

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G461	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/11/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 631 N ELM ST SEYMOUR, IN 47274
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W 0000 Bldg. 00	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 9/8/15, 9/9/15, 9/10/15 and 9/11/15.</p> <p>Facility Number: 000975 Provider Number: 15G461 AIMS Number: 100244820</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/16/15.</p>	W 0000		
W 0159 Bldg. 00	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL</p> <p>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the QIDP (Qualified Intellectual Disabilities Professional) failed to integrate, coordinate and monitor clients #1, #2, #3, #4, #5, #6, #7 and #8's active treatment programs by</p>	W 0159	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> · Ann Sanchez, former QIDP, is no longer working for DSI and will not be eligible for rehire. · Mel Fields, Director of Industry and Community Services 	10/11/2015

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

TITLE

(X6) DATE

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

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	<p>failing to ensure clients #1, #2, #3 and #4's formal training objectives were monitored for progression/regression of skills, to ensure clients #1, #2, #3 and #4's performance regarding their IPP (Individual Program Plan) objectives was documented to enable analysis of their progression/regression of skills, to ensure the facility's HRC (Human Rights Committee) ensured clients #1, #2, #3 and #4 or their guardians gave their written informed consent regarding the facility's practice of utilizing video monitoring devices in the group home, to ensure the facility's HRC reviewed, monitored and made recommendations regarding the facility's practice of utilizing video monitoring devices in the group home for clients #1, #2, #3, #4, #5, #6, #7 and #8 and to ensure staff provided training in meal preparation when formal and informal opportunities existed for clients #1, #2, #4, #6 and #8.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 9/9/15 at 9:35 AM. Client #1's (IPP Individual Program Plan) dated 7/22/15 indicated client #1 had formal training objectives to increase her independence regarding brushing her hair, brushing her teeth, selecting an outfit, washing her</p>		<p>In-serviced QIDPs & RPM on monthly summaries on 9/16/15 (attachment A)</p> <ul style="list-style-type: none"> · Monthly Summary has been revised to include RPM review and Director review (attachment B) · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on Guardian phone approval protocol and signature follow-up protocol (attachment C) and program oversight on 9/16/15 (attachment A) · Guardian and HRC approval has been obtained for the use of video monitoring devices (attachment D) · Video monitoring is now part of the annual IPP process and subject to HRC approval at their annual date. · Cheryl Yeager, QIDP, will in-service house staff on informal meal prep training opportunities and active treatment <p>How will we identify others:</p> <ul style="list-style-type: none"> · QIDPs will review monthly summaries to ensure completion · RPM and QIPDs will review 				

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	<p>upper body, taking her dishes to the sink after meals, identify the purpose of her medications, make monthly purchases with her petty cash, identify coin denominations and communicate her feelings.</p> <p>The review did not indicate documentation tracking/analysis of the goals for progression/regression of skills prior to August 2015.</p> <p>2. Client #2's record was reviewed on 9/9/15 at 9:11 AM. Client #2's IPP dated 3/24/15 indicated client #2 had formal training objectives to increase her independence regarding comb/brush her hair, wash her hair, setting the table for meals, participating in meal preparation, prepare simple foods, physical exercise, folding/hanging laundered items, verbally communicate with staff when she needs assistance, communicate her wants/needs, identify her medications, identify bill currency and make change for \$5.00 or less.</p> <p>The review did not indicate documentation tracking/analysis of the goals for progression/regression of skills prior to August 2015.</p> <p>3. Client #3's record was reviewed on 9/9/15 at 11:35 AM. Client #3's IPP</p>		<p>video monitoring device approvals to ensure HRC and guardian approval has been obtained</p> <p>Measures put in place:</p> <ul style="list-style-type: none"> · New monthly summary has been implemented · Guardian approval documentation protocol · Group home observation form has been implemented (attachment E) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> · QIDPs will perform monthly record reviews of all clients · Aaron Starr, RPM, will conduct monthly record review · Regional Management staff, Aaron Starr and Kay Boas, will review and sign off on monthly summaries that will include tracking/analysis of client goals for the prior month 		

