

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/01/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274
--	--

(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
W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: May, 29, 30, 31 and June 1, 2012.</p> <p>Surveyor: Dotty Walton, Medical Surveyor III</p> <p>Facility Number: 000632 AIM Number: 100233940 Provider Number: 15G092</p> <p>The following deficiencies reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 6/8/12 by Tim Shebel, Medical Surveyor III.</p>	W0000		

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:  15G092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/01/2012
NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274		
(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	
W0289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based on observation, record review and interview for one additional client (#5), the facility failed to ensure the client's program contained methodology to decrease his dependence upon door alarms.</p> <p>Findings include:</p> <p>During observations at the facility on the evening of 5/29/12 from 2:00 PM until 6:00 PM, door alarms were observed on the three exit door of the facility. On 5/30/12 from 6:00 AM until 1:30 PM, door alarms were observed to be engaged and sounded at the facility on three exit doors.</p> <p>Review of client #5's record on 5/31/12 at 3:00 PM indicated his last behavior support plan/BSP was dated 1/02/2007 and addressed the behaviors of physical aggression, elopement, and inappropriate toileting (flushing excessively and clogging.) Door alarms were part of the interventions to address client #5's elopement. There was no plan to</p>	W0289	<p>QIDP and IDT will review Client #5's support plan and revise as needed to address the use of door alarms and the goal to reduce or possibly eliminate the use of door alarms. HRC approval will continue to be sought for any restrictions as identified in the plan. Staff will be trained on any revisions. QIDP will review all behavior support plans at least annually to ensure each contain plans to decrease restrictions as behaviors are reduced.</p> <p>Responsible for QA: QIDP</p>	07/01/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/01/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274
--	--

(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>decrease the dependence on the door alarms as client #5's behaviors decreased.</p> <p>Interview with Qualified Intellectual Disabilities Professional/QIDP #1 on 5/31/12 at 3:20 PM indicated there had not been an elopement attempt by client #5 since 2007. The interview indicated there should be methodology the BSP to decrease the alarm usage based on staffing ratios, client #5's behaviors and time of day.</p> <p>9-3-5(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/01/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274
--	--

(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
W0316	<p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually.</p> <p>Based on record review and interview for 1 of 1 sampled clients who use drugs to control behavior, (#3) and one additional client (#5), the facility failed to ensure an attempt to gradually withdraw the drugs was attempted annually.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of client #3's record on 5/30/12 at 10:00 Am indicated he received Naltrexone 50 mg/milligrams daily for self injurious behavior, Seroquel 50 mg. for self injurious behavior and Risperadone 2 mg. daily for self injurious behavior. The record review indicated a behavior support program/BSP dated 2012 which defined self injury as "hitting self in head or mouth." The record review indicated no behavior tracking data for self injury for client #3.</li> <li>2. Review of client #5's record on 5/31/12 at 3:00 PM indicated his last behavior support plan was dated 1/02/2007 and addressed the behaviors of physical aggression, elopement, and inappropriate toileting (flushing excessively and clogging.) Review of client #5's 5/12 Medication</li> </ol>	W0316	<p>QIDP and IDT will review Clients #3 and #5's behavior support plan. Appropriate behavior tracking data will be put in place for the behaviors which medication has been prescribed. QIDP will submit data on behaviors to the psychiatrist for review and will seek reduction in medication as goals identified in the BSP are met. Staff will be trained on behavior tracking and any revisions in BSP's. QIDP will review all behavior support plans at least annually to ensure each contain plans to decrease restrictions as behaviors are reduced. Responsible for QA: QIDP</p>	07/01/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/01/2012	
NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274			
(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>Administration Record/MAR indicated client #5 received 20 mg. of the antidepressant Celexa daily and 100 mg. of the antidepressant trazodone daily for behavior management. The review indicated no behavior tracking data for client #5.</p> <p>Interview with Qualified Intellectual Disabilities Professional/QIDP #1 on 5/31/12 at 3:30 PM indicated there had not been an attempt to reduce client #3's or client #5's behavioral medications in over a year. The interview failed to indicate behavior data associated with self injury which would contraindicate an attempt at a gradual reduction of client #3's behavioral medication. The interview indicated client #5 had not tried to elope from the facility since 2007. The interview failed to indicate contraindication for an attempt to gradually withdraw client #5's behavior medication.</p> <p>9-3-5(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/01/2012	
NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274			
(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			
W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview for 1 additional client (#5), the facility's nursing services failed to ensure the client's esophageal stricture was monitored and medication recommendations were addressed.</p> <p>Findings include:</p> <p>Review of agency reportable incidents on 5/31/12 at 11:52 AM indicated an episode wherein client #5 began coughing on 3/11/12 at 5:25 PM during the evening meal. "[Client #5]was taking a drink of pop when he began spitting up liquids and was having difficulty swallowing. Staff noted that he appeared to be trying to dislodge something. Both staff encouraged [client #5] to cough, which he was having difficulty doing." The incident report indicated emergency medical technicians/EMTs were called and evaluated client #5 on site.</p> <p>Review of client #5's record on 5/31/12 at 3:00 PM indicated his diagnoses included, but were not limited to, GERD (gastro esophageal reflux disease), dysphagia, Barrett's Esophagus (erosion of tissue by acid), and Distal Esophageal Stricture.</p>	W0331	<p>QIDP and RN will consult with Client #5's physician on the possible increase of the Omeprazole. New physician orders will be implemented and staff trained as needed. QIDP and RN will ensure that Client #5's esophageal stricture is evaluated at least annually by his physician. RN will be responsible for monthly assessments and will work with QIDP to ensure each client's medical needs are being addressed timely.</p> <p>Responsible for QA: QIDP, RN</p>	07/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/01/2012	
NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274			
(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>The review indicated client #5 had undergone an esophageal dilation on 11/19/10 due to swallowing issues associated with his diagnosis of esophageal stricture. The record review indicated the client had not been evaluated by his Gastroenterologist since 11/19/10. Client #5 was evaluated by a Gastroenterologist on 4/11/12. The physician indicated client #5 may need to increase his Omeprazole to 40 mg. (milligrams) daily if he has erosion in the esophagus. Client #5 and underwent an esophageal dilation on 4/26/12. The physician indicated client #5 had "mild erosion" along with the esophageal stricture. A 5/31/12 review at 3:00 PM of client #5's 5/12 Medication Administration Record/MAR indicated client #5 received 20 mg. of the Omeprazole daily (to neutralize stomach acid). The record review indicated no evidence the facility nurse had not had ongoing evaluations of client #5's esophageal stricture since 11/19/10. The record review indicated the nurse had not consulted with the physician regarding the possible need to increase his Omeprazole or his diet to treat the Barrett's Esophagus.</p> <p>Interview with Qualified Intellectual Disabilities Professional/QIDP #1 on 5/31/12 at 3:30 PM indicated the facility nurse had not referred client #5 for</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/01/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274
--	--

