

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G639		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/24/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 426 E MONTGOMERY RD. 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
W0000	<p>This visit was for a fundamental annual recertification and state licensure survey.</p> <p>Dates of Survey: 1/14/13, 1/15/13 and 1/24/13.</p> <p>Facility Number: 001214 Provider Number: 15G639 AIMS Number: 100234330</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 2/1/13 by Tim Shebel, Medical Surveyor III.</p>			W0000			

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

TITLE

(X6) DATE

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

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W0157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review, observation and interview for 1 of 6 allegations of abuse, neglect, mistreatment, exploitation and/or injuries of unknown origin reviewed, the facility failed to implement a plan of correction following a fall with injury for client #1.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 1/14/13 at 3:20 PM. The review indicated the following:</p> <p>-BDDS report dated 11/18/12 indicated, "On 11/17/12 at 11:30 AM, reported that [client #1] tripped on a rug in the bathroom while running to avoid urinating on herself, hit her forehead on wall (sic)- knot on forehead 1 and 1/2 inches in diameter." The 11/18/12 BDDS report indicated client #1 was taken to the emergency room and a CT (Computed Tomography) scan was completed. The 11/18/12 BDDS report indicated the plan of correction/resolution to prevent further reoccurrence was to remove the rugs from the bathroom floor.</p>	W0157	<p>W157 QIDP has retrained staff on the falls risk plan for client #1. All rugs have been removed. QIDP or designee will conduct random observations in the home weekly for one month and at least monthly thereafter to ensure compliance in this area.</p> <p>Responsible for QA: QIDP</p>	02/23/2013			

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	<p>Observations were conducted at the group home on 1/15/12 from 5:45 AM to 1:22 PM. At 10:30 AM the group home's restroom directly across from client #1's bedroom was observed. The restroom had two rugs. The restroom had a rug directly in front of the vanity and one in front of the toilet/shower area.</p> <p>QMRP/A #1 (Qualified Mental Retardation Professional Assistant) was interviewed on 1/15/13 at 10:35 AM. QMRP/A #1 indicated the restroom directly across from client #1's bedroom was the restroom where client #1 had fallen on 11/17/12. QMRP/A #1 indicated the rugs should have been removed from the restroom following client #1's fall.</p> <p>Client #1's record was reviewed on 1/15/13 at 9:48 AM. Client #1's 9/12 Fall Risk Plan document indicated client #1 was at risk for falls. Client #1's 9/12 Fall Risk Plan indicated the floors of the group home should not have rugs.</p> <p>9-3-2(a)</p>				

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W0159	<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 record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure client #2 received a recommended hearing evaluation.</p> <p>Findings include:</p> <p>Client #2's record was reviewed on 1/15/13 at 11:59 AM. Client #2's Hearing Evaluation form dated 10/12/11 indicated, "Retest one year, higher pitched nerve hearing loss in each ear." Client #2's record did not indicate documentation of a follow up hearing evaluation.</p> <p>Interview with QMRP/A (Qualified Mental Retardation Professional/Assistant) #1 on 1/15/13 at 11:25 AM indicated client #2's follow up hearing evaluation had not been scheduled. QMRP/A #1 indicated his responsibilities included scheduling and facilitating medical appointments.</p> <p>9-3-3(a)</p>	W0159	<p>W159 QIDP's have been retrained on requirements for timely annual medical exams to include hearing. Client #2 will be scheduled for hearing exam as recommended. QIDP and agency nurse will review each client's chart at least monthly to ensure all medical exams are obtained timely.</p> <p>Responsible for QA: QIDP</p>	02/23/2013	

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W0186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure there were enough staff to supervise the clients during the morning shift.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/15/13 from 5:45 AM to 1:22 PM. Clients #1, #2, #3, #4, #5 and #6 were present in the home throughout the observation period. Staff #1 was the on duty staff from 5:45 AM through 7:52 AM. There were no additional staff on duty in the group home from 5:45 AM through 7:52 AM. At 6:00 AM staff #1 prompted clients #3 and #6 to wake for the day. At 6:06 AM staff #1 finished administering client #6's medications in the medication administration room. Staff #1 walked from the medication administration room, through the dining room, through the kitchen, through the front door entry foyer and then through</p>	W0186	<p>W186</p> <p>Schedule of the morning staff was reviewed and staff were retrained in supervision duties during morning routine. QIDP or designee will conduct on-going random observations at least monthly to ensure the adjustment provides adequate supervision.</p> <p>Responsible for QA: QIDP</p>	02/23/2013	