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	<p>dated 8/28/15 indicated client #3 had formal training objectives to increase her independence regarding identifying coins, identifying paper currency, learn coin and paper currency equivalencies, identify medications, care for her dentures, operate the microwave, participate in cooking activity, learn the food groups, know her address and phone number, pedestrian safety skills and operate the washer and dryer.</p> <p>The review did not indicate documentation tracking/analysis of the goals for progression/regression of skills prior to August 2015.</p> <p>4. Client #4's record was reviewed on 9/9/15 at 10:30 AM. Client #4's IPP dated 7/22/15 indicated client #4 had formal training objectives to increase his independence regarding grooming and hygiene, using a napkin during meals, folding laundry skills, participation in leisure and community activities, make decisions, identify his phone number and to identify his medications.</p> <p>The review did not indicate documentation tracking/analysis of the goals for progression/regression of skills prior to August 2015.</p> <p>QIDP (Qualified Intellectual Disabilities</p>						

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	<p>Professional) #1 was interviewed on 9/9/15 at 10:28 AM. QIDP #1 indicated she had assumed the QIDP responsibilities for the home July 2015. QIDP #1 indicated prior to August 2015 clients #1, #2, #3 and #4's goals had not been tracked for progression/regression of skills. QIDP #1 indicated she had initiated tracking and monitoring upon being assigned to the home.</p> <p>5. The QIDP failed to integrate, coordinate and monitor clients #1, #2, #3 and #4's active treatment programs by failing to ensure clients #1, #2, #3 and #4's performance regarding their IPP objectives was documented to enable analysis of their progression/regression of skills. Please see W252.</p> <p>6. The QIDP failed to integrate, coordinate and monitor clients #1, #2, #3 and #4's active treatment programs by failing to ensure the facility's HRC ensured clients #1, #2, #3 and #4 or their guardians gave their written informed consent regarding the facility's practice of utilizing video monitoring devices in the group home. Please see W263.</p> <p>7. The QIDP failed to integrate, coordinate and monitor clients #1, #2, #3, #4, #5, #6, #7 and #8's active treatment programs by failing to ensure the</p>				

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W 0252 Bldg. 00	<p>facility's HRC reviewed, monitored and made recommendations regarding the facility's practice of utilizing video monitoring devices in the group home for clients #1, #2, #3, #4, #5, #6, #7 and #8. Please see W264.</p> <p>8. The QIDP failed to integrate, coordinate and monitor clients #1, #2, #4, #6 and #8's active treatment programs by failing to ensure staff provided training in meal preparation when formal and informal opportunities existed for clients #1, #2, #4, #6 and #8. Please see W488.</p> <p>9-3-3(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility failed to ensure clients #1, #2, #3 and #4's performance regarding their IPP (Individual Program Plan) objectives was documented to enable analysis of their progression/regression of skills.</p> <p>Findings include:</p>	W 0252	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> · Ann Sanchez, former QIDP, is no longer working for DSI and will not be eligible for rehire. · Mel Fields, Director of Industry and Community Services In-serviced QIDPs & RPM on monthly summaries, program oversight on 9/16/15 (attachment A) 	10/11/2015

