

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W0000	<p>This visit was for the investigation of complaint #IN00122252.</p> <p>Complaint #IN00122252: Substantiated, Federal/state deficiencies related to the allegation are cited at W102, W104, W122, W149, W153, W154, W189, W240 and W331.</p> <p>Dates of Survey: January 24, 25, 28 and 29, 2013</p> <p>Facility Number: 008879 AIMS Number: 200076390 Provider Number: 15G672</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 2/1/13 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on interview and record review for 2 of 3 clients in the sample (B and F) and one additional client (D), the facility failed to meet the Condition of Participation: Governing Body by failing to: 1) prevent client to client abuse, report injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS), and conduct thorough investigations of injuries of unknown origin and client to client abuse, 2) report to the Bureau of Developmental Disabilities Services (BDDS) injuries of unknown origin, 3) conduct thorough investigations of client to client abuse and injuries of unknown origin, 4) ensure client B's risk plan for falls included specific instructions for staff to implement the plan, and 5) ensure staff contacted the nurse in order for the nurse to conduct assessments of client B.</p> <p>Findings include:</p> <p>1) Please refer to W104. For 2 of 3 clients in the sample (B and F) and one additional client (D), the governing body failed to exercise policy and operating direction over the facility to ensure its policies and procedures were</p>	W0102	<p>W102</p> <p>Agency policies and procedures have been reviewed and determined to appropriately address preventing client to client abuse, reporting injuries of unknown origin to BDDS, and conducting thorough investigations of incidents including injuries of unknown origin and client to client abuse. SGL Manager has retrained QIDP's on agency SOP's in this area and QIDP's across the agency in all divisions will be retrained on these SOP's. SGL Manager and Health Care Coordinator met and reviewed concern with risk plans and protocol for contacting the nurse. Nurses and QIDP's will be retrained on developing risk plans with specific instructions for staff on implementing the plan and the agency protocol for contacting the nurse. Clients in this specific group home with plans found to be non-compliant in this area will be reviewed and revised as needed to ensure compliance. Staff will be retrained on all revised plans and the protocol for contacting the nurse. Staff are required to update training annually on incident reporting. Investigations and BDDS</p>	02/28/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>implemented to: 1) prevent client to client abuse, report injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS), and conduct thorough investigations of injuries of unknown origin and client to client abuse, 2) report to the Bureau of Developmental Disabilities Services (BDDS) injuries of unknown origin, 3) conduct thorough investigations of client to client abuse and injuries of unknown origin, 4) ensure client B's risk plan for falls included specific instructions for staff to implement the plan, and 5) ensure staff contacted the nurse in order for the nurse to conduct assessments of client B.</p> <p>2) Please refer to W122. For 2 of 3 clients in the sample (B and F) and one additional client (D), the governing body failed to meet the Condition of Participation: Client Protections by failing to ensure its policies and procedures were implemented to: 1) prevent client to client abuse, report injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS), and conduct thorough investigations of injuries of unknown origin and client to client abuse, 2) report to the Bureau of Developmental Disabilities Services (BDDS) injuries of unknown origin, 3) conduct thorough investigations of client to client abuse and injuries of unknown</p>		<p>reports are reviewed by the Division Manager and Director of Quality Assurance.</p> <p>Responsible for QA: QIDP, Nurse, SGL Manager, Health Care Coordinator, Director of Quality Assurance, Director of Family Services</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>origin, 4) ensure client B's risk plan for falls included specific instructions for staff to implement the plan, and 5) ensure staff contacted the nurse in order for the nurse to conduct assessments of client B.</p> <p>This federal tag relates to complaint #IN00122252.</p> <p>9-3-1(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 2 of 3 clients in the sample (B and F) and one additional client (D), the governing body failed to exercise policy and operating direction over the facility to ensure its policies and procedures were implemented to: 1) prevent client to client abuse, report injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS), and conduct thorough investigations of injuries of unknown origin and client to client abuse, 2) report to the Bureau of Developmental Disabilities Services (BDDS) injuries of unknown origin, 3) conduct thorough investigations of client to client abuse and injuries of unknown origin, 4) ensure client B's risk plan for falls included specific instructions for staff to implement the plan, and 5) ensure staff contacted the nurse in order for the nurse to conduct assessments of client B.</p> <p>Findings include:</p> <p>1. Please refer to W149. For 8 of 14 incident/investigative reports affecting clients B, D and F, the facility neglected to implement its policies and procedures to prevent client to client abuse, report</p>	W0104	<p>W104</p> <p>Agency policies and procedures have been reviewed and determined to appropriately address preventing client to client abuse, reporting injuries of unknown origin to BDDS, and conducting thorough investigations of incidents including injuries of unknown origin and client to client abuse. SGL Manager has retrained QIDP's on agency SOP's in this area and QIDP's across the agency in all divisions will be retrained on these SOP's. SGL Manager and Health Care Coordinator met and reviewed concern with risk plans and protocol for contacting the nurse. Nurses and QIDP's will be retrained on developing risk plans with specific instructions for staff on implementing the plan and the agency protocol for contacting the nurse. Clients in this specific group home with plans found to be non-compliant in this area will be reviewed and revised as needed to ensure compliance. Staff will be retrained on all revised plans and the protocol for contacting the nurse. Investigations and BDDS reports are reviewed by the Division Manager and Director of Quality</p>	02/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS), and conduct thorough investigations of injuries of unknown origin and client to client abuse.</p> <p>2. Please refer to W153. For 3 of 14 incident/investigative reports affecting client B, the facility failed to report to the Bureau of Developmental Disabilities Services (BDDS) injuries of unknown origin, in accordance with state law.</p> <p>3. Please refer to W154. For 7 of 14 incidents/investigative reports reviewed affecting clients B and F, the facility failed to conduct thorough investigations of client to client abuse and injuries of unknown origin.