

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
| W000000 | <p>This visit was for the post-certification revisit (PCR) survey to the full recertification and state licensure survey completed on 10/27/14.</p> <p>Survey Dates: December 2, 3 and 9, 2014.</p> <p>Facility Number: 001190 Provider Number: 15G652 AIM Number: 100233930</p> <p>Surveyor: Vickie Kolb, RN</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/16/14 by Ruth Shackelford, QIDP.</p> | W000000 | | |
| W000102 | <p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview for 3 of 3 sample clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to meet the Condition of Participation: Governing</p> | W000102 | In order to correct this deficiency, body checks have been implemented for clients #1, #2, #3, #4, #5 and #6. The MARs has a space wherestaff can initial that they have conducted a body | 01/07/2015 |

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

TITLE

(X6) DATE

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

| | | | | | |
|--|--|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | |
| (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>Body.</p> <p>The facility's Governing Body failed to implement sufficient corrective actions to address the deficient practices cited during the full annual recertification and state licensure survey completed on 10/27/14 (13 of 20 deficient practices and 2 of 3 Conditions of Participation were re-cited).</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure a system was developed and implemented to assess and monitor clients #1, #2, #3, #4, #5 and #6 for injury, to ensure all allegations of abuse and inappropriate sexual conduct of staff toward clients were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients #4 and #5, to ensure all injuries of unknown origin and all allegations of abuse were investigated for clients #3 and #6 and to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored client #1's, #2's #3's #4's #5's and #6's treatment programs and services. Please</p> | | <p>check. These checks are done in the evening. The staff will then record their findings in the medical communication log. They will note what they found or note that they found nothing. An in-service training on 12/18/14 for Joseph house staff was held to inform the staff on how to conduct these checks. Investigations were conducted by the program manager for clients #3 and #6 for injuries of unknown origin that the former QIDP failed to complete. An in-service for Joseph house staff was held on 12/18/14. This in-service instructed the staff on proper abuse, neglect and exploitation reporting. The staff were instructed that any possible allegations of ANE were to be reported to the QIDP or available supervisor within 1 hour. All QIDPs will be re-trained in DSIs policy and procedures regarding ANE reporting. The Quality Assurance Social Service Manager will conduct monthly inspections to ensure these procedures are in place. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will hold monthly house meetings in order to reinforce these standards. The RPM will continue to review incident reports and conduct investigations if they meet the criteria.</p> | | |

| | | | | | | | |
|--|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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 | | | |
| W000104 | <p>see W104.</p> <p>2. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for clients #1, #2, #3, #4, #5 and #6. The governing body failed to ensure a system was developed and implemented to assess and monitor clients #1, #2, #3, #4, #5 and #6 for injury, to ensure all allegations of abuse and inappropriate sexual conduct of staff toward clients were reported immediately to the administrator and to the BDDS per IAC 9-3-1(b)(5) and APS per IC 12-10-3 according to state law for clients #4 and #5 and to ensure all injuries of unknown origin and all allegations of abuse were investigated for clients #3 and #6. Please see W122.</p> <p>This deficiency was cited on 10/27/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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 facility.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the governing body failed to exercise general policy and operating direction over the facility to ensure:</p> <p>__A system was developed and implemented to assess and monitor clients #1, #2, #3, #4, #5 and #6 for injury.</p> <p>__All allegations of abuse and inappropriate sexual conduct of staff toward clients were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients #4 and #5.</p> <p>__All injuries of unknown origin and all allegations of abuse were investigated for clients #3 and #6.</p> <p>__The QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored client #1's, #2's #3's #4's #5's and #6's treatment programs and services.</p> <p>Findings include:</p> <p>1. The governing body failed to exercise general policy and operating direction over the facility to ensure a system was</p> | W000104 | <p>In order to correct this deficiency, body checks have been implemented for clients #1, #2, #3, #4, #5 and #6. The MARs has a space where staff can initial that they have conducted a body check. These checks are done in the evening. The staff will then record their findings in the medical communication log. They will note what they found or note that they found nothing. An in-service training on 12/18/14 for Joseph house staff was held to inform the staff on how to conduct these checks. Investigations were conducted by the program manager for clients #3 and #6 for injuries of unknown origin that the former QIDP failed to complete. An in-service for Joseph house staff was held on 12/18/14. This in-service instructed the staff on proper abuse, neglect and exploitation reporting. The staff were instructed that any possible allegations of ANE were to be reported to the QIDP or available supervisor within 1 hour. Clients #1, #2, #3, #4, #5 and #6's IPPs were modified by the QASSM in order to ensure that they are coordinated, integrated and monitored. The QIDP will be responsible for revising IPPs as needed. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will be responsible for</p> | 01/07/2015 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>developed and implemented to assess and monitor clients #1, #2, #3, #4, #5 and #6 for injury, to ensure all allegations of abuse and inappropriate sexual conduct of staff toward clients were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients #4 and #5 and to ensure all injuries of unknown origin and all allegations of abuse were investigated for clients #3 and #6. Please see W149.</p> <p>2. The governing body failed to exercise general policy and operating direction over the facility to ensure all allegations of abuse and inappropriate sexual conduct were reported immediately to the administrator and to the BDDS and APS according to state law for clients #4 and #5. Please see W153.</p> <p>3. The governing body failed to exercise general policy and operating direction over the facility to ensure an investigation was conducted for all injuries of unknown origin and all allegations of abuse for clients #3 and #6. Please see W154.</p> <p>4. The governing body failed to ensure the QIDP (Qualified Intellectual</p> | | <p>reviewing the programs, treatments and services monthly. The QIDP will update and change as necessary. The QIDP will hold monthly house meetings in order to reinforce these standards. The RPM will continue to review incident reports and conduct investigations if they meet the criteria.</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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 |
|--------------------|---|---------------|---|----------------------|
| W000122 | <p>Disabilities Professional) integrated, coordinated and monitored client #1's, #2's #3's #4's #5's and #6's treatment programs and services. Please see W159.</p> <p>This deficiency was cited on 10/27/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to meet the Condition of Participation: Client Protections.</p> <p>The facility failed to implement its policy and procedures to ensure a system was developed and implemented to assess and monitor clients #1, #2, #3, #4, #5 and #6 for injury, to ensure all allegations of abuse and inappropriate sexual conduct of staff toward clients were reported immediately to the administrator and to</p> | W000122 | <p>In order to correct this deficiency, body checks have been implemented for clients #1, #2, #3, #4, #5 and #6. The MARs has a space where staff can initial that they have conducted a body check. These checks are done in the evening. The staff will then record their findings in the medical communication log. They will note what they found or note that they found nothing. An in-service training on 12/18/14 for Joseph house staff was held to inform the staff on how to conduct these checks. Investigations were conducted by the program manager for clients # 3 and #6 for injuries of unknown</p> | 01/07/2015 |

| | | | | | | | |
|--|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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 BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients #4 and #5 and to ensure all injuries of unknown origin and all allegations of abuse were investigated for clients #3 and #6.</p> <p>Findings include:</p> <p>1. The facility failed to implement its policy and procedures to ensure a system was developed and implemented to assess and monitor clients #1, #2, #3, #4, #5 and #6 for injury, to ensure all allegations of abuse and inappropriate sexual conduct of staff toward clients were reported immediately to the administrator and to BDDS per IAC 9-3-1(b)(5) and APS per IC 12-10-3 according to state law for clients #4 and #5 and to ensure all injuries of unknown origin and all allegations of abuse were investigated for clients #3 and #6. Please see W149.</p> <p>2. The facility failed to immediately report allegations of abuse and inappropriate sexual conduct to the administrator and to the BDDS per IAC 9-3-1(b)(5) and APS per IC 12-10-3 according to state law for clients #4 and #5. Please see W153.</p> | | <p>originthat the former QIDP failed to complete. An in-service for Joseph house staffwas held on 12/18/14. This in-service instructed the staff on proper abuse,neglect and exploitation reporting. The staff were instructed that any possibleallegations of ANE were to be reported to the QIDP or available supervisorwithin 1 hour. The Quality Assurance Social Service Manager will conductmonthly inspections to ensure these procedures are in place. The QIDP willensure, through multiple monthly observations that these procedures are beingcarried out. The QIDP will hold monthly house meetings in order to reinforcethese standards. The RPM will continue to review incident reports and conductinvestigations if they meet the criteria.</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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 |
|--------------------|--|---------------|--|----------------------|
| W000130 | <p>3. The facility failed to ensure an investigation was conducted for all injuries of unknown origin and all allegations of abuse for clients #3 and #6. Please see W154.</p> <p>This deficiency was cited on 10/27/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-2(a)</p> <p>483.420(a)(7) PROTECTION OF CLIENTS RIGHTS 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 2 additional clients (#4 and #6), the facility failed to ensure the clients were provided privacy while toileting and dressing.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/2/14 between 3:45 PM and 6:15 PM. __At 4:30 PM staff #1 and #2 were in the kitchen. Client #6 left the kitchen and</p> | W000130 | An in-service training was held on 12/18/14 for Joseph housestaff. Part of this training included the client's right to privacy. The staffwere instructed to encourage the clients to close doors when they are in theirrooms or using the bathroom. A privacy TA was developed for each client in order to help them realize that they have the right to privacy and that theydeserve this right. The QASSA has affixed signs to the bathroom doors to remindclients and staff that doors are to be closed when in use. The | 01/07/2015 |