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	<p>1. Client #1's record was reviewed on 9/9/15 at 9:35 AM. Client #1's (IPP Individual Program Plan) dated 7/22/15 indicated client #1 had formal training objectives to increase her independence regarding brushing her hair, brushing her teeth, selecting an outfit, washing her upper body, taking her dishes to the sink after meals, identify the purpose of her medications, make monthly purchases with her petty cash, identify coin denominations and communicate her feelings.</p> <p>Client #1's record indicated the facility started tracking client #1's performance regarding her formal training objectives August 2015.</p> <p>The review did not indicate documentation of specific criteria for completion, specify the number or frequency of trials or the results of trials client #1 had completed prior to August 2015.</p> <p>2. Client #2's record was reviewed on 9/9/15 at 9:11 AM. Client #2's IPP dated 3/24/15 indicated client #2 had formal training objectives to increase her independence regarding comb/brush her hair, wash her hair, setting the table for meals, participating in meal preparation, prepare simple foods, physical exercise,</p>		<ul style="list-style-type: none"> · Aaron Starr, Regional Program Manager, will in-service QIDPs on implementation of goals and tracking. <p>How will we identify others:</p> <ul style="list-style-type: none"> · Regional Management Staff, Aaron Starr and Kay Boas, will review monthly summaries, goals and client involvement in meal prep to ensure that they are being completed in all DSI group homes. <p>Measures put in place:</p> <ul style="list-style-type: none"> · New monthly summary has been implemented · Group home observation form has been implemented (attachment E) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> · QIDPs will perform monthly record reviews of all clients · QIDPs will perform weekly observations to ensure goals are being completed and documented · Regional Management staff, Aaron Starr and Kay Boas, will review and sign off on monthly summaries that will include tracking/analysis of client goals for 	

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	<p>folding/hanging laundered items, verbally communicate with staff when she needs assistance, communicate her wants/needs, identify her medications, identify bill currency and make change for \$5.00 or less.</p> <p>Client #2's record indicated the facility started tracking client #2's performance regarding her formal training objectives August 2015.</p> <p>The review did not indicate documentation of specific criteria for completion, specify the number or frequency of trials or the results of trials client #2 had completed prior to August 2015.</p> <p>3. Client #3's record was reviewed on 9/9/15 at 11:35 AM. Client #3's IPP dated 8/28/15 indicated client #3 had formal training objectives to increase her independence regarding identifying coins, identifying paper currency, learn coin and paper currency equivalencies, identify medications, care for her dentures, operate the microwave, participate in cooking activity, learn the food groups, know her address and phone number, pedestrian safety skills and operate the washer and dryer.</p> <p>Client #3's record indicated the facility</p>		the prior month				

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	<p>started tracking client #3's performance regarding her formal training objectives August 2015.</p> <p>The review did not indicate documentation of specific criteria for completion, specify the number or frequency of trials or the results of trials client #3 had completed prior to August 2015.</p> <p>4. Client #4's record was reviewed on 9/9/15 at 10:30 AM. Client #4's IPP dated 7/22/15 indicated client #4 had formal training objectives to increase his independence regarding grooming and hygiene, using a napkin during meals, folding laundry skills, participation in leisure and community activities, make decisions, identify his phone number and to identify his medications.</p> <p>Client #4's record indicated the facility started tracking client #4's performance regarding her formal training objectives August 2015.</p> <p>The review did not indicate documentation of specific criteria for completion, specify the number or frequency of trials or the results of trials client #4 had completed prior to August 2015.</p>			

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W 0263 Bldg. 00	<p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/9/15 at 10:28 AM. QIDP #1 indicated she had assumed the QIDP responsibilities for the home July 2015. QIDP #1 indicated there was not documentation available prior to August 2015 of goal tracking for clients #1, #2, #3 and #4.</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.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), the facility's HRC (Human Rights Committee) failed to ensure clients #1, #2, #3 and #4 or their guardians gave their written informed consent regarding the facility's practice of utilizing video monitoring devices in the group home.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 9/8/15 from 5:08 PM</p>	W 0263	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on Guardian phone approval protocol & follow-up protocol (attachment C) and program oversight on 9/16/15 (attachment A) · Guardian and HRC approval has been obtained for the use of video monitoring devices (attachment D) 	10/11/2015			

