

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 01/10/2012
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448		
(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	
W000C	<p>This visit was for the post certification revisit to the fundamental annual recertification and state licensure survey completed on 10/17/11.</p> <p>Dates of Survey: January 9 and 10, 2012.</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>	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: 15G197	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448
--	--

(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>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.</p> <p>Based on observation, record review and interview for 5 of 6 clients (#2, #3, #4, #5 and #6), the facility failed to ensure the clients' rights by: 1) restricting access to their lunchboxes while at the facility-operated workshop and 2) the use of video cameras in the common areas of the home.</p> <p>Findings include:</p> <p>1) An interview was conducted with workshop staff (WS) #1 on 1/9/12 at 3:01 PM. WS #1 indicated client #2, #3, and #4's lunchboxes were kept in the office, which was unlocked, until after lunch. WS #1 indicated the clients were not aware of the office door being unlocked. WS #1 indicated the door was kept closed. WS #1 indicated the door had been unlocked recently but prior to being unlocked, the door had been locked for years. WS #1 indicated if clients #2, #3 and #4 had access to their lunches, they would get into them and eat them prior to lunch.</p> <p>An interview with Administrative staff (AS) #1 was conducted on 1/9/12 at 3:02 PM. AS #1 indicated the clients' lunches could not be kept in the office and unavailable to them unless it was a part of their plans. AS #1 indicated clients #2, #3 and #4 did not have plans for storing their lunchboxes in the office.</p> <p>On 1/9/12 at 4:18 PM, a review of client #2's Individual Program Plan (IPP), dated 5/11-5/12, did not indicate her lunchbox needed to be kept in the office.</p>	W0125	<p>W125 Group home QIDP discussed the restriction with the lunchboxes at the workshop with the Day Program QIDP. The workshop staff have been retrained specifically on the lunchbox protocol for clients #2, #3, and #4. Random observations will be conducted by the QIDP or designee weekly for one month to ensure compliance and at least monthly after that. Guardians have been notified of the use of video cameras in the home. Documentation will be obtained regarding this. Responsible for QA: QIDP</p>	02/09/2012
-------	--	-------	--	------------

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 01/10/2012	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448			
(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>On 1/9/12 at 4:31 PM, a review of client #3's Individual Program Plan (IPP), dated 7/11-7/12, did not indicate her lunchbox needed to be kept in the office.</p> <p>On 1/9/12 at 4:31 PM, a review of client #4's Individual Program Plan (IPP), dated 8/9/11, did not indicate her lunchbox needed to be kept in the office.</p> <p>2) An observation was conducted at the group home on 1/9/12 from 4:00 PM to 5:40 PM. During the observations, video cameras were noted in the common areas (upstairs and downstairs living rooms, dining room, and kitchen) of the group home as well as on the outside of the group home. The camera's images were being displayed on a monitor on a desk in the living room.</p> <p>A review of client #2's record was conducted on 1/10/12 at 1:23 PM. Her Individual Program Plan (IPP), dated 5/11-5/12, indicated she had a guardian. The facility was unable to provide documentation her guardian consented to the use of video cameras in the group home.</p> <p>A review of client #3's record was conducted on 1/10/12 at 1:25 PM. Her IPP, dated 7/11-7/12, indicated she had a guardian. The facility was unable to provide documentation her guardian consented to the use of video cameras in the group home.</p> <p>A review of client #4's record was conducted on 1/10/12 at 1:26 PM. Her IPP, dated 9/11-9/12, indicated she had a guardian. The facility was unable to provide documentation her guardian consented to the use of video cameras in the group home.</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 01/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448
--	--

