STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G393	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 01/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICES INC	113 JENNINGS ST NORTH VERNON, IN 47265

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W000000	This visit was for an annual fundamental recertification and state licensure survey. Survey Dates: January 12 and 13, 2015. Facility Number: 000907 Provider Number: 15G393 AIM Number: 100244410 Surveyor: Dotty Walton, QIDP. These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/21/15 by Ruth Shackelford, QIDP.	W000000		
W000192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, record review and interview for 1 of 3 sampled clients (#2), and one additional client (#5), the facility failed to ensure staff was sufficiently trained to document medications	W000192	In order to address this deficiency, the agency has retrained staff regarding proper med pass procedures. There was an in-service for staff on 2/5/2015. The staff were	02/12/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	correctly and protect clients' health information. Findings include: On 1/13/15 at 6:16 AM, client #2's medications(levetiracetam 1500 milligrams/mg. for seizures and loratadine 10 mg. for allergies) were administered by staff #3. The medications were dispensed from a small plastic envelope which contained the client's name, the name and dosage of the medications, a description of them and the date and time. Staff #3 placed the empty envelope with client #2's medical information in the trash without shredding it or marking out the information. On 1/13/15, staff #3 dispensed client #5's levothyroxine 25 mcg./micrograms (hormone) and administered it at 6:23 AM. The medication was dispensed from a small plastic envelope which contained the client's name, the name and dosage of the medication, a description of it and the date and time. Staff #3 placed the empty envelope with client #5's medical information in the trash without shredding it or marking out the client's health information. Staff #3 administered the rest of client #5's morning medications at 7:35 AM on 1/13/15.		instructed to keep empty medication packages on hand for month. They were instructed that this was done on order to keep track of what medications had been distributed. The staff were then told to mark out client's names and personal information on medication packages before disposing of them after the month has ended. The staff was also instructed to follow the proper med pass procedure regarding the referencing of the physicians order, the prescription labelling on the medication package and the MARs in order to make sure what medications are to be given and when they are to be stopped. The QIDP and house lead will monitor med pass on a weekly basis. The QIDP will take advantage of required, written observations to document the staff's proficiency at proper med pass procedures. The House RN will ensure future MAR entries for temporary treatments will have a definite stop date marked in the MAR. The QIDP and team lead will ensure that these actions are systemic for all county homes and followed out through formal, documented observations of staff as well as daily and weekly informal house visits.	

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	Interview with staff #3 on 1/13/15 at 6:50 AM indicated the clients' empty medication envelopes used to be kept for the nurse but she had since been instructed to throw them away. Review of/and interview with staff #3 regarding client #5's 1/15 Medication Administration Record/MAR on 1/13/15 at 7:45 AM indicated client #5 had received Enlace nail treatment as signified by staff #3's initials beside the medication on 1/13/15 at 7:00 AM in the MAR. Staff #3 indicated the Enlace was to have been given for 7 days only and the RN had not discontinued the medication. The medication remained on the MAR so she initialed it but did not administer the medication. Interview with the Medical Care Coordinator/RN #1 on 1/13/15 at 3:30 PM indicated the envelopes with the clients' health information on them were not to be put into the trash. The envelopes were supposed to be kept and given to the facility's nursing staff. The Enlace medication should not have been signed by staff #3 as having been administered. The medication should have been discontinued on the 1/15 MAR sheet for client #5. This constituted a documentation error.			

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	9-3-3(a)			
W000211	483.440(c)(3) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must take into consideration the client's age (for example, child, young adult, elderly person) and the implications for active treatment at each stage, as applicable. Based on observation, interview and record review for 1 additional client (#5), the facility failed to ensure client #5's age related issues were taken into account regarding her day program. Findings include: Client #5's record was reviewed on	W000211	The QIDP and day program manager have discussed client #5's wishes regarding her work and what is available to her at the workshop. On 1/30/2015, the day program manager and the regional program managers for SGL and industry will meet and include provisions in client #5's plan. These provisions will offer client #5 the ability to sit in the	02/12/2015

