

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/07/2014
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150		
(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 for an annual recertification and state licensure survey. This visit included the investigation of complaint #IN00145443.</p> <p>Complaint #IN00145443: Substantiated. Federal/state deficiency related to the allegation(s) is cited at W154.</p> <p>Dates of Survey: March 4, 5, and 7, 2014.</p> <p>Surveyor: Dotty Walton, QIDP.</p> <p>Facility Number: 000939 AIM Number: 100368660 Provider Number: 15G425</p> <p>This deficiency reflects state findings in accordance with 460 IAC 9. Quality Review completed 3/14/14 by 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: 15G425		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/07/2014	
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150			
(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 for 1 of 1 investigation of abuse/neglect reviewed (clients A and B), the facility failed to ensure all allegations were thoroughly investigated (contained witness statements and staff/client interviews).</p> <p>Findings include:</p> <p>Review of facility Client Injury/ Event Reports, Investigations and Reportable Incident reports (Bureau of Developmental Disabilities Services/BDDS) on 3/04/14 at 2:30 PM and on 3/7/14 at 1:30 PM indicated the following:</p> <p>A BDDS report dated 2/27/14 (also date of knowledge) by RN #1 indicated a state agency reported to the facility an anonymous allegation of inappropriate client to client sexual contact had been made. The 2/27/14 BDDS report indicated the alleged sexual encounter (between clients A and B) had happened on 2/24/14 at 8:00 PM.</p> <p>Review of the facility's investigation on 3/4/14 at 3:30 PM and on 3/7/14 at 3:00 PM indicated two direct care staff (staff</p>	W000154	<p>The clients alleged to be involved in the incident were interviewed by BDDS. QCS administrative staff were present during one of the interviews and was informed of the out come at the other interview conducted by BDDS personnel. The BDDS personnel interview was assumed to be sufficient to be cited in our internal investigation. Due to the fact that both clients allegedly involved, all staff present at the time of the alleged event, and physicians examination indicated no incident occurred; it was not deemed to be necessary to interview clients that would not have been present for the incident if it had occurred. A formalized incident investigation check-list will be created. Personnel conducting investigation will complete all items listed on the check-list or indicate why they are not applicable The Director of Operations and the QMRP will monitor all investigations for completion. The Director of Operations and QMRP/RN will create this check-list and utilize it for investigations.</p>	04/06/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/07/2014	
NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150			
(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>#2 and #3) working the evening in question (2/24/14 8:00 PM) had been interviewed. The investigation contained a summary of the interviews with staff #2 and #3; not their witness statements. The summary by Administrative staff #1 indicated a typical, uneventful evening at the facility. Staff indicated clients A and B were never alone together without supervision. There was no evidence additional staff, who worked at the facility, had been questioned in an effort to ensure any relevant information was not overlooked.</p> <p>The investigative summary by the facility indicated clients A and B "denied any sexual contact." The actual interviews with the clients were not part of the investigation. The facility also served clients C, D, E, F, G and H. Clients C, D, F, G and H were not interviewed regarding the activities at the facility on 2/24/14. Client E, who was able to respond to questions via sign language, was not interviewed.</p> <p>Administrative staff #1 and QIDP/Qualified Intellectual Disabilities Professional staff #1 were asked (3/7/14 4:30 PM) if all other clients living in the facility (C, D, E, F, G and H) had been interviewed in the course of the investigation. QIDP #1</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G425	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/07/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER QUALITY COMMUNITY SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1620 SHELBY PL NEW ALBANY, IN 47150
--	---

(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>indicated they had not attempted to interview any other clients living in the facility. QIDP #1's reasoning for not interviewing other clients was they (clients) would not remember what had transpired on Monday 2/24/14 if asked on Thursday 2/27/14.</p> <p>This federal tag relates to complaint #IN00145443.</p> <p>9-3-2(a)</p>			
--	---	--	--	--