

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G090		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  12/17/2012	
NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3839 CAMELOT LN COLUMBUS, IN 47201			
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: December 11, 12, 13, 14, and 17, 2012.</p> <p>Facility Number: 000630 Provider Number: 15G090 AIM Number: 100233920</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/21/12 by Ruth Shackelford, 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.

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W0126	<p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Based on record review and interview for 5 of 5 clients living in the group home (#2, #3, #4, #5 and #6), the facility failed to ensure the clients accessed their petty cash routinely.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 12/11/12 at 3:05 PM. Client #2: During the past 12 months, client #2 did not access his petty cash in January, March, May, June, July, October, November and December 2012. Client #3: During the past 12 months, client #3 did not access his petty cash in May, June, July, October, November and December 2012. Client #4: During the past 12 months, client #4 did not access his petty cash in January, March, May, June, July, September, October, November and December 2012. Client #5: During the past 12 months, client #5 did not access his petty cash in January, March, May, June, July, September, October, November and December 2012.</p>	W0126	<p>W126 SGL Manager has retrained the QIDP's on the importance of clients accessing their petty cash routinely. QIDP's will retrain their staff in this area. QIDP will review this at house meetings. QIDP or designee will review petty cash expenditures at least monthly to ensure compliance in this area. Responsible for QA: SGL Manager, QIDP</p>	01/16/2013			

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	<p>Client #6: During the past 12 months, client #6 did not access his petty cash in May, June, August, September, October, November and December 2012.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/13/12 at 11:06 AM. The QMRP indicated the clients should access their petty cash at least monthly.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/12/12 at 11:51 AM. AS #1 indicated the clients should be making more transactions with their money. AS #1 indicated the clients should access their petty cash at least monthly.</p> <p>9-3-2(a)</p>						

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 12 incident/investigative reports reviewed affecting client #4, the facility failed to implement their policies and procedures for reporting an incident of client to client abuse to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours and conducting an investigation of client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/11/12 at 2:35 PM. There was no documentation in the facility's incident reports, BDDS reports or investigative reports client #4 was scratched by a peer at the facility-operated day program.</p> <p>A review of client #4's record was conducted on 12/13/12 at 9:42 AM. A review of the nursing notes in client #4's record indicated the following, in part, on 12/3/12, "Scalp/skin unremarkable, (except he had 4 big scratches on the underside of his L (left) upper arm. He was attacked by another client in the PEP (day program) room. These areas were</p>	W0149	<p>W149 Agency policy and procedures on prohibiting mistreatment, neglect, or abuse of clients, reporting of incidents to the state, and investigations were reviewed and determined appropriate. SGL manager has retrained QIDP's on timely reporting of incidents and completing investigations per agency policy. QIDP's will retrain staff on policy for reporting of incidents. SGL manager will review internal incident reports to ensure state reports and investigations are completed as required. Responsible for QA: SGL Manager, QIDP</p>	01/16/2013	

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	<p>cleaned and bandaids applied."</p> <p>A review of the facility's policy and procedure for Identifying and Reporting Violations of Client Rights, dated 4/12/06, was reviewed on 12/11/12 at 2:20 PM. The policy indicated rights violations included abuse, neglect, exploitation and mistreatment. Abuse was defined as, "the intentional or willful infliction of physical injury, the unnecessary use of physical or chemical restraints or isolation, punishment that results in physical harm or pain." Verbal/Emotional Abuse was defined as "includes oral, written, and/or gestured language that includes disparaging or derogatory remarks. Also includes demeaning tones or harsh language. Includes unreasonable confinements, intimidation or humiliation." Neglect was defined as, "Placing an individual in a situation that may endanger his or her life or health; includes failure to provide appropriate care, food, medical care, shelter, or supervision." The policy indicated, in part, "1. The staff person should document their concern or the reason for suspicion and submit to their supervisor/QMRP within 24 hours. The supervisor/QMRP is responsible to complete the state incident report and submit to the appropriate entities: Bureau of Developmental Disabilities/Bureau of</p>			

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	<p>Quality Improvement Services/Bureau of Aging and In Home Services."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/13/12 at 11:06 AM. The QMRP indicated the facility should have submitted a BDDS report and conducted an investigation of client to client abuse.</p> <p>9-3-2(a)</p>			

