

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G115	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/24/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 830 EVERGREEN DRIVE 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>Survey dates: July 21, 22, 23 and 24, 2015</p> <p>Facility number: 000652 Provider number: 15G115 AIM number: 100239590</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p>	W 0000		
W 0154 Bldg. 00	<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 3 of 10 incident/investigative reports reviewed affecting clients #1 and #2, the facility failed to conduct thorough investigations of client to client abuse and an injury of unknown origin.</p> <p>Findings include:</p> <p>On 7/21/15 at 1:37 PM, a review of the facility's incident/investigative reports was conducted and indicated the</p>	W 0154	<p>The initiation of an investigation will no longer be at the QIDP's discretion. Every incident (including but not limited to adverse behaviors, medical incidents and medication errors) documented by staff will include a cursory investigation form that will identify if the incident warrants a more in depth investigation. The initial investigation form will be attached to the incident form along with any applicable state report or health risk plan. The regional program manager will</p>	08/23/2015

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>following:</p> <p>1) On 5/5/15 at 12:10 PM at the facility-operated day program, client #1 entered the building after an outing. Client #1 scratched another client's face and neck. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 5/6/15, did not indicate who she scratched. There was no documentation the facility conducted an investigation.</p> <p>On 7/22/15 at 8:35 AM, the Quality Assurance/Social Services Manager (QA) indicated client to client aggression was considered abuse. The QA indicated client to client abuse should be investigated.</p> <p>2) On 5/9/15 at 4:00 PM, the BDDS report, dated 4/10/15, indicated, in part, "[Client #2] has two superficial scratches on her chest. One is red and is 4 inches long. The second is fading and one inch long. Upon discovery, [client #2] also had two hangnails. Erring on the side of caution, this recorder has opened an investigation since these scratches were not there Wednesday night at bedtime. Abuse or neglect is not suspected, but this recorder wants to rule out all possible factors...." The follow up BDDS report, dated 4/17/15, indicated, "After speaking</p>		<p>also receive a copy of the forms within 24 hours. The regional program manager or quality assurance social services manager will then make a final determination and root cause analysis. If the RPM or QASSM will then determine if a more in depth investigation should occur. All allegations of abuse, neglect, mistreatment and exploitation will be further investigated, completed with systemic changes and routed to the agency quality control administrator within 5 days for review. The quality control administrator will also review every incident and make an independent decision to investigate further if need be. An in-service on 8/19/15 for the county QIDPs will address this procedure. During this QIDP in-service, the QIDPs will be instructed to never assume a client is an unreliable witness. The QIDPs will ensure that the clients have the opportunity to give their statement. The QIDPs will also be encouraged to use other means of communication. Body checks for the clients will be put in place at this facility. The treatment record in the clients' medical books will indicate times that the staff should conduct body checks: 7am and 4pm. These checks will help identify client injuries and isolate the potential cause and place the injury took place. These checks will be a required part of daily</p>				

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	<p>with the staff that worked with [client #2], this recorder feels that [client #2's] scratches are the result of self-injury from two hangnails...." There was no documentation of an investigation being conducted.</p> <p>On 7/22/15 at 8:25 AM, the QA indicated an investigation should have been conducted, as indicated.</p> <p>3) On 11/4/14 at 1:00 PM at the facility-operated day program, client #2 cleaned off the table. A peer was sitting at the table. The peer did not want client #2 to take his papers. The peer grabbed client #2's arm to take back his papers. Client #2 pulled away from the peer and the peer let go of her arm. The peer scratched her arm trying to stop her from taking his papers. Client #2 had two scratches, one 2 inches long and one 4 inches long. There was no documentation the incident was investigated.</p> <p>On 7/22/15 at 8:35 AM, the Quality Assurance/Social Services Manager (QA) indicated client to client aggression was considered abuse. The QA indicated client to client abuse should be investigated.</p> <p>9-3-2(a)</p>		<p>documentation. Staff will look for sharp nails and trim accordingly. Failure to do so will result in staff counseling. The QIDP or team lead will review this documentation daily. Daily Medication/treatment administration buddy checks will also help ensure compliance. In order to further protect clients at the facility, closed circuit cameras will be installed in the common areas per guardian and human rights commission approval. The cameras will be viewed and the events documented at least four times a month by the QIDP or RPM. The cameras will also be utilized to help facilitate investigations. Those findings will also be documented by the RPM or QIDP. The county QIDP will attend INARF's investigation training on 8/11/15. The team lead, QIDP, Quality assurance social services manager or regional program manager will follow up with at least 5 weekly observations to ensure these measures are being followed. The QIDP or RPM will utilize the mandated 3 in house documented observations and 4 mandated video surveillance observations to ensure that staff are following proper procedures. For the IR regarding the scratches, it has been determined that either her beads, used for sensory stimulation, or a sharp fingernail caused the scratches. Staff will inspect her beads</p>		

