

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  07/23/2014
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR SEYMOUR, IN 47274
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W000000	<p>This visit was for the recertification and state licensure survey.</p> <p>Dates of Survey: July 22 and 23, 2014.</p> <p>Surveyor: Dotty Walton, QIDP</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. Quality Review completed 7/30/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000140	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to maintain a system which ensured an accurate accounting of clients' funds.</p> <p>Findings include:</p>	W000140	<p>Staff will be retrained on finance procedures including accurate record keeping and nightly auditing by staff. Staff will notify the QIDP by the end of the shift when any discrepancies are found in any finance book. Monthly auditing by the Administrative Finance Specialist and notification to the</p>	08/29/2014

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.

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W000186	<p>On July 22, 2014, at 3:30 PM, client financial records were reviewed and Qualified Intellectual Disabilities Professional/QIDP #1 was observed to count clients' personal cash kept on hand at the facility.</p> <p>The following was found during the record review/observation:</p> <p>Client #1's financial record indicated a balance of the cash on hand as \$40.43. During the 7/22/14 3:30 PM audit, the actual cash on hand was \$46.43; a discrepancy of \$6.00.</p> <p>Interview with QIDP #1 on 7/22/14 at 3:30 PM indicated the client's funds should match the financial records. No explanation for the discrepancy could be found.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, interview and</p>	W000186	<p>QIDP and SGLdivision manager of anydiscrepancies will continue.Responsible for QA: QIDPAddendum: QIDP or designee will review finance books weekly for one month to ensure accuracy. Should discrepancies be found with weekly audits, QIDP will review finance books daily and retrain staff to ensure compliance.</p> <p>Additional direct support staff</p>	08/22/2014			

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	<p>record review for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to ensure the facility maintained a staffing ratio/sufficient staff to ensure clients' safety, programming and behavioral/psychological needs would be met during the morning hours.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 7/23/14 from 5:50 AM until 7:45 AM. Staff #6 was observed to be working alone in the facility with clients #1, #2, #3, #4, #5, and #6 until staff #3 came at 6:30 AM. During the observations, the medication pass was observed for all clients, clients participated in hygiene (toothbrushing), cooking breakfast, client #4 was in and out of the facility smoking cigars, and clients were to be supervised during the eating of the breakfast. Client #1's edema protocol was implemented by staff #6 at 6:40 AM (unwrapping/storage of bilateral ACE bandages). Client #3's breakfast was pureed by staff #6 and he sat without supervision to eat.</p> <p>BDDS/Bureau of Developmental Disabilities Services reports reviewed on 7/22/14 at 2:30 PM indicated an incident report dated 04/01/14 at 7:00 AM</p>		<p>will be scheduled during morning hours in this home to ensure the needs of the clients are met during this time. QIDP's or designee will observe at least weekly for one month and at least monthly thereafter to ensure client needs are met with appropriate staffing. Responsible for QA: QIDP</p>				

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	<p>wherein client #6 had been admitted to the local hospital for overnight observation after taking a housemate's medications. Staff #6 had dispensed client #2's medications (Metformin two 500 mg. (milligram) tablets (diabetes), Meloxicam one 15 mg. tablet (anti-inflammatory), Lisinopril two 20/125 mg. tablets (blood pressure), Glimepiride 1 mg. (diabetes), and Amlodipine one 5 mg. tablet (blood pressure) and left them unlocked/unsecured. Staff #6 stepped away from the medication area to check on another client using the restroom (client #3 who required close supervision while toileting) and client #6 took the medication by mistake. Staff #6 was the only staff passing medications and supervising 6 clients at the time of the medication errors.</p> <p>According to review of the residential facility's staffing list on 7/22/14 at 1:15 PM, staff #6 was scheduled at the facility on Mondays, Tuesdays and Wednesdays from 10:00 PM until 8:00 AM. The staffing schedule made no reference to additional staffing during that time frame on a weekday basis.</p> <p>Client #3's record was reviewed on 7/23/14 at 11:50 AM and indicated he was at risk for choking and required a pureed diet and nectar thickened</p>						

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	<p>consistency fluids. The review indicated client #3 would stuff the toilet with paper and had eloped from the facility in the past. The client was to be monitored while eating for his safety.</p> <p>Client #6's record review of 7/23/14 at 11:45 AM indicated his diagnoses, included, but were not limited to, Dementia and TIAs (Transient Ischemic Attacks or mini strokes). The record indicated client #6 was not diabetic and he was monitored in the hospital to ensure his blood sugar was kept within normal limits.</p> <p>When asked (7/23/14 7:15 AM) why she was at the facility on 7/23/14 during the morning hours' observations, staff #3 indicated she was a team leader for the agency and was to be available for surveyor's questions. The interview indicated the agency was looking into making additional staff available in the morning hours.</p> <p>Interview with the Qualified Intellectual Disabilities Professional/QIDP staff #1 on 7/23/14 at 10:00 AM indicated staff #6 was a highly competent staff and she was upset about the errors. The interview indicated staff #6 had to redirect client #3 (a client who had behavioral issues with stuffing the toilet with paper causing it to overflow). The interview indicated only</p>						