(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 client #5's record was conducted on 1/10/12 at 1:27 PM. Her IPP, dated 9/11-9/12, indicated she had a guardian. The facility was unable to provide documentation her guardian consented to the use of video cameras in the group home.</p> <p>A review of client #6's record was conducted on 1/10/12 at 1:29 PM. Her IPP, dated 9/11-9/12, indicated she had a guardian. The facility was unable to provide documentation her guardian consented to the use of video cameras in the group home.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/10/12 at 12:59 PM. AS #1 indicated she was unable to locate documentation for clients #2, #3, #4, #5 and #6 indicating their guardians consented to the use of video cameras in the group home.</p> <p>This deficiency was cited on 10/17/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</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 01/10/2012	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448			
(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			
W013C	<p>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation and interview for 1 of 2 clients observed to receive medications (#2), the facility failed to ensure the client's privacy during med administration.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/9/12 from 4:00 PM to 5:40 PM. At 4:10 PM, client #2 received her medications (Phenytoin and Seroquel) from staff #1. During the med pass, staff #1 stated in a normal conversation voice to client #2 the name of one of her medications, Seroquel, prior to client #2 getting up and walking away. Clients #3 and #4 were sitting on the couch, 4 feet away, from the med administration area. Prior to and during the med pass to client #2, clients #3 and #4 were not prompted out of the area by staff #1.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/9/12 at 2:45 PM. AS #1 indicated the med administration area had not been moved since the annual. AS #1 indicated the staff received training to ensure the privacy of each client during med pass. AS #1 indicated the staff should prompt the clients out of the area who were not receiving their medications. AS #1 indicated the staff should use a quiet voice to provide training to the clients.</p> <p>This deficiency was cited on 10/17/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>	W0130	W130 Efforts are being made to relocate the med administration area to a more private location within the home. QIDP or designee will observe a med pass at least weekly for one month and at least monthly thereafter to ensure compliance in this area. Responsible for QA: QIDP	02/09/2012			

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 01/10/2012	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448			
(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>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 observation, interview and record review for 2 of 6 clients living in the group home (#2 and #4), the facility failed to ensure staff were trained to implement client #2's communication training objective at the facility-operated workshop.</p> <p>Findings include:</p> <p>An observation was conducted at the facility-operated workshop on 1/9/12 from 2:06 PM to 2:30 PM and 2:59 PM to 3:10 PM. At 2:10 PM, client #2's supervisor, Workshop Supervisor #2 (WS #2) was asked to verify client #2's communication book was present at the facility-operated workshop. WS #2 produced the communication book and stated client #2's communication book "showed up" on his desk about one week ago. WS #2 indicated he was not given instructions or training on how or when to implement her communication book. WS #2 indicated client #2 was not informed of the communication book being present for her to use and had not been used by him or client #2. WS #2 indicated there was no communication training objective to implement for client #2's communication book.</p> <p>A review of client #2's Individual Program Plan (IPP), dated 5/11-5/12, was conducted on 1/10/12 at 1:35 PM. The IPP indicated the following, "1. 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." The IPP indicated her training objectives included using</p>	W0189	W189 SGL Manager and QIDP spoke with the workshop program manager to coordinate training for the workshop staff on client #2's communication book. All workshop staff will be trained on the use of this communication book as defined in the program plan. QIDP or designee will observe at least weekly for one month and at least monthly thereafter to ensure compliance in this area. Responsible for QA: QIDP	02/09/2012			

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 01/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448
--	--

(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>her communication book to identify secondary colors and the numbers 10 through 15.</p> <p>An interview was conducted on 1/9/12 at 2:28 PM with Administrative Staff (AS) #1. AS #1 indicated the staff should have received training on client #2's communication book and they should be implementing the communication book. At 2:38 PM, AS #1 indicated she spoke to the workshop administrative staff. AS #1 indicated the workshop administrative staff did not train the staff on client #2's communication book; the workshop administrative staff knew about the book but did not train the staff on how and when to implement the communication book with client #2.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/9/12 at 2:31 PM. The QMRP indicated the workshop staff should have been trained and implementing client #2's communication book.</p> <p>9-3-3(a)</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 01/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448
--	--