</p> <p>4. Please refer to W240. For 1 of 3 clients in the sample (B), the facility failed to ensure client B's risk plan for falls included specific instructions for staff to implement the plan.</p> <p>5. Please refer to W331. For 1 of 3 clients in the sample, the facility failed to ensure staff contacted the nurse in order for the nurse to conduct assessments of client B.</p> <p>This federal tag relates to complaint #IN00122252.</p>		<p>Assurance at least monthly.</p> <p>Responsible for QA: QIDP, Nurse, SGL Manager, Health Care Coordinator, Director of Quality Assurance, Director of Family Services</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9-3-1(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview for 2 of 3 clients in the sample (B and F) and one additional client (D), the facility failed to meet the Condition of Participation: Client Protections by failing to ensure its policies and procedures were implemented to: 1) prevent client to client abuse and report injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS), and conduct thorough investigations of injuries of unknown origin and client to client abuse, 2) report to the Bureau of Developmental Disabilities Services (BDDS) injuries of unknown origin, 3) conduct thorough investigations of client to client abuse and injuries of unknown origin, 4) ensure client B's risk plan for falls included specific instructions for staff to implement the plan, and 5) ensure staff contacted the nurse in order for the nurse to conduct assessments of client B.</p> <p>Findings include:</p> <p>1. Please refer to W149. For 8 of 14 incident/investigative reports affecting clients B, D and F, the facility neglected to implement its policies and procedures to prevent client to client abuse and report injuries of unknown origin to the Bureau</p>	W0122	<p>W122 Agency policies and procedures have been reviewed and determined to appropriately address preventing client to client abuse, reporting injuries of unknown origin to BDDS, and conducting thorough investigations of incidents including injuries of unknown origin and client to client abuse. SGL Manager has retrained QIDP's on agency SOP's in this area and QIDP's across the agency in all divisions will be retrained on these SOP's. All new staff receive training on these procedures initially and are required to renew this training annually. Client service workers in this home and day program will be retrained on SOP for reporting incidents and preventing client to client abuse. SGL Manager and Health Care Coordinator met and reviewed concern with risk plans and protocol for contacting the nurse. Nurses and QIDP's will be retrained on developing risk plans with specific instructions for staff on implementing the plan and the agency protocol for contacting the nurse. Clients in this specific group home with plans found to be non-compliant in this area will be reviewed and revised as needed to</p>	02/28/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>of Developmental Disabilities Services (BDDS), and conduct thorough investigations of injuries of unknown origin and client to client abuse.</p> <p>2. Please refer to W153. For 3 of 14 incident/investigative reports affecting client B, the facility failed to report to the Bureau of Developmental Disabilities Services (BDDS) injuries of unknown origin, in accordance with state law.</p> <p>3. Please refer to W154. For 7 of 14 incidents/investigative reports reviewed affecting clients B and F, the facility failed to conduct thorough investigations of client to client abuse and injuries of unknown origin.</p> <p>4. Please refer to W240. For 1 of 3 clients in the sample (B), the facility failed to ensure client B's risk plan for falls included specific instructions for staff to implement the plan.</p> <p>5. Please refer to W331. For 1 of 3 clients in the sample, the facility failed to ensure staff contacted the nurse in order for the nurse to conduct assessments of client B.</p> <p>This federal tag relates to complaint #IN00122252.</p>		<p>ensure compliance. Staff will be retrained on all revised plans and the protocol for contacting the nurse. Investigations and BDDS reports are reviewed by the Division Manager and Director of Quality Assurance at least monthly.</p> <p>Responsible for QA: QIDP, Nurse, SGL Manager, Health Care Coordinator, Director of Quality Assurance, Director of Family Services</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
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 observation, record review and interview for 8 of 14 incident/investigative reports reviewed affecting clients B, D and F, the facility neglected to implement its policies and procedures to prevent client to client abuse, report injuries of unknown origin to the Bureau of Developmental Disabilities Services (BDDS), and conduct thorough investigations of injuries of unknown origin and client to client abuse.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/24/13 from 3:54 PM to 5:46 PM. Client B was pacing through the living room, dining room and kitchen. From 3:54 PM until 4:08 PM, client B was being supervised by staff #2. Staff #2 stayed right next to client B as she moved through the home. At 3:58 PM, client B spit on the kitchen floor. Client B continued to walk around the home, moaning and grunting, and wringing her hands. At 4:08 PM, staff #3 assumed client B's one on one supervision from staff #2. Staff #3 kept client B within line of sight however staff #3 did not walk</p>	W0149	<p>W149</p> <p>Agency policies and procedures have been reviewed and determined to appropriately address preventing client to client abuse, reporting injuries of unknown origin to BDDS, and conducting thorough investigations of incidents including injuries of unknown origin and client to client abuse. SGL Manager has retrained QIDP's on agency SOP's in this area and QIDP's across the agency in all divisions will be retrained on these SOP's. All new staff receive training on these procedures initially and are required to renew this training annually. Client service workers in this home and day program will be retrained on SOP for reporting incidents and preventing client to client abuse. SGL Manager and Health Care Coordinator met and reviewed concern with risk plans and protocol for contacting the nurse. Nurses and QIDP's will be retrained on developing risk plans with specific instructions for staff on implementing the plan and the agency protocol for contacting the nurse. Clients in this specific group home with plans found to be non-compliant in this area will be</p>	02/28/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>next to and stay right with client B. At 4:12 PM, client B got on her hands and knees and put her mouth to the floor. At 4:16 PM, client B hit client D on the back in the dining room area when staff #3 was supervising client B.</p> <p>A review of the facility incident/investigative reports was conducted on 1/24/13 at 12:37 PM.</p> <p>1. On 10/19/12 at 10:20 AM, client B was found to have a bruise on her tail bone, two on her lower right side of her back and one on her lower left leg. There was no investigation into the bruises of unknown origin.