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W000368	<p>one staff was in the facility to manage behaviors and provide active treatment at 7:00 AM when the medication errors occurred.</p> <p>9-3-3(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 additional client (#6), the facility failed to ensure the clients received medications according to the physician's orders.</p> <p>Findings include:</p> <p>Facility reportable incidents and investigations were reviewed on 7/22/14 at 2:30 PM.</p> <p>The review indicated the following medication errors:</p> <p>An incident report (BDDS/Bureau of Developmental Disabilities Services) dated 04/01/14 at 7:00 AM indicated client #6 had been admitted to the local hospital after taking a housemate's medications. Staff #6 had dispensed client #2's medications (Metformin 2 500 mg. (milligram) tablets (diabetes),</p>	W000368	<p>Staff were retrained on agency procedures for medication administration. QIDP or designee, or agency nurse will observe at least weekly for one month to ensure staff are following agency procedures for medication administration and at least monthly thereafter. Responsible for QA: QIDP, Agency nurse Addendum: Staff are required to complete retraining in Core A, medication administration procedures, per agency policy after identified non-compliance in this area to include observation of med pass. QIDP, agency nurse or designee, will conduct observations of med passes at least three times weekly for one month or daily should failure to follow procedures be evident. QIDP or designee will continue to observe med passes in the home at least monthly to ensure compliance in</p>	08/29/2014

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	<p>Meloxicam 1 15 mg. tablet (anti-inflammatory), Lisinopril 2 20/125 mg. tablets (blood pressure), Glimepiride 1 mg. (diabetes), and Amlodipine 1 5 mg. tablet (blood pressure) and left them unlocked/unsecured. Staff #6 stepped away from the medication area to check on another client using the restroom and client #6 took the medication by mistake. The facility's RN was contacted as was poison control and the decision was made to take client #6 to the emergency room. Client #6 was admitted and stayed in the hospital over night for observation.</p> <p>Interview with the Qualified Intellectual Disabilities Professional/QIDP staff #1 on 7/23/14 at 10:00 AM indicated staff #6 was a highly competent staff and she was upset about the errors. The interview indicated staff #6 received counseling and retraining as the agency's policy prohibited medication errors.</p> <p>9-3-6(a)</p>		this area.				
W000440	<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),</p>	W000440	<p>QIDP will retrain staff on therequirements for regular evacuationdrills. A schedule of the drills will beposted in the</p>	08/22/2014			

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W009999	<p>the facility failed to ensure evacuation drills were conducted at least quarterly for all shifts of personnel.</p> <p>Findings include:</p> <p>Fire evacuation drills from 7/13/13 until the time of the survey with clients #1, #2, #3, #4, #5 and #6 as participants, were reviewed on 7/22/14 at 3:45 PM. The review indicated no sleeptime drills for the fourth quarter of 2013, (October, November, December), the first quarter of 2014 (January, February, March) or the second quarter of 2014 (March, April, May).</p> <p>Interview with the Qualified Intellectual Disabilities Professional/QIDP staff #1 on 7/22/14 at 4:00 PM indicated no additional drills were done.</p> <p>9-3-7(a)</p> <p>State Findings: The following Community Residential</p>	W009999	<p>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. QIDP will report monthly to SGL Manager the dates of drills conducted that month for tracking to ensure compliance. Responsible for QA: QIDP</p> <p>Staff are expected to update their TB test annually. All Staff in this home are current at this time. QIDP will ensure that staff remain</p>	08/22/2014	

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	<p>Facilities for Persons with Developmental Disabilities rules were not met:</p> <p>460 IAC 9-3-2 Resident Protections</p> <p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is:</p> <p>(3) conviction of a crime substantially related to a dependent population or any violent crime.</p> <p>The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, SECTION 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>This State Rule is not met as evidenced by:</p> <p>Based on record review and interview, for 1 of 2 (staff #4) personnel files reviewed, the facility failed to ensure three references were obtained prior to employment.</p> <p>Findings include:</p>		<p>incompliance in this area. Observations have been noted and reviewed with the HR department. Appropriate references will be sought for each new employee. Responsible for QA: QIDP, HR, SGL Manager</p>				

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	<p>The facility's personnel records were reviewed on 7/22/14 at 1:45 P.M. Review of the personnel files for staff #4 indicated one reference was obtained which met the above rule.</p> <p>An interview with the Agency's Residential Director on 7/22/14 at 2:00 PM indicated staff #4 did not have the required three references prior to be working in the facility.</p> <p>460 IAC 9-3-3 Facility Staffing</p> <p>(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 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.</p> <p>This state rule is not met as evidenced by:</p>			
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	<p>Based on interview and record review for 1 of 2 staff personnel records reviewed (staff #5), the facility failed to ensure staff #5 received an annual Mantoux test/screening.</p> <p>Findings include:</p> <p>The facility's employee records were reviewed on 7/22/14 at 1:45 P.M. Review of staff #5's personnel file indicated her most recent TB (tuberculosis) skin test was given on 6/25/12.</p> <p>The Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 7/23/14 at 10:00 A.M. The QIDP indicated staff #5's TB skin test documentation was outdated and staff #5 was contacting the local health department. No current TB test for staff #5 was available at the time of the survey.</p> <p>9-3-2(c)(3) 9-3-3(e)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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