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W0153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 12 incident/investigative reports reviewed affecting client #4, the facility failed to report an incident of client to client abuse to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/11/12 at 2:35 PM. There was no documentation in the facility's incident reports, BDDS reports or investigative reports client #4 was scratched by a peer at the facility-operated day program.</p> <p>A review of client #4's record was conducted on 12/13/12 at 9:42 AM. A review of the nursing notes in client #4's record indicated the following, in part, on 12/3/12, "Scalp/skin unremarkable, (except he had 4 big scratches on the underside of his L (left) upper arm. He</p>	W0153	<p>w153 Agency policy and procedures on prohibiting mistreatment, neglect, or abuse of clients, reporting of incidents to the state, and investigations were reviewed and determined appropriate. SGL manager has retrained QIDP's on timely reporting of incidents and completing investigations per agency policy. QIDP's will retrain staff on policy for reporting of incidents. SGL manager will review internal incident reports to ensure state reports and investigations are completed as required. Responsible for QA: SGL Manager, QIDP</p>	01/16/2013	

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	<p>was attacked by another client in the PEP (day program) room. These areas were cleaned and bandaids applied."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/13/12 at 11:06 AM. The QMRP indicated the facility should have submitted a BDDS report.</p> <p>9-3-2(a)</p>			

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 12 incident/investigative reports reviewed affecting client #4, the facility failed to conduct an investigation of client to client abuse.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 12/11/12 at 2:35 PM. There was no documentation in the facility's incident reports, BDDS reports or investigative reports client #4 was scratched by a peer at the facility-operated day program.</p> <p>A review of client #4's record was conducted on 12/13/12 at 9:42 AM. A review of the nursing notes in client #4's record indicated the following, in part, on 12/3/12, "Scalp/skin unremarkable, (except he had 4 big scratches on the underside of his L (left) upper arm. He was attacked by another client in the PEP (day program) room. These areas were cleaned and bandaids applied."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was</p>	W0154	<p>w154 Agency policy and procedures on prohibiting mistreatment, neglect, or abuse of clients, reporting of incidents to the state, and investigations were reviewed and determined appropriate. SGL manager has retrained QIDP's on timely reporting of incidents and completing investigations per agency policy. QIDP's will retrain staff on policy for reporting of incidents. SGL manager will review internal incident reports to ensure state reports and investigations are completed as required. Responsible for QA: SGL Manager, QIDP</p>	01/16/2013	

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	<p>conducted on 12/13/12 at 11:06 AM. The QMRP indicated the facility should have conducted an investigation of client to client abuse.</p> <p>9-3-2(a)</p>			

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W0227	<p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 1 of 3 non-sampled clients (#5), the facility failed to ensure client #5 had a plan to address spitting.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/11/12 from 3:39 PM to 5:34 PM. At 4:16 PM, client #5 spit on the floor. Staff #1 told client #5 he would need to clean up the floor. At 4:48 PM, client #5 was walking around the dining room and spit on the floor. At 4:55 PM, client #5 spit on the floor. Client #5 did not clean up the spit on the floor. Staff did not clean up the spit on the floor.</p> <p>A review of client #5's record was conducted on 12/13/12 at 9:00 AM. Client #5's IPP, dated 6/12 - 6/13, did not address spitting. His Behavior Support Plan, dated 7/7/12, did not address spitting.</p> <p>An interview with the QMRP was conducted on 12/13/12 at 11:06 AM. The QMRP stated spitting was an "occasional"</p>	W0227	<p>W227 QIDP will review Client #5's program plan and BSP along with behavior documentation from the home. Program plan and BSP will be revised as necessary to address behaviors such as spitting. QIDP will retrain staff on any revisions to program plan or BSP. QIDP will review daily documentation at least monthly for each client and modify plans as necessary based on information. Program plans and BSP's will be updated at least annually. Responsible for QA: QIDP</p>	01/16/2013			

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	<p>issue. The QMRP indicated she had heard client #5 had been spitting more recently during the past week.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/13/12 at 11:06 AM. AS #1 indicated client #5 needed a plan to address spitting.</p> <p>9-3-4(a)</p>				