</p> <p>2. On 10/24/12 at 1:30 PM, client B was walking around the facility-operated day program. She walked past client F, hugged client F and then bit client F on the cheek. Client F had a scratched area on her cheek with no bleeding. The facility did not conduct an investigation.</p> <p>3. On 11/29/12 at 11:08 AM, client B was walking around the facility-operated day program. Client F went to put lunchboxes away. Client B went up to client F and bit her on the chin. Client F had three scratches. The facility did not conduct an investigation.</p> <p>4. On 12/6/12 at 8:11 AM, client B was</p>		<p>reviewed and revised as needed to ensure compliance. Staff will be retrained on all revised plans and the protocol for contacting the nurse. Investigations and BDDS reports are reviewed by the Division Manager and Director of Quality Assurance at least monthly.</p> <p>Responsible for QA: QIDP, Nurse, SGL Manager, Health Care Coordinator, Director of Quality Assurance, Director of Family Services</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>found to have multiple bruises up and down both arms, left buttocks, spine and a spot on her nose. The injuries of unknown origin were not reported to BDDS and the facility did not conduct an investigation.</p> <p>5. On 12/17/12 at 8:30 AM, client B was found to have, at the facility-operated day program, a large bruise on her right side and her nose was swollen and bruised. The facility did not report the injuries of unknown origin to BDDS or conduct an investigation.</p> <p>6. On 12/31/12 at 8:30 AM, client B was found to have, at the facility-operated day program, a scrape on her right side 2.5 inches long. The facility did not report the injuries of unknown origin to BDDS or conduct an investigation.</p> <p>7. On 1/3/13 at 6:16 PM, client B was found to have a large bruise on her right side with areas that were abraided. Staff #4 touched the area and client B drew back in pain. Staff #4 notified staff #2. Staff #2 contacted the pager. Staff #1 responded to call and instructed the staff to take client B to the emergency room (ER). At the ER, it was determined client B had some fractured ribs and a pneumothorax (collapsed lung). Client B was airlifted to another hospital in another</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>city. The facility conducted an investigation. The conclusion of the investigation indicated, in part, "After thorough review of documentation and individual interviews, it is inconclusive as to the origin of the injuries sustained by [client B]. These injuries were 4 fractured ribs and a pneumothorax." The investigation indicated, "It was determined that there are no clients with the ability to respond to interview questions for this investigation." The investigation indicated, in part, "Concerns that were generated by the investigation include lack of good communication between the day program and the group home, failure to report as trained, and failure to document as trained."</p> <p>8. On 1/24/13 at 4:30 PM, client B slapped client D on the back (noted above in the observation section). The BDDS report, dated 1/24/13, indicated, "[Staff #3] was doing 'line of sight' with [client B] and she went towards [client B] to redirect her from [client D] and [client B] continued walking to another area in the house, and [staff #3] had to follow." The report indicated, "[Staff #3] was asked if she saw any cues from [client B] that may have help (sic) her to prevented (sic) from slapping [client D] on his back and she said there was (sic) not."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A review of the facility's policy on conducting investigations was conducted on 1/24/13 at 12:22 PM. The facility's Protocol for Completing Investigations, dated 1/3/06, indicated, "Any event involving the potential or actual risk of harm to a client served, will be documented, reported, investigated and corrective action taken to alleviate the potential for future risk." The investigation must be initiated within 24 hours and completed within 5 working days." The policy indicated, in part, "...will be investigated immediately and thoroughly." The policy indicated, "1. Instances of suspected violations of rights, abuse or neglect, or inadequate protection of the health and safety of individuals served will be investigated immediately and thoroughly. Examples of inadequate protection of health and safety include but are not limited to: injuries of unknown origin, behavior incidents resulting in client/staff injuries, accidents resulting in the need of medical treatment, incidents caused by possible staff neglect and suspected criminal activity by staff or clients. The investigation must be thorough and shall include the following: a. Review of the incident reports, b. Interview with the client and or guardian and/or advocate, c. Interview of all staff involved including whenever possible." The policy			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>indicated, "The investigative report should include the following information as applicable: a. Description of the concern, b. Review and summary of any documentation, c. Listing and summary of personal interviews, d. Review of agency policies, e. A summary of findings/conclusions investigation has discovered, f. Resolution/outcome, and g. Suggestive Corrective Action to prevent further issues from reoccurring." The policy indicated, "The supervisor/QMRP is responsible to complete the state incident report and submit to the appropriate entities: Bureau of Developmental Disabilities/Bureau of Quality Improvement Services/Bureau of Aging and In Home Services." The policy indicated, in part, "Developmental Services Inc. staff will report all appropriate incidents to the Bureau of Developmental Disabilities/Bureau of Quality Improvement Services (BDDS/BAITHS/BQIS) as outlined in the current state policy... 4. Peer to peer aggression. 12. Injuries of unknown origin."</p> <p>A review of client B's record was conducted on 1/25/13 at 1:20 PM. Client B's Individual Program Plan (IPP), dated 4/20/12, indicated, in part, "Potential for bruising/broken bones, (added 7/8/02), [client B] will sit, cross her legs and curl</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>them in positions that will likely result in bruises to her lower extremities in particular. She will often sit with her hand in a fist resting on her chin, which will also cause bruises to her lower face. At the day program she will often stand with her back to a preferred window and bump against it resulting in bruising there also. Additionally, she will flex both arms to reach behind her and then cross the elbows behind her. She has been observed to move her knee cap(s) to right or left and then move them back in place. She has been observed to seemingly move her knuckle(s) out of place and then back into place." The IPP indicated, "[Client B] requires 24 hour staff supervision for medications and diet control, appropriate psychiatric and medical care, close monitoring output, and someone to administer medications." The plan indicated, "[Client B] should continue to reside in an environment that provides her with 24-hour supervision where she can receive appropriate training to develop a basic level of independence in functional daily living skills."