(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>evaluation of his esophagus since 11/19/10 until the 4/11/12 appointment. the interview indicated the nurse had not consulted the physician about increasing or changing his Omeprazole and had not reviewed the client's diet as pertaining to his Barrett's Esophagus.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/01/2012	
NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274			
(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			
W0440	<p>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 sleeptime evacuation drills were conducted at least quarterly.</p> <p>Findings include:</p> <p>Fire/evacuation drills from 4/11 to 5/12 with clients #1, #2, #3, #4, #5 and #6, as participants were reviewed on 5/29/12 at 2:30 PM. The review indicated no third shift fire/evacuation drill (10:30 PM until 8:30 AM) for the fourth quarter of 2011 (October, November and December) or the third quarter of 2011 (July, August and September). The review indicated no daytime (8:30 AM to 2:30 PM) evacuation drills for the fourth quarter of 2011 (October, November and December), the third quarter of 2011 (July, August and September), and for the first quarter of 2011 (January, February and March). Additional review indicated there were no evening shift (2:30 PM to 10:30 PM) evacuation drills during the first quarter of 2012 (January, February and March).</p>	W0440	<p>QIDP will retrain staff on the requirements for regular evacuation drills. A schedule of the drills will be posted in the home. Staff will turn in monthly documentation to the QIDP of the evacuation drills completed that month. QIDP will compare with the drill schedule to ensure compliance in this area. Responsible for QA: QIDP</p>	07/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/01/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274
--	--

(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>Interview with Qualified Intellectual Disabilities Professional/QIDP #1 on 5/29/12 at 10:45 AM indicated no additional drill records for the facility.</p> <p>9-3-7(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/01/2012	
NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274			
(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			
W0460	<p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure the client's menu was followed.</p> <p>Findings include:</p> <p>During observations at the facility on 5/30/12 from 6:00 AM until 8:30 AM, breakfast was observed.</p> <p>Client #2 was observed to have coffee in the living room. The client obtained two toaster pastries from the pantry and ate the pastries in the living room with coffee. The client was also observed to pack his lunch independently. He made a luncheon meat with cheese sandwich, placed a bag of potato chips, a cookie, 2 pudding cups and snack crackers into his lunch container. Client #2 was not prompted by staff #9 or #10 to consult the facility's menu when eating/preparing breakfast or preparing/packing his lunch. Review of food items (7:30 AM 5/30/12) indicated the pudding cups were not sugar or fat free, the potato chips were 150 calories per serving and the toaster pastries were 400 calories and contained sugar. Client #2 was weighed by staff #10 on 5/30/12 at 6:35 AM and was 282</p>	W0460	<p>Staff will be retrained on menus and how to ensure each client eats a nutritionally balanced meal. QIDP's will review with house staff at team meetings the importance of ensuring clients receive adequate nutrition and ways to accomplish this. QIDP or designee will observe staff at least weekly through July to ensure compliance then periodic checks will continue at least once monthly.</p> <p>Responsible for QA: QIDP</p>	07/01/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/01/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>pounds.</p> <p>Review of the breakfast menu in use on 5/30/12 indicated clients had a choice of 3/4 cup dry cereal or an egg, a cup of skim milk or 1 cup yogurt, 1/2 cup of apple juice or 1/2 cup melon, whole wheat toast with diet jelly. The lunch menu for 5/30/12 indicated a 2 ounce sliced turkey sandwich, 6 ounces vegetable or a v-eight juice drink, an orange or or another fresh fruit choice, and a peanut butter cookie.</p> <p>Review of client #2's record on 5/30/12 at 12:00 PM indicated his diagnoses included, but was not limited to, non insulin dependent type II diabetes mellitus. The record review indicated: A dietary evaluation dated 5/11/11 which indicated client #2's ideal weight range was from 166 to 202 pounds. The client was to receive an 1800 calorie low fat diet with no second servings. The dietician indicated his weight was 282 pounds and recommended the client lose 1 to 2 pounds per month during the coming year.</p> <p>Interview with Qualified Intellectual Disabilities Professional/QIDP #1 on 5/31/12 at 3:30 PM indicated staff #9 and #10 should have ensured client #2 followed his menu for breakfast and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/01/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	lunch.  9-3-8(a)			