

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 |
|--|---|

| (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 a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: October 12, 13, 14 and 17, 2011.</p> <p>Facility number: 000727 Provider number: 15G197 AIM number: 100239620</p> <p>Surveyor: Steven Schwing, Medical Surveyor III.</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review W. Chris Greeney-ICF-ID Surveyor Supervisor on 11/3/11</p> | W0000 | | |
| W0104 | <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's governing body failed to ensure the group home was free of rodents.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/12/11 from 5:53 AM to 7:22 AM. At 5:55 AM, a mouse was</p> | W0104 | <p>W104 The pest control vendor has now treated this home using more aggressive measures than the normal monthly treatments in order to free this home of rodents. The QIDP will continue to monitor to ensure the home remains free of pests by requesting updates from the staff. The QIDP or designee is required to conduct random observations at least monthly. The pest control vendor does regular monthly treatments in the</p> | 11/16/2011 |

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: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>observed on a shelving unit in the kitchen near the front door. The shelf contained stored food items such as cereal bars snack bags of chips. There were several mouse traps on the kitchen floor with bait in them.</p> <p>An interview with staff #8 was conducted on 10/12/11 at 5:55 AM. Staff #8 indicated the group home had issues with mice. Staff #8 indicated the mice had been coming into the home since the weather started getting cooler. Staff #8 indicated there were several traps in the kitchen area put out nightly while the clients were asleep. Staff #8 indicated the traps were put away when the clients woke up.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated the group home was treated monthly for pests. The QMRP indicated that on 10/17/11, the pest control company was visiting the home to spray especially for mice and spiders.</p> <p>9-3-1(a)</p> | | home. Responsible for QA: QIDP, SGL Manager | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/17/2011 | |
|--|--|---|--|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 | | | |
| W0124 | <p>The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>Based on record review and interview for 2 of 4 clients' records reviewed (#4 and #6), the facility failed to ensure the clients' guardians consented to the program plans.</p> <p>Findings include:</p> <p>A review of client #6's record was conducted on 10/14/11 at 10:28 AM. Client #6's Individual Program Plan (IPP), dated 9/11-9/12, did not contain consent from her guardian to implement the plan.</p> <p>A review of client #4's record was conducted on 10/14/11 at 11:03 AM. Client #4's IPP, dated 8/9/11, did not contain consent from her guardian to implement the plan.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated she did not send clients #4 and #6's plans for consent from their guardians. The QMRP indicated the guardians were invited to the IPP meeting and the plans were sent to them however she did not request the guardians'</p> | W0124 | <p>The QIDP will obtain guardian consent for the program plans for client #4 and #6. QIDP's will review caseloads to ensure guardian consent has been obtained for current program plans. Should guardians not attend program plan meetings, QIDP's will send for written consent to the program plans and will document any communication, verbal or written, with guardians regarding the program plans.</p> <p>Responsible for QA: QIDP</p> | 11/16/2011 | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| W0125 | <p>signatures on the plans.</p> <p>9-3-2(a)</p> <p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and record review for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients' rights by: 1) locking cleaning supplies, 2) restricting client #4's access to her lunchbox at the group home, 3) restricting access to the clients' lunchboxes while at the workshop and 4) restricting client #1's access to coffee creamer.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 10/12/11 from 5:53 AM to 7:22 AM and 4:15 PM to 5:45 PM. During the observations, the cabinet below the sink was locked with a pad lock. The cabinet contained cleaning supplies.</p> <p>A review of client #1's record was conducted on 10/13/11 at 1:09 PM. Client #1's Behavior Support Plan (BSP), dated 8/8/11, indicated cleaning supplies</p> | W0125 | <p>QIDP will review restrictions affecting each client cited in this report. Any necessary restrictions will be reviewed by HRC and approval will be obtained from guardians and HRC members. Any unnecessary restrictions will be removed. Staff will be retrained on approved restrictions and the removal of unnecessary restrictions. QIDP or designee will conduct random observations at least monthly to ensure client rights are being upheld and no unnecessary restrictions are in place.</p> <p>Responsible for QA: QIDP</p> | 11/16/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 | | |
