

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/31/2014
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 426 E MONTGOMERY RD. GREENSBURG, IN 47240
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W000000	<p>This visit was for the fundamental recertification and state licensure survey.</p> <p>Survey dates: January 28, 29, 30 and 31, 2014</p> <p>Facility Number: 001214 Provider Number: 15G639 AIM Number: 100234330</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/4/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 3 of 3 clients in the sample (#1, #3 and #5) and one additional client (#4), the Qualified Intellectual Disabilities Professional (QIDP) failed to ensure: 1) data was collected for clients #1, #3 and #5's training objectives and action was taken to address the clients not meeting</p>	W000159	<p>QIDP's have been retrained on reviewing data collection on training objectives and follow up action needed when training objectives are not being met. QIDP will ensure that all staff are trained on appropriate documentation for training objective. QIDP will ensure that not only Clients #1, #3, and #5's training objectives are reviewed</p>	03/02/2014

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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	<p>their training objectives, 2) client #4 had a medication training objective included in her Individual Program Plan (IPP), and 3) client #3's Behavior Management Plan (BMP) included accurate information regarding client #3's current psychotropic medication.</p> <p>Findings include:</p> <p>1) A review of client #1's record was conducted on 1/29/14 at 9:19 AM. Client #1's Residential Monthly Report (RMR), dated January 2013, indicated the data collection for exercise and laundry was blank. The data for hygiene and making toast indicated, "Did not have this month." In February 2013, the data was blank for exercise, hygiene and making toast. There was no RMR for March 2013. In April 2013, the data sheet was lined out for hygiene, making toast and identifying her medication. There were no RMRs for April and May 2013. In June 2013, the RMR indicated, "Didn't have" for hygiene, making toast, identifying her medication, and cleaning her room. There was no RMR for July 2013. In August 2013, the RMR was blank for exercise, hygiene, making toast, identifying her medication, laundry (learn dryer) and cleaning her room. In September 2013, the RMR was blank for exercise and indicated,</p>		<p>and revised as needed. QIDP will revise Client #4's IPP to included a medication training objective. Client #3's behavior management plan will be updated to reflect accurate information. QIDP will review training objective monthly and take appropriate action as needed to modify these to meet client needs or retrain staff as needed in data collection. SGL Manager will review plans to ensure compliance in this area. Responsible for QA: QIDP, SGL Manager</p>		

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	<p>"didn't do" for hygiene. In Oct 2013, the RMR was blank for exercise. In November 2013, the RMR was blank for exercise and indicated "didn't do" for identifying her medication and making her bed. In December 2013, the RMR was blank for exercise, hygiene, identifying her medication and cleaning her room. Laundry (learn dryer) was crossed out. There was no documentation on the RMRs or in the client's record indicating the QIDP took action to address the information on the RMRs.</p> <p>A review of client #3's record was conducted on 1/29/14 at 10:02 AM. Client #3 did not have a RMR for January 2013. In February 2013, the RMR was blank for exercise and indicated zero percent completion for safe driving and laundry skills. In March 2013, the RMR indicated, "No charting" for clipping her fingernails and zero percent completion for safe driving and sewing a button back on clothes. In April 2013, the RMR was blank for exercise and clipping her fingernails. The RMR indicated laundry skills was zero percent completion. In May 2013, the RMR was blank for exercise. The RMR indicated zero percent completion for safe driving and laundry skills. The RMR indicated for clipping fingernails,</p>			

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	"Nurse does it." In June 2013, the RMR was blank for exercise and indicated "No charting" for clipping her fingernails. The RMR indicated zero percent completion for safe driving, culinary skills, and laundry skills. In July 2013, the RMR was blank for exercise and clipping her fingernails. The RMR indicated "didn't have" for stating her home address. The RMR indicated zero percent completion for laundry skills. In August 2013, the RMR indicated zero percent completion for safe driving, clipping her fingernails, and laundry skills. The RMR was blank for exercise. In September 2013, the RMR indicated zero percent completion for safe driving, clipping her fingernails and laundry skills. The RMR was blank for exercise. In October 2013, the RMR indicated indicated zero percent completion for safe driving, clipping her fingernails, and laundry skills. The RMR was blank for exercise. In November 2013, the RMR indicated zero percent completion for safe driving and laundry skills (learn to sew a button back on). The RMR indicated "didn't do" for clipping her fingernails. The RMR was blank for exercise. In December 2013, the RMR was blank for exercise. The RMR indicated zero percent completion for safe driving, clipping her fingernails and laundry			