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 1 of 3 clients in the sample (#2), the facility failed to ensure their were specific ambulation guidelines in his program plan.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/11/12 from 3:39 PM to 5:34 PM and 12/13/12 from 6:01 AM to 7:48 AM. During both observations, staff assisted client #2 with his ambulation by walking in front of client #2, facing him, holding his hands up over his head and extended away from his body. The staff then walked backward trying to get client #2 to stand up straight instead of leaning forward.</p> <p>A review of client #2's record was conducted on 12/13/12 at 9:09 AM. His Individual Program Plan (IPP), dated 6/12 - 6/13, indicated, in part, "Due to blindness, [client #2] needs a sighted guide with him when he is in unfamiliar settings. His house has handrails to assist him in getting around his home environment. [Client #2] is ambulatory and is able to move all extremities."</p>	W0240	<p>W240 QIDP will revise Client #2's program plan to include specific information on ambulation and appropriate ways for staff to assist. Staff will be retrained on any revision to the plan. QIDP or designee will observe at random times when staff are with Client #2 to ensure appropriate assistance is being provided. Routine observations will continue at least monthly in the home. Responsible for QA: QIDP</p>	01/16/2013			

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	<p>There was no documentation in client #2's record indicating staff should walk backward in front of him holding his hands above his head.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/14/12 at 1:45 PM. The QMRP indicated there was no plan in place for staff to assist client #2 with ambulating. The QMRP indicated the staff should not be assisting client #2 to walk with his hands above his head and the staff walking backward in front of him, holding his hands. The QMRP indicated a plan may be needed so the staff know how to assist. The QMRP indicated client #2 was capable of walking on his own at the group home and did not know why the staff were assisting him in the manner they were.</p> <p>An interview with the nurse was conducted on 12/14/12 at 9:53 AM. The nurse indicated the staff were unable to use a gait belt due to the way client #2 pitches forward. The nurse indicated she was unsure if there was a plan in place. The nurse indicated it was preferable to have two staff assist with client #2's ambulation.</p> <p>9-3-4(a)</p>			

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation, record review and interview for 4 of 5 clients (#2, #4, #5 and #6) living in the group home, the facility failed to ensure staff implemented the clients' plans, as written.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 12/11/12 from 3:39 PM to 5:34 PM. At 4:33 PM, staff #2 was pureeing salad in the food processor. None of the clients was prompted to assist. At 4:55 PM, staff #2 used the food processor to puree vegetables. At 5:09 PM, staff #2 was using the food processor to puree meat. At 5:13 PM, staff #2 used the food processor to puree macaroni and cheese. At 5:17 PM, staff #2 used scissors to cut up Salisbury steak into bite sized pieces. At 5:30 PM, staff #2 used the food processor to puree Fig Newtons. During dinner preparation, client #2 was not prompted to assist with stirring.</p> <p>An observation was conducted at the</p>	W0249	<p>W249</p> <p>Staff will be retrained on implementation of each client's individual program plans. Specific training will include but not be limited to client's objectives for meal prep, the implementation of medication training objectives during each med pass for each client, appropriate use of the wedge for Client #2 during meal time, appropriate use of gait belt for Client #4, dining plan for Client #5, the laundry training objectives for clients #2, #4, and #6, and actively engaging Client #2 at day program. QIDP or designee will observe at least weekly for one month then monthly thereafter in the home and at the workshop to ensure compliance in these areas. Responsible for QA: QIDP</p>	01/16/2013			

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	<p>group home on 12/13/12 from 6:01 AM to 7:48 AM. At 6:35 AM, staff #7 was in the kitchen making breakfast (oatmeal, toast, sausage and eggs). At 6:40 AM, staff #7 continued to make breakfast. Client #2, was in the home and available to assist with breakfast preparation however he was not asked to assist. At 7:00 AM, staff #7 was putting jelly on the toast. All the clients were in the dining room and none was asked to assist. At 7:02 AM, staff #7 used a pair of scissors to cut up the toast. At 7:04 AM, staff #7 used the food processor to puree eggs. During breakfast preparation, client #2 was not prompted to assist with stirring.</p> <p>A review of client #2's record was conducted on 12/13/12 at 9:09 AM. His Individual Program Plan (IPP), dated 6/12 - 6/13, indicated he had a training objective to assist with stirring during meal preparation.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/13/12 at 11:06 AM. The QMRP indicated client #2's goal should have been implemented during meal prep.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/13/12 at 11:06 AM. AS #1 indicated client #2's goal should have been implemented</p>						

