1] is in his room, and his roommate is in the room with [Client #1], a monitoring device will be used to listen to the interaction between [Client #1] and the roommate to ensure that if [Client #1] makes an allegation toward his roommate the allegation can be verified by staff."</p> <p>On 10/10/13 at 11:49 AM, during an interview, the QIDP (Qualified Intellectual Disabilities Professional) indicated the monitor has been on all the time depending on who was working. The QIDP indicated staff should not have had the monitor on at all times. The QIDP indicated staff did not use the monitor as indicated in Client #1's BSP.</p> <p>9-3-4(a)</p>						

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 10/23/2013
NAME OF PROVIDER OR SUPPLIER CDC INC			STREET ADDRESS, CITY, STATE, ZIP CODE 107 S COUNTRYBROOK MONTICELLO, IN 47960		
(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	