

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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: August 22, 23, 24 and 29, 2012</p> <p>Surveyor: Jo Anna Scott, Medical Surveyor III</p> <p>Facility Number: 008879 Provider Number: 15G672 AIMS Number: 200076390</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 9//7/12 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: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2012	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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			
W0288	<p>483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. Based on record review and interview for 1 of 3 sample clients (client #2), the facility failed to provide a training program for dental appointments to avoid having to take a behavior medication.</p> <p>Findings include:</p> <p>The record review for client #2 was conducted on 8/23/12 at 1:04 PM. The Behavior Support Plan indicated client #2 received Diazepam .25 mg. for dental appointments only. The record did not include a training program for dental appointments to avoid taking a behavior medication.</p> <p>Interview with staff #4 on 8/23/12 at 9:00 AM indicated client #2 did not like strangers touching her and would not cooperate at the dentist office without the Diazepam.</p> <p>9-3-5(a)</p>	W0288	<p>w288 QIDP will revise Client #2's program plan to include training to help decrease the client's fear of the dentist and the need for medication to help her relax prior to the visit. Staff will be trained on the revised plan. Monthly documentation will be reviewed by the QIDP to assess progress in this training. Responsible for QA: QIDP</p>	09/28/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2012	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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			
W0327	<p>483.460(a)(3)(iv) PHYSICIAN SERVICES</p> <p>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 sample clients (client #1), the facility failed to provide an annual tuberculosis screening.</p> <p>Findings include:</p> <p>The record review for client #1 was conducted on 8/23/12 at 9:31 AM. The record indicated client #1 had a chest x-ray on 3/16/11. There was no indication a tuberculosis screening or another chest x-ray on been conducted.</p> <p>Interview with staff #2, Assistant QMRP (Qualified Mental Retardation Professional) on 8/23/12 at 11:30 AM indicated the order for another chest x-ray dated 7/15/12 for client #1 was not accepted at the hospital since it did not have a diagnosis listed on the order. Staff #2, Assistant QMRP, indicated they had to get another order from the primary care physician.</p> <p>9-3-6(a)</p>	W0327	<p>W327</p> <p>Client #1 has now had a chest x-ray screening for TB. SGL Manager has retrained staff on guidelines for timely annual screenings. QIDP along with the agency nurse will review each client's file monthly to ensure that annual screenings are obtained timely. Responsible for QA: QIDP, Agency nurse</p>	09/28/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2012	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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			
W0369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 1 of 28 medication doses given for 1 of 5 clients (client #2) observed, the facility failed to ensure the medication was administered without error.</p> <p>Findings include:</p> <p>During the morning observation period on 8/23/12 from 6:00 AM to 7:50 AM, client #2 received her medication at 7:10 AM. Staff #4 removed two plastic packets for client #2 at 7:10 AM. Staff #4 cut the corner off each plastic packet and put all the medications in a medicine cup. One of the packets contained 1 Risperidone 2 mg, (milligrams) for behavior, the other packet contained the following:</p> <ul style="list-style-type: none"> 1 Calcium with Vitamin D (supplement) 2 Docusate Sodium 100 mg. (constipation) 1 Risperidone 2 mg. (behavior) <p>Client #2 took the medication with water and staff #4 proceeded to mark the medication administration record as being given. Staff #4 then called a telephone number and stated "I gave client #2 her</p>	W0369	<p>W369</p> <p>Staff are trained on Medication Administration procedures initially when hired and are required to renew this training annually. QIDP is responsible for ensuring staff keep their annual trainings current. QIDP reviewed this medication error with this staff person and addressed appropriately per agency policy and procedures. QIDP or designee will observe at least monthly in the home to ensure med passes are completed per agency procedures. Responsible for QA: QIDP</p>	09/28/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2012	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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>4:00 PM medication by mistake. Staff #4 then called the nurse and told her that she had given client #2 her 4:00 PM Risperidone as well as her 7:00 AM Risperidone.</p> <p>Review of the medication administration record (MAR) at 9:00 AM indicated client #2 was suppose to receive 1 Risperidone 2 mg, 2 Docusate Sodium 100 mg., and 1 Calcium with Vitamin D at 7:00 AM and 1 Risperidone 2 mg at 4:00 PM.</p> <p>Interview with staff #1, Administrator, on 8/23/12 at 9:30 AM indicated the pharmacy they use puts the medication in plastic bags that are attached in one big roll and they should be given in the order they come off the roll. Staff #1, Administrator, indicated the person passing the medications is suppose to check the medicine listed on the plastic bag against the medication administration record (MAR) before giving the medication to the client and the time it is to be given should also be checked on the MAR.</p> <p>9-3-6(a)</p>						