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	<p>the hallway that led to client #2 and #3's bedroom to prompt them to wake for medication and breakfast. Client #6 stood in the kitchen waiting for staff #1 to return to the kitchen to assist her with making eggs. At 6:15 AM staff #1 continued assisting client #2 in her bedroom while client #6 waited in the kitchen. At 6:17 AM client #5 woke and came to the medication administration room and received her morning medications. At 6:25 AM client #5 entered the kitchen area with client #6 and waited for staff #1 to assist with morning meal preparation. At 6:30 AM staff #1 assisted client #6 prepare fried eggs for the morning meal then returned to client #3's bedroom to prompted her to wake for the day. At 6:40 AM staff #1 assisted clients #5 and #6 set the table and prepare for the morning meal. At 6:41 AM client #1 entered the kitchen area and requested her medications. Staff #1 directed client #1 to wait until she was finished assisting clients #5 and #6 with meal preparation. Client #1 began yelling that she wanted her medication. Clients #2, #5 and #6 sat down at the table to eat fried eggs, a bowl of cereal and drink their coffee. While clients #2, #5 and #6 were eating, staff #1 and client #1 were in the medication administration room. Staff #1 did not supervise client #2's meal. At 6:45 AM staff #1 walked from the medication</p>			

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	<p>administration room, through the dinning room, through the kitchen, through the front door entry foyer and then through the hallway that lead to client #3's bedroom to prompt her to wake for medication and breakfast while client #2 was seated at the kitchen table eating breakfast. At 7:05 AM client #1 continued eating breakfast at the kitchen table while staff #1 administered client #4's medications. Staff #1 did not supervise client #1's morning meal. At 7:15 AM staff #1 assisted clients #1, #2, #4 and #5 pack their lunch bags for day program. At 7:20 AM client #3 entered the kitchen area and requested her medication. Staff #1 exited the kitchen area and entered the medication administration room with client #3 to administer her morning medications while clients #1, #2, #4 and #5 remained in the kitchen area preparing their lunch bags for the day. At 7:30 AM staff #1 assisted client #1 brush her hair and complete oral hygiene while client #5 cleaned the kitchen and client #3 showered and dressed.</p> <p>Interview with staff #1 on 1/15/13 at 7:45 AM indicated there was only one staff on duty during the morning hours from 6:00 AM through 8:00 AM. Staff #1 indicated the clients wake at 6:00 AM and leave for day services at 8:00 AM. Staff #1 stated,</p>			

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	<p>"It's difficult for one person to monitor everything that's going on in the morning. I can't be in two places at once. I can't be monitoring the kitchen while I do the medication pass."</p> <p>Client #1's record was reviewed on 1/15/13 at 9:48 AM. Client #1's ISP (Individual Support Plan) dated 7/11/12 indicated, "[Client #1] needs staff supervision in the kitchen at all times to ensure her safety." The 7/11/12 ISP indicated client #1 required physical prompts to pack her lunch. Client #1's High Risk Plan dated 9/12 indicated, "Potential for choking, diagnosed with dementia, diagnosis of gerd and gastritis, displays dysphasia trigger at meal, snack and medication time. Displays choking behavior: grabbing at throat, breathing difficulty. Supervise during meals. Encourage to slow down if eating fast."</p> <p>Client #2's record was reviewed on 1/15/13 at 11:59 AM. Client #2's High Risk Plan dated 11/11/12 indicated, "Will have episodes of choking or aspiration of foods or fluids, history of difficulty swallowing large pills, requires assistance in cutting food into small pieces. [Client #2] also requires assistance in cutting food into small pieces. [Client #2] requires prompting to not overfill fork or spoon when she eats. Displays dysphasia</p>						

