

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Survey Dates: 1/4/16, 1/5/16, 1/6/16 and 1/7/16.</p> <p>Facility Number: 008879 Provider Number: 15G672 AIMS Number: 200076390</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed on 1/12/16 by #09182.</p>	W 0000		
W 0130 Bldg. 00	<p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS</p> <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 3 sampled clients (#2), the facility failed to ensure client #2's privacy during personal care.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/5/16 from 6:00 A.M. through 8:25 A.M. At 7:47 A.M., staff #1 stated to staff #2, "[Client #2] is on her</p>	W 0130	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> -All county QIDPs were in-serviced on client rights and client privacy on 1/20/16 (Attachment A) -Group home staff will be in-serviced on client rights and client privacy -Clients bedroom doors will have signs affixed reminding client and staff of client rights to privacy 	02/06/2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2016	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W 0149 Bldg. 00	<p>[menstrual cycle]." Staff #2 assisted client #2 to the restroom. Staff #2 and client #2 were in the restroom with the door open. Clients #1, #4, #5 (male client) were seated in the home's living room ten feet away (location of surveyor). With the restroom door open, staff #2 was heard from the living room stating to client #2 "Don't touch yourself there, wipe yourself there, that's nasty."</p> <p>SSM (Social Services Manager) #1 was interviewed on 1/5/16 at 1:05 P.M. SSM #1 indicated the restroom door should be shut for privacy while completing self care with clients.</p> <p>9-3-2(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to implement its written policy and procedures to prevent staff mistreatment regarding client #3 and to ensure two</p>	W 0149	<p>How will we identify others:</p> <ul style="list-style-type: none"> All county QIDPs will utilize their multiple documented observations to ensure proper client privacy (Attachment B) Group Home Quality assurance manager will observe staff to ensure they are ensuring proper client privacy on a monthly basis <p>Measures put in place:</p> <ul style="list-style-type: none"> Group home observation sheet (Attachment B) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> QIDP will perform 8 monthly documented observations on all shifts to ensure staff understand the importance of client privacy for 2 months. <p>Corrective actions taken:</p> <ul style="list-style-type: none"> All county QIDPs were in-serviced on client rights, DSI's ANE policy, incident reporting and 	02/06/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>separate incidents of alleged staff mistreatment of client #3 were thoroughly investigated.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 1/4/16 at 2:18 PM. The review indicated the following:</p> <p>1. Incident Investigation Form (IIF) dated 12/18/15 indicated the facility investigated the circumstances of a behavioral incident (throwing items, yelling, attempting to hit staff) regarding client #3 in the group home. The IIF dated 12/18/15 indicated the following written notes regarding the QIDP's (Qualified Intellectual Disabilities Professional) review of the home's video surveillance system for the 12/13/15 incident:</p> <p>-"7:02 AM: [Client #3] advances toward [staff #3] and she backs into kitchen, swatting at her several times."</p> <p>-"7:02 - 7:18 AM: [Client #3] reaches up and pulls the curtain rod down between kitchen and dining room. [Staff #3] advances toward [client #3] and he reaches down and picks up the curtain</p>		<p>investigations on 1/20/16 (Attachment A)</p> <ul style="list-style-type: none"> ·Group home staff will be in-serviced on client rights, ANE policy & incident reporting. <p>How will we identify others:</p> <ul style="list-style-type: none"> ·The Quality assurance director will review all incidents to ensure proper reporting and investigations <p>Measures put in place:</p> <ul style="list-style-type: none"> ·Group home observation sheet (Attachment B) ·Group home monthly record review (Attachment C) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> ·QIDP will perform 8 monthly documented observations on all shifts to ensure staff are following client BSPs and IPPs ·The QA for group homes will audit the home monthly to ensure proper incident reporting and documentation. ·RPM will review all incident reports to ensure proper follow up and investigation 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>rod. [Staff #3] continues to advance, [client #3] drops the rod, walks backward and picks up napkins off the floor and throws at [staff #3]. [Staff #3] advances and waves hand in [client #3's] face."