| | | | | | | | |
|--|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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>walked to the bathroom to use the toilet. Client #6 did not close the bathroom door while going to the bathroom for toileting. Clients #1 and #4 walked past the bathroom door while client #6 was using the bathroom.</p> <p>__At 5:35 PM staff #1 was in client #6's bedroom assisting client #6 to change her top. While changing her clothes staff #1 did not prompt client #6 to close her bedroom door and/or close the bedroom door for client #6.</p> <p>__At 6:05 PM client #4 was in her bedroom changing into her pajamas. Client #4's bedroom door was open. Staff #2 walked past client #4's bedroom to go to client #1's bedroom. Client #4 was not prompted to close her bedroom door while changing her clothing.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the QASSM (Quality Assurance Social Service Manager) on 12/3/14 at 2 PM, the QIDP indicated the staff were to provide the clients privacy whenever toileting and/or dressing and should have closed the doors to provide the clients privacy while dressing. The QASSM stated, "So from what you (the surveyor) are saying then we may need to implement some client training in privacy."</p> | | QualityAssurance Social Service Manager will conduct monthly inspections to ensure these procedures are in place. The QIDP will reinforce the client's right to privacy during the house's monthly meetings and how to reinforce this with the clients. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will hold monthly house meetings in order to reinforce these standards. | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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 |
|--------------------|--|---------------|--|----------------------|
| W000149 | <p>This deficiency was cited on 10/27/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</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 observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to implement its policy and procedures to ensure:</p> <p>__A system was developed and implemented to assess and monitor clients #1, #2, #3, #4, #5 and #6 for injury.</p> <p>__All allegations of abuse and inappropriate sexual conduct of staff toward clients were reported immediately to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients #4 and #5.</p> <p>__All injuries of unknown origin and all allegations of abuse were investigated for</p> | W000149 | In order to correct this deficiency, body checks have been implemented for clients #1, #2, #3, #4, #5 and #6. The MARs has a space where staff can initial that they have conducted a body check. These checks are done in the evening. The staff will then record their findings in the medical communication log. They will note what they found or note that they found nothing. An in-service training on 12/18/14 for Joseph house staff was held to inform the staff on how to conduct these checks. A communication binder has been created for each client that will travel between the home and the day program. This binder will be used to more fully communicate client activity and needs between staff at both locations. This will help alleviate any confusion over incidents that need to be investigated. An investigation was completed on 12/5/14 for client | 01/07/2015 |