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/24/13 at 1:18 PM. The QMRP indicated none of the other clients (A, C, D, E and F) was interviewed for the investigation of client B's injuries of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>unknown origin found on 1/3/13.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/25/13 at 1:52 PM. AS #1 indicated injuries of unknown origin and falls with injury should be reported to BDDS within 24 hours. AS #1 indicated injuries of unknown origin should be investigated. On 1/24/13 at 1:16 PM, AS #1 indicated client B's peers (clients A, C, D, E and F) were not interviewed and interviews were not attempted with them in regard to client B's injury of unknown origin found on 1/3/13. AS #1 indicated clients A, C, D, E and F were not reliable reporters and would probably not understand the questions. AS #1 indicated, on 1/24/13 at 1:07 PM, incidents of client to client aggression should be investigated.</p> <p>This federal tag relates to complaint #IN00122252.</p> <p>9-3-2(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
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.</p> <p>Based on record review and interview for 3 of 14 incident/investigative reports affecting client B, the facility failed to report to the Bureau of Developmental Disabilities Services (BDDS) injuries of unknown origin, in accordance with state law.</p> <p>Findings include:</p> <p>A review of the facility incident/investigative reports was conducted on 1/24/13 at 12:37 PM.</p> <p>1. On 12/6/12 at 8:11 AM, client B was found to have multiple bruises up and down both arms, left buttocks, spine and a spot on her nose. The injuries of unknown origin were not reported to BDDS.</p> <p>2. On 12/17/12 at 8:30 AM, client B was found to have, at the facility-operated day program, a large bruise on her right side and her nose was swollen and bruised. The facility did not report the injuries of unknown origin to BDDS.</p>	W0153	<p>W153 Agency policies and procedures have been reviewed and determined to appropriately address preventing client to client abuse, reporting injuries of unknown origin to BDDS, and conducting thorough investigations of incidents including injuries of unknown origin and client to client abuse. SGL Manager has retrained QIDP's on agency SOP's in this area and QIDP's across the agency in all divisions will be retrained on these SOP's. All new staff receive training on these procedures initially and are required to renew this training annually. Client service workers in this home and day program will be retrained on SOP for reporting incidents and preventing client to client abuse. Investigations and BDDS reports are reviewed by the Division Manager and Director of Quality Assurance at least monthly. Responsible for QA: QIDP, Nurse, SGL Manager, Health Care Coordinator, Director of Quality Assurance, Director of Family Services</p>	02/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>3. On 12/31/12 at 8:30 AM, client B was found to have, at the facility-operated day program, a scrape on her right side 2.5 inches long. The facility did not report the injuries of unknown origin to BDDS.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/25/13 at 1:52 PM. AS #1 indicated injuries of unknown origin should be reported to BDDS within 24 hours.</p> <p>This federal tag relates to complaint #IN00122252.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
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 7 of 14 incidents/investigative reports reviewed affecting clients B and F, the facility failed to conduct thorough investigations of client to client abuse and injuries of unknown origin.</p> <p>Findings include:</p> <p>A review of the facility incident/investigative reports was conducted on 1/24/13 at 12:37 PM.</p> <p>1. On 10/19/12 at 10:20 AM, client B was found to have a bruise on her tail bone, two on her lower right side of her back and one on her lower left leg. The facility did not conduct an investigation.</p> <p>2. On 10/24/12 at 1:30 PM, client B was walking around the facility-operated day program. She walked past client F, hugged client F and then bit client F on the cheek. Client F had a scratched area on her cheek with no bleeding. The facility did not conduct an investigation.</p> <p>3. On 11/29/12 at 11:08 AM, client B was walking around the facility-operated day program. Client F went to put lunchboxes away. Client B went up to</p>	W0154	<p>W154</p> <p>Agency policies and procedures have been reviewed and determined to appropriately address preventing client to client abuse, reporting injuries of unknown origin to BDDS, and conducting thorough investigations of incidents including injuries of unknown origin and client to client abuse. SGL Manager has retrained QIDP's on agency SOP's in this area and QIDP's across the agency in all divisions will be retrained on these SOP's. All new staff receive training on these procedures initially and are required to renew this training annually. Client service workers in this home and day program will be retrained on SOP for reporting incidents and preventing client to client abuse. Investigations and BDDS reports are reviewed by the Division Manager and Director of Quality Assurance at least monthly.</p> <p>Responsible for QA: QIDP, Nurse, SGL Manager, Health Care Coordinator, Director of Quality Assurance, Director of Family Services</p>	02/28/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>client F and bit her on the chin. Client F had three scratches. The facility did not conduct an investigation.</p> <p>4. On 12/6/12 at 8:11 AM, client B was found to have multiple bruises up and down both arms, left buttocks, spine and a spot on her nose. The facility did not conduct an investigation.</p> <p>5. On 12/17/12 at 8:30 AM, client B was found to have, at the facility-operated day program, a large bruise on her right side and her nose was swollen and bruised. The facility did not conduct an investigation.</p> <p>6. On 12/31/12 at 8:30 AM, client B was found to have, at the facility-operated day program, a scrape on her right side 2.5 inches long. The facility did not conduct an investigation.</p> <p>7. On 1/3/13 at 6:16 PM, client B was found to have a large bruise on her right side with areas that were abraided. Staff #4 touched the area and client B drew back in pain. Staff #4 notified staff #2. Staff #2 contacted the pager. Staff #1 responded to call and instructed the staff to take client B to the emergency room (ER). At the ER, it was determined client B had some fractured ribs and a pneumothorax (collapsed lung). Client B</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>was airlifted to another hospital in another city. The facility conducted an investigation. The conclusion of the investigation indicated, in part, "After thorough review of documentation and individual interviews, it is inconclusive as to the origin of the injuries sustained by [client B]. These injuries were 4 fractured ribs and a pneumothorax." The investigation indicated, "It was determined that there are no clients with the ability to respond to interview questions for this investigation." The investigation indicated, in part, "Concerns that were generated by the investigation include lack of good communication between the day program and the group home, failure to report as trained, and failure to document as trained."