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	<p>through 6:08 PM and on 9/9/15 from 5:45 AM through 8:30 AM. Clients #1, #2, #3 and #4 were present in the home through the observation periods. The home utilized video recording devices in the common areas of the house such as the living room, dining area and medication administration area.</p> <p>The facility's Community Residential Facility Surveyor Worksheet dated 9/8/15 was reviewed on 9/9/15 at 9:00 AM. The 9/8/15 form indicated client #1 had a legal guardian/POA (Power of Attorney), client #2 was emancipated with a HCR (Health Care Representative), client #3 had a legal guardian and client #4 was emancipated with a HCR.</p> <p>1. Client #1's record was reviewed on 9/9/15 at 9:35 AM. Client #1's record did not indicate documentation of client #1's guardian/POA's written informed consent regarding the facility's practice of utilizing video monitoring devices in the group home.</p> <p>2. Client #2's record was reviewed on 9/9/15 at 9:11 AM. Client #2's record did not indicate documentation of client #2's written informed consent regarding the facility's practice of utilizing video monitoring devices in the group home.</p>		<p>· Video monitoring is now part of the annual IPP process and subject to HRC approval at their annual date.</p> <p>How will we identify others:</p> <p>· RPM and QIPDs will review video monitoring device approvals to ensure HRC and guardian approval has been obtained</p> <p>Measures put in place:</p> <p>· Guardian approval documentation protocol</p> <p>Monitoring of corrective action:</p> <p>· QIDPs will perform monthly record reviews of all clients</p> <p>· Aaron Starr, RPM, will conduct monthly record review</p>				

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	<p>3. Client #3's record was reviewed on 9/9/15 at 11:35 AM. Client #3's record did not indicate documentation of client #3's guardian's written informed consent regarding the facility's practice of utilizing video monitoring devices in the group home.</p> <p>4. Client #4's record was reviewed on 9/9/15 at 10:30 AM. Client #4's record did not indicate documentation of client #4's written informed consent regarding the facility's practice of utilizing video monitoring devices in the group home.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/9/15 at 10:28 AM. QIDP #1 indicated the group home utilized video monitoring devices in the home's common areas. QIDP #1 indicated there was not documentation available for review of client #1's guardian/POA's written informed consent, client #2's written informed consent, client #3's guardian's written informed consent or client #4's written informed consent regarding the use of video monitoring devices in the home.</p> <p>9-3-4(a)</p>			

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W 0264 Bldg. 00	<p>483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE</p> <p>The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed.</p> <p>Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) plus 4 additional clients (#5, #6, #7 and #8), the facility's HRC (Human Rights Committee) failed to review, monitor and make recommendations regarding the facility's practice of utilizing video monitoring devices in the group home for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>Findings include:</p> <p>Observations were conducted in the group home on 9/8/15 from 5:08 PM through 6:08 PM and on 9/9/15 from 5:45 AM through 8:30 AM. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were present in the home through the observation periods. The home utilized video recording devices in the common areas of the house such as the living room, dining area and medication administration area.</p> <p>1. Client #1's record was reviewed on</p>	W 0264	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> · Mel Fields, Director of Industry and Community Services in-serviced QIDPs on Guardian phone approval protocol & signature follow-up protocol (attachment C) and program oversight on 9/16/15 (attachment A) · Guardian and HRC approval has been obtained for the use of video monitoring devices (attachment D) · Video monitoring is now part of the annual IPP process and subject to HRC approval at their annual date. <p>How will we identify others:</p> <ul style="list-style-type: none"> · RPM and QIPDs will review video monitoring device approvals 	10/11/2015			

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	<p>9/9/15 at 9:35 AM. Client #1's record did not indicate documentation of HRC review, monitoring or recommendations regarding the facility's practice of utilizing video monitoring devices in the group home.</p> <p>2. Client #2's record was reviewed on 9/9/15 at 9:11 AM. Client #2's record did not indicate documentation of HRC review, monitoring or recommendations regarding the facility's practice of utilizing video monitoring devices in the group home.</p> <p>3. Client #3's record was reviewed on 9/9/15 at 11:35 AM. Client #3's record did not indicate documentation of HRC review, monitoring or recommendations regarding the facility's practice of utilizing video monitoring devices in the group home.</p> <p>4. Client #4's record was reviewed on 9/9/15 at 10:30 AM. Client #4's record did not indicate documentation of HRC review, monitoring or recommendations regarding the facility's practice of utilizing video monitoring devices in the group home.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/9/15 at 10:28 AM. QIDP #1 indicated</p>		<p>to ensure HRC and guardian approval has been obtained</p> <p>Measures put in place:</p> <ul style="list-style-type: none"> Guardian approval documentation protocol <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> QIDPs will perform monthly record reviews of all clients Aaron Starr, RPM, will conduct monthly record review 	