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	<p>during meal prep.</p> <p>2) Observations were conducted at the group home on 12/11/12 from 3:39 PM to 5:34 PM and 12/13/12 from 6:01 AM to 7:48 AM.</p> <p>2a) On 12/11/12 at 3:53 PM, client #6 received his medications (Cal-gest and Eucerin cream) from staff #1. Staff #1 did not implement med administration training to client #6. On 12/13/12 at 6:23 AM, client #6 received his medications (Oyster shell, Quetiapine, Vitamin D-3, Polyethylene Glycol, and Cal-gest) from staff #5. Staff #5 did not implement med administration training to client #6.</p> <p>A review of client #6's record was conducted on 12/13/12 at 10:09 AM. His IPP, dated 5/12 - 5/13, indicated he had a medication training objective to identify the purpose of his medications and identify Paxil.</p> <p>An interview with the QMRP was conducted on 12/13/12 at 11:06 AM. The QMRP indicated client #6's med training objectives should be implemented at every med pass.</p> <p>2b) On 12/11/12 at 4:01 PM, client #2 received Ensure from staff #1. Staff #1 did not implement med administration</p>						

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	<p>training to client #2.</p> <p>A review of client #2's IPP, dated 6/12 - 6/13, indicated he had a training objective to get a glass of water and staff would review his medications side effects.</p> <p>An interview with the QMRP was conducted on 12/13/12 at 11:06 AM. The QMRP indicated client #6's med training objectives should be implemented at every med pass.</p> <p>2c) On 12/11/12 at 4:29 PM, client #4 received his medications (Saline Mist and Simethicone) from staff #1. Staff #1 did not implement client #4's med administration training objectives. On 12/13/12 at 6:05 AM, client #4 received his medications (Abilify, Levetiracetam, Quetiapine, Therapeutic M, Polyethylene Glycol, Saline Mist and Simethicone) from staff #7. Staff #7 crushed his pills. Staff #7 did not implement client #4's med goals.</p> <p>A review of client #4's record was conducted on 12/13/12 at 9:42 AM. His IPP, dated 6/12 - 6/13, indicated he had medication training objectives to get his own water, identify the drawer with his medications, and clean his pill crusher.</p> <p>An interview with the QMRP was</p>						

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	<p>conducted on 12/13/12 at 11:06 AM. The QMRP indicated client #6's med training objectives should be implemented at every med pass.</p> <p>3) An observation was conducted at the facility-operated day program on 12/12/12 from 10:18 AM to 11:43 AM. From 10:18 AM to 10:54 AM, client #2 sat in a chair with his feet propped up on a bean bag. Client #2 was not engaged by the staff. The staff did not interact with client #2 or prompt client #2 to engage in making a holiday card. At 10:54 AM, staff #11 prompted client #2 to wake up to use the restroom.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/13/12 at 11:06 AM. AS #1 indicated the day program staff should engage the client.</p> <p>An interview with the QMRP was conducted on 12/13/12 at 11:06 AM. The QMRP indicated the day program staff should engage the client every 15 minutes.</p> <p>4) An observation was conducted at the group home on 12/13/12 from 6:01 AM to 7:48 AM. At 7:06 AM when client #2 sat down at the dining room table to eat breakfast, the wedge in his dining room chair was slanted toward the front of the</p>				

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	<p>chair. The thick part of the wedge was in the back.</p> <p>A review of client #2's record was conducted on 12/13/12 at 9:09 AM. Client #2's Dining Plan, dated 5/27/12, indicated, "wedge on chair with the thick part of wedge to the front."</p> <p>An interview with the QMRP was conducted on 12/13/12 at 11:06 AM. The QMRP indicated the use of the wedge was in his Dining Plan and staff should have ensured the plan was implemented.</p> <p>5) An observation was conducted at the group home on 12/11/12 from 3:39 PM to 5:34 PM. At 4:16 PM, staff #1 assisted client #4 to the dining room table. Client #4 was wearing a gait belt. Staff #1 walked in front of client #4 holding onto his gait belt while the staff walked backward. An observation was conducted at the group home on 12/13/12 from 6:01 AM to 7:48 AM. At 7:04 AM, staff #5 assisted client #4 to the dining room table. Staff #5 walked backward while holding onto client #4's gait belt buckle.</p> <p>A review of client #4's record was conducted on 12/13/12 at 9:42 AM. Client #4's Gait Belt Usage Instructions, dated 10/24/12, indicated, in part, "Staff should walk with their hand holding onto</p>			