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	<p>trigger at meal and snack time. Supervision provided at all times while eating or drinking."</p> <p>Client #3's record was reviewed on 1/15/13 at 10:58 AM. Client #3's BSP (Behavior Support Plan) dated 2/12 and revised on 9/12 indicated the target behavior of refusal to do hygiene. Client #3's 9/12 BSP indicated client #3 required support/supervision to ensure her hygiene was completed.</p> <p>Interview with QMRP #1 (Qualified Mental Retardation Professional) on 1/15/13 at 1:15 PM indicated there was one staff on duty from 6:00 AM through 8:00 AM.</p> <p>9-3-3(a)</p>				

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W0289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on observation, interview and record review for 1 of 3 sampled clients (#3), the facility failed to ensure client #3's tobacco titration/restriction was included in the BSP (Behavior Support Plan)/ISP (Individual Support Plan).</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/15/13 from 5:45 PM through 1:22 PM. At 7:45 AM client #3 was preparing to leave the group home to go to her day service provider. Client #3 requested her cigarettes from staff #1 for the day before leaving for the workshop.</p> <p>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 1/15/13 at 12:05 PM. When asked if client #3 was on a tobacco restriction, QMRP #1 stated, "We keep it. [Client #3] can have so many cigarettes a day, gets two cigarettes for workshop, then when she gets home gets two more and gets the last one around 8:00 PM to 8:30 PM. [Client #3] also gets some in the</p>	W0289	<p>w289</p> <p>QIDP and Behavioral Specialist will review Client #3's behavior support plan and revise as needed to address the tobacco titration/restrictions for this client. HRC approval will continue to be sought for any restrictions as identified in the plan. Staff will be trained on any revisions. QIDP will review all behavior support plans at least annually to ensure each contain plans to decrease restrictions as behaviors are reduced. Responsible for QA: QIDP</p>	02/23/2013	

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	<p>morning." When asked how client #3 obtains tobacco, QMRP #1 stated, "[Client #3] can ask for them." QMRP #1 indicated client #3's tobacco titration/restriction should be included in her BSP.</p> <p>Client #3's record was reviewed on 1/15/13 at 10:58 AM. Client #3's BSP dated 2/12 and revised on 9/12 did not indicate client #3 was on a tobacco titration plan/restriction.</p> <p>9-3-5(a)</p>			

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W0327	<p>483.460(a)(3)(iv) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on record review and interview for 2 of 3 sampled clients (#2 and #3), the facility failed to ensure an annual TB (Tuberculosis) testing, x-ray or symptom checklist screening was completed.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Client #2's record was reviewed on 1/15/13 at 11:59 AM. Client #2's record indicated an annual TB test had been completed on 9/16/11. Client #2's record did not indicate an additional or more recent TB test, x-ray or screening checklist. Client #3's record was reviewed on 1/15/13 at 10:58 AM. Client #3's record did not indicate documentation of an annual TB test, x-ray or symptom checklist screening for client #3. <p>Interview with QMRP/A (Qualified Mental Retardation Professional/Assistant) #1 on 1/15/13 at 11:25 AM indicated client #3's annual TB</p>	W0327	<p>W327</p> <p>Client #2 and Client #3 have now had required screening for TB. SGL Manager has retrained staff on guidelines for timely annual screenings. QIDP along with the agency nurse will review each client's file monthly to ensure that annual screenings are obtained timely.</p> <p>Responsible for QA: QIDP, Agency nurse</p>	02/23/2013			

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	testing documents should be filed in her chart. QMRP/A indicated clients #2 and #3's TB screening should be completed annually. 9-3-6(a)						

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W0436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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 3 clients with adaptive equipment, the facility failed to address client #3's refusal to wear eyeglasses.</p> <p>Findings include:</p> <p>Observations were conducted at the group home on 1/14/13 from 4:55 PM through 5:55 PM and on 1/15/13 from 5:45 AM through 8:00 AM. Client #3 was observed throughout the observation periods. Client #3 did not wear eyeglasses. Client #3 was not prompted or encouraged to wear eyeglasses.</p> <p>Client #3's record was reviewed on 1/15/13 at 10:58 AM. Client #3's Vision record of visit form dated 10/6/11 indicated client #3 had prescription eyeglasses. Client #3's ISP (Individual Support Plan) dated 9/19/12 did not indicate formal or informal training for client #3 to use her eyeglasses.</p> <p>Interview with QMRP (Qualified Mental Retardation Professional) #1 on 1/15/13</p>	W0436	<p>W436</p> <p>QIDP will review client #3's plan and revise as needed to include information on use of eyeglasses. Staff will be trained on any revisions to program plan. QIDP or designee will observe weekly for one month and at least monthly thereafter to ensure staff are encouraging client to use her eyeglasses and educating her on reasons for this.</p> <p>Responsible for QA: QIDP</p>	02/23/2013			