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/24/13 at 1:18 PM. The QMRP indicated none of the other clients (A, C, D, E and F) was interviewed for the investigation of client B's injuries of unknown origin found on 1/3/13.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/25/13 at 1:52 PM. AS #1 indicated injuries of unknown origin should be investigated. On 1/24/13 at 1:16 PM, AS #1 indicated client B's peers (clients A, C, D, E and F) were not</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>interviewed and interviews were not attempted with them in regard to client B's injury of unknown origin found on 1/3/13. AS #1 indicated clients A, C, D, E and F were not reliable reporters and would probably not understand the questions. AS #1 indicated, on 1/24/13 at 1:07 PM, incidents of client to client aggression should be investigated.</p> <p>This federal tag relates to complaint #IN00122252.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (B), the facility failed to ensure staff were retrained on when to notify the nurse.</p> <p>Findings include:</p> <p>A review of the facility incident/investigative reports was conducted on 1/24/13 at 12:37 PM.</p> <p>1. On 10/19/12 at 10:20 AM, client B was found to have a bruise on her tail bone, two on her lower right side of her back and one on her lower left leg at the facility-operated day program. The report indicated, "Watch for any trends to further investigate." There was no documentation the nurse was notified.</p> <p>2. On 10/24/12 at 1:30 PM, client B was walking around the facility-operated day program. She walked past client F, hugged client F and then bit client F on the cheek. Client F had a scratched area on her cheek with no bleeding. There was no documentation the nurse was notified.</p>	W0189	<p>W189</p> <p>SGL Manager and Health Care Coordinator met and reviewed agency protocol for contacting the nurse. It was determined to be thorough in addressing this area in general. Individual clients may have more expectations identified in their individual plans. Nurses and QIDP's will be retrained on the agency protocol for contacting the nurse. Clients in this specific group home with plans found to be non-compliant in this area will be reviewed and revised as needed to ensure compliance. Staff will be retrained on all revised plans and the protocol for contacting the nurse. Agency nurse will review and assess each client at least monthly. Any concerns with appropriate notification to the nurse will be addressed by the QIDP and retraining implemented as needed.</p> <p>Responsible for QA: QIDP, Nurse</p>	02/28/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>3. On 11/29/12 at 11:08 AM, client B was walking around the facility-operated day program. Client F went to put lunchboxes away. Client B went up to client F and bit her on the chin. Client F had three scratches. There was no documentation the nurse was notified.</p> <p>4. On 12/5/12 at 2:35 PM, client B was leaning over backwards at the facility-operated day program. Client B lost balance and fell to the floor. Client B hit the corner of her right eye on the leg of a table. Her eye was swollen and bruised. Client B scraped her right eye lid. There was no documentation the nurse was notified.</p> <p>5. On 12/6/12 at 8:11 AM, client B was found to have multiple bruises up and down both arms, left buttocks, spine and a spot on her nose. There was no documentation the nurse was notified.</p> <p>6. On 12/17/12 at 8:30 AM, client B was found to have, at the facility-operated day program, a large bruise on her right side and her nose was swollen and bruised. There was no documentation the nurse was notified.</p> <p>7. On 12/31/12 at 8:30 AM, client B was found to have, at the facility-operated day program, a scrape on her right side 2.5</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>inches long. There was no documentation the nurse was notified.</p> <p>8. On 1/2/13 at 8:45 AM, the day program staff completed a Medical Incident Report. The report indicated, "[Client B] pale in the face, not acting herself, warm to touch; took temp 100.3." The Comments and corrective action or follow up section indicated, "Filled out Incident Report." There was no documentation the group home staff or the nurse were notified.</p> <p>9. A review of a handwritten statement from Day Program Staff (DPS) #1, also signed by DPS #2 and #3, dated 1/3/13, indicated, "On 1/3/13 @ (at) 1:00 PM, [Qualified Mental Retardation Professional Assistant (QMRPA)] for [name of group home] came into w/s (workshop) to drop off med sheets. Told her then that something is wrong with [client B] that she doesn't look good - pale in the face and not acting herself. [QMRPA] said she didn't know what it could be that she's been to dr (doctor) and nothing and that next week she would be having colonoscopy done and to see what happens w/ (with) that." There was no documentation the nurse was notified.</p> <p>10. On 1/3/13 at 6:16 PM, client B was found to have a large bruise on her right</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>side with areas that were abraised. Staff #4 touched the area and client B drew back in pain. Staff #4 notified staff #2. Staff #2 contacted the pager. Staff #1 responded to call and instructed the staff to take client B to the emergency room (ER). At the ER, it was determined client B had some fractured ribs and a pneumothorax (collapsed lung). Client B was airlifted to another hospital in another city. The facility conducted an investigation. The conclusion of the investigation indicated, in part, "After thorough review of documentation and individual interviews, it is inconclusive as to the origin of the injuries sustained by [client B]. These injuries were 4 fractured ribs and a pneumothorax." The investigation indicated, "It was determined that there are no clients with the ability to respond to interview questions for this investigation." The investigation indicated, in part, "Concerns that were generated by the investigation include lack of good communication between the day program and the group home, failure to report as trained, and failure to document as trained."</p> <p>11. A handwritten statement, not dated, requested from Administrative Staff (AS) #1 for the investigation of client B's injuries found on 1/3/13 indicated, "I (staff #9) worked on 1-1-13 from 2 pm -</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>10 pm, [client B] had no new bruises and was acting herself. She ate well and done (sic) her normal routine (ate, shower, bed). On 1-2-13 I worked and noticed [client B] had a new bruise, very purple but wasn't very noticeable as other bruises. I seen (sic) the bruise at about 4 pm when I showered her. [Client B] ate a little bit of everything that evening but didn't eat like she usually does. After she ate she layed (sic) down for about 1 hour and 30 mins (minutes) and at 8:30 pm she went back to sleep till 9:30 and than (sic) the other staff that was coming in (name of staff #5) arrived. [Client B] was quietly coughing while I was giving her a shower and I told other staff [staff #2 and #3] about it. Staff checked temperature, it was normal. In between her sleep she was sitting on the couch smiling." There was no documentation the nurse was notified.