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	<p>the gait belt keeping constant contact with the belt to steady [client #4] while he is walking. Staff should walk to the side of [client #4] while holding onto the gait belt."</p> <p>An interview with the nurse was conducted on 12/14/12 at 9:53 AM. The nurse indicated this was recently addressed at a staff team meeting. The nurse indicated the plan should be implemented as written.</p> <p>An interview with the QMRP was conducted on 12/13/12 at 11:06 AM. The QMRP indicated the staff should implement the plan as written.</p> <p>6) An observation was conducted at the group home on 12/13/12 from 6:01 AM to 7:48 AM. At 7:13 AM, client #5 was holding his divided plate with his right hand so part of the plate was raised in the air. Client #5 was using his left hand to scoop bite after bite of food into his mouth. Client #5 was bent over with his head and mouth down near his plate. At 7:14 AM when client #5 was almost finished with his breakfast, staff #5 prompted client #5 to slow down. At 7:15 AM, staff #5 stated, "[Client #5's] already done." Staff #7 stated to client #5, "Good job, [client #5]. [Client #5's] a clean plater." Staff #5 and #7 did not</p>						

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	<p>prompt client #5 to slow down, take a drink, wipe his mouth, hold his head up or double swallow. The staff were not seated within arm's length of client #5 during breakfast.</p> <p>A review of client #5's record was conducted on 12/13/12 at 11:53 AM. Client #5's Dining Plan, dated 5/28/12, indicated, in part, "Staff seated at eye level within arm's length and is supervised. Monitor and prompt to take small bites, not shovel food. Prompt to slow down, smaller bites, sips, hold head up, swallow 2x's (times)."</p> <p>An interview with the nurse was conducted on 12/14/12 at 9:53 AM. The nurse indicated the staff should implement client #5's dining plan as written.</p> <p>An interview with the QMRP was conducted on 12/13/12 at 11:06 AM. The QMRP indicated the staff should intervene during meals to ensure client #5 did not eat too fast. The QMRP indicated the staff should implement his plan as written. The QMRP indicated the staff should sit within arm's length of client #5. The QMRP indicated the staff should ensure client #5 sits upright at meals and eats slowly.</p>			

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	<p>7) An observation was conducted at the group home on 12/11/12 from 3:39 PM to 5:34 PM. At 3:50 PM, staff #9 moved laundry from the washing machine to the dryer. At 4:07 PM and 4:09 PM, staff #9 was folding laundry. At 4:16 PM, staff #9 took a pile of laundry to the clients' bedrooms. At 4:17 PM, staff #9 put away towels and washcloths. At 4:20 PM, staff #9 put away client #5's belt she took out of the dryer. During the observation, staff #9 did not prompt clients #2, #3, #4, #5 and #6 to assist her.</p> <p>A review of client #2's record was conducted on 12/13/12 at 9:09 AM. Client #2's IPP, dated 6/12 - 6/13, indicated he had a training objective to carry his laundry to the washer.</p> <p>A review of client #4's record was conducted on 12/13/12 at 9:42 AM. Client #4's IPP, dated 6/12 - 6/13, indicated he had a training objective to learn to sort his laundry.</p> <p>A review of client #6's record was conducted on 12/13/12 at 10:09 AM. Client #6's IPP, dated 5/12 - 5/13, indicated he had a training objective to launder his sheets.</p> <p>An interview with the QMRP was conducted on 12/13/12 at 11:06 AM. The</p>						

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	<p>QMRP indicated the clients should be involved with completing the laundry. The QMRP indicated the staff should not be doing laundry by herself. The QMRP indicated the staff should implement the clients' training objectives for laundry.</p> <p>9-3-4(a)</p>			

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W0264	<p>483.440(f)(3)(iii) PROGRAM MONITORING &amp; CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, interview and record review for 3 of 3 clients in the sample who attended the facility-operated day program (#2, #4 and #6), the facility's specially constituted committee (HRC) failed to review, monitor and approve the facility's practice of using audible door alarms on the exit doors of the day program room.</p> <p>Findings include:</p> <p>An observation was conducted at the facility-operated day program on 12/12/12 from 10:18 AM to 11:43 AM. During the observation, when either of the exit doors to the day program room were opened, an audible alert sounded. This affected clients #2, #4 and #6.</p> <p>A review of client #2's record was conducted on 12/13/12 at 9:09 AM. There was no documentation in his Individual Program Plan (IPP), dated 6/12 - 6/13, or Behavior Support Plan (BSP),</p>	W0264	<p>W264 QIDP will review with day program QIDP the use of the audible door alarm on the day program room. HRC review and approval will be sought for the use of this alarm for each client affected. QIDP will seek HRC review and approval at least annually for any facility practice seen to be restrictive of or infringing on client rights. Responsible for QA: QIDP</p>	01/16/2013	