| | | | | | | | |
|--|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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>clients #3 and #6.</p> <p>Findings include:</p> <p>1. Observations were conducted at the group home on 12/2/14 between 3:30 PM and 6:30 PM. At 4 PM client #1 was in her bedroom sitting on her bed and taking off her compression socks. Client #1 was asked if she had any bruises on her body. Client #1 stated, "Yes, I do." and pulled her pant leg up exposing a large blue/green/yellow bruise that was approximately 5 cm (centimeters) by 7 cm on the inner aspect of her left knee. When asked if she had reported the bruise to her staff, client #1 stated, "Yes I did, yesterday, but they didn't do anything about it."</p> <p>During interview with staff #1 on 12/2/14 at 4:30 PM when asked if the staff conducted daily body assessments, staff #1 stated, "No, not that I'm aware of."</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the QASSM (Quality Assurance Social Service Manager) on 12/3/14 at 2 PM, the QIDP indicated no knowledge of any injuries for client #1. When asked if clients #1, #2, #3, #4, #5 and #6 could reliably report injuries to the staff the QIDP stated, "That's</p> | | <p>#1's bruised knee of unknown origin. Investigations were conducted by the program manager for clients # 3 and #6 for injuries of unknownorigin that the former QIDP failed to complete. All incidents that involve aninjury of unknown origin have been investigated. An in-service for Joseph housestaff was held on 12/18/14. This in-service instructed the staff on properabuse, neglect and exploitation reporting. The staff were instructed that anypossible allegations of ANE were to be reported to the QIDP or availablesupervisor within 1 hour. The Quality Assurance Social Service Manager willconduct monthly inspections to ensure these procedures are in place. The QIDPwill ensure, through multiple monthly observations that these procedures arebeing carried out. The QIDP will hold monthly house meetings in order toreinforce these standards. The QIDP & RPM will continue to review incidentreports and conduct investigations if they meet the criteria.</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
|--|--|---|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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>questionable." The QIDP indicated the staff would report injuries when they were noted when assisting the clients with their ADLS (Adult Daily Living Skills). The QIDP and QASSM indicated no system was in place to monitor for injuries for those clients who could not accurately report injuries for themselves (clients #1, #2, #3, #4, #5 and #6).</p> <p>During interview with staff #1 and the TL (Team Leader) on 12/3/14 at 3 PM, staff #1 and the TL indicated they had worked the past few days and staff #1 and the TL were not aware of any injuries on any of the clients at the present time. Both staff #1 and the TL indicated they had no knowledge of a bruise on client #1. When staff #1 was asked if she had observed client #1 yesterday while showering, staff #1 stated, "Yes, but I just stuck my head in the door and checked on her."</p> <p>During interview with client #1 on 12/3/14 at 3:35 PM client #1 indicated she had told the staff at the day program that her knee hurt. Client #1 provided the name of the staff she spoke with and indicated the staff did not check or assess her knee for injury.</p> <p>Review of an email from the SGLRM (Supported Group Living Regional Manager) on 12/5/14 at 2 PM indicated a</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>12/4/14 BDDS (Bureau of Developmental Disabilities Services) report. The report indicated on 12/3/14 "[Client #1] has a bruise 4 in (inches) by 2 in on her left inner knee area. [Client #1] does not know if she hit it on something or another client had kicked her in the pep room of the workshop."</p> <p>2. The facility's reportable and investigative records were reviewed on 12/3/14 at 8:30 AM. The 10/23/14 BDDS report indicated: __ On 10/21/14 the TL witnessed staff #6 sitting on the couch at the group home with clients #4 and #5 with staff #6's arms around clients #4 and #5. "They (clients #4 and #5) would say I love you [staff #6] and he (staff #6) would respond I love you too baby to [client #4] and I love you sweetie to [client #5]." __ On 10/21/14 staff #4 indicated she was cleaning the table and observed staff #6 slap client #4 on the buttocks and client #4 then slapped staff #6 on the buttocks and stated I love you baby. The report indicated staff #6 had sat down on the couch between clients #4 and #5 and placed his arms around them "saying thay (sic) are his babys (sic). Staff #4 reported another incident when client #4 was holding her underwear in front of staff #6 and staff #4 asked client #4 to "please go do that in her room please" and staff #6</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>"said that's ok I don't mind." ___The report indicated the staff failed to immediately report the allegations of inappropriate conduct of a coworker to the administrator.</p> <p>During interview with the QIDP and the QASSM on 12/3/14 at 2 PM, the QIDP indicated the staff failed to immediately report the allegations of inappropriate conduct at the time it was observed. The QIDP indicated the allegation was verified and staff #6's employment with the facility was terminated. The QASSM indicated staff were to immediately report all allegations of abuse and/or inappropriate conduct to the administrator and to BDDS and APS within 24 hours of knowledge of the abuse and/or inappropriate conduct.</p> <p>3. The facility's reportable and investigative records were reviewed on 12/3/14 at 8:30 AM. The 10/21/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 10/20/14 at 11:30 AM while at the day program client #6 showed staff her arm and the staff noticed a bruise on client #6's upper right arm and a bruise on her right hand. The staff contacted the DP manager and was instructed to contact the QIDP. "When contacted, she (the QIDP) had no reports of bruises but did note that [client</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>#6] has exhibited some self-injurious behavior of biting herself. She said she would check with [name of TL (Team Lead)] of the home. [The TL] did not know either where the bruises came from. Report was completed based on the injuries being of unknown origin at this time."</p> <p>__The facility records indicated no investigation in regard to client #6's injuries of unknown origin.</p> <p>The 10/27/14 BDDS report indicated on 10/26/14 at 6:30 AM "Staff noticed a small bruise on right upper leg, [client #3] said that another client hit (sic) but overnight shift staff said she came into the office for medication administration and walked into the corner of the desk. Staff notified the QIDP at 3:10 p.m. 10/27/14. QIDP told the staff to watch the bruise to see if get (sic) worse and told staff to watch more closely when [client #3] comes into the office in the morning."</p> <p>__The facility records indicated no investigation in regard to client #3's allegation of abuse.</p> <p>An interview with the QIDP was conducted on 12/3/14 at 2 PM. The QIDP: __Stated client #6 had displayed SIB (Self Injurious Behavior) "a few days</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>prior to the discovery of the injury" and it was thought that was how client #6 obtained the bruising.</p> <p>__ Indicated the injury was not observed by staff.</p> <p>__ Indicated no investigation had been conducted in regard to client #6's bruises of unknown origin.</p> <p>__ Indicated client #3's allegation she was hit by another client was not investigated.</p> <p>__ Indicated all allegations of abuse and all injuries of unknown origin were to be investigated.</p> <p>An interview with the QASSM (Quality Assurance Social Service Manager) was conducted on 12/3/14 at 2:30 PM. The QASSM indicated all allegations of abuse and all injuries of unknown origin were to be investigated.</p> <p>Review of the 4/12/06 facility policy "Identifying and Reporting Suspected Abuse and Neglect" on 12/3/14 at 2 PM indicated:</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>__ "Injuries of unknown origin: Any significant injury of unknown origin should be investigated as potential abuse or neglect. Description of any area that is</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
|--|--|---|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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 | | | |
| W000153 | <p>visibly swollen or red; finger like bruising as if grabbed; any unusual complaints of pain by the client with no known medical reason." ___ "Any DSI staff member or consultant who suspects an individual is the victim of abuse or neglect will immediately report this suspicion within one hour of discovery to their supervisor/QIDP or the emergency response system. The QIDP will report the incident immediately to the Program Manager, Program Director, and Executive Director or other identified designee of the Executive Director. The QIDP is ultimately responsible for ensuring the report is also made to the Adult Protective Services Representative or Child Protective Services within 24 hours."</p> <p>This deficiency was cited on 10/27/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 1 allegation of abuse and inappropriate sexual conduct of staff toward clients for clients #4 and #5, the facility failed to immediately report allegations of abuse and inappropriate sexual conduct to the administrator and to the BDDS (Bureau of Developmental Disabilities Services) per IAC 9-3-1(b)(5) and APS (Adult Protective Services) per IC 12-10-3 according to state law for clients #4 and #5.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 12/3/14 at 8:30 AM. The 10/23/14 BDDS report indicated:</p> <p>__ On 10/21/14 the TL witnessed staff #6 sitting on the couch at the group home with clients #4 and #5 with staff #6's arms around clients #4 and #5. "They (clients #4 and #5) would say I love you [staff #6] and he (staff #6) would respond I love you too baby to [client #4] and I love you sweetie to [client #5]."</p> <p>__ On 10/21/14 staff #4 indicated she was cleaning the table and observed staff #6 slap client #4 on the buttocks and client #4 then slapped staff #6 on the buttocks</p> | W000153 | <p>An in-service for Joseph house staff was held on 12/18/14. This in-service instructed the staff on proper abuse, neglect and exploitation reporting. The staff were instructed that any possible allegations of ANE were to be reported to the QIDP or available supervisor within 1 hour. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will be responsible for reviewing the programs, treatments and services monthly. The QIDP will update and change as necessary. The QIDP will hold monthly house meetings in order to reinforce these standards. The RPM will continue to review incident reports and conduct investigations if they meet the criteria.</p> | 01/07/2015 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>and stated I love you baby. The report indicated staff #6 had sat down on the couch between clients #4 and #5 and placed his arms around them "saying thay (sic) are his babys (sic). Staff #4 reported another incident when client #4 was holding her underwear in front of staff #6 and staff #4 asked client #4 to "please go do that in her room please" and staff #6 "said that's ok I don't mind."</p> <p>__The report indicated the staff failed to immediately report the allegations of abuse and inappropriate conduct of a coworker immediately to the administrator.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) and the QASSM (Quality Assurance Social Service Manager) on 12/3/14 at 2 PM, the QIDP indicated the staff failed to immediately report the allegations of abuse and inappropriate sexual conduct at the time observed. The QIDP indicated the allegation was verified and staff #6's employment with the facility was terminated. The QASSM indicated staff were to immediately report all allegations of abuse and/or inappropriate conduct to the administrator and to BDDS and APS within 24 hours of knowledge of the abuse and/or inappropriate conduct.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
| W000154 | <p>This deficiency was cited on 10/27/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</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.</p> <p>Based on record review and interview for 1 of 1 injury of unknown origin and 1 of 2 allegations of abuse reviewed, the facility failed to ensure an investigation was conducted for clients #3 and #6.</p> <p>Findings include:</p> <p>The facility's reportable and investigative records were reviewed on 12/3/14 at 8:30 AM. The 10/21/14 BDDS (Bureau of Developmental Disabilities Services) report indicated on 10/20/14 at 11:30 AM while at the day program client #6 showed staff her arm and the staff noticed a bruise on client #6's upper right arm and a bruise on her right hand. The staff contacted the DP manager and was instructed to contact the QIDPD (Qualified Intellectual Disabilities</p> | W000154 | <p>Inorder to correct this deficiency, body checks have been implemented for clients#1, #2, #3, #4, #5 and #6. The MARs has a space where staff can initial thatthey have conducted a body check. These checks are done in the evening. Thestaff will then record their findings in the medical communication log. Theywill note what they found or note that they found nothing. An in-servicetraining on 12/18/14 for Joseph house staff was held to inform the staff on howto conduct these checks. Investigations were conducted by the program managerfor clients # 3 and #6 for injuries of unknown origin that the former QIDPfailed to complete. The new QIDP and</p> | 01/07/2015 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>Professional Designee). "When contacted, she (the QIDPD) she had not (sic) reports of bruises but did note that [client #6] has exhibited some self-injurious behavior of biting herself. She said she would check with [name of TL (Team Lead)] of the home. [The TL] did not know either where the bruises came from. Report was completed based on the injuries being of unknown origin at this time."</p> <p>__The facility records indicated no investigation in regard to client #6's injuries of unknown origin.</p> <p>The 10/27/14 BDDS report indicated on 10/26/14 at 6:30 AM "Staff noticed a small bruise on right upper leg, [client #3] said that another client hit (sic) but overnight shift staff said she came into the office for medication administration and walked into the corner of the desk. Staff notified the QIDP at 3:10 p.m. 10/27/14. QIDP told the staff to watch the bruise to see if get (sic) worse and told staff to watch more closely when [client #3] comes into the office in the morning."</p> <p>__The facility records indicated no investigation in regard to client #3's allegation of abuse.</p> <p>An interview with the QIDP (Qualified Intellectual Disabilities Professional) was</p> | | <p>the other QIDPs will be retrained on ANE reporting at the next QIDP monthly meeting. An in-service for Joseph house staff was held on 12/18/14. This in-service instructed the staff on proper abuse, neglect and exploitation reporting. The staff were instructed that any possible allegations of ANE were to be reported to the QIDP or available supervisor within 1 hour. The Quality Assurance Social Service Manager will conduct monthly inspections to ensure these procedures are in place. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will hold monthly house meetings in order to reinforce these standards. The QIDP & RPM will continue to review incident reports and conduct investigations if they meet the criteria</p> | |

| | | | | | |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | |
| (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>conducted on 12/3/14 at 2 PM. The QIDP:</p> <p>__ Stated client #6 had displayed SIB (Self Injurious Behavior) "a few days prior to the discovery of the injury" and it was thought that was how client #6 obtained the bruising.</p> <p>__ Indicated the injury was not observed by staff.</p> <p>__ Indicated no investigation had been conducted in regard to client #6's bruises of unknown origin.</p> <p>__ Indicated client #3's allegation she was hit by another client was not investigated.</p> <p>__ Indicated all allegations of abuse and all injuries of unknown origin were to be investigated.</p> <p>An interview with the QASSM (Quality Assurance Social Service Manager) was conducted on 12/3/14 at 2:30 PM. The QASSM indicated all allegations of abuse and all injuries of unknown origin were to be investigated.</p> <p>This deficiency was cited on 10/27/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-2(a)</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