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	<p>skills. There was no documentation on the RMRs or in the client's record indicating the QIDP took action to address the information on the RMRs.</p> <p>A review of client #5's record was conducted on 1/29/14 at 10:58 AM. Client #5's January and February 2013 RMRs were blank for exercise and hygiene. The RMR dated April 2013 was blank for exercise and indicated, "didn't have" for nutrition. The May 2013 RMR was blank for exercise and indicated, "Didn't have" for hygiene and nutrition. In June 2013, the RMR was blank for exercise and indicated, "didn't have" for nutrition. In July 2013, the RMR was blank for exercise and nutrition. In August 2013, the RMR was blank for exercise, hygiene and grooming. In September 2013, the RMR was blank for exercise, hygiene and grooming. In October 2013, the RMR was blank for exercise, hygiene and grooming. In November 2013, the RMR was blank for exercise, hygiene and grooming. In December 2013, the RMR was blank for exercise, hygiene, money and grooming. There was no documentation on the RMRs or in the client's record indicating the QIDP took action to address the information on the RMRs.</p>			

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	<p>On 1/30/14 at 11:29 AM, the Division Manager (DM) indicated the QIDP was responsible for ensuring the clients' data collection sheets were in the home for staff to document on. The DM indicated when the QIDP was sent the data collection information at the end of the month, the QIDP should have followed up on the missing data and training objectives that were not implemented.</p> <p>On 1/29/14 at 9:55 AM, the QIDP indicated she should have ensured the training sheets were in the home. The QIDP indicated it was her responsibility to ensure the training sheets were in the home and she was responsible for the oversight of the home. On 1/29/14 at 11:27 AM, the QIDP stated, "I don't know what happened." The QIDP indicated the staff were not implementing the training objectives that were blank. The QIDP indicated the RMRs indicating "didn't have" was her fault. The QIDP indicated she should have asked questions and followed up to ensure the data sheets were in the home. The QIDP stated, "I didn't follow up to ensure the TAs (teaching aids) were being done."</p> <p>2) A review of client #4's record was conducted on 1/29/14 at 11:48 AM. Client #4's IPP, dated 7/12/13, indicated</p>				

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	<p>in the recommendations section, "[Client #4] will continue to have daily training on the self-administration of her medications, to be able to identify her medications by name, appearance, purpose and possible side effects." The IPP did not include a formal training objective addressing medication administration training.</p> <p>On 1/30/14 at 11:29 AM, the DM indicated client #4 should have a medication related training objective included in her IPP.</p> <p>On 1/29/14 at 11:46 AM, the QIDP indicated client #4's IPP should include a training objective addressing her medication administration skills. The QIDP indicated client #4's current IPP did not include a medication training objective.</p> <p>3) A review of client #3's record was conducted on 1/29/14 at 10:02 AM. Client #3's Behavior Management Program (BMP), dated 9/19/13, indicated she had targeted behaviors of temper outburst and verbal aggression. The BMP indicated client #3 took two psychotropic medications, Lexapro and Buspar. Buspar was discontinued on 6/27/12 per the Office Visit/Treatment Plan/Med Order form from the</p>			