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	<p>dated 6/1/12, indicating client #2 needed audible door alarms at the facility-operated day program. There was no documentation presented during the survey indicating the HRC reviewed, approved and monitored the facility's practice of using audible door alarms on the exit doors at the facility-operated day program.</p> <p>A review of client #4's record was conducted on 12/13/12 at 9:42 AM. There was no documentation in his IPP, dated 6/12 - 6/13, or BSP, dated 7/7/12, indicating client #4 needed audible door alarms at the facility-operated day program. There was no documentation presented during the survey indicating the HRC reviewed, approved and monitored the facility's practice of using audible door alarms on the exit doors at the facility-operated day program.</p> <p>A review of client #6's record was conducted on 12/13/12 at 10:09 AM. There was no documentation in his IPP, dated 5/12 - 5/13, or BSP, dated 10/26/12, indicating client #6 needed audible door alarms at the facility-operated day program. There was no documentation presented during the survey indicating the HRC reviewed, approved and monitored the facility's practice of using audible door alarms on the exit doors at the</p>						

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	<p>facility-operated day program.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/14/12 at 1:45 PM. The QMRP indicated she was unsure why the alarms were on the doors at the day program. The QMRP indicated the alarms had been in place for years. The QMRP indicated the alarms were not present for clients #2, #4, and #6. On 12/14/12 at 3:21 PM, the QMRP indicated she checked with the staff of the day program to find out the purpose of the alarms. The QMRP indicated the purpose of the alarms was to alert staff when someone entered the room. The QMRP indicated this was to ensure the safety of the clients in the day program room. The QMRP indicated the HRC should review, approve and monitor the use of the door alarms.</p> <p>9-3-4(a)</p>			

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W0323	<p><b>483.460(a)(3)(i) PHYSICIAN SERVICES</b></p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#6), the facility failed to ensure his vision was evaluated every 2 years as recommended by the optometrist.</p> <p>Findings include:</p> <p>A review of client #6's record was conducted on 12/13/12 at 9:09 AM. Client #6's most recent vision exam was conducted on 10/28/10. The Office Visit/Treatment Plan/Med Order form indicated in the follow-up plan/appointment section, "2 years or sooner." There was no documentation client #6's vision was assessed since 10/28/10.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/13/12 at 11:06 AM. The QMRP indicated client #6 should have had a vision exam in 2011 or 2012.</p> <p>An interview with the nurse was conducted on 12/14/12 at 9:53 AM. The nurse indicated client #6 should have had a vision exam in October 2012. The</p>	W0323	<p>W323</p> <p>QIDP's have been retrained on requirements for timely annual medical exams to include vision, hearing, and dental for each client. Client will be scheduled for vision exam as recommended. QIDP and agency nurse will review each client's chart at least monthly to ensure all medical exams are obtained timely.</p> <p>Responsible for QA: QIDP</p>	01/16/2013	

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	nurse stated, "need to get him in there."  9-3-6(a)			

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 2 of 3 clients in the sample (#4 and #6) and one additional client (#5), the facility's nurse failed to ensure: 1) clients #4 and #6 had follow-up neurology appointments, as recommended and 2) staff prompted client #5 to sniff or breathe after receiving a nasal spray.</p> <p>Findings include:</p> <p>1) A review of client #4's record was conducted on 12/13/12 at 9:42 AM. On 2/24/12, client #4 was seen by his neurologist. The form indicated the follow-up plan/appointment as, "6 months." The appointment was scheduled on 8/24/12 at 2:00 PM. There was no documentation in client #4's record indicating the follow-up appointment was held. There was no documentation in client #4's record indicating client #4 was seen by his neurologist since 2/24/12.</p> <p>A review of client #6's record was conducted on 12/13/12 at 10:09 AM. On 4/5/12, client #6 was seen by his neurologist. The form indicated the follow-up plan/appointment as, "6 months." The appointment was scheduled for 10/4/12. There was no documentation</p>	W0331	<p>W331</p> <p>QIDP's and agency nurse will work with staff to ensure all recommended medical follow up appointments are completed timely and as ordered for each client. QIDP along with agency nurse will train staff on appropriate administration of Client #5's nasal spray. Client #4 and Client #6 will be scheduled for follow up neurology appointments as recommended by their physicians. QIDP and agency nurse will review each client's chart at least monthly to ensure all medical exams are obtained timely.</p> <p>Responsible for QA: QIDP</p>	01/16/2013			