| | | | | |
|---------|--|---------|--|------------|
| W000159 | <p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, interview and record review for 3 of 3 sample clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, coordinated and monitored the clients' treatment programs.</p> <p>The QIDP failed to ensure: ___ Clients #4 and #6 were provided privacy while toileting and dressing. ___ Client #2's ISP (Individualized Support Plan) and Health/Risk Plan addressed how and when the staff were to use a seat alarm and failed to include how the staff were to supervise, monitor and assist client #2 throughout the day while at home, while at the day program/work and while in the community to prevent client #2 from falling and/or prevent injury due to falls. ___ Client #2's ISP (Individual Support Plan) was implemented in regard to the client's line of sight supervision due to falls risk and client #2's dining plan in regard to choking risks and lack of dining skills. ___ A written informed consent was</p> | W000159 | <p>In order to address standards not met regarding privacy in the house, an in-service training was held on 12/18/14 for Joseph house staff. Part of this training included the client's right to privacy. The staff were instructed to encourage the clients to close doors when they are in their rooms or using the bathroom. A privacy TA was developed for each client in order to help them realize that they have the right to privacy and that they deserve this right. The QASSM has affixed signs to the bathroom doors in order to help clients remember to shut doors when in use and to reinforce this right to privacy. Client #2 has had her IPP and health risk plan updated. Staff have been trained on her new falls risk plan as of 12/18/14. Staff are to wear a badge indicating that they are client #2's line of sight. Client #2 has an HRC approved bed alarm that will alert staff when Client #2 would get up during the night. Client #2's seat alarm has been discontinued as of 12/23/14 as line of sight has been deemed sufficient. An in-service held on 12/18/14 outlines the staff's line of sight responsibilities. Client #2 also has a chart for 30 minute</p> | 01/07/2015 |
|---------|--|---------|--|------------|

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>obtained from client #6's legal representative for client #6's restrictive program that included the use of Seroquel.</p> <p>__ Client #2 was provided wrist weights to wear while eating and while working and to provide client #2 with a non-skid mat and a sturdy plate and/or a high sided plate while at the day program.</p> <p>__ The staff offered the clients substitutions for menu items that were refused and/or not eaten, to ensure the staff followed the clients prescribed diet orders and to ensure the staff provided the clients water and/or tea with their meal.</p> <p>__ The staff provided training in meal preparation and family style dining when formal and informal training opportunities existed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. The QIDP failed to ensure clients #4 and #6 were provided privacy while toileting and dressing. Please see W130. 2. The QIDP failed to ensure client #2's ISP (Individualized Support Plan) and Health/Risk Plan addressed how and when the staff were to use a seat alarm and failed to include how the staff were to supervise, monitor and assist client #2 throughout the day while at home, while | | <p>bedchecks that staff initial when they check on her during sleeping hours. Written consent for the psychotropic drug Seroquel has been obtained from the client's guardian. Client #2 has been provided all needed adaptive equipment, including: 2 handled cup, 1lb wrist weights, high sided partitioned plate/dish with rim, non-skid place mat, weighted utensils and clothing protector. These same implements have been provided for client #2 at her day program with the exception of when she works. Due to the nature of her job, tremors do not interfere with her work. An in-service training was held on 12/18/14 for the house staff. During this, we discussed dining plans and what were appropriate substitutions for menu items. A substitution list has been provided and hangs on the refrigerator. We trained the staff on dining plans and have been encouraging staff to offer the clients portion sizes that are reflective of their dining plans. Their weights have begun to drop down to more healthy levels. We spoke about how important it was to offer the clients choices regarding drinks during meal time. We trained staff on how to prompt client #2 to slow down during meal time and to closely supervise her during mealtime. We also discussed how to involve the clients in meal</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>at the day program/work and while in the community to prevent client #2 from falling and/or prevent injury due to falls. Please see W240.</p> <p>3. The QIDP failed to ensure client #2's ISP (Individual Support Plan) was implemented in regard to the client's line of sight supervision due to falls risk and client #2's dining plan in regard to choking risks and lack of dining skills. Please see W249.</p> <p>4. The QIDP failed to obtain written informed consent from client #6's legal representative for client #6's restrictive program that included the use of Seroquel. Please see W263.</p> <p>5. The QIDP failed to ensure client #2 was provided wrist weights to wear while eating and while working and to provide client #2 with a non-skid mat and a sturdy plate and/or a high sided plate while at the day program. Please see W436.</p> <p>6. The QIDP failed to ensure the staff offered the clients substitutions for menu items that were refused and/or not eaten, to ensure the staff followed the clients prescribed diet orders and to ensure the staff provided the clients water and/or tea with their meal for clients #1, #2, #3, #4,</p> | | <p>prep and how to successfully hold a family style dining meal. We have received written consent from client#6's guardian for the use of Seroquel. . The Quality Assurance Social Service Managerwill conduct monthly inspections to ensure these procedures are in place. TheQIDP will ensure, through multiple monthly observations that these proceduresare being carried out. The QIDP will hold monthly house meetings in order toreinforce these standards. The QIDP & RPM will continue to review incidentreports and conduct investigations if they meet the criteria.</p> | |

| | | | | | | | |
|--|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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 | | | |
| | #5 and #6. Please see W460. 7. The QIDP failed to ensure the staff provided training in meal preparation and family style dining when formal and informal training opportunities existed for clients #1, #2, #3, #4, #5 and #6. Please see W488. This deficiency was cited on 10/27/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence. 9-3-3(a) | | | | | | |
| W000240 | 483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observations, record review and interview for 1 of 3 sampled clients (#2), the client's ISP (Individualized Support Plan) and Health/Risk Plan failed to address how and when the staff were to use a seat alarm and failed to include how the staff were to supervise, monitor and assist client #2 throughout the day while at home, while at the DP (Day Program) and while in the community to prevent client #2 from falling and/or prevent | W000240 | Client#2's seat alarm has been discontinued as of 12/23/14 because line of sight has been deemed adequate. Staff were trained on 12/18/14 regarding proper line of sight implementation. An addendum has been added to her IPP. On 12/18/14, an in-service training was provided to Joseph housestaff. The training covered how Client #2 is to have a line of sight in the house as well as day program. The house staff are | | | 01/07/2015 | |

| | | | | | | | |
|--|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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>injury due to falls.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/2/14 between 3:45 PM and 6:15 PM.</p> <p>__ Client #2 was an elderly heavy set woman that walked independently with a slow unsteady gait slightly pulling her right foot/right side while walking. Client #2 would reach out for items near her and/or the walls for stability while ambulating.</p> <p>__ At 3:45 PM client #2 arrived home from the DP (Day Program). Staff #2 stated, "You [client #2] want to watch some television?" Staff #2 walked with client #2 to the living room where staff #2 positioned a seat alarm on the couch prior to client #2 sitting down on the couch. Staff #2 stated, client #2 was a falls risk and "We have to use a seat alarm now to let us (the staff) know when she gets up so we can be with her." Staff #2 left client #2 sitting on the couch in the living room and returned to the kitchen area with staff #1. Staff #2 proceeded to wash the containers from the clients' lunch boxes and then to give the evening medications. Staff #1 began the preparations for the evening meal.</p> <p>__ At 4:30 PM staff #1 was in the kitchen and staff #2 was in the rear of the home</p> | | <p>wear a badge that designates them as Client #2's line of sight staff for that day. Client #2's falls risk plan has been updated. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will hold monthly house meetings in order to reinforce these standards. The QIDP & RPM will continue to review incident reports and conduct investigations if they meet the criteria.</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>with another client. Client #2's seat alarm sounded. Client #2 was not within eyesight of staff #1 and/or staff #2. Staff #1 was opening cans of food and yelled "[Client #2], what are you doing girly?" Client #2 was standing in the living room beside the couch. After hearing staff #1's voice, client #2 then walked to the kitchen.</p> <p>__ From 5:03 PM to 5:30 PM client #2 sat in the dining room eating her evening meal. Client #2 did not have the seat alarm in use while sitting at the dining room table.</p> <p>Client #2's record was reviewed on 12/3/14 at 11 AM.</p> <p>Client #2's Falls Risk Plan dated 10/10/14 indicated diagnoses of, but not limited to, Kyphosis (excessive outward curvature of the spine causing hunching of the back), Scoliosis (an abnormal curvature of the spine), Degenerative Joint Disease (a form of arthritis that predominantly affects the large weight bearing bones, spine, hips and knees). The risk plan indicated client #2 was blind in the right eye and had limited vision. The plan indicated, not all inclusive: __ "Provide non-slip footwear/shoes that fit. __ Provide safe environment: good</p> | | | |

