

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/16/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR 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
W 0000  Bldg. 00	<p>This visit was for a Post Certification Revisit to the full recertification and state licensure survey completed on 8/27/15.</p> <p>Survey Dates: October 15 and 16, 2015</p> <p>Facility Number: 000632 Provider Number: 15G092 AIM Number: 100233940</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed by #09182 on 10/20/2015.</p>	W 0000		
W 0268  Bldg. 00	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, interview and record review for 1 of 3 clients in the sample (#5), the facility failed to ensure client #5's dignity by failing to ensure his shoes did not have black "R" and "L" letters written on the top of his white shoes.</p> <p>Findings include:  On 10/15/15 from 1:05 PM to 1:37 PM,</p>	W 0268	<p><b>Corrective actions taken:</b></p> <ul style="list-style-type: none"> <li>· Client #5's shoes have been replaced at DSI's expense.</li> <li>· Group home staff will be in-serviced on client rights.</li> </ul> <p><b>How will we identify others:</b></p> <ul style="list-style-type: none"> <li>· County QIDPs will ensure that all other clients' shoes and clothing are free from humiliating marks such</li> </ul>	11/15/2015

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:  15G092		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  10/16/2015	
NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR 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			
	<p>an observation was conducted at the facility-operated day program. At 1:31 PM when client #5 approached the surveyor to talk, client #5's right shoe had an "R" and his left shoe had a "L" written in black marker on the top of his shoes. Client #5 indicated he did not know who put the letters on his shoes. Client #5 indicated the letters were not necessary due to knowing his right from his left. Client #5 stated he "tried to scrub it off" but was unable to remove the letters from the top of his shoes. Client #5 stated he "didn't like it."</p> <p>On 10/15/15 from 3:23 PM to 5:08 PM, an observation was conducted at the group home. During the observation, client #5 was wearing the shoes with the letters "L" and "R" on them. At 4:12 PM, client #5 stated to the Regional Program Manager, "Whoever did this, I don't think it's funny. I know my left and right."</p> <p>On 10/15/15 at 1:36 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she had never seen the letters on client #5's shoes. The QIDP indicated it was a dignity issue. The QIDP indicated if his shoes needed a way to differentiate between the left and the right, it should be done discreetly.</p> <p>On 10/15/15 at 2:50 PM, staff #3</p>		<p>as "L", "R" or visible client initials.</p> <p><b>Measures put in place:</b></p> <ul style="list-style-type: none"> <li>· Group Home Observation Form ( attachment A)</li> <li>· Client Personal Inventory Form ( attachment B)</li> </ul> <p><b>Monitoring of corrective action:</b></p> <ul style="list-style-type: none"> <li>· During group home observations, county QIDPs will ensure that client clothing is free from humiliating marks.</li> <li>· Staff will look for humiliating or demeaning marks on clothing while auditing client inventories on a quarterly basis.</li> </ul>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/16/2015
--------------------------------------------------	-----------------------------------------------------------------	---------------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR 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
	<p>indicated client #5's sister put the letters on client #5's shoes when his shoes were purchased. Staff #3 indicated the staff at the group home did not put the letters on client #5's shoes. On 10/15/15 at 2:58 PM, staff #3 indicated the letters on client #5's shoes were not appropriate. Staff #3 indicated client #5 knew his left from his right and did not need the letters on his shoes. Staff #3 indicated the staff at the group home attempted to assist client #5 with removing the letters however they were unable to remove the letters.</p> <p>On 10/15/15 at 2:57 PM, the nurse indicated client #5's shoes could have been marked on the tongue of the shoe. The nurse stated, "Too bad she (sister) didn't think of it first."</p> <p>On 10/15/15 at 3:26 PM, the Regional Program Manager (RPM) indicated client #5's shoes were inappropriate. The RPM stated, "He's an adult. We will replace his shoes."</p> <p>On 10/15/15 at 3:44 PM, the Quality Assurance (QA) staff stated, "He's an adult. Should not be on there." The QA staff indicated client #5 needed to purchase new shoes. The QA staff stated the letters on his shoes were "not appropriate." The QA staff indicated the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G092	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/16/2015
--------------------------------------------------	-----------------------------------------------------------------	--------------------------------------------------------------	---------------------------------------------

NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 583 CAMELOT DR 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
W 9999  Bldg. 00	<p>letters could have been placed on the tongue of the shoes instead of the outside of his shoes.</p> <p>On 10/15/15 at 4:08 PM, the Director of Business and Industry stated client #5's shoes were "not appropriate."</p> <p>On 10/16/15 at 8:32 AM, a review of client #5's 8/18/15 Individual Support Plan and 7/14/15 Behavior Management Program did not indicate a need for client #5's shoes to be labeled left and right on the top of the shoes.</p> <p>9-3-5(a)</p>	W 9999	N/A	11/15/2015