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W000249	<p>psychiatrist dated 6/27/12. The QIDP failed to remove Buspar from the BMP when it was discontinued.</p> <p>On 1/30/14 at 11:29 AM, the DM indicated the information in client #3's BMP should contain accurate information related to her current psychotropic medications.</p> <p>On 1/29/14 at 11:46 AM, the QIDP indicated client #3's BMP should include accurate information regarding client #3's current psychotropic medications.</p> <p>9-3-3(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 2 of 4 clients (#1 and #5) observed to receive their medications, the facility failed to ensure staff implemented the clients' medication training objectives as</p>	W000249	Staff will be retrained on implementation of each client's IPP, specifically the medication training objectives. Staff will be retrained on implementing these objectives at each med pass. QIDP or designee will observe staff during med passes at least	03/09/2014
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	<p>written.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/29/14 from 5:55 AM to 7:40 AM. At 6:05 AM, client #1 received her medications from staff #1. Client #1 was not prompted by staff #1 to identify her medications. At 6:33 AM, client #5 received her medications from staff #1. Client #5 was not prompted by staff #1 to identify her medications, time taken, side effects and the purpose of her medications.</p> <p>A review of client #1's record was conducted on 1/29/14 at 9:19 AM. Client #1's Individual Program Plan (IPP), dated 10/22/13, indicated client #1 had a medication training objective to identify her medications.</p> <p>A review of client #5's record was conducted on 1/29/14 at 10:58 AM. Client #5's IPP, dated 4/12/13, indicated client #5 had a medication training objective to identify her medications, time taken, side effects and purpose.</p> <p>On 1/29/14 at 11:46 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the clients' medication training objectives should be</p>		<p>weekly for one month to ensure that all staff are implementing training objectives. QIDP or designee will continue random observations at least monthly to ensure compliance in this area. Responsible for QA: QIDP</p> <p>Addendum: QIDP or designee will visit the home at least 4 times weekly to observe med passes on various shifts. Each staff working in the home will be observed completing each med pass on their shift. QIDP or designee will mentor and provide instruction immediately as needed to ensure staff are understanding procedures. These observations will continue until all staff demonstrate competence in procedures. QIDP or designee will continue to conduct observations in each home at least monthly and more often as needed to ensure compliance in this area.</p>		

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W000316	<p>implemented at each medication pass.</p> <p>On 1/30/14 at 11:29 AM, the Division Manager (DM) indicated the clients' medication training objectives should be implemented at every medication pass.</p> <p>9-3-4(a)</p> <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 3 clients in the sample (#3), the facility failed to ensure an annual reduction of her psychotropic medication was implemented based on client #3 meeting the criteria in her medication reduction plan.</p> <p>Findings include:</p> <p>A review of client #3's record was conducted on 1/29/14 at 10:02 AM. Client #3's Behavior Management Program (BMP), dated 9/19/13, indicated she had targeted behaviors of temper outburst and verbal aggression. The BMP indicated client #3 took two psychotropic medications, Lexapro and Buspar (Buspar was discontinued on 6/27/12 per the Office Visit/Treatment</p>	W000316	<p>Client #3 has been seen by her psychiatrist and a medication reduction was requested based on criteria being met. Psychiatrist feels medication is at therapeutic level based on past history of depression. QIDP will revise clients behavior management plan to include this information and revise criteria to meet clients needs at this time. QIDP will ensure that psychiatrist continues to review documentation at least quarterly for Client #3 in consideration of medication reduction. Responsible for QA: QIDP</p>	03/02/2014

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	<p>Plan/Med Order form from the psychiatrist dated 6/27/12). A review of client #3's behavior data tracking from February 2013 to December 2013 indicated client #3 did not exhibit (zero instances) her targeted behaviors during the 11 month period. The BMP indicated, in part, "Medication reduction will be sought in conjunction with psychiatric review and consultation per below criteria: Medication reduction will be sought when instance (sic) are at or below: temper tantrums - 0 instances for 6 months; verbal aggression - 0 instances for 1 month." There was no documentation in client #3's record indicating a reduction of Lexapro was attempted. A review of client #3's Medication Administration Records, from April 2012 (as far back as the facility had to review) to January 2014 indicated the dosage of Lexapro had not changed. The facility did not have documentation indicating a medication reduction had been attempted for client #3's psychotropic medication since 6/27/12.</p> <p>On 1/29/14 at 9:55 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #3's medication reduction plan should have been implemented as written. The QIDP indicated a reduction in client #3's</p>						