| | | | | | | | |
|--|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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>lighting, free of clutter, no loose rugs, no wet floors.</p> <p>__ Assist with walking as needed especially on uneven surfaces and unfamiliar territory.</p> <p>__ Caution client to slow down when she walks too fast.</p> <p>__ Complete Medical Incident Report and give to Supervisor."</p> <p>Client #2's fall risk plan did not include the use of a seat alarm and/or eyesight supervision. Client #2's fall risk plan did not indicate how the staff were to supervise and/or assist client #2 throughout the day while at the home and while at the day program.</p> <p>Client #2's ISP dated 10/26/14 indicated "[Client #2] is able to ambulate independently but should be monitored as she easily falls. She does have a Falls Risk Plan that staff are ready to execute daily. [Client #2] has an unsteady gait and needs staff assistance while out in the community or on unfamiliar ground.... [Client #2] has a chair alarm to be used at the home to help staff monitor when she get up, but her guardian does not want her to use it at the workshop."</p> <p>On 12/3/14 at 2:30 PM the QIDP (Qualified Intellectual Disabilities Professional) provided a revised copy of</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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 ISP dated 12/3/14 and stated, "I was just working on the changes." The 12/3/14 ISP was reviewed on 12/3/14 at 2:30 PM. The ISP indicated "[Client #2] needs to be line of sight at all times with the staff."</p> <p>Client #2's ISP and Health/Risk Plan failed to specifically indicate when client #2 was to use a chair alarm and how the staff were to supervise, monitor and assist client #2 while at home, while at work and while out in the community throughout the day to prevent client #2 from falling.</p> <p>During interview with DP (Day Program) staff #1 on 12/3/14 at 12:30 PM, DP staff #1 indicated client #2 would get up from her work station whenever she wanted and walk to the bathroom independently and unsupervised. DP staff #1 indicated client #2 was not maintained within staff eyesight while at the DP. DP staff #1 indicated client #2's gait was unsteady at times and was not aware of any changes in her plan of care since the annual survey of 10/27/14.</p> <p>Interview with staff #1 and staff #2 on 12/2/14 at 5 PM indicated client #2 was to be in line of sight of the staff due to client #2's history of falls. When asked if client #2 was to be in line of sight while</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>using the seat alarm, staff #2 stated, "We can walk into the other room when she's sitting down and the alarm is on. We just make sure to keep an eye on her." Staff #1 indicated the alarm was to alert the staff that she (client #2) had gotten up from a seated position and the staff were to go check on her.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 12/3/14 at 2:30 PM. The QIDP: ___ Indicated client #2 was to be within eyesight of the staff at all times. ___ Indicated the staff were not to be in one room and client #2 to be in another room and the staff not be able to see her and stated, "That is not line of sight." ___ Indicated the staff were to use the seat alarm at the home while client #2 was in a seated position. ___ Indicated client #2's mother did not want a seat alarm while at the DP. ___ Indicated she (the QIDP) was still working on client #2's plan of care.</p> <p>Telephone interview with the facility MCC (Medical Care Coordinator) on 12/5/14 at 2 PM indicated no change in client #2's fall risk plan since the annual survey of 10/27/14.</p> <p>This deficiency was cited on 10/27/14.</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
| W000249 | <p>The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION 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, record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure client #2's ISP (Individual Support Plan) was implemented in regard to the client's line of sight supervision due to falls risk and client #2's dining plan in regard to choking risks and lack of dining skills.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/2/14 between 3:45 PM and 6:15 PM.</p> <p>___At 3:45 PM client #2 arrived home from the DP (Day Program). Client #2 emptied her lunch box. Staff #2 stated,</p> | W000249 | <p>Due to confusion regarding line of sight and when to employ the use of a seat alarm, Client#2' seat alarm has been discontinued as of 12/23/14. An addendum has been added to her IPP. Staff were trained on 12/18/14 regarding proper line of sight implementation. On 12/18/14, an in-service training was provided to Joseph house staff. The training covered how Client #2 is to have a line of sight in the house as well as day program. The house staff are wear a badge that designates them as Client #2's line of sight staff for that day. Client #2's falls risk plan has been updated. An in-service training was held on 12/18/14 for the house staff. During this, we discussed dining plans and what were appropriate</p> | 01/07/2015 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>"You [client #2] want to watch some television?" Staff #2 walked with client #2 to the living room where staff #2 positioned a seat alarm on the couch prior to client #2 sitting down on the couch. Staff #2 stated, client #2 was a falls risk and "We have to use a seat alarm now to let us (the staff) know when she gets up so we can be with her." Staff #2 left client #2 sitting on the couch in the living room and returned to the kitchen area with staff #1. Staff #2 proceeded to wash the containers from the clients' lunch boxes and then to give the evening medications. Staff #1 began the preparations for the evening meal.</p> <p>__At 4:30 PM staff #1 was in the kitchen and staff #2 was in the rear of the home with another client. Client #2's seat alarm sounded. Client #2 was not within eyesight of staff #1 and/or staff #2. Staff #1 was opening cans of food and yelled "[Client #2], what are you doing girly?" Client #2 was standing in the living room beside the couch. After hearing staff #1's voice, client #2 then walked to the kitchen with staff #1.</p> <p>__From 5:03 PM to 5:30 PM client #2 ate her evening meal of chili, crackers, cottage cheese, and a jello dessert. Client #2 used her hands to pick out some of the crackers and the macaroni from her chili and ate it with her fingers. Client #2 also picked up chunks of jello from her plate</p> | | <p>substitutions for menu items. We trained the staff on diningplans and have been encouraging staff to offer the clients portion sizes thatare reflective of their dining plans. Their weights have begun to drop down tomore healthy levels. We spoke about howimportant it was to offer the clients choices regarding drinks during mealtime. We trained staff on how to promptclient #2 to slow down during meal time and to closely supervise her duringmealtime. We also discussed how to involve the clients in meal prep and how tosuccessfully hold a family style dining meal. Client #2's IPP has line of sightincluded in it. Her seat alarm was discontinued as of 12/23/14 in order toencourage staff to stay with her at all times. The Quality Assurance SocialService Manager will conduct monthly inspections to ensure these procedures arein place. The QIDP will ensure, through multiple monthly observations that theseprocedures are being carried out. The QIDP will hold monthly house meetings inorder to reinforce these standards. The QIDP & RPM will continue to reviewincident reports and conduct investigations if they meet the criteria.</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>and ate it with her hands. Client #2 took large bites of food and ate at a fast pace.</p> <p>__The staff did not prompt client #2 to use her silverware when using her hands to eat and/or to take smaller bites of food and/or to slow her pace of eating. The staff did not monitor client #2 during all food intake.</p> <p>__Throughout this observation period, client #2 was not within eyesight of staff #1 and/or staff #2 at all times.</p> <p>__The staff did not use the seat alarm for client #2 while seated at the dining room table.</p> <p>Client #2's record was reviewed on 12/3/14 at 11 AM.</p> <p>Client #2's Falls Risk Plan dated 10/10/14 indicated diagnoses of, but not limited to, Kyphosis (excessive outward curvature of the spine causing hunching of the back), Scoliosis (an abnormal curvature of the spine), Degenerative Joint Disease (a form of arthritis that predominantly affects the large weight bearing bones, spine, hips and knees). The risk plan indicated client #2 was blind in the right eye and had limited vision.</p> <p>Client #2's ISP dated 10/26/14 indicated "Client #2 is able to ambulate independently but should be monitored as</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>she easily falls. She does have a Falls Risk Plan that staff are ready to execute daily. [Client #2] has an unsteady gait and needs staff assistance while out in the community or on unfamiliar ground.... [Client #2] has a chair alarm to be used at the home to help staff monitor when she get up, but her guardian does not want her to use it at the workshop."</p> <p>Client #2's 12/14 quarterly physician's orders indicated client #2 "Requires close mealtime supervision."</p> <p>Client #2's swallow study dated 10/29/14 indicated "It is reported by the caregiver that pt (patient) takes very large bites of foods when self-feeding.... Pt may be at risk for choking due to poor condition of teeth and difficulty chewing food adequately, as well as self-feeding large bolus size.... should be reminded to take smaller bites of food and smaller or single sips of liquids."</p> <p>Client #2's revised dining plan dated 11/10/14 indicated: ___ "Needs verbal and physical prompts to slow down while eating and take smaller bites. ___ "Staff should be seated at eye-level and monitor client during all food intakes." ___ "Verbal and physical prompts should be offered during the meal to remind</p> | | | |
|--|--|--|--|--|