</p> <p>"Conclusion/Outcome/Systemic Changes: Staff have been re-trained on [client #3's] BSP (Behavior Support Plan). The QIDP (Qualified Intellectual Disabilities Professional) will continually stress the importance of applying BSP approved intervention techniques. In this case, staff failed to give [client #3] the space required in his BSP in order to let him relax. [Staff #3] was seen in video to apparently make the behavior seem worse by bending a curtain rod and throwing pillows and blankets on the ground. [Staff #3] will be given a disciplinary action 'A' for her lack of professionalism. The QIDP will conduct regular in home observations and video observations to ensure staff/client interactions are in-line with the IPP (Individual Program Plan) and BSP Directives."</p> <p>The 12/18/15 IIF did not indicate documentation of a finding of fact and determination of substantiated, unsubstantiated or inconclusive regarding staff #3's interactions with client #3. The 12/18/15 IIF did not indicate</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>documentation of reconciliation of staff #3's gestures of "waving her hand" in client #3's face.</p> <p>2. BDDS report dated 9/16/15 indicated, "Staff noticed [client #3] had on a female client's clothing and asked him to change. [Client #3] went to take more of the clothing and was swatting at staff. [Client #3] was escorted to his room which in return he threw his mattress into the hallway."</p> <p>-IIF dated 9/16/15 indicated, "[QIDP #1] observed the camera footage from 7:10 PM to 7:20 PM. The camera showed [client #3] being visually upset and swatting around (sic) with other clients close to him. [Staff #4] appeared to come and redirect him and then [client #3] started to walk towards his room. In the kitchen, [client #3] stopped and then began swatting at [staff #4], went towards him (sic) and deflected a hit and appears to be shoving [client #3] towards his room. [Client #3] walked into the laundry room where the camera only allowed for partial vision. [Client #3] continued to swat at [staff #4] and [staff #4] was not visible at this point. Then it appeared that [staff #4] again shoved [client #3] down the hall towards his room."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2016
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>The IIF dated 9/20/15 did not indicate documentation of a finding of fact or determination if client #3's rights were violated regarding staff #4's "shoving and/or pushing" client #3.</p> <p>SSM (Social Service Manager) #1 was interviewed on 1/5/16 at 11:45 AM. SSM #1 indicated the facility's abuse and neglect policy should be implemented. SSM #1 indicated the IIF dated 12/18/15 should address staff #3's interactions with client #3. SSM #1 indicated the IIF dated 9/20/15 should address staff #4's interactions with client #3. SSM #1 indicated the 12/18/15 IIF and the 9/20/15 IIF did not indicate documentation of thorough investigations.</p> <p>The facility's policy and procedures were reviewed on 1/7/16 at 10:00 AM. The facility's operating procedure entitled, "Individual Rights and Protection" dated 4/12/06 indicated the following:</p> <p>- "Neglect: Placing an individual in a situation that may endanger his or her life or health; includes failure to provide appropriate care, food, medical care, shelter or supervision."</p> <p>The 4/12/06 Individual Rights and Protection protocol indicated allegations</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0154 Bldg. 00	<p>of abuse, neglect and mistreatment should be thoroughly investigated.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 2 of 6 allegations of abuse, neglect, mistreatment and injuries of unknown origin reviewed, the facility failed to ensure two separate incidents of alleged staff mistreatment of client #3 were thoroughly investigated.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 1/4/16 at 2:18 PM. The review indicated the following:</p> <p>1. Incident Investigation Form (IIF) dated 12/18/15 indicated the facility investigated the circumstances of a behavioral incident (throwing items, yelling, attempting to hit staff) regarding client #3 in the group home. The IIF</p>	W 0154	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> ·All county QIDPS were in-serviced on thorough investigations, client rights, peer on peer aggression reporting & unknown injury reporting on 1/20/16. (Attachment A) ·Group home staff will be in-serviced on client rights, ANE policy, injuries of unknown origin incident reporting & incident reporting. ·Staff #3 voluntarily quit her position. DSI was prepared to terminate her before she quit. Staff #3 is not eligible for rehire. <p>How will we identify others:</p> <ul style="list-style-type: none"> ·The regional program manager will receive all incident reports, BDDS reportable and internal, in order to ensure QIDPs conduct investigations when appropriate. ·The Quality assurance director 	02/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2016