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	<p>in client #6's record indicating the follow-up appointment was held. There was no documentation in client #6's record indicating client #6 was seen by his neurologist since 4/5/12.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/13/12 at 11:06 AM. The QMRP indicated the clients should have documentation in their records indicating the appointments were held. The QMRP indicated the appointments with clients #4 and #6's neurologist should have been held on their scheduled dates.</p> <p>An interview with the nurse was conducted on 12/14/12 at 9:53 AM. The nurse indicated the clients should have documentation in their records indicating the appointments were held. The nurse indicated the appointments with clients #4 and #6's neurologist should have been held on their scheduled dates or within the timeframe of 6 months, as indicated.</p> <p>2) An observation was conducted at the group home on 12/11/12 from 3:39 PM to 5:34 PM. At 4:29 PM, client #5 received his medications from staff #1. His medications included Saline Mist nasal spray. Staff #1 did not prompt client #5 to sniff or take a breath through his nose after spraying the medication.</p>				

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	<p>An observation was conducted at the group home on 12/13/12 from 6:01 AM to 7:48 AM. At 6:05 AM, client #5 received his medications from staff #7. His medications included Saline Mist nasal spray. Staff #7 sprayed two sprays into each nostril. Staff #7 did not prompt client #7 to sniff or take a breath through nose after spraying the medication. The medication dripped out of client #5's nose and onto his sweatshirt.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/13/12 at 11:06 AM. AS #1 indicated the staff should have prompted client #5 to sniff or take a breath through his nose during the med pass.</p> <p>An interview with the nurse was conducted on 12/14/12 at 9:53 AM. The nurse indicated the staff should prompt client #5 to sniff or breath through his nose after administering the medication.</p> <p>9-3-6(a)</p>			
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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 5 of 5 clients living at the group home (#2, #3, #4, #5 and #6), the facility failed to ensure quarterly evacuation drills were conducted for each shift.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 12/13/12 at 8:29 AM. On day shift (7:00 AM to 3:00 PM), there were no drills conducted from 7/21/12 to 11/2/12. On the night shift (11:00 PM to 7:00 AM), there were no drills conducted from 1/27/12 to 9/8/12.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/13/12 at 11:06 AM. The QMRP indicated the facility should conduct one drill per shift per quarter.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/13/12 at 11:06 AM. AS #1 indicated the facility should conduct one drill per shift per quarter.</p> <p>9-3-7(a)</p>	W0440	<p>W440 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>	01/16/2013
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W0488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 5 of 5 clients living in the group home (#2, #3, #4, #5 and #6), the facility failed to ensure the clients were involved in breakfast, lunch and dinner preparation.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 12/11/12 from 3:39 PM to 5:34 PM. At 4:16 PM, staff #2 gave client #6 a cookie while he sat at the dining room table. Client #6 was not prompted to get his own cookie from the kitchen. At 4:20 PM, client #3 was given prune juice with thickener by staff #1. Client #3 was not prompted to get a cup, pour the juice, add thickener or stir the thickener. At 4:33 PM, staff #2 was pureeing salad in the food processor. None of the clients was prompted to assist. At 4:55 PM, staff #2 used the food processor to puree vegetables. At 5:09 PM, staff #2 was using the food processor to puree meat. Clients #3, #4, #5 and #6 were in the dining room adjacent to the kitchen and none was prompted to assist. At 5:13 PM, staff #2 used the food processor to puree macaroni and cheese. At 5:17 PM, staff #2 used scissors to cut</p>	W0488	<p>W488 QIDP will retrain staff in how to support each client in the meal preparation and clean up, and in dining that is consistent with their skill level and as identified in their IPP's both at home and in the day program. The QIDP or designee will observe mealtime procedures at least weekly for one month to ensure compliance in this area. Random observations will continue at least monthly.</p>	01/16/2013			