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | |
| (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] to slow down while eating."</p> <p>On 12/3/14 at 2:30 PM the QIDP provided a revised copy of client #2's ISP dated 12/3/14 and stated, "I was just working on the changes." The 12/3/14 ISP was reviewed on 12/3/14 at 2:30 PM. The ISP indicated "[Client #2] needs to be line of sight at all times with the staff."</p> <p>Interview with staff #1 and staff #2 on 12/2/14 at 5 PM indicated client #2 was to be in line of sight of the staff due to client #2's history of falls. When asked if client #2 was to be in line of sight while using the seat alarm, staff #2 stated, "We can walk into the other room when she's sitting down and the alarm is on. We just make sure to keep an eye on her." Staff #1 indicated the alarm was to alert the staff that she (client #2) had gotten up from a seated position and the staff were to go check on her.</p> <p>The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 12/3/14 at 2:30 PM. The QIDP: ___ Indicated client #2 was to be within eyesight of the staff at all times. ___ Indicated the staff were not to be in one room and client #2 to be in another room and the staff not be able to see her</p> | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
|--|---|---|--|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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 | | | |
| W000263 | <p>and stated, "That is not line of sight." ___ Indicated the staff were to use the seat alarm at the home while client #2 was in a seated position. ___ Indicated the staff were to monitor client #2 closely because of client #2's potential for choking. ___ Indicated the staff were to prompt client #2 to take smaller bites of food, to slow her pace of eating and to take small sips of liquids. ___ Indicated the staff were to implement client #2's plan of care/ISP/dining plan at every available opportunity.</p> <p>This deficiency was cited on 10/27/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-4(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on interview and record review for 1 of 3 clients with restrictive programs (client #6), the facility failed to obtain written informed consent from client #6's</p> | W000263 | On 12/8/2014, guardian approval was obtained for client #6's psychotropic drug Seroquel. The QIDP will ensure that all clients have proper written | 01/07/2015 | | | |

| | | | | | | | |
|--|--|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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>legal representative for client #6's restrictive program that included the use of Seroquel.</p> <p>Findings include:</p> <p>Client #6's record was reviewed on 12/3/14 at 1 PM. Client #6's revised 12/2013 BSP indicated client #6 received Seroquel 200 mg a day for depression. Client #6's record indicated client #6 was represented by a guardian. Client #6's record indicated the facility had not obtained written informed consent from client #6's guardian for client #6's restrictive program plan that included the use of Seroquel.</p> <p>Interview with the QIDPD (Qualified Intellectual Disabilities Professional Designee) on 12/3/14 at 2 PM indicated she was unable to provide written informed consent from client #6's guardian for client #6's BSP that included the use of Seroquel. The QIDPD stated she had mailed a consent form to client #6's guardian "sometime after" 11/24/14.</p> <p>This deficiency was cited on 10/27/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-4(a)</p> | | <p>consent for all psychotropic drugs, including HRC approval. The RPM will remind the QIDPs that written consent and approval is needed when psychotropic drugs are prescribed by a physician, and must be obtained prior to administering psychotropic drugs. The QIDP & RPM will continue to review incident reports and conduct investigations if they meet the criteria.</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
| W000331 | <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 additional client (#6), the facility failed to ensure nursing services developed and implemented a specific plan of care in regard to client #6's history of chronic UTIs (Urinary Tract Infections) to include specific preventive measures, to include client #6's hygiene, toileting and showering needs, to include how the staff were to assist client #6 while toileting, to include the amount of fluids client #6 was to consume daily and how the staff were to monitor client #6's fluid intake throughout the day, to include when and what the staff were to notify nursing of in regard to client #6's UTIs and to include how and when the staff were to monitor client #6 for pain in regard to client #6's recurring UTIs.</p> <p>Findings include:</p> <p>Client #6's record was reviewed on 12/3/14 at 1 PM. Client #6's most recent signed quarterly Physician's Orders dated 8/5/14 indicated client #6 had diagnoses of, but not limited to, Senile Dementia</p> | W000331 | <p>Client #6's UTI health risk plan has been changed in order to better serve the client. House staff are tracking the client's fluid intake at the home as well as the day program and recording it on the MAR. The client should intake at least 2000 ccs a day. A pain assessment scale has been added to her UTI risk plan. Staff were trained on the use of her pain scale on 12/18/14. When the client has a UTI, staff are to use it to assess the client's pain. When the client does not have a UTI, Staff are to utilize the pain chart twice a week, Wednesday and Sunday and record it on the TAR, in order to acclimate the client to the chart in order to increase its efficacy and to determine its validity. Her behaviorist will work with her to improve her use of it. Dr. Hatcher has her on suppression therapy with daily antibiotics until March. She has an appointment with Dr. Psaff, a Urologist, on 1/19/14. Incongruence with her UTI risk plan, her dining plan states that she should have no carbonated drinks or caffeinated drinks in order to lessen the risk of a UTI. Workshop is also sending her to</p> | 01/07/2015 |

| | | | | | | | |
|--|---|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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>(severe mental deterioration in old age, characterized by loss of memory and control of bodily functions) and Alzheimer's (a type of dementia).</p> <p>The Medical Communication log indicated: ___3/30/14 the staff took client #6 to the clinic at 9 AM. The doctor at the clinic sent client #6 to the hospital where she was admitted with a UTI and bowel problems. Client #6 was returned home on 4/3/14. ___4/15/14 client #6 was started on a new antibiotic for ten days, Macrochantin (an antibiotic used to treat urinary tract infections). ___5/7/14 client #6 was taken to an after hours clinic and tested positive for a UTI and was started on Cipro (an antibiotic) for 7 days for the infection. ___7/10/14 client #6 was diagnosed with a UTI based on a urine sample that was taken to the hospital on 7/7/14 and was started on Cipro for the infection. ___9/3/14 client #6 wet her pants while at the workshop and was complaining of lower abdominal pain. The staff took client #6 to the clinic where she was diagnosed with a UTI and given antibiotics and her Colace (stool softener) to two capsules twice a day because the doctor thought client #6 might be constipated also.</p> | | <p>the restroom every 2 hours and documenting and charting this.</p> <p>The staff are charting the frequency of her urination when the client has a UTI, her new UTI risk plan specifies what is to be done if a UTI is suspected or has one. Staff will encourage the client to use the restroom every 2 hours, per her UTI risk plan and they will chart it. In order to further alleviate the risks for UTIs, the staff will observe and assist the client during showering and toileting. There have been showering TAs and wiping TAs added to further assist her. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will hold monthly house meetings in order to reinforce these standards. The QIDP will continue to provide oversight in regards to clients #2's UTI risk.</p> | | | | |

| | | | | | | | |
|--|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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>__ 9/23/14 client #6 saw a NP (Nurse Practitioner) for a UTI and was given antibiotics.</p> <p>Client #6's Health/Risk Plan for Reoccurring UTIs dated 3/5/14 indicated, not all inclusive, client #6:</p> <p>__ "Had a history of MRSA (Methicillin-resistant Staphylococcus Aureus, a bacterium responsible for several difficult-to-treat infections that are resistant to antibiotics) in her urine in 2013."</p> <p>__ Was hospitalized in March 2014 due to UTI and continued having problems with UTI after her hospitalization in April 2014.</p> <p>__ "Has poor toileting techniques."</p> <p>__ Had UTIs in July and September 2014.</p> <p>__ "Observable signs: Fever, c/o (complaint of) abdominal pain, pain with urination, refusing to eat/poor appetite, frequent urination and cloudy urine."</p> <p>__ "Preventative measures: Encourage fluid intake, check temperature with c/o new pain/symptoms as above, check blood sugar with symptoms above,... check blood pressures and report abnormals to QA/RN (Quality Assurance/RN)."</p> <p>__ The staff were to document on the Medical Communication Log any signs or symptoms of UTI, pain, fever, change in normal behavior from client.</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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 #6's Health/Risk Plan for Reoccurring UTIs failed to indicate:</p> <p>__ The amount of fluids the client was to drink per day and how the staff were to ensure the client consumed enough fluids throughout the day.</p> <p>__ How the staff were to monitor and document client #6's fluid intake/output to ensure client #6 was getting sufficient fluids while at home and at the workshop.</p> <p>__ A specific toileting plan to encourage and train client #6 to go to the bathroom at frequent intervals throughout the day including while at the day program.</p> <p>__ How the staff were to assist and monitor client #6 with toileting, showering and hygiene to prevent further infections.</p> <p>__ How/when the staff were to monitor client #6 for pain related to UTIs.</p> <p>__ The liquids client #6 would be encouraged to drink and/or not drink (coffee, tea, etc.)</p> <p>Client #6's ISP dated 3/5/14 indicated "She [client #6] may need extra prompting with toileting due to a strong urine smell that result from UTIs that she commonly gets.... [Client #6] was diagnosed with Senile Dementia - Alzheimer's type where she was prescribed medications to help her....</p> | | | |
|--|--|--|--|--|