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W 0159 Bldg. 00	<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 3 of 3 clients in the sample (#2, #3 and #5), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans.</p> <p>Findings include:</p> <p>1) On 7/22/15 at 10:33 AM, a review of client #3's record was conducted. Client #3's record did not contain monthly reviews of her program plans in May and June 2015. Client #3's Individual Program Plan (IPP), dated 11/14 to 11/15, indicated she had the following</p>	W 0159	<p>weekly, following a bead inspection chart in the client's training book, to ensure that there are no sharp edges and staff will also make sure through daily checks that client fingernails are trimmed properly. An in-service for staff on 8/14/15 will instruct staff to complete incident reports in a timely manner and report to their supervisor immediately. They will also be instructed upon trimming the clients nails when needed and how often to inspect client #2's beads.</p> <p>An in-service on 8/19/15 for all county QIDPs will include training on how to develop and implement training objectives that are tailored to specific client needs. Staff of the house will be in-serviced on 8/14/15 upon prompting clients to help them fully utilize client health risk plans. The staff will also be instructed to report any failed medical test to their QIDP and house nurse, The QIDP will contact the doctor for further instructions on how to successfully obtain the test. The QIDP, team lead, Quality assurance social services manager will review the medical communication log at least 3 times a week to ensure any</p>	08/23/2015

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	<p>training objectives: Client #3 will learn to place deodorant under each arm daily without verbal prompts. Client #3 will learn to shave her legs with an electric razor with decreasing staff assistance. Initially, hand-over-hand assistance may be necessary. Client #3 will learn to brush her teeth independently with decreasing staff assistance and verbal prompts. Client #3 will develop an understanding of privacy through direct training to close the bathroom and bedroom doors when she is unclothed, toileting, sleeping, or using the shower. Client #3 will increase her culinary skills through participating in meal preparation, focusing on using the can opener, pouring and stirring foods. Client #3 will increase her kitchen safety skills through learning the proper use of a potholder to prevent burns. Client #3 will increase her kitchen safety skills through learning how to operate the microwave while preparing a simple food dish. Client #3 will initiate and complete her daily chore using the household chore chart. Client #3 will increase her housekeeping skills through putting away her lunchbox daily with decreasing verbal prompts. Client #3 will increase her housekeeping skills through learning to vacuum an entire room</p>		<p>issues regarding this are addressed. The QIDP, team lead, Quality assurance manager or regional program manager will inspect client training sheets weekly in order to ensure clients are receiving an adequate number of support interventions in order to assist clients in achieving the goals laid out for them in their plans. The QIDP will let all staff know of any changes to client plans before they work their next shift. Staff will then sign off on a training sheet that they are aware of specific changes to client plans. The staff will be in-serviced on 8/14/15 regarding the proper implementation of client health risk plans. The county QIDP will attend INARF's investigation training on 8/11/15. The team lead, QIDP, Quality assurance social services manager or regional program manager will follow up with at least 5 weekly observations to ensure these measures are being followed. The QIDP or RPM will utilize the mandated 3 in house documented observations and 4 mandated video surveillance observations to ensure that staff are following proper procedures. Client #2 will accompany her guardian to a specialist on 8/14/15 to attempt another mammogram.</p>	