</p> <p>12. A second handwritten statement, not dated, from staff #9 indicated, "I [staff #9] was giving [client B] a shower on 1-2-13 at 7:00 pm and found & reported a bruise on her right side under her right breast." The note did not indicate who she reported this information to.</p> <p>13. A handwritten statement, not dated, from staff #3 indicated, "1-2-13 when [client B] was being showered by [staff</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#9] she noticed a light mark on [client B's] right side. [Staff #9] called me into the bathroom to look at it. At that time it was so faint that it looked like a shadow. I told [staff #9] that we needed to document it in [client B's] book and keep an eye on it to see if it turned into a bruise. 1-3-13 [staff #4] was showering [client B] and saw the bruising from the underarm at the brest (sic) and on down to her hip. This large area of bruising was spotted and had a red mark near her brest (sic) and another on her hips. [Staff #4] called me into the bathroom to see it and ask if she [client B] had the bruise yesterday. I told [staff #4] about what [staff #9] and I had seen but this area was much worse now. It was decided to take [client B] to the ER when [staff #4] called the pager."</p> <p>The facility's Protocol for Contacting Nursing Staff, dated 6/6/11, was reviewed on 1/28/13 at 10:43 AM. The protocol indicated, in part, "These are guidelines to assist staff in determining if the nursing staff needs to be contacted due to the medical condition of a Client. Staff are encouraged to err on the side of caution; so, a call to the Nurse is advised if you are not sure how to proceed with a medical situation. It is also required that you contact the supervising QIDP (Qualified Intellectual Disability Professional)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	during regular business hours or follow the Emergency Pager Procedures after hours, on week-ends and Holidays to keep him/her abreast of any situation that involves unusual medical interventions." The protocol indicated for staff to call the nurse, "If an Individual has a temperature less than 95 degrees or over 100 degrees. If Individual has unusual swelling and/or redness of upper or lower extremities (arms or legs). If Individual falls affecting range of motion of limbs, weight bearing, suffers a head injury, immediate bruising or has an increase in falls. If one Individual bites another and breaks or punctures the skin." The protocol indicated, "When the staff talks to the Nurse, document the instructions given as well as the reason the Nurse was notified in the Medical Communication Logs (yellow sheets). Please be specific and note what the vital signs are, what the injury is or whatever is going on with the Individual. If the staff is unable to contact the Nurse, contact the Physician's office and request further instructions. If unable to contact the Physician, take the Individual to the county emergency room or clinic (if available) for further evaluation. If there is any question concerning the individual's condition being life threatening, call 911 and institute the procedures provided by the CPR and First Aid training provided by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the Agency."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/29/13 at 11:04 AM. The QMRP indicated the protocol should be implemented by the group home staff. The QMRP indicated the group home staff have not been retrained on the protocol since 1/3/13.</p> <p>An interview was conducted with Administrative Staff (AS) #1 on 1/29/13 at 10:39 AM. AS #1 indicated the protocol was for the group home staff and should be implemented. AS #1 indicated the group home staff had not been retrained on the protocol since 1/3/13.</p> <p>An interview with the Day Program Manager (DPM) was conducted on 1/29/13 at 10:50 AM. The DPM indicated the Protocol for Contacting Nursing Staff should be implemented by the day program staff. The DPM indicated the day program staff have not been retrained on the protocol.</p> <p>An interview with the Medical Care Coordinator (MCC) was conducted on 1/29/13 at 10:16 AM. The MCC indicated the group home and day program staff should implement the Protocol for Contacting Nursing Staff.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The MCC indicated the staff should contact the nurse of fever, trauma to head or face, fall with head injury, bites, injuries of unknown origin. The MCC indicated she was not sure if the staff have been retrained. The MCC indicated the staff at the group home and day program need to be retrained on the protocol.</p> <p>This federal tag relates to complaint #IN00122252.</p> <p>9-3-3(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 1 of 3 clients in the sample (B), the facility failed to ensure client B's risk plan for falls included specific instructions for staff to implement the plan.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/24/13 from 3:54 PM to 5:46 PM. Client B was pacing through the living room, dining room and kitchen. From 3:54 PM until 4:08 PM, client B was being supervised by staff #2. Staff #2 stayed right next to client B as she moved through the home. At 3:58 PM, client B spit on the kitchen floor. Client B continued to walk around the home, moaning and grunting, and wringing her hands. At 4:08 PM, staff #3 assumed client B's one on one supervision from staff #2. Staff #3 kept client B within line of sight however staff #3 did not walk next to and stay right with client B. At 4:12 PM, client B got on her hands and knees and put her mouth to the floor.</p> <p>A review of client B's record was conducted on 1/25/13 at 1:20 PM. Client</p>	W0240	<p>W240</p> <p>SGL Manager and Health Care Coordinator met and reviewed concern with risk plans. Nurses and QIDP's will be retrained on developing risk plans with specific instructions for staff on implementing the plan. Clients in this specific group home with plans found to be non-compliant in this area will be reviewed and revised as needed to ensure compliance. Staff will be retrained on all revised plans. QIDP's will conduct random observations within the home at least monthly to ensure compliance in this area. Nurse will do assessments of each client at least monthly and will revise plans as needed. Staff will be retrained on all revised plans.</p> <p>Responsible for QA: QIDP, Nurse</p>	02/28/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>B's Health/Risk Plan, dated 1/7/13, indicated the risk plan addressed falls. The Prescribed Treatments/Medications/Preventive Measures section indicated, in part, "4. Provide one on one assistance to her while she is walking." The plan did not contain additional instructions to staff for one on one assistance. A Special Case Conference Notes form, dated 1/18/13, indicated, in part, "[Client B] will be line of sight supervision @ (at) home, except when sleeping." The hospital discharge instructions, dated 1/7/13, indicated for activity, "Up with assistance only."