(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
W0249	<p>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.</p> <p>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: 1) client #2's communication training objective was implemented at the facility-operated workshop and 2) client #4's Dining Plan was implemented as written.</p> <p>Findings include:</p> <p>1) An observation was conducted at the facility-operated workshop on 1/9/12 from 2:06 PM to 2:30 PM and 2:59 PM to 3:10 PM. At 2:10 PM, client #2's supervisor, Workshop Supervisor #2 (WS #2) was asked to verify client #2's communication book was present at the facility-operated workshop. WS #2 produced the communication book and stated client #2's communication book "showed up" on his desk about one week ago. WS #2 indicated he was not given instructions or training on how or when to implement her communication book. WS #2 indicated client #2 was not informed of the communication book being present for her to use and had not been used by him or client #2. WS #2 indicated there was no communication training objective to implement for client #2's communication book.</p> <p>A review of client #2's Individual Program Plan (IPP), dated 5/11-5/12, was conducted on 1/10/12 at 1:35 PM. The IPP indicated the following, "1. Communication is a significant issue for client #2.</p>	W0249	<p>W249 SGL Manager and QIDP spoke with the workshop program manager to coordinate training for the workshop staff on client #2's communication book. All workshop staff will be trained on the use of this communication book as defined in the program plan. Staff were retrained on client #4's dining plan to include providing appropriate utensils and ensuring that food is served as directed per the plan. QIDP or designee will observe at least weekly for one month and at least monthly thereafter to ensure compliance in these areas. Responsible for QA: QIDP</p>	02/09/2012

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 01/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448
--	--

(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 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." The IPP indicated her training objectives included using her communication book to identify secondary colors and the numbers 10 through 15.</p> <p>An interview was conducted on 1/9/12 at 2:28 PM with Administrative Staff (AS) #1. AS #1 indicated the staff should be implementing the communication book.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/9/12 at 2:31 PM. The QMRP indicated the workshop staff should have implemented client #2's communication book.</p> <p>2) An observation was conducted at the group home on 1/9/12 from 4:00 PM to 5:40 PM. At 5:23 PM, dinner started. Client #4 was not provided a knife. Client #4 ate bite after bite of her ravioli (not cut into bite size portions) and salad (not cut into bite size portions). At 5:25 PM, client #4 pointed to and then stood and pointed to the ravioli serving bowl after finished her initial serving of ravioli. She was redirected to finish her salad first. Client #4 ate bite after bite of salad. Client #4 chewed each bite one or two times before swallowing and taking another bite. At 5:26 PM, client #4 pointed to the ravioli serving bowl and then stood and pointed to the bowl. At 5:27 PM, staff #5 stated to no one in particular, "I should have cut this lettuce up." Staff #5 stood up and went to obtain a knife for herself and returned to the table. At 5:28 PM, client #4 ate large bites of salad without thoroughly chewing it before swallowing and taking another bite. At 5:30 PM, client #4 obtained a second serving of ravioli. She</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 01/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448
--	--