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W 0488 Bldg. 00	<p>the group home utilized video monitoring devices in the home's common areas. QIDP #1 indicated there was not documentation available for review of HRC review, monitoring or recommendations regarding the use of video monitoring devices in the home for clients #1, #2, #3, #4, #5, #6, #7 and #8.</p> <p>9-3-4(a)</p> <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. Based on observation and interview for 3 of 4 sampled clients (#1, #2 and #4) plus 2 additional clients (#6 and #8), the facility failed to ensure staff provided training in meal preparation when formal and informal opportunities existed for clients #1, #2, #4, #6 and #8.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 9/9/15 from 5:45 AM through 8:30 AM. At 7:15 AM, TL (Team Leader) #1 was in the kitchen area with clients #4, #6 and #8 seated at the dining room table. At 7:27 AM, TL #1 prepared a frozen toaster pastry, cup of</p>	W 0488	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> QIDP and staff will be in-serviced on informal meal prep training opportunities and active treatment <p>How will we identify others:</p> <ul style="list-style-type: none"> QIDPs will perform active treatment observations to ensure active treatment is present both formal and informally and that custodial care is not present <p>Measures put in place:</p> <ul style="list-style-type: none"> Group home observation 	10/11/2015			

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	juice and cup of milk in the kitchen area. TL #1 then brought the pastry and cups of milk and juice to client #8 who was seated at the dining room table. TL #1 did not encourage client #8 to participate in the preparation of his morning meal. At 7:39 AM, TL #1 prepared a serving of instant oatmeal in the microwave, poured a cup of milk and then served client #4 oatmeal, drink and utensils. TL #1 did not encourage client #4 to participate in the preparation of his morning meal. At 7:40 AM, client #8 was finished with his meal. TL #1 then retrieved client #8's dishes and took them to the sink. TL #1 did not encourage client #8 to assist with meal time clean up activities. At 7:51 AM, client #4 finished eating his morning meal. TL #1 then retrieved client #4's dishes from the table and took them to the kitchen sink. TL #1 did not encourage client #4 to participate with meal time clean up activities. At 7:52 AM, Direct Support Staff (DSP) #1 arrived and began assisting TL #1 with the morning meal time activities. At 7:55 AM, DSP #1 prepared two cups of hot tea and pancakes. DSP #1 then served client #4 a cup of tea and served client #1 a cup of tea and a plate of pancakes. DSP #1 did not encourage clients #1 or #4 to serve themselves tea or pancakes. At 8:13 AM, DSP #1 prepared and served client #6 his oatmeal and cup of milk/juice. At		form has been implemented, to be performed weekly(attachment E) Monitoring of corrective action: · QIDPs will be performing weekly active treatment observations · Aaron Starr, RPM, will perform monthly active treatment observations	

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W 9999 Bldg. 00	<p>8:21 AM, DSP #1 prepared and served client #2 her oatmeal and cup of milk and juice. Clients #1, #2, #4, #6 or #8 were not encouraged to participate in the preparation of their morning meals or with clean up activities after eating their morning meal.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/9/15 at 10:28 AM. QIDP #1 indicated clients #1, #2, #4, #6 and #8 could assist in the preparation and clean up of the morning meal with assistance from staff. QIDP #1 indicated clients #1, #2, #4, #6 and #8 should be encouraged to participate in the preparation and clean up of the morning meals to the extent of their individual capabilities.</p> <p>9-3-8(a)</p> <p>1. STATE FINDINGS: The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met. (1) 460 IAC 9-3-3 Facility Staffing</p>	W 9999	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> ·LPN has received TB test ·DSP #2 will successfully complete core B with a passing grade on 10/8/15 <p>How will we identify others:</p> <ul style="list-style-type: none"> ·HR will review employee files for TB test compliance ·HR will review employee files 	10/11/2015