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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 |
|--------------------|---|---------------|--|----------------------|
| W000436 | <p>[Client #6] has a history of frequent UTIs and should drink cranberry juice and eat yogurt daily to help prevent UTIs."</p> <p>Telephone interview with the facility MCC (Medical Care Coordinator) on 12/5/14 at 2 PM indicated no change in client #6's Health/Risk Plan for UTIs in regard to the annual survey of 10/27/14.</p> <p>This deficiency was cited on 10/27/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT 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, record review and interview for 1 of 2 sampled clients with adaptive equipment (#2), the facility failed to ensure client #2 was provided wrist weights to wear while eating and while working and to provide client #2 with a non-skid mat and a sturdy plate</p> | W000436 | Client #2 has been provided all needed adaptive equipment, including: 2 handled cup, 1lb wrist weights, high sided partitioned plate/dish with rim, non-skid place mat, weighted utensils and clothing protector. Thesesame implements have been provided for client #2 at her | 01/07/2015 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>and/or a high sided plate while at the DP (Day Program).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 12/2/14 between 3:45 PM and 6:15 PM. ___ During this observation period client #2 was observed eating her evening meal. ___ Client #2 had tremors of both hands and spilled food onto the front of her clothing. ___ Client #2 was not provided weighted wrist weights to use while eating her evening meal.</p> <p>Observations were conducted at the facility owned DP on 12/3/14 between 11:45 AM and 12:45 PM. ___ At 11:45 AM client #2 was at her work station doing piece work. ___ Client #2 was not observed using weighted wrist weights while working. ___ At 12 PM client #2 walked to the dining area for her afternoon meal. ___ DP staff #2 pulled out 3 small plastic containers from client #2's lunch box. ___ DP staff #1 provided client #2 a styrofoam plate and a plate guard. ___ DP staff #2 placed the plate guard onto the styrofoam plate and dumped the contents of one of the containers onto client #2's plate and stated, "I think it's</p> | | <p>day program. Anin-service training was held on 12/18/14 for the house staff regarding theimplementation and proper use of her adaptive equipment. Client #2's work atthe day program does not warrant the use of wrist weights because of the natureof her job. She operates a press that does not require fine motor skills. The QIDP will ensure, through multiple monthlyobservations that these procedures are being carried out. The QIDP will holdmonthly house meetings in order to reinforce these standards. The QIDP & RPMwill continue to review incident reports and conduct investigations if theymeet the criteria for non-compliance.</p> | |

| | | | | | | | |
|--|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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>what they had last night. It might be chili."</p> <p>__ While eating client #2 dropped food down the front of her clothing.</p> <p>__ Client #2 was not provided a non skid mat for her plate.</p> <p>Client #2's record was reviewed on 12/3/14 at 11 AM.</p> <p>Client #2's Office Visit record dated 9/24/14 indicated client #2 saw a neurologist due to the tremors she was experiencing. The record indicated "Diagnosis.... Benign Essential Tremor (a nervous system disorder that causes a rhythmic shaking." The record indicated the neurologist increased client #2's Propranolol (for tremors) from 30 milligrams a day to 80 milligrams a day.</p> <p>Client #2's 2014 Nutritional Assessment indicated client #2 had tremors of the left hand and used weighted utensils, a clothing protector and a non skid mat while eating.</p> <p>Client #2's revised dining plan dated 11/10/14 indicated "Wrist weights to help with shaking, weighted utensils. Weighted cup with lid and two handles. Plate guard." The revised dining plan did not include the use of the non skid mat.</p> | | | | | | |

| | | | | | | | |
|--|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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 ISP (Individualized Support Plan) dated 10/26/14 indicated:</p> <p>__ Client #2 "has wrist weights to be worn while at the workshop to help steadying her hands and while eats (sic)."</p> <p>__ Client #2's "OT (Occupational Therapy) evaluation has been done and advised that she (client #2) is to use weighted silverware, weighted cup, wrist weights and high sided plate or plate guard."</p> <p>DP staff #1 and #2 were interviewed on 12/3/14 at 12:30 PM.</p> <p>__ DP staff #1 indicated the facility provided client #2 wrist weights to wear while dining.</p> <p>__ DP staff #1 indicated client #2 did not wear wrist weights while working and doing piece work.</p> <p>__ DP staff #2 indicated the group home did not provide a specific plate for client #2 to use while at the DP and client #2 would benefit from a sturdy plate not a paper plate and/or a styrofoam plate that client #2 was now using.</p> <p>__ DP staff #2 stated, "She (client #2) needs a non skid mat. She has hand tremors really bad and it's hard for her to hold her plate still."</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 12/3/14 at 2 PM indicated client #2 was</p> | | | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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 |
|--------------------|--|---------------|---|----------------------|
| W000460 | <p>supposed to use wrist weights while eating and/or working to help steady her (client #2's) hands while eating and working. The QIDP indicated the staff were to provide client #2 with all of her adaptive equipment at the group home and at the WS.</p> <p>This deficiency was cited on 10/27/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-7(a)</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, interview and record review for 3 of 3 sampled clients (#1, #2 and #3) and 3 additional clients (#4, #5 and #6), the facility failed to ensure the staff offered the clients substitutions for menu items that were refused and/or not eaten, to ensure the staff followed the clients' prescribed diet orders and to ensure the staff provided the clients water and/or tea with their meal.</p> | W000460 | An in-service training was held on 12/18/14 for the housestaff. During this, we discussed dining plans and what were appropriate substitutions for menu items. We trained the staff on dining plans and have been encouraging staff to offer the clients portion sizes that are reflective of their dining plans. Their weights have begun to drop down to more healthy levels. We spoke about how important it was to offer the clients choices regarding drinks during meal | 01/07/2015 |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>Findings include:</p> <p>Observations were conducted at the group home on 12/2/14 between 3:45 PM and 6:15 PM.</p> <p>During the PM observation period clients #1, #2, #3, #4, #5 and #6 were served the following for their evening meal: chili, a salad mix, crackers and a store prepared orange parfait jello dessert.</p> <p>__At 4:45 PM staff #2 got out the lettuce and stated, "[Client #5 and client #6] would get cottage cheese instead of the lettuce because they can't have raw vegetables."</p> <p>__At 5:05 PM clients #1, #2 and #3 asked for tea and staff #2 stated, "No, It's not on the menu."</p> <p>__At 5:10 PM client #3 asked for margarine for her saltine crackers and was told by staff #2 "It's not on the menu so you can't have it."</p> <p>__The plastic container with the store prepared jello indicated the jello was not a diet jello. The container indicated the first three ingredients in the jello mixture were water, sugar and high fructose corn syrup.</p> <p>__A salt shaker was placed on the table for all of the clients to use.</p> <p>__A salt substitute was not offered and/or provided to the clients on a no sodium and/or low sodium diet.</p> | | <p>time. We trained staff on how to prompt client #2 to slow down during meal time and to closely supervise her during mealtime. We also discussed how to involve the clients in meal prep and how to successfully hold a family style dining meal. The staff have been purchasing sugar-free alternatives per the menu and dining plans. A salt substitute has been offered to the clients during meal time in lieu of salt. Low fat salad dressing is now being offered. Staff were instructed to encourage the clients to eat healthy but to also respect client wishes regarding food. The Quality Assurance Social Service Manager will conduct monthly inspections to ensure these procedures are in place. The QIDP will ensure, through multiple monthly observations that these procedures are being carried out. The QIDP will hold monthly house meetings in order to reinforce these standards. The QIDP & RPM will continue to review incident reports and conduct investigations if they meet the criteria.</p> | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>__ Three bottles of salad dressing were placed on the table as well as a bag of salad croutons. The bottles of salad dressing did not indicate the dressing was low fat.</p> <p>__ Client #3 was not offered a homemade dressing.</p> <p>__ Client #2 ate chili, cottage cheese, 3 crackers and jello. Client #2 was not prompted on portion control and/or to follow the menu.</p> <p>__ Client #3 ate half of the chili served to her and 3 saltine crackers. Client #3 refused the salad and the jello dessert. Client #3 was not offered a substitute for the salad and/or jello dessert.</p> <p>__ Client #6 ate chili, cottage cheese and crackers and refused the jello dessert. Client #6 was not offered salad. Client #6 was not offered a substitute for the salad and/or the jello dessert.</p> <p>The staff did not offer clients #2, #3 and #6 a vegetable substitution for the salad that was refused. The staff did not provide and/or offer the clients water and/or tea with their meal along with the milk on the menu.</p> <p>Review of the facility's 11/6/14 week #2 Regular/Living Lite/ NAS (No Added Salt) menu on 12/2/14 at 5 PM indicated the clients were to have the following for their evening meal:</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>1 cup of "Hearty chili"</p> <p>1 cup of tossed salad</p> <p>3 crackers</p> <p>1/2 cup diet fruit gelatin whip</p> <p>1 cup of skim milk.</p> <p>Client #1's record was reviewed on 12/3/14 at 10:30 AM. Client #1's 12/1/14 quarterly physician's orders indicated client #1 was to have a regular diet, no concentrated sweets, no added salt and no extra portions.</p> <p>Client #2's record was reviewed on 12/3/14 at 11 AM. Client #2's 12/1/14 quarterly physician's orders indicated client #2 was to have an 1800 calorie mechanical soft ADA (American Diabetes Association) diet with no salads, no raw vegetables and regular consistency liquids.</p> <p>Client #3's record was reviewed on 12/3/14 at 11:30 AM. Client #3's 12/1/14 quarterly physician's orders indicated client #3 was to have a 1500 calorie, low cholesterol, low fat diet. Client #3's revised dining plan dated 5/6/14 indicated "She (client #3) will eat salad if homemade dressing is provided. Vegetable (sic) are not her favorite."</p> <p>Client #4's record was reviewed on 12/3/14 at 12 PM. Client #4's 1/21/14</p> | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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>revised dining plan indicated client #4 was to have a regular, low fat, low cholesterol, high fiber diet.</p> <p>Client #5's record was reviewed on 12/3/14 at 12:30 PM. Client #6's 3/5/14 revised dining plan indicated client #6 was to have a regular diet with no added salt.</p> <p>Client #6's record was reviewed on 12/3/14 at 1 PM. Client #6's 3/5/14 revised dining plan indicated client #6 was to have a regular 1800 calorie diet with no extra portions and no concentrated sweets.</p> <p>During interview with the QIDP (Qualified Intellectual Disabilities Professional) on 12/3/14 at 2 PM, the QIDP indicated:</p> <p>__ The staff were to follow the facility menus as written and were to offer all of the food on the menus.</p> <p>__ The staff were to follow the substitution list provided by the dietician when foods were not available or the clients refused the menu items.</p> <p>__ She (the QIDP) was not able to locate a substitution list for the staff to follow.</p> <p>__ When asked if cottage cheese was an approved substitute for a salad, the QIDP stated, "No, they (the staff) should have offered another green vegetable."</p> | | | |