| (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>would be locked and labeled with "Mr. Ulk" stickers. The plan indicated one on one supervision would be provided while using cleaning supplies.</p> <p>A review of client #2's record was conducted on 10/13/11 at 1:50 PM. Client #2's Individual Program Plan (IPP), dated 4/13/11 and her BSP, dated 9/30/10, did not indicate client #2 needed to have the cleaning supplies locked. There was nothing in her plans indicating client #2 was being taught to access the cleaning supplies.</p> <p>A review of client #4's record was conducted on 10/14/11 at 11:03 AM. Client #4's IPP, dated 8/9/11, and her BSP, dated 8/12/11, did not indicate client #4 needed to have cleaning supplies locked. There was nothing in her plans indicating client #4 was being taught to access the cleaning supplies.</p> <p>A review of client #6's record was conducted on 10/14/11 at 10:28 AM. Client #6's IPP, dated 9/11-9/12, did not indicate client #6 needed to have cleaning supplies locked. There was nothing in her plan indicated client #6 was being taught to access the cleaning supplies.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>conducted on 10/14/11 at 11:26 AM. The QMRP indicated client #1 had a restriction to the cleaning supplies. The QMRP indicated the restriction affected the other clients but there was no plan teaching those clients to access the cleaning supplies. The QMRP indicated clients #2, #3, #4, #5 and #6 did not need the cleaning supplies locked. On 10/13/11 at 2:33 PM, the QMRP indicated she did not think the chemicals needed to be locked.</p> <p>2) An observation was conducting at the group home on 10/12/11 from 5:53 AM to 7:22 AM. At 6:28 AM, client #4 attempted to go behind the staff desk in the living room to get her lunchbox. Client #4's lunchbox was on the floor behind the staff's desk. Staff #2 prompted client #4 out of the area. At 6:37 AM, client #4 attempted to put additional food and drinks into her lunchbox. Staff #5 prompted client #4 to put the food and drinks away since her lunch and snacks were already packed.</p> <p>An interview with staff #2 was conducted on 10/12/11 at 6:28 AM. Staff #2 indicated client #4 was not allowed to have her lunchbox since she would eat her food prior to lunch. Staff #2 indicated staff carry client #4's lunchbox to the group home vehicle for transport to the</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 |
|--|---|

| (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>workshop and then carry her lunchbox into the workshop.</p> <p>A review of client #4's record was conducted on 10/14/11 at 11:03 AM. Client #4's IPP, dated 8/9/11, and her BSP, dated 8/12/11, did not indicate client #4 needed to have restricted access to her lunchbox.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated restricting client #4's access to her lunchbox was not part of her plan and should not be implemented.</p> <p>3) An observation at the facility-operated workshop was conducted on 10/13/11 from 9:39 AM to 10:34 AM. During the observations at the workshop, client #1, #2, #3, #4, #5, #6, #7 and #8's lunchboxes were locked in an office.</p> <p>A review of client #1's record was conducted on 10/13/11 at 1:09 PM. Client #1's Behavior Support Plan (BSP), dated 8/8/11, and IPP (Individual Program Plan), dated 8/9/11, did not indicate client #1's lunchbox needed to be locked at the workshop.</p> <p>A review of client #2's record was conducted on 10/13/11 at 1:50 PM.</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 | | |
| (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 #2's IPP, dated 4/13/11 and her BSP, dated 9/30/10, did not indicate client #2 needed to have her lunchbox locked while at the workshop.</p> <p>A review of client #4's record was conducted on 10/14/11 at 11:03 AM. Client #4's IPP, dated 8/9/11, and her BSP, dated 8/12/11, did not indicate client #4 needed to have her lunchbox locked while at the workshop.</p> <p>A review of client #6's record was conducted on 10/14/11 at 10:28 AM. Client #6's IPP, dated 9/11-9/12, did not indicate client #6 needed to have her lunchbox locked while at the workshop.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated she was aware the clients' lunchboxes were being locked at the workshop. The QMRP indicated this was implemented due to the clients' food disappearing prior to locking up the lunchboxes. The QMRP indicated this restriction was not part of the clients' plans.</p> <p>4) An observation was conducted at the group home on 10/12/11 from 5:53 AM to 7:22 AM. At 6:15 AM after client #1 finished eating her cereal she got a cup of</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|---|--|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 | | |
| (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 | |