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	<p>independently. Client #3 will increase her housekeeping skills through dusting a room independently, using the appropriate amount of dusting spray and a dust cloth. Client #3 will learn to dispense the appropriate amount of liquid detergent into the washer prior to washing her clothes. Client #3 will increase her learning skills through learning how to write the letters D and C, the initials of her first and last name, so that she can develop a distinguished signature. Client #3 will increase her monetary skills through identifying five dollar and ten dollar bills from mixed bill currency. Client #3 will choose an activity she would like to do other than watching TV and will then participate in that activity for at least 20 minutes. Client #3 will increase her medical skills through learning to identify the names of her medications, one at a time. Client #3 will develop a broader understanding of her rights through individual rights training as well as privacy training. Client #3 will increase her safety skills through demonstrating an improvement in responding to safety drills as conducted by the home and the workshop.</p> <p>On 7/22/15 at 11:02 AM, a review of client #5's record was conducted. Client</p>			

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	<p>#5's record indicated she was admitted to the group home on 4/21/15. There was no documentation in client #5's record indicating the QIDP conducted a review of the progress on her program plans. Client #5's IPP, dated 5/15 to 5/16, indicated she had the following training objectives in her IPP: Client #5 will tolerate tooth brushing with minimal resistance. Client #5 will hold her sippy cup during mealtimes with minimal prompting. Client #5 will have the opportunity to make a petty cash purchase twice monthly to increase her awareness that money has value and also allow her the opportunity to shop in the community. Client #5 will have the opportunity to expand her social and leisure interests through exposure to a wide variety of activities. Client #5 will participate in medication administration through consistently opening her mouth with decreasing prompts. Client #5 will learn to identify functional items to enhance communication skills, such as her sippy cup, toothbrush, and spoon. Client #5 will tolerate dental cleanings with decreasing use of Halcion through a desensitization program. Client #5 will participate in facility group activity.</p> <p>On 7/23/15 at 11:23 AM, the Quality</p>			

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	<p>Assurance/Social Services Manager (QA) indicated the reviews of the clients' program plans were supposed to be conducted each month.</p> <p>2) On 7/22/15 at 9:57 AM, a review of client #2's record was conducted. On 10/23/14, client #2 had an medical appointment to have a mammogram. The Office Visit/Treatment Plan/Med Order, dated 10/23/14, indicated, "Pt (patient) unable to perform mammo (mammogram) due to motion issues - 2 people attempted to hold pt w/out (without) success." The nurse documented "Noted 11-5-14 (initials)." There was no documentation the QIDP addressed the failed appointment in client #2's record. There was no documentation of an interdisciplinary team meeting or an update to her program plan with a desensitization plan put in place to assist client #2 to tolerate the appointment.</p> <p>On 7/23/15 at 11:23 AM, the QA indicated client #2's annual Individual Program Plan (IPP) meeting was held on 7/22/15. The QA indicated client #2's guardian (mother) discussed the failed appointment with a different doctor and a different facility. The new doctor was willing to attempt to perform the mammogram. The QA indicated client #2's guardian was going to take client #2</p>			

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W 0225 Bldg. 00	<p>to the appointment. The QA indicated this information was going to be in client #2's new IPP. The QA indicated this issue should have been addressed by now. The QA indicated client #2's guardian wanted client #2 to have a mammogram. The QA stated, "It should have been addressed sooner." The QA indicated the former QIDP should have followed through to see what else could have been done for client #2 to have a successful mammogram.</p> <p>9-3-3(a)</p> <p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on record review and interview for 2 of 3 clients in the sample (#2 and #3), the facility failed to ensure client #2's vocational assessment contained relevant information and client #3's assessment was updated annually.</p> <p>Findings include:</p> <p>On 7/22/15 at 9:57 AM, a review of client #2's record was conducted. Client #2's current vocational assessment, dated 2015, indicated "N/A" for the assessment. The assessment did not assess client #2's</p>	W 0225	All documentation will include the month, day and year. QIDPs will have an in-service on 8/19/15 that will instruct them to do so and require this. The in-service will also include the instruction that all assessments will address all aspects of a client's life and ensure that the assessor will not assume client wishes.* Client #2's vocational assesment was completed by the QASSM*Client #3's 2015-2016 vocational assesment was completed by the QASSM*All assesments are to be updated annually. Quarterly reviews will be completed for each client. The Director of group	08/23/2015