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W000365	<p>psychotropic medication should be attempted annually.</p> <p>On 1/30/14 at 11:29 AM, the Division Manager (DM) indicated a psychotropic medication reduction should be sought when the criteria was met.</p> <p>9-3-5(a)</p> <p>483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. Based on observation, record review and interview for 2 of 4 clients (#4 and #5) observed to receive their medication, the facility failed to ensure staff initialed the Medication Administration Record (MAR) after the clients took their medications.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/29/14 from 5:55 AM to 7:40 AM. At 6:23 AM, client #4 received her medications from staff #1. Prior to client #4 taking her medications, staff #1 initialed the MAR. At 6:33 AM, client #5 received her medications from staff #1. Prior to client #5 taking her medications, staff #1 initialed the MAR.</p>	W000365	<p>All staff will be trained on correct procedures for medication administration to include appropriate documentation procedures such as initialing MAR only after medication has actually been taken by client. QIDP or designee or Agency nurse will conduct random observation for one week to ensure all staff are following appropriate medication administration procedures. QIDP or designee, or Agency nurse will continue to conduct random observation at least monthly to ensure compliance in this area. Responsible for QA: QIDP</p> <p>Addendum: QIDP or designee will visit the home at least 4 times weekly to observe med passes on various shifts. Each staff working in the home will be observed completing each med pass on</p>	03/09/2014			

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W009999	<p>On 1/29/14 at 9:07 AM, the Qualified Intellectual Disabilities Professional (QIDP) Assistant (A) indicated the staff should initial the MAR after the staff observed the clients swallow their pills. The QIDP-A indicated the staff should not sign the MAR prior to the medications being administered.</p> <p>On 1/29/14 at 11:46 AM, the QIDP indicated the staff should initial the MAR after the clients took their medications.</p> <p>On 1/30/14 at 11:29 AM, the Division Manager (DM) indicated she completed training with the staff about not signing the MAR prior to administering medications in January 2014. The DM indicated the staff should not sign the MAR before administering the clients' medications.</p> <p>9-3-6(a)</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met:</p> <p>1) 460 IAC 9-3-2 Resident Protections:</p>	W009999	<p>their shift. QIDP or designee will mentor and provide instruction immediately as needed to ensure staff are understanding procedures. These observations will continue until all staff demonstrate competence in procedures. QIDP or designee will continue to conduct observations in each home at least monthly and more often as needed to ensure compliance in this area.</p> <p>Observations have been noted and reviewed with the HR department. Appropriate references will be sought for each new employee. TB screening for these employees has been obtained. All employees are expected to maintain compliance</p>	03/02/2014			

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	<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. 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, 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 was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 employee files reviewed, the facility failed to ensure three reference checks were completed.</p> <p>Findings include:</p> <p>A review of employee files on 1/28/14 at 12:15 PM indicated one employee (direct care staff #5), hired on 8/22/11, did not have three reference checks in the file. Direct care staff #5 works at the group home on Fridays from 3:00 PM to</p>		in this area. Responsible for QA: QIDP, SGL Manager, HR		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/31/2014	
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	<p>10:00 PM, Mondays and Wednesdays from 3:00 PM to 9:00 PM and Sundays from 8:00 AM to 10:00 PM.</p> <p>On 1/28/14 at 12:15 PM, the Division Manager (DM) indicated staff #5's employee file contained two references. The DM indicated the facility should obtain three reference checks. On 1/30/14 at 11:29 AM, the DM indicated the human resources department should check for three references prior to employment being offered to an employee. The DM indicated she was not sure how staff #5 was hired without having three reference checks.</p> <p>9-3-2(c)(3)</p> <p>2) 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</p>						

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	<p>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 was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 3 employee files reviewed, the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted.</p> <p>Findings include:</p> <p>A review of employee files on 1/28/14 at 12:15 PM indicated 2 of 3 employee files (#2 and #4) did not include an annual Mantoux tuberculosis screening. Staff #2's most recent TB screening was completed on 6/5/12. The physician's documentation indicated, in part, "Pt. (patient) has completed course of tx (treatment) for TB exposure. Pt. currently has no signs or symptoms of TB." There was no documentation in staff #2's employee file indicating staff #2 had a TB screening conducted since 6/5/12. Staff #4's most recent Mantoux test was conducted on 6/19/12. There was no documentation in staff #4's employee file indicating he had a TB test conducted since 6/19/12.</p>						

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	<p>An email from the Division Manager (DM) was received on 1/29/14 at 11:11 AM. The DM indicated, in part, "[Staff #4] went yesterday and got his TB test. It will be read on Thursday. I have left a message for [staff #2] regarding her TB screening but have not heard back from her yet."</p> <p>On 1/28/14 at 12:15 PM, the DM indicated staff should have an annual Mantoux or TB screening conducted.</p> <p>9-3-3(e)</p>			
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