| | | | | | | | |
|--|---|---|--|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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 staff were not to place the salt shaker on the table and should have offered the clients a salt substitute.</p> <p>__ Indicated sugar free and/or diet foods/liquids were to be offered to clients #1, #2 and #6 instead of foods high in sugar content.</p> <p>__ Indicated the staff should have provided water and/or tea with the meal along with the milk that was on the menu.</p> <p>This deficiency was cited on 10/27/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-8(a)</p> | | | | | | |
| W000488 | <p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation and interview for 6 of 6 clients living in the home (clients #1, #2, #3, #4, #5 and #6), the facility failed to ensure the staff provided training in meal preparation and family style dining when formal and informal training opportunities existed.</p> | W000488 | <p>An in-service training was held on 12/18/14 for the housestaff. During this, we discussed dining plans and what were appropriate substitutions for menu items. We trained the staff on dining plans and have been encouraging staff to offer the clients portion sizes that are reflective of their dining plans.</p> | 01/07/2015 | | | |

| | | | | | | | |
|--|---|---|---|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 | |
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | | |
| (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>Findings include:</p> <p>Observations were conducted at the group home on 12/2/14 between 3:45 PM and 6:15 PM.</p> <p>__At 4:10 PM staff #1 began the evening meal preparation.</p> <p>__Staff #1 browned hamburger and placed a pot of water on the stove to boil noodles. Staff #1 drained the hamburger, opened cans of Armour Chili and cans of tomatoes. Staff #1 drained the noodles and then added the opened cans of Armour Chili, the opened cans of tomatoes, the noodles and chili spices to the browned hamburger and mixed everything together.</p> <p>__At 4:45 PM staff #2 got out a bag of salad mix and put it into a bowl.</p> <p>__At 4:50 PM staff #2 and client #5 set the table for the evening meal.</p> <p>__At 5 PM staff #2 poured milk into each of the cups on the table while staff #1 dipped up the chili into a serving bowl. Staff #1 took the bowl of chili to the table as well as a bowl of salad, a bowl of cottage cheese and store prepared container of jello/whip.</p> <p>__At 5:03 PM the clients (clients #1, #2, #3, #4, #5 and #6) were prompted to come to the table for their evening meal.</p> <p>__Staff #1 went from client to client and dipped up a serving of chili for each of the clients.</p> | | <p>Their weights have begun to drop down to more healthy levels. We spoke about how important it was to offer the clients choices regarding drinks during meal time. We trained staff on how to prompt client #2 to slow down during meal time and to closely supervise her during mealtime. We also discussed how to involve the clients in meal prep and how to successfully hold a family style dining meal. The staff have been purchasing sugar-free alternatives per the menu and dining plans. A salt substitute has been offered to the clients during meal time in lieu of salt. Low fat salad dressing is now being offered. Staff were instructed to encourage the clients to eat healthy but to also respect client wishes regarding food. The Quality Assurance Social Service Manager will conduct monthly inspections to ensure these procedures are in place. The QIDP will ensure, through multiple monthly observations, especially during mealtime, that these procedures are being carried out. The QIDP will hold monthly house meetings in order to reinforce these standards. The RPM will continue to review incident reports and conduct investigations if they meet the criteria.</p> | | | | |

| | | | |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|--|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 |
|--|--|

| (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 #4 reached into a bag of croutons with her hands and placed the croutons on her salad. Client #5 then reached into the same bag with her hands and also placed a handful of croutons onto her salad.</p> <p>__ Client #2 used her hands to pick out some of the crackers and the macaroni from her chili and ate it with her fingers. Client #2 also picked up chunks of jello from her plate and ate it with her hands. Client #2 took large bites of food and ate at a fast pace. The staff did not prompt client #2 to use her silverware when using her hands to eat and/or to take smaller bites of food and to slow her pace of eating.</p> <p>__ During the preparation of the evening meal, all of the clients (clients #1, #2, #3, #4, #5 and #6) were in and out of the kitchen. Clients #1 and #3 spent most of the time during the meal preparation in their bedrooms. None of the clients assisted in the preparation of the food for the evening meal.</p> <p>__ During this observation period the staff failed to provide the clients with formal and informal training in meal preparation and/or family style dining when opportunity existed.</p> <p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 12/3/14 at 2 PM indicated the staff were</p> | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G652 | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 12/09/2014 |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC | | | STREET ADDRESS, CITY, STATE, ZIP CODE 901 JOSEPH ST GREENSBURG, IN 47240 | | |
| (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 | |
| W009999 | <p>to provide the clients with training in meal preparation and family style dining at every available opportunity. The QIDP indicated the staff were to prompt the clients verbally and physically with hand over hand assistance as needed while preparing the meal and during meal time.</p> <p>This deficiency was cited on 10/27/14. The facility failed to implement a systemic plan of correction to prevent reoccurrence.</p> <p>9-3-8(a)</p> | W009999 | All deficiencies will be corrected by 1/07/15 | 01/07/2015 | |