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W 0249 Bldg. 00	<p>work interests, work skills, work attitude, work-related behavior and her present and future employment options.</p> <p>On 7/22/15 at 10:33 AM, a review of client #3's record was conducted. Client #3's current vocational assessment was dated 2013-2014. There was no documentation client #3's vocational assessment was updated since 2013-2014.</p> <p>On 7/23/15 at 11:23 AM, the Quality Assurance/Social Services Manager (QA) indicated client #2's assessment was completed by her. The QA indicated she should not have indicated "N/A" throughout the assessment. The QA indicated the assessment needed to be revised with the information requested in the assessment filled out and completed thoroughly. The QA indicated client #3's vocational assessment should be updated annually.</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</p>		homes will receive documentation for all updated annual assessments for review. *All QIDPs will conduct monthly client record reviews to ensure continuing compliance. Copies of the record reviews will be forwarded to the Director of Group Homes for review.				

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	<p>achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 2 of 3 clients in the sample (#2 and #3), the facility failed to ensure staff implemented the clients' dining plans as written.</p> <p>Findings include:</p> <p>1) On 7/21/15 from 3:50 PM to 5:35 PM, an observation was conducted at a hotel where client #2 was staying due to the group home having environmental issues requiring relocation to a hotel. On 7/21/15 at 5:10 PM, client #2 was observed to eat Cheetos with her fingers. Client #2 refused to eat the food prepared for dinner. Client #2 got a bag of Cheetos and ate them. While eating the Cheetos, client #2 used both of her hands to eat the food. Client #2 was not prompted to put one of her hands in her lap or to use a napkin.</p> <p>On 7/22/15 from 9:27 AM to 9:57 AM, an observation was conducted at the facility-operated day program. Client #2, at 9:40 AM, was awakened and told it was time for a snack. Client #2 had juice and a brownie. At 9:43 AM, client #2 was eating with both hands and had the brownie smeared over her face and ears. Client #2 ate rapidly and stuffed the</p>	W 0249	<p>An in-service on 8/19/15 for all county QIDPs will include training on how to develop and implement training objectives that are tailored to specific client needs. Staff of the house will be in-serviced on 8/14/15 to help them fully utilize client health risk plans. The QIDP, team lead, Quality assurance manager or regional program manager will observe 5 meal per week in order to ensure clients are receiving an adequate number of support interventions in order to assist clients in achieving the goals laid out for them in their plans. The QIDP will let all staff know of any changes to client plans before they work their next shift. Staff will then sign off on a training sheet that they are aware of specific changes to client plans. The team lead, QIDP, Quality assurance social services manager or regional program manager will follow up with at least 5 weekly observations to ensure these measures are being followed. The QIDP or RPM will utilize the mandated 3 in house documented observations and 4 mandated video surveillance observations to ensure that staff are following proper procedures.</p>	08/23/2015

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	<p>brownie into her mouth. Client #2 was not prompted to keep one of her hands in her lap, use a napkin and take smaller bites and not stuff food in her mouth.</p> <p>During the observations, client #2 was not observed and was not prompted to keep one of her hands in her lap. Client #2 was not prompted to use a napkin and take smaller bites and not stuff food into her mouth.</p> <p>On 7/22/15 at 9:57 AM, a review of client #2's record was conducted. Client #2's Dining Plan, dated 7/22/15, indicated, in part, "[Client #2] should continue to eat with her right dominant hand and keep her left hand in her lap while eating." Client #2's Individual Program Plan, dated 7/2014 to 7/2015, indicated, in part, "She had been noted to have poor table manners at times as she eats with her hands and will stuff food in her mouth. She needs to keep at least one hand in her lap during meals. She must have prompts to use a napkin and may require prompts to take smaller bites and not stuff food..."</p> <p>On 7/23/15 at 11:23 AM, the Quality Assurance/Social Services Manager (QA) indicated client #2's dining plan and program plan should have been implemented as written.</p>			

