

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/31/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203
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W 0000 Bldg. 00	<p>This visit was for a Post Certification Revisit (PCR) to the investigation of complaint #IN00174891 completed on 6/16/15.</p> <p>Complaint #IN00174891: Not corrected.</p> <p>Survey Dates: August 27, 28 and 31, 2015</p> <p>Facility Number: 003184 Provider Number: 15G697 AIM Number: 200368720</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/3/15.</p>	W 0000		
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 6 of 6 clients living in the group home (A, B, C, D, E and F), the governing body failed to exercise operating direction over</p>	W 0104	Corrective actions taken: Day program staff received abuse, neglect and exploitation training and incident reporting Training and will receive additional	09/30/2015

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

TITLE

(X6) DATE

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

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	<p>the facility by failing to train the day program staff on abuse, neglect and exploitation, create a policy and procedure for monitoring the surveillance system in the group home, implement a video surveillance monitoring program, conduct observations at the group home and facility-operated day program to monitor and document staff to client interactions.</p> <p>Findings include:</p> <p>On 8/27/15 at 1:32 PM a review of the facility's Plan of Correction for the complaint investigation completed on 6/16/15 was conducted and indicated the following:</p> <p>1) The facility's Plan of Correction (POC), with a completion date of 7/16/15, indicated, in part, "...Day program staff have been trained by the day program manager and all new hires have been made aware of the critical nature of proper client treatment and reporting. The staff were instructed that any possible allegations of ANE (abuse, neglect and exploitation) are to be reported to the QIDP (Qualified Intellectual Disabilities Professional) or available supervisor immediately." There was no documentation the facility trained the day program staff as indicated in the</p>		<p>training(attachment A) · QIDPs will be in-serviced upon video surveillance documentation and implementation · Bartholomew QIDP will be in-serviced on PEP room visit expectations · A new day program observation sheet (attachment B)and pep room log sheet (attachment C) was created and the QIDPs will be in-serviced on it · Video surveillance policy was created (attachment D) How will we identify others: · RPM will review required surveillance documentation from group homes that have cameras on a monthly basis · Day program Mgr will review all dsp training records to ensure staff are trained on abuse, neglect and exploitation · RPM will review log to ensure daily visits are occurring Measures put in place: · Video surveillance policy · Pep room visit log · Day program observation form · HR will generate and disperse monthly training report needs · QIDPs trained on day program observation form and log Monitoring of corrective action: · RPM and Quality Assurance Director will review monthly video documentation and RPM will sign off on documentation to ensure it has been done · RPM will review pep room visit log on a weekly basis · RPM and QASSM will review day program staff training on a monthly basis Competition date: · 9/30/15</p>				

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	<p>POC. This affected clients A, B, C, D, E and F.</p> <p>On 8/28/15 at 1:00 PM, the Regional Program Manager (RPM) indicated the day program staff were supposed to be trained on identifying and reporting abuse, neglect and exploitation according to the facility's POC. The RPM indicated the facility did not have documentation the day program staff was trained.</p> <p>2) The POC indicated, "...The agency is also in the process of updating our video surveillance system as well as video surveillance review implementation. The improvement will allow approved managers to more easily view the cameras from multiple electronic platforms, including company smart phones. The regional program manager for group homes will create and implement a mandatory observation schedule for QIDPs (Qualified Intellectual Disabilities Professionals) in the counties that have group homes with video surveillance. The QIDPs will be required to observe portions of each shift per week. The QIDPs will then be required to document what they observed in a shared folder accessible only to relative program managers. The regional program manager will review the documented observations and determine</p>			

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	<p>if staff training or other action is appropriate." This affected clients A, B, C, D, E and F.</p> <p>A review of the Video Surveillance Log was conducted on 8/27/15 at 1:33 PM. The QIDP documented watching the video surveillance on 8/20/15 from 4:30 AM to 6:00 AM and 8/20/15 from 7:15 AM to 7:45 AM. There was no documentation the QIDP reviewed the video surveillance weekly as indicated in the POC from 7/16/15 to 8/20/15. There was documentation the facility created and implemented a mandatory observation schedule. The Video Surveillance Log indicated at the top of the spreadsheet, "Minimum of 4 observations per month, vary shifts." There was no documentation the RPM reviewed the documented observations.</p> <p>On 8/28/15 at 1:21 PM, the RPM stated, "I will develop a more thorough policy and procedure (for monitoring the cameras) and distribute it for homes with cameras." The RPM indicated the reviews of the cameras were documented on the Video Surveillance Log. The RPM indicated the cameras were to be reviewed weekly by the QIDP. The RPM indicated the facility did not have documentation the reviews were conducted.</p>						