| W0130 | <p>coffee. Client #1 took the coffee cup to staff #2 in the med administration area. Staff #2 got creamer out of a locked filing cabinet, poured it into client #1's coffee and then locked the creamer back in the cabinet.</p> <p>A review of client #1's record was conducted on 10/13/11 at 1:09 PM. Client #1's Behavior Support Plan (BSP), dated 8/8/11, and IPP (Individual Program Plan), dated 8/9/11, did not indicate client #1 required coffee creamer to be locked.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated she did not know why the creamer was being locked. The QMRP stated, "I'm sorry. They are obviously doing things that I'm not aware of." The QMRP indicated there was no need for the creamer to be locked.</p> <p>9-3-2(a) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview for 2 of 3 clients observed to receive their medications (#3 and #4), the facility failed to ensure the clients' privacy during medication administration.</p> | W0130 | QIDP will retrain staff on the importance of ensuring privacy during medication administration. QIDP or designee will conduct on-going random observations at least monthly to ensure privacy is | 11/16/2011 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>Findings include:</p> <p>An observation was conducted at the group home on 10/12/11 from 5:53 AM to 7:22 AM. At 6:27 AM, client #4 received her medications from staff #2. During client #4's medication administration in the living room of the group home, client #3 was in the same area and was not prompted to go to another area. Staff #2 utilized a small curtain to block the view of client #4 from the living room, however the med pass area was located in the living room of the group home. At 6:35 AM, client #3 received her medications from staff #2. Client #2 was in the living room. Staff #2 used a small curtain to block client #2's view of the med pass. An observation was conducted at the group home on 10/12/11 from 4:15 PM to 5:45 PM. At 4:23 PM, client #2 received medications from staff #3. Client #1 was in the same area. At 4:25 PM, client #1 received her meds in the living room. Clients #2 and #4 were in the same area as the med pass and close enough to hear the medication training being provided by staff #3 to client #1.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated she did not like the</p> | | <p>being supported.</p> <p>Responsible for QA: QIDP</p> | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|---|---------------|--|----------------------|
| W0186 | <p>current arrangement for the med pass. The QMRP indicated if the clients were not receiving medications from the staff, they should be prompted out of the area to ensure the client who was receiving meds was given privacy.</p> <p>9-3-2(a)</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation and interview for 5 of 6 clients living in the group home (#2, #3, #4, #5 and #6), the facility failed to ensure there was sufficient staff to supervise the clients during the morning observations.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/12/11 from 5:53 AM to 7:22 AM. At 6:03 AM, client #4 came downstairs from her bedroom and was told by staff #2 to go back to bed until 6:30 AM. At 6:10 AM, client #4 came downstairs from her bedroom. Staff #2 verbal prompted client #4 to go back to her room two times. Client #4 went into the basement where staff #8 was assisting another client. Staff #8 told client #4 to go back upstairs two times. Clients #2, #3, #4, #5 and #6's bedrooms were located on the second floor of the group home. Client #1's bedroom was located on the first floor.</p> | W0186 | <p>Schedule of the morning staff was reviewed and the times were adjusted to allow for sufficient staffing during the morning. QIDP or designee will conduct on-going random observations at least monthly to ensure the adjustment provides adequate supervision.</p> <p>Responsible for QA: QIDP</p> | 11/16/2011 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|--|---------------|---|----------------------|
| W0249 | <p>An interview with staff #2 was conducted on 10/12/11 at 6:20 AM. Staff #2 indicated none of the clients were allowed to come downstairs until 6:30 AM when the second morning staff arrived. Staff #2 indicated client #1, who wakes up around 6:00 AM most days and client #4 were both line of sight supervision. Staff #2 indicated it was nearly impossible for both clients to remain within line of sight so the staff tell clients #2, #3, #4, #5 and #6 they are not allowed to go downstairs to the main level of the home until the second morning staff arrived.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated the staff telling clients #2, #3, #4, #5 and #6 they could not go downstairs until 6:30 AM was not part of the clients' plans. The QMRP indicated the staff should not be telling the clients they can not go downstairs until 6:30 AM. The QMRP indicated it was easier for the staff when client #4 stayed upstairs until 6:30 AM. The QMRP indicated the facility may need to change the second staff's schedule to arriving at 6:00 AM to address this issue.</p> <p>9-3-3(a) As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 2 of 6 clients living in the group home (#2 and #4), the facility failed to ensure staff implemented 1) client #2's communication training and 2) client</p> | W0249 | QIDP has retrained staff on client #2's use of the communication book and client #4's behavior plan. QIDP or designee will conduct on-going | 11/16/2011 |

| | | | | | | | |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/17/2011 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 | | | |