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	<p>2) On 7/21/15 from 3:50 PM to 5:35 PM, an observation was conducted at a hotel where client #3 was staying due to the group home having environmental issues requiring relocation to a hotel. At 5:10 PM, dinner started. During dinner, client #3 was not prompted to eat slowly, take small, single bites/sips. Client #3 was not prompted to swallow 2-3 times after each bite/sip. Client #3 was not prompted to drink 8 ounces of water before dinner.</p> <p>On 7/22/15 from 6:08 AM to 7:48 AM, an observation was conducted at the hotel. At 7:21 AM, client #3 started eating her breakfast. During breakfast, client #3 was not prompted to eat slowly, take small, single bites/sips. Client #3 was not prompted to swallow 2-3 times after each bite/sip. Client #3 was not prompted to drink 8 ounces of water before dinner.</p> <p>On 7/22/15 at 10:33 AM, a review of client #3's record was conducted. Client #3's 1/6/14 Dining Plan indicated she was at mild risk of aspiration due to delayed swallow initiation and behavioral reasons. The plan indicated client #3 should be reminded to eat slowly. Client #3 should be prompted to take small, single bites/sips. Client #3 should</p>			

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W 0259 Bldg. 00	<p>swallow 2-3 times after each bite/sip. Client #3 should drink 8 ounces of water before each meal.</p> <p>On 7/23/15 at 11:23 AM, the QA indicated client #3's dining plan should have been implemented as written.</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 2 of 3 clients in the sample (#2 and #3), the facility failed to ensure the clients' comprehensive functional assessments (CFA) were revised and updated annually.</p> <p>Findings include:</p> <p>On 7/22/15 at 9:57 AM, a review of client #2's record was conducted. Client #2's current CFA was dated 2013-2014. There was no documentation in client #2's record her CFA was revised and updated since the 2013-2014 CFA was completed.</p>	W 0259	An IPP schedule has been created that includes all SGL client IPP dates. All components of the CFA will be included at the time of the IPP. An in-service on 8/19/15 for the county QIDPs will ensure that this expectation is followed. The regional manager or the quality assurance social services manager will follow up with all IPPs in order to ensure all components of the IPP are updated annually and on time.	08/23/2015			

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W 0263 Bldg. 00	<p>On 7/22/15 at 10:33 AM, a review of client #3's record was conducted. Client #3's current CFA was dated 2013-2014. There was no documentation in client #3's record her CFA was revised and updated since the 2013-2014 CFA was completed.</p> <p>On 7/23/15 at 11:23 AM, the Quality Assurance/Social Services Manager (QA) indicated the clients' CFAs should be revised and updated annually.</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 record review and interview for 3 of 3 clients in the sample (#2, #3 and #5), the facility's specially constituted committee (Human Rights Committee - HRC) failed to ensure written informed consent was obtained from client #2, #3 and #5's guardians for their restrictive program plans.</p> <p>Findings include:</p> <p>1) On 7/22/15 at 9:57 AM, a review of client #2's record was conducted. Client</p>	W 0263	An IPP schedule has been created that includes all SGL client IPP dates. All components of the IPP, including signatures, will be included at the time of the IPP. A copy of the IPP will be mailed to the guardian to sign and return if they are not able to participate in the meeting in person. An in-service on 8/19/15 for the county QIDPs will ensure that this expectation is followed. A written approval from the guardians will be sought before the BSP is sent to HRC. The regional manager or the quality	08/23/2015			

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	<p>#2's Individual Program Plan (IPP), dated 7/2014 to 7/2015, indicated she had a guardian. The IPP indicated, in part, "Consumer requires 24 hour nursing supervision for medication and appropriate medical care. [Client #2] requires someone to monitor and give medication daily. [Client #2] needs someone to schedule medical appointments and provide appropriate medical follow-up. [Client #2] has a fall and a constipation risk plan. [Client #2] is considered high-risk for financial, emotional, and mental exploitation without supervision. [Client #2] requires access to 24-hour supervision to assist in decision-making skills." There was no documentation the facility obtained written informed consent from client #2's guardian for the implementation of her program plan.</p> <p>On 7/23/15 at 11:23 AM, the Quality Assurance/Social Services Manager (QA) indicated there was no documentation of the facility obtained written informed consent for client #2's IPP.</p> <p>2) On 7/22/15 at 10:33 AM, a review of client #3's record was conducted. Client #3's IPP, dated 11/2014 to 11/2015, indicated she had a guardian. The plan indicated, "[Client #3] is presently prescribed Prozac and Buspirone HCL daily for obsessive compulsive disorder, major depression, and PMS (premenstrual syndrome)." Client #3's Behavior Support Plan (BSP), dated 11/2014, indicated she was prescribed Prozac and Buspirone.</p>		<p>assurance social services manager will follow up with all IPPs as they occur in order to ensure all components of the IPP are updated annually and on time. Other clients were affected by this deficient practice, so in order to correct this, all county QIDPs will be instructed on 8/19/15 to obtain written consent from guardians before submitting for human rights committee approval. *Quarterly reviews will be completed for each client. The Director of group homes will receive documentation for all updated annual plans for review. The Director will only accept plans that have appropriate written consent. *All QIDPs will conduct monthly client record reviews to ensure continuing compliance, this includes looking for proper written consent paperwork. Copies of the record reviews will be forwarded to the Director of Group Homes for review.</p>				