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	<p>up Salisbury steak into bite sized pieces. At 5:30 PM, staff #2 used the food processor to puree Fig Newtons.</p> <p>An observation was conducted at the facility-operated day program on 12/12/12 from 10:18 AM to 11:43 AM. At 11:24 AM, staff #10 entered the room pushing a cart with clients #2, #3, #4 and #6's lunch on plates and warmed up. At 11:26 AM, client #4 was given his plate with his food warmed up. At 11:27 AM, clients #3, #2 and #6 were given their lunches with the food prepared. Clients #2, #3, #4 and #6 were not involved with preparing their own lunches. Clients #2, #3, #4 and #6 did not serve themselves and were not prompted to assist with preparing their own lunches.</p> <p>An observation was conducted at the group home on 12/13/12 from 6:01 AM to 7:48 AM. At 6:35 AM, staff #7 was in the kitchen making breakfast (oatmeal, toast, sausage and eggs). At 6:38 AM, staff #7 poured client #6 a glass of juice and took it to him as he sat at the dining room table. Client #6 was not asked to assist. At 6:40 AM, staff #7 continued to make breakfast. Clients #2, #3, #4, #5 and #6 were in the home and available to assist with breakfast preparation however none of the clients was asked to assist. At 6:42 AM, staff #5 stated to client #6, "Are</p>						

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	<p>you okay? Waiting for [staff #7] to fix breakfast?" At 6:43 AM, staff #7 stated to client #6, who was sitting and watching staff #7 make breakfast from the dining room table, "working on it" after client #6 stated, "eat." At 6:44 AM, staff #7 stated to client #6, "I'm getting stuff together and we will be eating before you know it." At 6:49 AM, staff #7 poured client #6's apple juice and stated, "Apple juice for [client #6]." At 6:53 AM, staff #7 poured all the clients' drinks. All the clients were present except client #2 who was getting his medications. None of the clients was asked to assist. At 7:00 AM, staff #7 was putting jelly on the toast. All the clients were in the dining room and none was asked to assist. At 7:02 AM, staff #7 used a pair of scissors to cut up the toast. At 7:04 AM, staff #7 used the food processor to puree eggs. At 7:09 AM, client #6 received hand over hand assistance to serve his oatmeal. Staff #7 gave client #2 his plate with all his breakfast items on the plate and client #6 received a plate with cut up toast. Staff #7 then gave client #5 his plate and told him she was going to bring his drink over. At 7:11 AM, staff #5 gave client #3 his breakfast. Staff #7 gave clients #4, #5 and #3 their drinks. At 7:23 AM when client #6 started to rinse off dishes, staff #5 stated, "We'll get it, honey." At 7:28 AM, staff #7 indicated to staff #5 she was</p>			
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	<p>going to do the dishes. At 7:30 AM, staff #7 started doing the dishes. Clients #2, #3, #4, #5 and #6 were available to assist however none was asked to assist. Staff #5 took client #5's dishes to the sink. At 7:34 AM, staff #5 took client #3's dishes to the sink. At 7:43 AM, staff #7 continued to rinse dishes and placed the dishes in the dishwasher.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/13/12 at 11:06 AM. The QMRP indicated the staff have been trained on having the clients assist with meal prep. The QMRP indicated client #6 should not receive hand over hand assistance to serve himself unless he was trying to serve himself too much food. The QMRP indicated the clients should be involved in all aspects of meal preparation and clean up.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/13/12 at 11:06 AM. AS #1 indicated the clients should be involved in all aspects of meal prep, including clean up.</p> <p>9-3-8(a)</p>				

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W9999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>460 IAC 9-3-1(a) Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division (15. A fall resulting in injury, regardless of the severity of the severity of the injury.).</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 12 incident/investigative reports reviewed affecting client #2, the facility failed to ensure a fall with injury was reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was</p>	W9999	<p>w9999</p> <p>QIDP's have been retrained on policy for reportable incidents. SGL Manager will review internal incident reports daily for compliance.</p> <p>Responsible for QA: SGL Manager, QIDP</p>	01/16/2013	

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	<p>conducted on 12/11/12 at 2:35 PM. On 10/10/12 at 7:30 PM, client #2 fell on the kitchen floor. Client #2 hit the heat vent cover under the window causing a scrape/scuff the size of a nickel on his right inner arm. The report indicated the pager was contacted and staff #1 washed off the blood.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 12/11/12 at 2:59 PM. The QMRP indicated falls with injury should be reported to BDDS within 24 hours. The QMRP indicated she had not seen the incident report and had not signed off on it.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 12/11/12 at 2:59 PM. AS #1 indicated falls with injury should be reported to BDDS within 24 hours.</p> <p>9-3-1(b)</p>				