| (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>#4's behavior plan as written.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 10/12/11 from 5:53 AM to 7:22 AM and 4:15 PM to 5:45 PM. During the observations, client #2 did not have a communication book. Staff #2, #3, #5 and #8 at the group home did not prompt client #2 to use a communication book. An observation was conducted at the facility-operated workshop on 10/13/11 from 9:39 AM to 10:34 AM. During the observation, client #2 did not have a communication book and the workshop staff did not prompt her to use a communication book.</p> <p>An interview with workshop staff #1 was conducted on 10/13/11 at 10:15 AM. Staff #1 indicated client #2 did not have a communication book for her to use at the workshop. Staff #1 indicated she had not seen a communication book for client #2 to use at the workshop. Staff #1 indicated client #2 would benefit from having a communication book at the workshop.</p> <p>A review of client #2's record was conducted on 10/13/11 at 1:50 PM. Client #2's Individual Program Plan (IPP), dated 4/13/11, indicated the following, "Communication is a significant issue for [client #2]. [Client #2] should be encouraged to use her communication book, sign language, and verbal communication when communicating with others in order to broaden her ability to express her wants and needs across all environments." Client #2's IPP indicated she had training objectives to use her communication book to identify secondary colors and the numbers 10-15.</p> | | <p>random observations at least monthly to ensure each clients program plans are being implemented.</p> <p>Responsible for QA: QIDP</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 10/14/11 at 11:26 AM. The QMRP indicated the staff at the group home and workshop should be prompting client #2 to use her communication book.</p> <p>2) An observation was conducted at the group home on 10/12/11 from 5:53 AM to 7:22 AM. At 6:03 AM, client #4 was told by staff #2 to go back to bed until 6:30 AM. At 6:10 AM, client #4 came downstairs from her bedroom. Staff #2 verbal prompted client #4 to go back to her room. Client #4 went into the basement. Staff #8 told client #4 to go back upstairs. At 6:37 AM, client #4 ate her breakfast. There was no music playing. At 6:59 AM, client #4 was prompted to go upstairs to brush her teeth by staff #3. Client #4 banged her elbow on a chair, yelled out and did not move. Staff #2 told client #4, at 7:01 AM, if she went upstairs to brush her teeth, she could have a water bottle to take to the workshop to recycle. Client #4 yelled two times and two minutes later, she went upstairs. On 10/12/11 at 5:40 PM during dinner, client #4 was finished with her meal. She got up and staff #8 stated to her, "stay right there." Staff #8, three seconds later, told client #4 she could leave the table. During the meal, there was no music playing. During the observations, staff did not utilize a timer.</p> <p>A review of client #4's record was conducted on 10/14/11 at 11:03 AM. Her Behavior Support Plan (BSP), dated 8/12/11, indicated the following, "When making a request of [client #4], ask her, do not tell her. She does not respond well to authoritative methods. Give [client #4] a minute to respond to a request, then repeat the request, adding use of cues, such as referring to a visual schedule or showing her how to complete</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|--|---------------|---|----------------------|
| W0317 | <p>the task. [Client #4] reportedly responds well to the use of a timer. Therefore, utilize a timer, when making requests, by telling her that when the timer goes off it is time for her to complete the requested task." The Control section, in capital letters indicated, " SHE DOES NOT LIKE TO BE TOLD WHAT TO DO. " Her BSP indicated that during meals, relaxing music should be played.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated the staff should implement client #4's BSP as written.</p> <p>9-3-4(a)</p> <p>Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated.</p> <p>Based on record review and interview for 2 of 6 clients living in the group home (#1 and #4), the facility failed to ensure there was a medication reduction plan for each psychotropic medication.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 10/13/11 at 1:09 PM. Her Behavior Support Plan (BSP), dated 8/8/11, indicated client #1 was prescribed the following psychotropic medications: Risperdal (schizo-affective disorder), Zoloft (depression), Lamictal (mood stabilization), Seroquel (schizo-affective disorder) and Ativan (as needed to severe anxiety). The medication reduction plan, dated 7/31/06, did not indicate specific criteria for reducing the medications. The</p> | W0317 | <p>QIDP will work the Behavior Clinicians for client #1 and client #4 to revise the behavior support plan for each to include specific criteria for reducing the medications. QIDP will review behavior plans at least annually to ensure that reductions plans are included.</p> <p>Responsible for QA: QIDP</p> | 11/16/2011 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|--|---------------|--|----------------------|