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W 0323 Bldg. 00	<p>There was no documentation the facility obtained written informed consent from client #3's guardian for the implementation of her program plans.</p> <p>On 7/23/15 at 11:23 AM, the QA indicated she obtained verbal consent by phone for the implementation of her program plans. The QA indicated she had the information in her desk to mail to the guardian but not had mailed the information for signature yet. The QA indicated written informed consent needed to be obtained.</p> <p>5) On 7/22/15 at 11:02 AM, a review of client #5's record was conducted. Client #5's BSP, dated 6/2/15, indicated she was prescribed Celexa and Remeron for depression and anxiety. Client #5's IPP, dated 5/2015 to 5/2016, indicated client #5 had a guardian. There was no documentation the facility obtained written informed consent for client #5's restrictive BSP.</p> <p>On 7/23/15 at 11:23 AM, the QA indicated the facility needed to obtain written informed consent from client #5's guardian for her BSP.</p> <p>9-3-4(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on record review and interview for</p>	W 0323	An in-service will be held on	08/23/2015			

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W 0331 Bldg. 00	<p>1 of 3 clients in the sample (#2), the facility failed to ensure client #2's hearing was assessed annually.</p> <p>Findings include:</p> <p>On 7/22/15 at 9:57 AM, a review of client #2's record was conducted. Client #2's most recent hearing exam was conducted on 11/11/13. There was no documentation in client #2's record indicating her hearing was assessed since 11/11/13. Client #2's most recent annual physical exam, dated 10/7/14, did not include an assessment of her hearing.</p> <p>On 7/23/15 at 11:23 AM, the Quality Assurance/Social Services Manager (QA) indicated client #2's hearing should be assessed annually. The QA indicated client #2's primary care physician should have assessed her hearing during her annual physical.</p> <p>9-3-6(a)</p> <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 2 of 3 clients in the sample (#2 and #5), the facility's nursing services failed to ensure: 1) client #2 had a plan to</p>			W 0331	<p>8/19/15 for all county QIDPs that will instruct them on the new process for annual physicals. At the annual physical, the staff will ask the doctor to either check the client's hearing and vision or refer the client to a hearing or vision specialist. Agency nurses will note upon examination of the physical form whether the doctor assessed the client's hearing. On 8/18/15, agency nurses will receive direction to monitor hearing and vision tests on the clients' physical forms. The county QIDPs, team leads or quality assurance social service manager will follow up with all staff in order to ensure this procedure takes place. The county QIDPs and/or team leads will follow up after all annual physicals are completed in order to ensure this process is being followed. Client #2's hearing was addressed on 8/7/15 with a follow-up scheduled for 8/25/15. The client had a buildup of wax in her ear. No other clients were affected by this deficient practice.</p> <p>An in-service for Evergreen staff on 8/14/15 will cover the need for better medical related documentation. All county QIDPs</p>		08/23/2015

