

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G461		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 06/29/2012	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 631 N ELM ST SEYMOUR, IN 47274			
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W0000	<p>This visit was for an annual recertification and state licensure survey. This visit included the investigation of complaint #IN00109666.</p> <p>Complaint #IN00109666: Substantiated, federal/state deficiencies related to the allegation(s) are cited at W149 and W157.</p> <p>Dates of Survey: June 25, 26, 27, 28 and 29, 2012.</p> <p>Facility Number: 000975 Provider Number: 15G461 AIMS Number: 100244820</p> <p>Surveyor: Dotty Walton, Medical Surveyor III.</p> <p>The following federal deficiencies reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed 7/6/12 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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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.</p> <p>Based record review and interview for 1 of 1 investigations for 1 of 4 sampled clients (A), the facility failed to implement written policies and procedures which prohibited neglect or exploitation of clients.</p> <p>Findings include:</p> <p>Review of facility investigations on 6/25/12 at 1:30 PM indicated the following incident dated 6/07/12: The Group Living Division Manager/Administrator #1 received a notification from the Qualified Intellectual Disabilities Professional/QIDP #3 concerning some missing medication for client A. The reportable incident date 6/8/12 indicated a thorough examination of client A's medications and the paperwork related to them, determined there were 7 hydrocodone/APAP 7/5-500 mg./milligrams missing. (The medication is a controlled substance schedule III opioid analgesic given to client A on an as needed basis for muscular-skeletal pain.) On the morning of 6/8/12 when client A was given her medications by staff #9, it was found her</p>	W0149	<p>W149 Agency policy and procedures were reviewed and determined to clearly prohibit the mistreatment, abuse, neglect, or exploitation of any client. All staff are required to complete training in this area prior to working in the home and must renew this training at least annually. Agency Medication Policy was reviewed also and determined to be sufficient in addressing how to handle the count for controlled substances. Staff are also required to complete Medication Administration initially and renew at least annually. The QIDP is now requiring more documentation in this home in the form of two staff signatures on all controlled substance counts and placement and removal/disposal of fentanyl patch. All staff have now been trained on these procedures. The QIDP or designee will ensure that any new staff to the home are trained on these house specific procedures. QIDP or designee will observe in the home at least weekly for one month and at least monthly thereafter to ensure staff are following these procedures and documenting correctly. Responsible for QA: QIDP, SGL Manager</p>	07/29/2012

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	<p>fentanyl patch was not on her body and was missing. (The fentanyl patch is a controlled substance schedule II opioid analgesic which delivers the medication transdermally for pain.) The fentanyl patch was placed every third day on client A's back for management of chronic muscular-skeletal pain.</p> <p>Review of the investigation indicated a procedure wherein staff counted the controlled medications and recorded the amounts during each shift of personnel was in place. The investigation determined staff #8 did not count the Hydrocodone pills on 6/5/12 at 7:00 AM. She merely recorded the previous number without actually counting the pills to verify the number. Staff #7 did not actually count the hydrocodone tablets on 6/4/12 at 10:00 PM or 6/5/12 at 10:00 PM. Staff #8 merely recorded the previous number without a count verification.</p> <p>Review of agency policies and procedures on 6/25/12 at 2:30 PM indicated a Standard Operating Procedure for Identifying and Reporting Suspected Abuse and Neglect dated 4/12/2006. The review indicated the agency prohibited client abuse/neglect/exploitation. Definitions were in the procedure:</p>						

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	<p>"4. Neglect: Placing an individual in a situation that may endanger his or her life or health; includes failure to provide appropriate care...or supervision.</p> <p>5. Exploitation: Unauthorized use of a person or his or her resources for one's own profit or advantage. Includes any deliberate misplacement or use of an individual's belongings or money."</p> <p>Interview with Group Living Division Manager/Administrator #1 on 6/25/12 at 3:00 PM indicated 7 of client A's controlled pain medication (hydrocodone) were missing and the reason had not been determined. The investigation had determined two staff (#7 and #8) had not followed protocol to count the medication at every shift. The agency had put new procedures in place wherein two staff counted the controlled medication and two staff witnessed the administration of the hydrocodone and the placement of the fentanyl patch.</p> <p>This federal tag relates to complaint #IN00109666.</p> <p>9-3-2(a)</p>						