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>dated 12/18/15 indicated the following written notes regarding the QIDP's (Qualified Intellectual Disabilities Professional) review of the home's video surveillance system for the 12/13/15 incident:</p> <p>-"7:02 AM: [Client #3] advances toward [staff #3] and she backs into kitchen, swatting at her several times."</p> <p>-"7:02 - 7:18 AM: [Client #3] reaches up and pulls the curtain rod down between kitchen and dining room. [Staff #3] advances toward [client #3] and he reaches down and picks up the curtain rod. [Staff #3] continues to advance, [client #3] drops the rod, walks backward and picks up napkins off the floor and throws at [staff #3]. [Staff #3] advances and waves hand in [client #3's] face."</p> <p>"Conclusion/Outcome/Systemic Changes: Staff have been re-trained on [client #3's] BSP (Behavior Support Plan). The QIDP (Qualified Intellectual Disabilities Professional) will continually stress the importance of applying BSP approved intervention techniques. in this case, staff failed to give [client #3] the space required in his BSP in order to let him relax. [Staff #3] was seen in video to apparently make the behavior seem worse by bending a</p>		<p>will review all incidents to ensure proper reporting and investigations.</p> <ul style="list-style-type: none"> ·Video camera surveillance log <p>Measures put in place:</p> <ul style="list-style-type: none"> ·Group home observation sheet (Attachment B) ·Group home monthly record review (Attachment C) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> ·Regional Program manager will review all investigations to ensure they address all issues and contain systemic changes. ·Quality assurance director will review all investigations to ensure proper client protections · QIDP will perform 8 monthly documented observations for 2 months on all shifts to ensure client rights are protected · QIDP will make 4 documented video observations per month with RPM oversight. 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>curtain rod and throwing pillows and blankets on the ground. [Staff #3] will be given a disciplinary action 'A' for her lack of professionalism. The QIDP will conduct regular in home observations and video observations to ensure staff/client interactions are in-line with the IPP (Individual Program Plan) and BSP Directives."</p> <p>The 12/18/15 IIF did not indicate documentation of a finding of fact and determination of substantiated, unsubstantiated or inconclusive regarding staff #3's interactions with client #3. The 12/18/15 IIF did not indicate documentation of reconciliation of staff #3's gestures of "waving her hand" in client #3's face.</p> <p>2. BDDS report dated 9/16/15 indicated, "Staff noticed [client #3] had on a female client's clothing and asked him to change. [Client #3] went to take more of the clothing and was swatting at staff. [Client #3] was escorted to his room which in return he threw his mattress into the hallway."</p> <p>-IIF dated 9/16/15 indicated, "[QIDP #1] observed the camera footage from 7:10 PM to 7:20 PM. The camera showed [client #3] being visually upset and swatting around (sic) with other clients</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2016	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>close to him. [Staff #4] appeared to come and redirect him and then [client #3] started to walk towards his room. In the kitchen, [client #3] stopped and then began swatting at [staff #4], went towards him (sic) and deflected a hit and appears to be shoving [client #3] towards his room. [Client #3] walked into the laundry room where the camera only allowed for partial vision. [Client #3] continued to swat at [staff #4] and [staff #4] was not visible at this point. Then it appeared that [staff #4] again shoved [client #3] down the hall towards his room."</p> <p>The IIF dated 9/20/15 did not indicate documentation of a finding of fact or determination if client #3's rights were violated regarding staff #4's "shoving and/or pushing" client #3.</p> <p>SSM (Social Service Manager) #1 was interviewed on 1/5/16 at 11:45 AM. SSM #1 indicated the IIF dated 12/18/15 should address staff #3's interactions with client #3. SSM #1 indicated the IIF dated 9/20/15 should address staff #4's interactions with client #3. SSM #1 indicated the 12/18/15 IIF and the 9/20/15 IIF did not indicate documentation of thorough investigations.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0234 Bldg. 00	<p>9-3-2(a)</p> <p>483.440(c)(5)(i) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the methods to be used.</p> <p>Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure clients #1, #2 and #3's IPP (Individual Program Plan) objectives included specific methods of implementation.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 1/5/16 at 8:50 AM. Client #1's IPP dated 1/15/15 indicated the following formal training objectives:</p> <p>-will gather her water to prepare to take her medications.</p> <p>-will identify denominations of money.</p> <p>-will wash her hands.</p> <p>Client #1's training objectives did not indicate how staff were to implement the objective in regard to the level and type</p>	W 0234	<p>Corrective actions taken:</p> <p>·All county QIDPs were in-serviced on TA completion dates on 12/23/15 (Attachment D) ·DSI group homes are in the process of implementing improved client training methodologies.