(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>ate each ravioli whole without cutting it into bite size portions and not chewing it thoroughly. At 5:33 PM, staff #1 prompted client #4 to put her fork down and to take a breath. Client #4 put her fork down and then immediately picked up her spoon and continued to eat quickly. At 5:35 PM, client #4 started eating her grapes. Client #4 put several grapes into her mouth at a time and did not chew them thoroughly before swallowing. Staff #1 prompted client #4 to slow down but client #4 put more grapes into her mouth and left the table. Staff were not observed to cut, or assist to cut, the client's food into bite-size portions.</p> <p>A review of client #4's Dining Plan, dated 4/7/11, was conducted on 1/10/12 at 12:22 PM. The Dining Plan indicated, "Food should be cut into bite sized pieces." The plan indicated, "Encourage to eat at a regular pace if she is eating too fast. If [client #4] doesn't slow down or isn't chewing her food she may be asked to lay down her utensil or food and chew thoroughly before taking an additional bite. Encourage to take small bites if she is stuffing food."</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/10/12 at 2:00 PM. AS #1 indicated the staff should provide a knife to client #4 for her to use to cut her food into bite-sized portions. AS #1 indicated the staff should implement client #4's plan as written.</p> <p>This deficiency was cited on 10/17/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-4(a)</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 01/10/2012	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448			
(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			
W0371	<p>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.</p> <p>Based on observation, interview and record review for 2 of 2 clients observed to receive medication (#2 and #3), the facility failed to ensure staff implemented the clients' medication training objectives.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/9/12 from 4:00 PM to 5:40 PM. At 4:05 PM, client #3 received her medication (Ferrous Sulfate) from staff #1. Client #3 told staff #1 the names of her medications and the purpose. No additional training was provided by staff #. At 4:10 PM, client #2 received her medications (Phenytoin and Seroquel) from staff #1. Staff #1 informed client #2 of the name of one of her medications, Seroquel, prior to client #2 getting up and leaving the medication administration area; staff #1 did not attempt to get client #2 to return to the med area for training. No additional training was implemented by staff #1.</p> <p>A review of client #2's Individual Program Plan (IPP), dated 5/11-5/12, was conducted on 1/9/12 at 4:18 PM. Her medication training objectives included identifying her medications, side effects and times taken.</p> <p>A review of client #3's IPP, dated 7/11-7/12, was conducted on 1/9/12 at 4:31 PM. Her medication training objectives included identifying her medications, side effects, times taken and purpose.</p> <p>An interview was conducted with Administrative</p>	W0371	<p>W371 QIDP will retrain staff on thorough implementation of medication training objectives. QIDP or designee will observe at least weekly for one month and at least monthly thereafter to ensure compliance in this area.</p> <p>On-going training for staff will be provided as needed for continued compliance. Responsible for QA: QIDP</p>	02/09/2012			

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 01/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448
--	--

(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>Staff (AS) #1 on 1/10/12 at 11:44 AM. AS #1 indicated the medication training objectives should be implemented at each med pass.</p> <p>This deficiency was cited on 10/17/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</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 01/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448
--	--

(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
W0484	<p>The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</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 failed to ensure staff provided or offered knives to the clients during dinner.</p> <p>Findings include:</p> <p>An observation was conducted at the group home on 1/9/12 from 4:00 PM to 5:40 PM. At 5:23 PM, dinner started. Client #4 was not provided a knife. Client #4 ate bite after bite of her ravioli (not cut into bite size portions) and salad (not cut into bite size portions). At 5:25 PM, client #4 pointed to and then stood and pointed to the ravioli serving bowl after finished her initial serving of ravioli. She was redirected to finish her salad first. Client #4 ate bite after bite of salad. Client #4 chewed each bite one or two times before swallowing and taking another bite. At 5:26 PM, client #4 pointed to the ravioli serving bowl and then stood and pointed to the bowl. At 5:27 PM, staff #5 stated to no one in particular, "I should have cut this lettuce up." Staff #5 stood up and went to obtain a knife for herself and returned to the table. At 5:28 PM, client #4 ate large bites of salad without thoroughly chewing it before swallowing and taking another bite. At 5:30 PM, client #4 obtained a second serving of ravioli. She ate each ravioli whole without cutting it into bite size portions and not chewing it thoroughly. At 5:33 PM, staff #1 prompted client #4 to put her fork down and to take a breath. Client #4 put her fork down and then immediately picked up her spoon and continued to eat quickly. At 5:35 PM, client #4 started eating her grapes. Client #4 put several grapes into her mouth at a time and did not chew them thoroughly before swallowing. Staff #1</p>	W0484	W484 Staff were retrained on client #4's dining plan to include providing appropriate utensils and ensuring that food is served as directed per the plan. QIDP or designee will observe at least weekly for one month and at least monthly thereafter to ensure compliance in this area. Responsible for QA: QIDP	02/09/2012

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 01/10/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3016 N HOOVER RD NASHVILLE, IN 47448
--	--

(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>prompted client #4 to slow down but client #4 put more grapes into her mouth and left the table. Staff did not offer or assist clients #1, #2, #3, #4, #5 and #6 with obtaining a knife during the meal.</p> <p>An interview with Administrative Staff (AS) #1 was conducted on 1/10/12 at 2:00 PM. AS #1 indicated the staff should provide or offer knives to the clients during meals.</p> <p>9-3-8(a)</p>			