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	<p>at 12:05 PM indicated client #3 had a pair of glasses. QMRP #1 indicated client #3 refused to wear her eyeglasses. QMRP #1 indicated the IDT (Interdisciplinary Team) had discussed an incentive plan to encourage client #3 to wear her eyeglasses but had not implemented the plan. QMRP #1 indicated client #3 did not have training/support to teach her to use her eyeglasses.</p> <p>9-3-7(a)</p>			

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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 426 E MONTGOMERY RD. 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			
W0440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3) plus 3 additional clients (#4, #5 and #6), the facility failed to conduct evacuation drills for each quarter on each shift.</p> <p>Findings include:</p> <p>The facility's evacuation drill record was reviewed on 1/15/13 at 9:35 AM. The review indicated the facility failed to conduct an evacuation drill for 6 of 6 clients (#1, #2, #3, #4, #5 and #6) for the first quarter, January through March 2011 for the 7:00 AM through 3:00 PM shift. The review indicated the facility failed to conduct an evacuation drill for the third quarter, July through September 2011 for the 11:00 PM through 7:00 AM shift.</p> <p>Interview with QMRP/A #1 (Qualified Mental Retardation Professional Assistant) was interviewed on 1/15/13 at 10:35 AM. QMRP/A #1 indicated the fire/evacuation drills for the first quarter, January through March 2011 for the 7:00 AM through 3:00 PM shift and for the third quarter, July through September 2011 for the 11:00 PM through 7:00 AM shift were scheduled. QMRP/A #1 indicated the facility staff had not</p>	W0440	<p>W440 QIDP will retrain staff on the requirements for regular evacuation drills. A schedule of the drills will be posted in the home. Staff will turn in monthly documentation to the QIDP of the evacuation drills completed that month. QIDP will compare with the drill schedule to ensure compliance in this area. Responsible for QA: QIDP</p>	02/23/2013			

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	completed the documentation to include the times of the scheduled drills. 9-3-7(a)			

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W9999	<p>STATE FINDINGS:</p> <p>1. The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>(1) 460 IAC 9-3-3 Facility Staffing</p> <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 record review and interview for 1 of 3 sampled staff (#3) personnel records reviewed, the facility failed to obtain a yearly PPD, chest x-ray and/or screening checklist was completed for staff #3.</p> <p>Findings include:</p> <p>Staff #3's personnel record was reviewed on</p>	W9999	<p>w9999</p> <p>Staff are expected to update their TB test annually. All Staff in this home are current at this time. QIDP will ensure that staff remain in compliance in this area. HR has been notified of requirement to obtain three references prior to employment.</p>	02/23/2013			

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	<p>1/14/13 at 2:30 PM. Staff #3's personnel record indicated the most recent TB test was completed on 8/19/11. Staff #3's personnel record did not indicate documentation of a chest x-ray and/or PPD screening checklist for staff #3.</p> <p>Interview with AS (Administrative Staff) #1 on 1/14/13 at 2:45 PM indicated there was no additional PPD documentation for staff #3.</p> <p>9-3-3(e)</p> <p>2. 460 IAC 9-3-2(c) Resident Protections</p> <p>(3) The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC5-2-5-5, and three references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.</p> <p>THIS STATE RULE WAS NOT MET AS EVIDENCED BY:</p> <p>Based on record review and interview, the facility failed for 1 of 3 facility staff (staff #2) to obtain three references prior to employment.</p> <p>Findings include:</p> <p>Staff #2's personnel file was reviewed on 1/14/13 at 2:30 PM. Staff #2's personnel file indicated the facility had completed two (2) reference checks. Staff #2's file did not</p>						

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	<p>indicate documentation of three (3) reference checks.</p> <p>Interview with AS #1 on 1/14/13 at 3:00 PM indicated the facility should complete three reference checks prior to employment. AS #1 indicated there was no additional documentation regarding reference checks for staff #2.</p> <p>9-3-3(c)</p>			