| W0371 | <p>medication reduction plan indicated, "At least quarterly, the interdisciplinary team (IDT) will review these medications doses relative to the current behavioral status... Psychoactive medications will be reduced.discontinued upon the recommendations of the prescribing physician and the IDT."</p> <p>A review of client #4's record was conducted on 10/14/11 at 11:03 AM. Her BSP, dated 8/12/11, indicated she was prescribed Trazadone (insomnia), Risperdal, Seroquel and Zolof. The Plan for Reduction section indicated, "The plan for reduction of medications will be re-evaluated by the team at least quarterly." There was no specific criteria for each medication for reduction.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated there was not a specific med reduction plan for each psychotropic medication. The QMRP indicated there should be a medication reduction plan for each psychotropic medication.</p> <p>9-3-5(a) The system for drug administration must assure that clients are taught to administer their own medications if the interdisciplinary team determines that self-administration of medications is an appropriate objective, and if the physician does not specify otherwise. Based on observation, interview and record review for 3 of 3 clients observed to receive their medications (#1, #3 and #4), the facility failed to ensure the staff implemented their self-administration of medications training objectives.</p> <p>Findings include:</p> | W0371 | QIDP will retrain staff on the Individual Program Plan for clients #1, #3, and #4 to include the medication training objective. QIDP or designee will then observe at least weekly for one month to ensure staff are implementing this objective for all clients. Random observations will | 11/16/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/17/2011 | |
|--|--|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 | | | |
| (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 group home on 10/12/11 from 5:53 AM to 7:22 AM. At 6:03 AM, client #1 received her medications from staff #3. Staff #3 did not provide training to client #1 regarding the medications she was taking, purpose or possible side effects. The staff did not prompt client #1 to name meds or their possible side effects. At 6:27 AM, client #4 received her medications. Staff #3 did not provide training to client #4 regarding the medications she was taking, purpose or possible side effects. The staff did not prompt client #4 to identify a medication or name possible side effects. At 6:35 AM, client #3 received her medications. Staff #3 did not provide training to client #3 regarding the medications she was taking, purpose or possible side effects. The staff did not prompt client #3 to name any meds or their purpose.</p> <p>A review of client #1's record was conducted on 10/13/11 at 1:09 PM. Client #1's Individual Program Plan (IPP), dated 8/9/11, indicated she had a training objective to name Risperdal and Lamictal and name two possible side effects.</p> <p>A review of client #3's record was conducted on 10/14/11 at 12:20 PM. Client #3's IPP, dated 7/11-7/12, indicated she had a training objective to state the purpose of Prazosine.</p> <p>A review of client #4's record was conducted on 10/14/11 at 12:20 PM. Client #4's IPP, dated 9/11-9/12, indicated she had a training objective to identify Seroquel and side effects.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated the staff should implement the clients medication training at each med pass.</p> | | <p>continue at least monthly and retraining for staff will be provided as needed.</p> <p>Responsible for QA: QIDP</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|---|---------------|---|----------------------|
| W0436 | <p>9-3-6(a)</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based on observation, interview and record review for 1 of 1 clients in the sample with a communication book (#2), the facility failed to ensure the communication book was available for client #2 to use at the facility-operated workshop.</p> <p>Findings include:</p> <p>An observation was conducted at the facility-operated workshop on 10/13/11 from 9:39 AM to 10:34 AM. During the observation, client #2 did not have a communication book. The workshop staff did not prompt client #2 to use a communication book. A communication book at the workshop was not located during the observation.</p> <p>An interview with workshop staff #1 was conducted on 10/13/11 at 10:15 AM. Staff #1 indicated client #2 did not have a communication book for her to use at the workshop. Staff #1 indicated she had not seen a communication book for client #2 to use at the workshop. Staff #1 indicated client #2 would benefit from having a communication book at the workshop.</p> <p>A review of client #2's record was conducted on 10/13/11 at 1:50 PM. Client #2's Individual Program Plan (IPP), dated 4/13/11, indicated the following, "Communication is a significant issue for [client #2]. [Client #2] should be encouraged</p> | W0436 | <p>QIDP will ensure that client #2's communication book is available for use in the workshop. Staff will be retrained on the use of the communication book per client #2's plan. QIDP or designee will conduct on-going random observations at least monthly to ensure each client's program plans are being implemented.</p> <p>Responsible for QA: QIDP</p> | 11/16/2011 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|---|---------------|--|----------------------|