</p> <p>How will we identify others:</p> <p>·The quality assurance manager will review all client individual program plans to ensure all goals have an appropriate completion date and methodology</p> <p>Measures put in place:</p> <p>·Group home monthly record review (Attachment C)</p> <p>Monitoring of corrective action:</p> <p>·The regional program manager will review all client monthly summaries to ensure client goals, or TAs, have appropriate completion</p>	02/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>of supports needed or methodology to train client #1 to accomplish the objective. Client #1's Methodology Sheet indicated staff were to monitor client #1 and record independent, verbal prompts, physical prompts, unable, unwilling or refused.</p> <p>2. Client #2's record was reviewed on 1/5/16 at 9:30 AM. Client #2's IPP dated 12/1/15 indicated the following formal training objectives:</p> <ul style="list-style-type: none"> -will prepare for med pass. -will make toast. -will identify coins. -will wash hands. <p>Client #2's training objectives did not indicate how staff were to implement the objective in regard to the level and type of supports needed or methodology to train client #2 to accomplish the objective. Client #2's Methodology Sheet indicated staff were to monitor client #2 and record independent, verbal prompts, physical prompts, unable, unwilling or refused.</p> <p>3. Client #3's record was reviewed on 1/5/16 at 10:07 AM. Client #3's IPP</p>		dates.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2016
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>dated 1/15/15 indicated client #3 had the following formal training objectives:</p> <ul style="list-style-type: none"> -will wash his hands. -will identify denominations of coins. -will prepare to take his medications. -will assist to prepare his meal. <p>Client #3's training objectives did not indicate how staff were to implement the objective in regard to the level and type of supports needed or methodology to train client #3 to accomplish the objectives. Client #3's Methodology Sheet indicated staff were to monitor client #3 and record independent, verbal prompts, physical prompts, unable, unwilling or refused.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/5/16 at 11:45 AM. QIDP #1 indicated clients #1, #2 and #3's training objectives did not specify how staff should implement their objectives, or the level or type of support needed.</p> <p>9-3-4(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0247 Bldg. 00	<p>483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include opportunities for client choice and self-management.</p> <p>Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3), plus 2 additional clients (#4 and #5), the facility failed to ensure clients #1, #2, #3, #4 and #5 were offered the opportunity to choose/utilize their preferred condiments during meal time.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/5/16 from 6:00 AM through 8:30 AM. Clients #1, #2, #3, #4 and #5 participated in the home's family style morning meal. The morning meal consisted of scrambled eggs, sausage patty, peaches and toast. Clients #1, #2, #3, #4 and #5 were not offered a choice of seasonings such as salt, pepper, ketchup, hot sauce or other preferred condiments during their morning meal.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/5/16 at 11:45 AM. QIDP #1 indicated clients #1, #2, #3, #4 and #5 should be offered a choice of seasonings such as salt, pepper, ketchup, hot sauce or other</p>	W 0247	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> · All county QIDPs were in-serviced on 1/20/16 for providing client choice for meal time condiments (Attachment A) · Group Home staff will be in-serviced on offering and providing client choices in condiments <p>How will we identify others:</p> <ul style="list-style-type: none"> · The quality assurance manager will review all homes to ensure condiment choice is available <p>Measures put in place:</p> <ul style="list-style-type: none"> · Group home monthly record review (Attachment C) · Group home observation sheet (Attachment B) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> · All county QIDPs will utilize their monthly documented observations to ensure clients are offered condiments choices during meal time. They will re-train staff as 	02/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/07/2016	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 0268 Bldg. 00	<p>preferred condiments during meal times.</p> <p>9-3-4(a)</p> <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 and interview for 1 of 3 sampled clients (#2), the facility failed to ensure client #2's dignity during personal care.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 1-5-16 from 6:00 A.M. through 8:25 A.M. At 7:47 A.M., staff #1 stated to staff #2, "[Client #2] is on her [menstrual cycle]." Staff #2 assisted client #2 to the restroom. Staff #2 and client #2 were in the restroom with the door open. Clients #1, #4, #5 (male client) were seated in the home's living room ten feet away (location of surveyor). With the restroom door open, staff #2 was heard from the living room stating to client #2 "Don't touch yourself there, wipe yourself there, that's nasty."