</p> <p>An interview with staff #3 was conducted on 1/24/13 at 4:04 PM. Staff #3 stated client B was to be kept "line of sight" at all times.</p> <p>An interview with client B's nurse was conducted on 1/28/13 at 1:13 PM. The nurse indicated staff should be right with client B when she is walking. The nurse indicated this was to ensure if client B started to fall, staff would break her fall. The nurse indicated the risk plan for falls needed additional information for staff to implement the plan the way she intended.</p> <p>An interview with the Medical Care Coordinator (MCC) was conducted on 1/25/13 at 11:42 AM. The MCC</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>indicated client B did not like to be touched. The MCC stated the risk plan for falls needed "more delineation in the plan" in order for staff to implement the plan. The MCC indicated the staff should by right with client B, close to client B.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/25/13 at 11:42 AM. AS #1 indicated the facility received no specific instructions from the hospital or the physical therapist. AS #1 indicated there should be consistency in the way the plan was implemented. AS #1 indicated client B was no longer stand by assist as the increased staffing caused behavior issues for client B. AS #1 indicated the plan needed to clearly define how staff were to assist client B while ambulating.</p> <p>This federal tag relates to complaint #IN00122252.</p> <p>9-3-4(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 clients in the sample (B), the facility failed to ensure staff contacted the nurse in order for the nurse to conduct assessments of client B.</p> <p>Findings include:</p> <p>A review of the facility incident/investigative reports was conducted on 1/24/13 at 12:37 PM.</p> <p>1. On 10/19/12 at 10:20 AM, client B was found to have a bruise on her tail bone, two on her lower right side of her back and one on her lower left leg at the facility-operated day program. The report indicated, "Watch for any trends to further investigate." There was no documentation the nurse was notified.</p> <p>2. On 10/24/12 at 1:30 PM, client B was walking around the facility-operated day program. She walked past client F, hugged client F and then bit client F on the cheek. Client F had a scratched area on her cheek with no bleeding. There was no documentation the nurse was notified.</p> <p>3. On 11/29/12 at 11:08 AM, client B was walking around the facility-operated</p>	W0331	<p>W331</p> <p>SGL Manager and Health Care Coordinator met and reviewed agency protocol for contacting the nurse. It was determined to be thorough in addressing this area in general. Individual clients may have more expectations identified in their individual plans. Nurses and QIDP's will be retrained on the agency protocol for contacting the nurse. Clients in this specific group home with plans found to be non-compliant in this area will be reviewed and revised as needed to ensure compliance. Staff will be retrained on all revised plans and the protocol for contacting the nurse. Agency nurse will review and assess each client at least monthly. Any concerns with appropriate notification to the nurse will be addressed by the QIDP and retraining implemented as needed.</p> <p>Responsible for QA: Nurse, QIDP</p>	02/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>day program. Client F went to put lunchboxes away. Client B went up to client F and bit her on the chin. Client F had three scratches. There was no documentation the nurse was notified.</p> <p>4. On 12/5/12 at 2:35 PM, client B was leaning over backwards at the facility-operated day program. Client B lost balance and fell to the floor. Client B hit the corner of her right eye on the leg of a table. Her eye was swollen and bruised. Client B scraped her right eye lid. There was no documentation the nurse was notified.</p> <p>5. On 12/6/12 at 8:11 AM, client B was found to have multiple bruises up and down both arms, left buttocks, spine and a spot on her nose. There was no documentation the nurse was notified.</p> <p>6. On 12/17/12 at 8:30 AM, client B was found to have, at the facility-operated day program, a large bruise on her right side and her nose was swollen and bruised. There was no documentation the nurse was notified.</p> <p>7. On 12/31/12 at 8:30 AM, client B was found to have, at the facility-operated day program, a scrape on her right side 2.5 inches long. There was no documentation the nurse was notified.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>8. On 1/2/13 at 8:45 AM, the day program staff completed a Medical Incident Report. The report indicated, "[Client B] pale in the face, not acting herself, warm to touch; took temp 100.3." The Comments and corrective action or follow up section indicated, "Filled out Incident Report." There was no documentation the group home staff or the nurse were notified.</p> <p>9. A review of a handwritten statement from Day Program Staff (DPS) #1, also signed by DPS #2 and #3, dated 1/3/13, indicated, "On 1/3/13 @ (at) 1:00 PM, [Qualified Mental Retardation Professional Assistant (QMRPA)] for [name of group home] came into w/s (workshop) to drop off med sheets. Told her then that something is wrong with [client B] that she doesn't look good - pale in the face and not acting herself. [QMRPA] said she didn't know what it could be that she's been to dr (doctor) and nothing and that next week she would be having colonoscopy done and to see what happens w/ (with) that." There was no documentation the nurse was notified.</p> <p>10. On 1/3/13 at 6:16 PM, client B was found to have a large bruise on her right side with areas that were abraised. Staff #4 touched the area and client B drew</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>back in pain. Staff #4 notified staff #2. Staff #2 contacted the pager. Staff #1 responded to call and instructed the staff to take client B to the emergency room (ER). At the ER, it was determined client B had some fractured ribs and a pneumothorax (collapsed lung). Client B was airlifted to another hospital in another city. The facility conducted an investigation. The conclusion of the investigation indicated, in part, "After thorough review of documentation and individual interviews, it is inconclusive as to the origin of the injuries sustained by [client B]. These injuries were 4 fractured ribs and a pneumothorax." The investigation indicated, "It was determined that there are no clients with the ability to respond to interview questions for this investigation." The investigation indicated, in part, "Concerns that were generated by the investigation include lack of good communication between the day program and the group home, failure to report as trained, and failure to document as trained."