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	1/13/15 at 10:05 AM. Client #5's Vocational Rehabilitation Assessment dated 5/15/14 contained no information regarding her age or retirement options for her day programming. The record indicated client #5 was 83 years old. Client #5 was interviewed regarding her day programming wishes on 1/13/15 at 7:17 AM. Client #5 stated, "I would like to stay home. I like to work but not too well." She indicated she liked to do things and go places but not everyday. Client #5 was observed at her workshop on 1/13/15 at 11:30 AM. She stated she had been working on cardboard that morning and she was "wore out." Workshop staff/WS #1 was interviewed on 1/13/15 at 11:40 AM. WS #1 indicated client #5 was tired by lunchtime every day at the workshop and would benefit from a reduced schedule. 9-3-4(a)		common area if she wishes. If the client needs to rest after lunch, the client will have programming available to her through the pep program or in the programming area at workshop. After several interviews with client #5, staff determined that she does like to work but that she gets tired sometimes. The new plan will reflect her desire to rest some days. The QIDP will stop by the workshop on a weekly basis to ensure that client #5 is having effective communication with her supervisors at the workshop. All supervisors, the industry manager and the day program mgr. as well as pep room staff will be trained on her new plan. The QIDP will continue to monitor client #5 for indications that the workshop environment is no longer stimulating or beneficial to her. On 1/30/2015, an addendum was added to her IPP that states “There has been some discussion about [Client #5] in regards to her age and working at JRI workshop. [Client # 5] has expressed a desire to occasionally take a break from her normal activities due to her being tired and her advancing age. It has been determined that she can choose which job she wants to work, or she can choose whether to work or not. If she chooses not to work, her options are: to remain in the workshop area in the break room working on activities of her choice, she can be added to the PEP room	

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			schedule for activities of her choice. [Client #5] can also choose to participate in community HAB if she desires. A workshop goal will be added: "I will communicate to my workshop staff when I need to take a break or when I feel tired". The team signed off on the addendum and [Client #5] signed the addendum on 1/30/2015. Staff will continue to monitor client #5's status daily and offer support as needed. The QIDP and team lead will ensure that these actions are systemic for all county homes and followed out through formal, documented observations of staff as well as daily and weekly informal workshop visits.	
W000369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 of 13 medications observed (client #5), the facility failed to ensure all medications were administered without error. Findings include: On 1/13/15, staff #3 prepared client #5's medications of one tablespoon of Natural Fiber powder in water and levothyroxine 25 mcg./micrograms (hormone) and	W000369	An in-service training was held on 2/5/2015 for the staff at Jennings St Group home. The staff were instructed to follow the proper med pass procedure regarding the referencing of the physicians order, the prescription labelling on the medication packaging and the MAR in order to make sure what medications are to be given and when they are to be stopped. The staff were instructed upon the proper way to pass thyroid medication. The QIDP and house lead will monitor	02/12/2015

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	administered them at 6:23 AM. Review of client #5's 1/15 Medication Administration Record/MAR and the medication label for the levothyroxine on 1/13/15 at 6:45 AM indicated client #5 was to receive levothyroxine at 6:00 AM "give one tablet by mouth daily (not to be given with calcium) give on empty stomach." Staff #3 asked client #5 on 1/13/15 at 6:20 AM, if she had eaten breakfast. Client #5 stated, "yes, I ate breakfast." Interview with staff #3 on 1/13/15 at 6:50 AM indicated the facility's medication policy indicated there was a 2 hour window (one hour before and one hour after) around the prescribed time of medication administration indicated in the MAR. Client #5's levothyroxine was listed at 6:00 AM and she had other medications, including calcium supplement listed at 7:00 AM. Staff #3 indicated she routinely gave all of client #5's medications at the same time. Interview with the Medical Care Coordinator/RN #1 on 1/13/15 at 3:30 PM indicated the administration of the levothyroxine after a meal and with other medication was an administration error.		med pass on a weekly basis. The QIDP will take advantage of required, written observations to document the staff's proficiency at proper med pass procedures. The RPM will ensure that all other group homes in the agency understand the importance of passing Levothyroxine and other like medications at the appropriate time. In-service training will be provided for those who do not display proficiency concerning this med pass procedure. The QIDP and Team Lead will ensure that these actions are systemic for all county homes and followed out through formal, documented observations of staff as well as daily and weekly informal house visits.	

