

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G115	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 830 EVERGREEN DRIVE SEYMOUR, IN 47274
--	---

(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 an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: July 30, 31, August 1, 2 and 15, 2012</p> <p>Facility Number: 000652 Provider Number: 15G115 AIM Number: 100239590</p> <p>Surveyor: Jo Anna Scott, Medical Surveyor III</p> <p>The following deficiencies reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 8/17/12 by Tim Shebel, 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: 15G115		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/15/2012	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 830 EVERGREEN DRIVE SEYMOUR, IN 47274			
(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 1 of 2 reportable incident reports reviewed, the facility failed to ensure the surgery that was conducted on 5/25/12 on client #4 (1 of 4 clients living in the home) was reported within 24 hours.</p> <p>Findings include:</p> <p>The facility incident reports were reviewed on 7/30/12 at 1:41 PM. The Bureau of Developmental Disability Services (BDDS) report with incident date of 5/24/12 was not reported to BDDS until 5/29/12. The report was reporting a cholecystectomy and appendectomy for client #4 and indicated she had remained in the hospital overnight.</p> <p>Interview with staff #2, administrator, on 7/30/12 at 2:45 PM indicated the report should have been made within 24 hours.</p> <p>9-3-2(a)</p>	W0154	<p>W154 QIDP's will be retrained on requirements for filing incident reports to BDDS especially in regards to timely reporting. SGL Manager will monitor this for compliance in this area. Responsible for QA: QIDP, SGL Manager</p>	09/14/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G115		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/15/2012	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 830 EVERGREEN DRIVE SEYMOUR, IN 47274			
(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			
W0242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on record review and interview for 1 of 2 sampled clients (client #2), the facility failed to ensure the clients' basic needs of bathing and dressing were addressed.</p> <p>Findings include:</p> <p>Review of client #2's record was conducted on 8/1/12 at 8:50 AM. The Individual Program Plan (IPP) dated 6/4/11 indicated client #2 was not independent in the areas of bathing and dressing. The record review indicated there was no training in these basic skill areas in client #2's IPP.</p> <p>Interview with staff #1, QDDP (Qualified Developmental Disabilities Professional), on 8/1/12 at 9:30 AM indicated client #2 was not independent in the basic skills of bathing and dressing.</p> <p>9-3-4(a)</p>	W0242	<p>W242</p> <p>QIDP will identify training objectives for Client #2 in her program plan in the areas of bathing and dressing. The annual IPP will be updated to include these objectives. Staff will be trained on the updated IPP and implementation of the training objectives. QIDP will monitor monthly for progress on the objectives and update as necessary. Responsible for QA: QIDP</p>	09/14/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G115		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/15/2012	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 830 EVERGREEN DRIVE SEYMOUR, IN 47274			
(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			
W0258	<p>483.440(f)(1)(iv) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client is being considered for training towards new objectives.</p> <p>Based on record review and interview for 1 of 2 sampled clients (client #2), the facility failed to provide an Individual Program Plan (IPP) annually.</p> <p>Findings include:</p> <p>The record review for client #2 was conducted on 8/1/12 at 8:50 AM. The record indicated the IPP was dated 6/14/11. The Qulified Developmental Disabilities Professional (QDDP) had provided an extension sheet indicating the ISP dated 6/14/11 was to be extended to 8/7/12.</p> <p>Interview with staff #1, QDDP, on 8/1/12 at 10:30 AM indicated she had been unable to conduct a meeting because of scheduling issues. Staff #1, QDDP, indicated there had been a lot of issues with another home and she had not been able to set up a meeting with the guardians.</p> <p>9-3-4(a)</p>	W0258	<p>w258 The annual program plan meeting for Client #2 was held on August 7, 2012. QIDP's will be retrained on the timeframe expected for the annual review which is 365 days after the last review. QIDP's report monthly to the SGL Manager the IPP's for that month. SGL Manager will monitor these review dates to ensure compliance in this area. Responsible for QA: QIDP, SGL Manager</p>	09/14/2012			

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

PRINTED: 09/11/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G115	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/15/2012
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 830 EVERGREEN DRIVE SEYMOUR, IN 47274		
(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	