</p> <p>11. A handwritten statement, not dated, requested from Administrative Staff (AS) #1 for the investigation of client B's injuries found on 1/3/13 indicated, "I (staff #9) worked on 1-1-13 from 2 pm - 10 pm, [client B] had no new bruises and was acting herself. She ate well and done</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>(sic) her normal routine (ate, shower, bed). On 1-2-13 I worked and noticed [client B] had a new bruise, very purple but wasn't very noticeable as other bruises. I seen (sic) the bruise at about 4 pm when I showered her. [Client B] ate a little bit of everything that evening but didn't eat like she usually does. After she ate she layed (sic) down for about 1 hour and 30 mins (minutes) and at 8:30 pm she went back to sleep till 9:30 and than (sic) the other staff that was coming in (name of staff #5) arrived. [Client B] was quietly coughing while I was giving her a shower and I told other staff [staff #2 and #3] about it. Staff checked temperature, it was normal. In between her sleep she was sitting on the couch smiling." There was no documentation the nurse was notified.</p> <p>12. A second handwritten statement, not dated, from staff #9 indicated, "I [staff #9] was giving [client B] a shower on 1-2-13 at 7:00 pm and found & reported a bruise on her right side under her right breast." The note did not indicate who she reported this information to.</p> <p>13. A handwritten statement, not dated, from staff #3 indicated, "1-2-13 when [client B] was being showered by [staff #9] she noticed a light mark on [client B's] right side. [Staff #9] called me into</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>the bathroom to look at it. At that time it was so faint that it looked like a shadow. I told [staff #9] that we needed to document it in [client B's] book and keep an eye on it to see if it turned into a bruise. 1-3-13 [staff #4] was showering [client B] and saw the bruising from the underarm at the brest (sic) and on down to her hip. This large area of bruising was spotted and had a red mark near her brest (sic) and another on her hips. [Staff #4] called me into the bathroom to see it and ask if she [client B] had the bruise yesterday. I told [staff #4] about what [staff #9] and I had seen but this area was much worse now. It was decided to take [client B] to the ER when [staff #4] called the pager."</p> <p>The facility's Protocol for Contacting Nursing Staff, dated 6/6/11, was reviewed on 1/28/13 at 10:43 AM. The protocol indicated, in part, "These are guidelines to assist staff in determining if the nursing staff needs to be contacted due to the medical condition of a Client. Staff are encouraged to err on the side of caution; so, a call to the Nurse is advised if you are not sure how to proceed with a medical situation. It is also required that you contact the supervising QIDP (Qualified Intellectual Disability Professional) during regular business hours or follow the Emergency Pager Procedures after</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>hours, on week-ends and Holidays to keep him/her abreast of any situation that involves unusual medical interventions." The protocol indicated for staff to call the nurse, "If an Individual has a temperature less than 95 degrees or over 100 degrees. If Individual has unusual swelling and/or redness of upper or lower extremities (arms or legs). If Individual falls affecting range of motion of limbs, weight bearing, suffers a head injury, immediate bruising or has an increase in falls. If one Individual bites another and breaks or punctures the skin." The protocol indicated, "When the staff talks to the Nurse, document the instructions given as well as the reason the Nurse was notified in the Medical Communication Logs (yellow sheets). Please be specific and note what the vital signs are, what the injury is or whatever is going on with the Individual. If the staff is unable to contact the Nurse, contact the Physician's office and request further instructions. If unable to contact the Physician, take the Individual to the county emergency room or clinic (if available) for further evaluation. If there is any question concerning the individual's condition being life threatening, call 911 and institute the procedures provided by the CPR and First Aid training provided by the Agency."</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/29/13 at 11:04 AM. The QMRP indicated the protocol should be implemented by the group home staff. The QMRP indicated she was not sure if the protocol was implemented by the day program staff. The QMRP indicated the group home staff have not been retrained on the protocol since 1/3/13.</p> <p>An interview was conducted with Administrative Staff (AS) #1 on 1/29/13 at 10:39 AM. AS #1 indicated she was not sure if the Protocol for Contacting Nursing Staff was implemented by the day program staff. AS #1 indicated the protocol was for the group home staff and should be implemented. AS #1 indicated the group home staff had not been retrained on the protocol since 1/3/13.</p> <p>An interview with the Day Program Manager (DPM) was conducted on 1/29/13 at 10:50 AM. The DPM indicated the Protocol for Contacting Nursing Staff should be implemented by the day program staff. The DPM indicated the day program staff were not documenting who was notified of incidents and injuries. The DPM indicated the notifications should be documented.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/29/2013
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>An interview with the Medical Care Coordinator (MCC) was conducted on 1/29/13 at 10:16 AM. The MCC indicated the group home and day program staff should implement the Protocol for Contacting Nursing Staff. The MCC indicated the staff should contact the nurse of fever, trauma to head or face, fall with head injury, bites, injuries of unknown origin. The MCC indicated she was not sure if the staff have been retrained. The MCC indicated the staff at the group home and day program need to be retrained on the protocol.</p> <p>This federal tag relates to complaint #IN00122252.</p> <p>9-3-6(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
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 14 incident/investigative reports reviewed affecting client B, 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>On 12/5/12 at 2:35 PM, client B was leaning over backwards at the</p>	W9999	<p>W9999</p> <p>QIDP's have been retrained on requirement to report all falls with injury to BDDS within 24 hours. SGL Manager will continue to review internal incident reports to ensure compliance in this area.</p> <p>Responsible for QA: QIDP, SGL Manager</p>	02/28/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/29/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>facility-operated day program. Client B lost balance and fell to the floor. Client B hit the corner of her right eye on the leg of a table. Her eye was swollen and bruised. Client B scraped her right eye lid. The fall with injury was not reported to BDDS.</p> <p>On 1/25/13 at 1:52 PM, the QMRP indicated client B's fall on 12/5/12 should have been reported to BDDS.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/25/13 at 1:52 PM. AS #1 indicated falls with injury should be reported to BDDS within 24 hours.</p> <p>9-3-1(b)</p>				