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	<p>3) The POC indicated, "...The day program manager, QIDP and RPM will make weekly visits to the PEP (Personal Enhancement Program) room/workshop in order to better monitor and document staff/client interactions. The house lead, county QIDP or the regional program manager will be present in the home and the day program on a daily basis in order to ensure proper staff/client interaction and to train and direct staff as needed." This affected clients A, B, C, D, E and F.</p> <p>On 8/27/15 at 1:45 PM, a review of the Community Living Group Home Supervision Forms was conducted. From 7/16/15 to 8/27/15, the QIDP conducted documented visits to the group home on 7/18/15, 8/3/15 and 8/15/15. The QIDP conducted a day program and workshop observation on 8/24/15. There was no documentation the day program manager, QIDP and RPM made weekly visits to the PEP room/workshop as indicated in the POC. There was no documentation the house lead, county QIDP or the RPM were present in the home and day program on a daily basis as indicated in the POC.</p> <p>On 8/28/15 at 1:00 PM, the RPM indicated there was no documentation of weekly visits to the PEP room/workshop.</p>			

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W 0149 Bldg. 00	<p>The RPM indicated there was no documentation of the house lead, county QIDP or the RPM being present in the home and the day program on a daily basis.</p> <p>On 8/28/15 at 1:00 PM, the QIDP indicated she visited the PEP room daily but did not have documentation of her visits.</p> <p>This deficiency was cited on 6/16/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00174891.</p> <p>9-3-1(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 4 of 6 clients living in the group home (A, B, C and E), the facility neglected to implement its policies and procedures to prevent client to client abuse.</p>	W 0149	<p>Corrective actions taken: · Day program staff received abuse, neglect and exploitation training and incident reporting Training and will receive additional training (attachment A) · Van supervision protocol implemented and QIDPswill be in-serviced on it (</p>	09/30/2015			

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	<p>Findings include:</p> <p>On 8/27/15 at 1:27 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>1) On 8/5/15 at 7:50 AM, a Bureau of Developmental Disabilities Services (BDDS) incident report, dated 8/5/15, indicated, "Peer [client E] was upset earlier in the AM (morning) and had gone to his room to calm down but enroute to day program he kicked [client B] on the left leg shin area causing a bruise of 1 cm (centimeter). Staff will ensure that all clients are calm before leaving in van at all time and if not will wait until calm. Ice was applied to area and staff will observe for any further development of the burise (sic)."</p> <p>2) On 8/6/15 at 7:45 AM, a BDDS incident report, dated 8/6/15, indicated, "[Client C] was attacked by peer #1 [client A] due to peer #2 [client B] yelling and hitting windows and making a lot of noise. Peer #1 [client A] attacked peer #1 (sic) who sits in the seat to the left of peer 2, peer 2 got out of his seat with seat belt still in place and attacked [client C] in the chest grabbing his shirt and pinching which resulted in 2 scratches 1/2 cm (centimeter) without</p>		<p>attachment E) How will we identify others: · Day program Mgr will review all dsp training records to ensure staff are trained on abuse, neglect and exploitation · RPM will review reports to see if there are other client on client aggression occurring Measures put in place: · Van supervision protocol · HR will generate and disperse monthly training report needs Monitoring of corrective action: · RPM and QASSM will review day program staff training on a monthly basis · RPM will review incident reports to ensure van protocol is being followed Competition date: · 9/30/15</p>		

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	<p>breaking the skin." The investigation, dated 8/6/15, indicated, "[Client C] was attacked by a peer on the van ride to (sic) day program." The Conclusion indicated, "[Client A] attacked [client C] on the van ride to day program. [Client B] was hitting windows and yelling which agitated [client A] and he attacked [client C] who sits in the seat to the left of [client A]. [Client A] got out of his seat with seat belt still in place and was pulling on [client C's] chest and shirt pinching him which resulted in 2 - 1/2 cm scratches on the chest that did not break the skin, just red marks. Staff intervened to stop [client A] from the attack and clamed (sic) so they could continue on the trip to day program."</p> <p>On 8/28/15 at 1:00 PM, the Regional Program Manager (RPM) indicated client to client aggression was abuse. The RPM indicated there was a policy and procedure in place prohibiting abuse of the clients. The RPM indicated the staff should prevent client to client abuse.</p> <p>A review of the facility's policy on conducting investigations was conducted on 8/27/15 at 1:01 PM. The Identifying and Reporting Suspected Abuse and Neglect policy, dated 4/12/06, defined physical abuse as, "The intentional or willful infliction of physical injury, the</p>			

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	<p>unnecessary use of physical or chemical restraints or isolation, punishment that results in physical harm or pain." The Reporting and Identifying Violations of Client Rights policy, dated 4/12/06, indicated, "Rights Violations Include: Abuse, neglect, exploitations, or mistreatment of an individual...."</p> <p>This deficiency was cited on 6/16/15. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>This federal tag relates to complaint #IN00174891.</p> <p>9-3-2(a)</p>			