</p>			W 0268	<p>needed.</p> <p>Corrective actions taken:</p> <ul style="list-style-type: none"> · All county QIDPs were in-serviced on client rights and client privacy on 1/20/16 (Attachment A) · Group home staff will be in-serviced on client rights and client privacy · Clients bedroom doors will have signs affixed reminding client and staff of client rights to privacy <p>How will we identify others:</p> <ul style="list-style-type: none"> · All county QIDPs will utilize their multiple documented observations to ensure proper client privacy · Group Home Quality assurance manager will observe staff to ensure they are ensuring proper client privacy on a monthly basis <p>Measures put in place:</p>		02/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
--	---	--	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0368 Bldg. 00	<p>SSM (Social Services Manager) #1 was interviewed on 1-5-16 at 1:05 P.M. SSM #1 indicated staff should ensure client #2's dignity in regard to privacy during personal care.</p> <p>9-3-4(a)</p> <p>483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 2 of 3 sampled clients (#1 and #3), the facility failed to ensure clients #1 and #3's routine medications were administered as ordered by their physicians.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 1/4/16 at 2:18 PM. The review indicated the following:</p> <p>1. BDDS report dated 1/19/15 indicated,</p>	W 0368	<p>·Group home observation sheet (Attachment B)</p> <p>Monitoring of corrective action:</p> <p>·QIDP will perform 8 monthly documented observations on all shifts to ensure staff understand the importance of client privacy for 2 months.</p> <p>Corrective actions taken:</p> <p>·All county QIDPs were in-serviced on the need for better communication with the pharmacy on 12/23/15. (Attachment D)</p> <p>·Group home staff will be in-serviced on the procedure for alerting their supervisor when a medication is not available. They will also be instructed upon the proper Genoa pharmacy staff to contact.</p> <p>·DSI group home management and Genoa pharmacy staff will meet on 1/4/16 and 1/25/16 in order to foster better lines of communication and</p>	02/06/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>"[Client #1's] 4:00 PM Risperidone (Psychosis) was given with her morning medications on 1/19/15."</p> <p>-BDDS report dated 4/30/15 indicated, "Staff (unspecified) called [QIDP (Qualified Intellectual Disabilities Professional) #2] and said morning staff missed giving medications to [client #1]."</p> <p>-BDDS report dated 5/19/15 indicated, "[Client #1's] Omeprazole (Gastric Upset) was changed by (her) doctor from being administered at 7:00 AM to 4:00 PM. The nurse changed the MAR (Medication Administration Record) on May 16, 2015 to match the doctor's order. Staff gave the pill at 7:00 AM instead of the new 4:00 PM time."</p> <p>-BDDS report dated 10/26/15 indicated, "[Client #1] missed 3 doses of her birth control medication (Estra/Noreth Tablet), due to it being in the controlled medication box and not seen by staff."</p> <p>-BDDS report dated 11/5/15 indicated, "[Client #1] was given 5 doses of Meloxicam (Inflammation/Arthritis) after the stop dated on the medication order (11/1/15)."</p> <p>Client #1's record was reviewed on 1/5/16 at 8:50 AM. Client #1's</p>		<p>understanding of policies and procedures in order to prevent future lapses in client medication administrations.</p> <p>How will we identify others:</p> <ul style="list-style-type: none"> ·Night audit checklist requires the night auditor to check the medication supply to ensure clients have an ample supply of medications(Attachment E) <p>Measures put in place:</p> <ul style="list-style-type: none"> ·Night auditor checklist (Attachment E) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> ·QIDPs will follow up on the night auditor checklist and address any shortage of medication immediately. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/07/2016
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Physician's Orders form dated 11/5/15 indicated client #1's physician's prescriptions included, but were not limited to, Meloxicam tablet 15 milligrams with a stop date of 11/1/15, Estra/Noreth Tablet and Risperidone Tablet 2 milligrams.</p> <p>2. BDDS report dated 1/11/15 indicated, "Staff reported to [QIDP #2] that a morning medication was missed on [client #3]. [Client #3] did not receive his Risperidone (sic) (Intermittent Explosive Disorder). All other medications were given at that time."</p> <p>Client #3's record was reviewed on 1/5/16 at 9:30 AM. Client #3's Physician's Orders form dated 11/5/15 indicated, "Risperidone Tablet 15 milligrams. Give one tablet by mouth twice daily.</p> <p>Nurse #1 was interviewed on 1/5/16 at 1:08 PM. Nurse #1 indicated clients #1 and #3's medications should be administered as prescribed by their physicians.</p> <p>9-3-6(a)</p>			