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on observation, record review and interview for 1 of 1 investigations reviewed (client A), the facility failed to provide evidence corrective action (staff training) had been taken regarding client A's missing medication and analgesic patches.</p> <p>Findings include:</p> <p>Review of facility investigations on 6/25/12 at 1:30 PM indicated the following incident dated 6/07/12: The Group Living Division Manager/Administrator #1 received a notification from the Qualified Intellectual Disabilities Professional/QIDP #3 concerning some missing medication for client A. The reportable incident date 6/8/12 indicated a thorough examination of client A's medications and the paperwork related to them, determined there were 7 hydrocodone/APAP 7/5-500 mg./milligrams missing. (The medication is a controlled substance schedule III opioid analgesic given to client A on an as needed basis for muscular-skeletal pain.) On the morning of 6/8/12 when client A was given her</p>	W0157	<p>W157 QIDP or designee will ensure that all staff are trained on the new procedures implemented in this home for documenting the count of controlled substances and the placement and removal/disposal of Client A's fentanyl patch. Documentation of training will be sent to the SGL Manager for proof of compliance. QIDP or designee are responsible to ensure any new staff coming to work in this home are trained on these procedures and this training documented. QIDP or designee will observe in the home at least weekly for one month and at least monthly thereafter to ensure staff are following these procedures and documenting correctly.</p> <p>Responsible for QA: QIDP, SGL Manager</p>	07/29/2012

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	<p>medications by staff #9, it was found her fentanyl patch was not on her body and was missing. (The fentanyl patch is a controlled substance schedule II opioid analgesic which delivers the medication transdermally for pain.) The fentanyl patch was placed every third day on client A's back for management of chronic muscular-skeletal pain.</p> <p>Review of the investigation indicated a procedure wherein staff counted the controlled medications and recorded the amounts during each shift of personnel was in place. The investigation determined staff #8 did not count the Hydrocodone pills on 6/5/12 at 7:00 AM. She merely recorded the previous number without actually counting the pills to verify the number. Staff #7 did not actually count the hydrocodone tablets on 6/4/12 at 10:00 PM or 6/5/12 at 10:00 PM. Staff #8 merely recorded the previous number without a count verification.</p> <p>Interview with Group Living Division Manager/Administrator #1 on 6/25/12 at 3:00 PM indicated 7 of client A's controlled pain medication (hydrocodone) were missing and the reason had not been determined. The investigation had determined two staff (#7 and #8) had not followed protocol to count the medication</p>						

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	<p>at every shift. The agency had put new procedures in place wherein two staff counted the controlled medication and two staff witnessed the administration of the hydrocodone on 6/15/12 and training was done that day. Two staff were to witness the placement of the fentanyl patch and they were to cut up the used patch, pour soda on it, place it in a plastic baggie and dispose of it in a locked sharps container on the medication cart effective 6/19/12. Interview with RN #2 on 6/25/12 at 4:15 PM verified the new procedures.</p> <p>During observations of the morning medication administration on 6/26/12 at 6:21 AM, staff #5 placed client E's hydrocodone 5/500 mg. tablet into a medication cup. At 6:34 AM, staff #4 came into the medication room and witnessed staff #5 administer a large white pill to client E which she indicated was the hydrocodone medication. Staff #4 did not witness the entire medication administration procedure of the hydrocodone; the pill in the cup was not identified.</p> <p>Staff #6 witnessed staff #8 apply client A's fentanyl patch at 8:30 AM on 6/26/12. Staff #8 cut up the used fentanyl patch but disposed of it in the wrong sharps container. It was placed in the medication cart's locking sharps container. The</p>			

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	<p>unlocked sharps container had other used fentanyl patches in it.</p> <p>Review of training records on 6/26/12 at 3:15 PM indicated staff had been trained on 6/15 and 6/19/12 concerning the new two staff methods of administering controlled medications (hydrocodone and fentanyl). Staff #4 and #5 had not attended the trainings. Staff #8 had not attended the training regarding the fentanyl patch placement and removal/disposal procedures</p> <p>Interview with QIDP #3 on 6/26/12 at 3:37 PM indicated staff #4, #5, and #8 required more training.</p> <p>This federal tag relates to complaint #IN00109666.</p> <p>9-3-2(a)</p>			