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	9-3-6(a)			
W000440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), and 3 additional clients (#4, #5 and #6), the facility failed to ensure day shift, evening shift and sleeptime evacuation drills were conducted at least quarterly. Findings include: Fire evacuation drills from 12/17/13 through 12/27/14 with clients #1, #2, #3, #4, #5 and #6, as participants were reviewed on 1/13/15 at 11:30 AM. The review indicated no sleeptime fire drill (11:00 PM until 5:00 AM) for the fourth quarter of 2014 (October, November and December). There was no daytime (6:00 AM to 2:00 PM) or evening drills (2:00 PM to 10:00 PM) for the third quarter of 2014 (July, August and September).	W000440	In order to ensure that drills are being done in a timely manner, the county QIDPs will continue to create monthly schedules, noting when drills are to take place. The QIDPs will post this schedule in the homes in order for staff to be more aware of when drills are to take place. The QIDPs will turn the schedules in to the RPM with other end of month paperwork. The RPM will receive a copy of the drills that were completed during the month and ensure that the appropriate numbers of drills are being conducted at each home for the quarter. An in service was held on 2/5/2015 and staff are to be instructed upon DSI's policy regarding the frequency of drills. The QIDP and Team Lead will ensure that these actions are systemic for all	02/12/2015

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	Interview with Administrative staff #1 on 1/13/15 at 2:15 PM indicated no additional drill records for the facility. 9-3-7(a)		county homes and followed out through formal, documented observations of staff as well as daily and weekly informal house visits.	
W000460	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3), and 3 additional clients (#4, #5 and #6), the facility failed to ensure clients were served their total menued diet. Findings include: Observations of the evening meal and its preparation were conducted on 1/12/15 from 3:45 PM until 6:00 PM. Clients #1, #2, #3, #4, #5, and #6 were served baked chicken, tater tots, carrots, green beans, and sherbet. The clients were not served gravy, bread or milk. Bread and milk were not on the dining table and gravy was not prepared. Review of the menu on 1/13/15 at 6:50 AM indicated the following menu for the	W000460	In order to ensure that staff are adequately aware of the expectations of providing clients meals that are in line with their menu, an in-service was held on 2/5/2015. The staff were instructed to ensure that the clients are offered everything that is listed on each day's menu. The house lead and the QIDP will make use of documented observations in order to ensure staff are following the menu. The house lead will assist staff with following the menu on a daily and weekly basis. The RPM expects all county QIDPs to ensure, through documented and undocumented observations that meals are being served in accordance with each facility's menu. If staff are seen to be confused or unable to follow the menu, the county QIDP will offer more focused training regarding adherence to the menu. The QIDP	02/12/2015

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	evening meal on 1/12/15: oven fried chicken, potatoes, buttered carrots, one slice of wheat bread, low fat ice cream, 8 fluid ounces of skimmed milk and poultry gravy. Interview with staff #5 on 1/12/15 at 5:40 PM indicated the clients had not been served the bread or milk. 9-3-8(a)		and Team Lead will ensure that these actions are systemic for all county homes and followed out through formal, documented observations of staff as well as daily and weekly informal house visits.	
W009999	State Findings: The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met. 460 IAC 9-3-3 Facility Staffing (e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the	W009999	Staff #5 did have a documented TB test that was less than a year old, but failed to provide this documentation to regional administration. Since then, regional has received her TB test results, which indicated no presence of tuberculosis. Each county QIDP has been trained and in-serviced upon the use of the company's training matrix. This matrix contains all staff and their needs of not only training but TB tests. This meeting , held on 1/22/2015, instructed QIDPs to ensure that all employees are on this matrix and that all information related to each staff is relevant and up to date. Any staff found to be without an annual TB test will be suspended pending the administration and negative reading	02/12/2015

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	skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician. This state rule is not met as evidenced by: Based on interview and personnel record review for 1 of 6 staff personnel records reviewed, (staff #5), the facility failed to ensure staff #5 received an annual Mantoux test/screening. Findings include: The facility's employee records were reviewed on 1/13/15 at 1:45 P.M. Review of personnel files indicated the most recent Mantoux test/screening for staff #5 was dated 2/11. There was no evidence of a TB/tuberculosis screening or chest x-ray being conducted since 2/11. Administrative staff #10 was interviewed on 1/13/15 at 2:10 P.M. and indicated staff #5 did not have a current TB screening or chest x-ray. 9-3-3(e)		of a TB test. The QIDP and Team Lead will ensure that these actions are systemic for all county homes and followed out through formal, documented observations of staff as well as daily and weekly informal house visits.	

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