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	<p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on observation, record review and interview for 1 of 3 sampled staff (LPN/DSP (Licensed Practical Nurse/Direct Support Professional) #1), the facility failed to ensure written documentation of annual PPD testing, x-ray or symptom checklist was completed for LPN/DSP #1.</p> <p>Findings include:</p> <p>LPN/DSP #1's personnel record was</p>		<p>for core B compliance</p> <p>Measures put in place: · HR will send out monthly report for training and TB needs</p> <p>Monitoring of corrective action:</p> <p>·RPM will review monthly HR report to ensure compliance for TB and core B training needs.</p>	

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	<p>reviewed on 9/8/15 at 3:43 PM. LPN/DSP #1's record indicated LPN/DSP #1's most recent TB testing was completed on 6/6/14. The review did not indicate documentation of annual testing, x-ray or symptom screening.</p> <p>PM (Program Manager) #1 was interviewed on 9/8/15 at 4:00 PM. PM #1 indicated LPN/DSP #1 had completed an annual TB test with another employer and would provide documentation of annual TB testing at the evening observations in the home.</p> <p>Observations were conducted in the group home on 9/8/15 from 5:08 PM through 6:08 PM and on 9/9/15 from 5:45 AM through 8:30 AM. LPN/DSP #1 was present throughout the 9/8/15 observation period and from 6:00 AM through 8:30 AM during the 9/9/15 observation period. LPN/DSP #1 did not provide documentation of TB testing, x-ray or symptom screening.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/9/15 at 8:25 AM. QIDP #1 indicated LPN/DSP #1 worked at a second job but was not able to obtain a copy of her TB testing documentation. QIDP #1 indicated LPN/DSP #1 had gone to the local health department for a TB test on</p>			

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	<p>9/8/15. QIDP #1 indicated there was not documentation available of LPN/DSP #1's annual TB testing.</p> <p>2. STATE FINDINGS:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>(1) 460 IAC 9-3-6 Health Care Services</p> <p>(b.) All personnel who administer medication to residents or observe residents self-administering medication shall have received and successfully completed training using materials approved by the council.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview for 1 of 3 sampled staff (DSP #2), the facility failed to ensure documentation of DSP #2's successful completion of Core B training.</p> <p>Findings include:</p> <p>DSP #2's personnel record was reviewed on 9/8/15 at 3:45 PM. DSP #2's record did not indicate documentation of completion/receiving Core B training.</p>						

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	<p>DSP #2's personnel record indicated DSP #2's date of hire was 12/4/14.</p> <p>PM #1 was interviewed on 9/8/15 at 4:00 PM. PM #1 indicated he would consult with the facility's human resource department to locate DSP #2's Core B training documentation.</p> <p>QIDP #1 was interviewed on 9/9/15 at 8:25 AM. QIDP #1 indicated DSP #2 provided direct care support and medication administration for clients #1, #2, #3, #4, #5 and #6. QIDP #1 indicated the agency human resources department was in the process of locating documentation of DSP #2's Core B training.</p> <p>Electronic correspondence from PM #1 dated 9/9/15 at 4:40 PM was reviewed on 9/10/15 at 12:00 PM. The 9/9/15 electronic correspondence from PM #1 indicated DSP #2 was scheduled to attend Core B training on 1/29/15. The form did not indicate documentation of successful completion of the 1/29/15 training.</p> <p>Electronic correspondence from PM #1 dated 9/10/15 at 11:47 AM was reviewed on 9/10/15 at 12:00 PM. The electronic correspondence from PM #1 indicated, "We have been through everything, there</p>			

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	is no score." 9-3-1(b)				