| W0440 | <p>to use her communication book, sign language, and verbal communication when communicating with others in order to broaden her ability to express her wants and needs across all environments."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated client #2 should have a communication book at the workshop.</p> <p>9-3-7(a) The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure an evacuation drill was conducted quarterly for each shift.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 10/13/11 at 11:08 AM. During the day shift (7:00 AM to 3:00 PM), there was no drill conducted from 11/15/10 to 3/21/11. This affected clients #1, #2, #3, #4, #5 and #6.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated evacuation drills were to be conducted quarterly for each shift.</p> | W0440 | <p>QIDP will retrain staff on requirements for regular evacuation drills. A schedule will be posted in the home to ensure drills are performed as required for each shift. QIDP will review this monthly at house meetings to ensure compliance.</p> <p>Responsible for QA: QIDP</p> | 11/16/2011 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 |
|--|---|

| (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 |
|--------------------|--|---------------|--|----------------------|
| W0454 | <p>9-3-7(a)</p> <p>The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation and interview for 5 of 6 clients who ate cheese during dinner (#2, #3, #4, #5 and #6), the facility failed to ensure: 1) the clients did not use their hands to serve themselves cheese from the package and 2) staff did not administer a medication that was dropped onto the desk.</p> <p>Findings include:</p> <p>1) An observation was conducted at the group home on 10/12/11 from 4:15 PM to 5:45 PM. At 5:25 PM, dinner started. A package of shredded cheese was passed from client to client (except client #1). The clients used their hands to serve themselves cheese from the package. Each client placed their hand inside the package to grab and handful of cheese to put on their plates. The staff did not prompt the clients to use a serving utensil or to pour the cheese onto their plates.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated the clients using their hands to serve themselves cheese was not sanitary. The QMRP indicated the cheese should have been served in a bowl with a serving utensil.</p> <p>2) An observation was conducted at the group home on 10/12/11 from 5:53 AM to 7:22 AM. At 6:03 AM, staff #3 started preparing client #1's meds for administration. While preparing client #1's meds at 6:09 AM, staff #2 dropped a Lamotrigine onto the desk (staff was not observed</p> | W0454 | <p>QIDP will retrain staff on sanitary dining habits and how to support the clients in using appropriate sanitary dining habits. QIDP will also retrain staff on correct procedures for dealing with dropped medications. QIDP or designee will conduct on-going random observations at least monthly to ensure compliance in each of these areas.</p> <p>Responsible for QA: QIDP</p> | 11/16/2011 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|--|---|

| | |
|--|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 |
|--|---|

| (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 |
|--------------------|--|---------------|---|----------------------|
| W0460 | <p>to sanitize the area prior to administering the meds). Staff #2, at 6:09 AM, asked the surveyor if it was OK to pass the pill she dropped. She was advised to follow the facility's policy. Staff #2 then indicated she did not know the policy since she was new. Staff #2 asked staff #8 if she should administer the medication. Staff #8 indicated to staff #2 that if the pill did not touch the floor she should go ahead and administer it. Staff #2 administered the pill to client #1.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated staff #2 should not have administered the dropped pill to client #1. The QMRP indicated it was not sanitary.</p> <p>9.3.7(a) Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to serve food from the breakfast menu.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 10/12/11 from 5:53 AM to 7:22 AM. At 6:11 AM, client #1 ate a bowl of cereal. At 6:37 AM, client #4 finished eating yogurt and drinking her juice. At 6:39 AM, client #2 ate a bowl of cereal. Client #3 ate a bowl of cereal and drank juice. At 6:52 AM, client #6 stood at the kitchen counter and ate a bowl of cereal. Client #5 ate a bowl of cereal. Staff #2, #5 and #8 did not prompt the clients to follow the menu or offer items from the menu.</p> | W0460 | <p>QIDP will retrain staff on ensuring clients receive a well-balanced diet by following menus and specific diet orders. QIDP or designee will do random observations at least weekly for one month and at least monthly thereafter to ensure compliance.</p> <p>Responsible for QA: QIDP</p> | 11/16/2011 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G197 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 10/17/2011 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN47448 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>A review of the breakfast menu, dated Week 2 Wednesday (no date), was conducted on 10/12/11 at 6:46 AM. The menu indicated the following items were to be served: 6 ounces fruit blend, 1/2 cup oatmeal or 3/4 dry cereal, 2 pieces of whole wheat toast, 2 tablespoons peanut butter, and 1 cup of 2% milk.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 10/14/11 at 11:26 AM. The QMRP indicated the staff should ensure the clients were prompted and offered food from the menu.</p> <p>9-3-8(a)</p> | | | | |