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	<p>address a failed mammogram appointment and 2) client #5's speech therapy recommendations were incorporated into her dining plan.</p> <p>Findings include:</p> <p>1) On 7/22/15 at 9:57 AM, a review of client #2's record was conducted. On 10/23/14, client #2 had an medical appointment to have a mammogram. The Office Visit/Treatment Plan/Med Order, dated 10/23/14, indicated, "Pt (patient) unable to perform mammo (mammogram) due to motion issues - 2 people attempted to hold pt w/out (without) success." The nurse documented "Noted 11-5-14 (initials)." There was no documentation the QIDP addressed the failed appointment in client #2's record. There was no documentation of an interdisciplinary team meeting or an update to her program plan with a desensitization plan put in place to assist client #2 to tolerate the appointment.</p> <p>On 7/23/15 at 11:23 AM, the Quality Assurance/Social Services Manager (QA) indicated client #2's annual Individual Program Plan (IPP) meeting was held on 7/22/15. The QA indicated client #2's guardian (mother) discussed the failed appointment with a different doctor and a different facility. The new doctor was</p>		<p>will address this issue with their respective counties. Staff will be instructed to notify the client's PCP for any missed or uncompleted test. The county QIDP will then follow up to determine why the test was missed. The staff will also be informed to notify the house nurse and county QIDP when a test has not been successfully completed. Staff will be instructed in the in-service to fax the office visit form to regional headquarters. The secretary will then route the form to the applicable nurse. The nurse will then follow-up with the house and the client and ensure that all services are received. The head nurse will follow-up with the nurses weekly in order to ensure this takes place. An in-service for all county QIDPs on 8/19/15 will cover the expectation that all dining and choking risk plans will reflect each other as well as all plan material. The QIDP, team lead, or Quality assurance social service manager will follow up with all office visit form in order to ensure future compliance. The Agency head nurse will ensure that this procedure is being followed by reviewing faxes to nurses on a daily basis. The QIDP, team lead or the quality assurance social services manager will make 4 weekly observations every week to ensure staff are faxing in visit forms . Staff will date and initial forms when they are faxed. No other clients were affected by this deficiency.</p>	

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	<p>willing to attempt to perform the mammogram. The QA indicated client #2's guardian was going to take client #2 to the appointment. The QA indicated this information was going to be in client #2's new IPP. The QA indicated this issue should have been addressed by now. The QA indicated client #2's guardian wanted client #2 to have a mammogram. The QA stated, "It should have been addressed sooner." The QA indicated the former QIDP should have followed through to see what else could have been done for client #2 to have a successful mammogram.</p> <p>On 7/24/15 at 9:10 AM, the nurse indicated the physician would not do a repeat mammogram. The nurse indicated the physician indicated it was not worth it. The nurse indicated she met this week with client #2's guardian. The guardian indicated she found a place with horizontal machine as opposed to a stand up machine. The guardian will be taking client #2 to the appointment. The nurse indicated client #2's guardian had been working on finding a place for client #2 to have a mammogram. The nurse indicated the former Qualified Intellectual Disabilities Professional (QIDP) told the nurse that she (QIDP) would handle getting client #2's mammogram rescheduled. The nurse</p>						

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	<p>indicated the former QIDP did not communicate to the nurse about what was going on. The nurse indicated she attempted to follow up with the former QIDP but she was unable to receive information regarding the status of the mammogram.</p> <p>2) On 7/21/15 from 3:50 PM to 5:35 PM, an observation was conducted at the hotel where client #5 was staying. Client #5 was relocated due to an environmental issue at the group home. At 5:10 PM, client #5 started eating dinner. Client #5's wheelchair backrest was not in the upright position. Client #5's backrest was reclined. During dinner, client #5 held onto her spouted cup and drank. Client #5 was not prompted to limit the number of successive drinks to 2-3. Client #5 was allowed to drink without prompts from staff.</p> <p>On 7/22/15 from 6:08 AM to 7:48 AM, an observation was conducted at the hotel. At 7:16 AM, client #5 started eating her breakfast. The backrest of client #5's wheelchair was not in the most upright position. Client #5, throughout the meal, continued to move to reposition herself. Client #5 was not sitting upright. Her buttocks were forward in the seat and her back was moved down on the backrest. Client #5 was not sitting</p>			

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	<p>upright during the meal. During the meal, client #5 held onto her spouted cup and allowed to drink as much as she wanted without staff prompting her to stop drinking after 2-3 successive drinks. Client #5 was not prompted to reposition herself by staff and staff did not assist her to sit upright during the meal.</p> <p>On 7/22/15 from 9:27 AM to 9:57 AM, an observation was conducted at the facility-operated day program. At 9:45 AM, client #5 was awakened and told it was time for her snack. During her snack, client #5 held onto her spouted cup. Client #5 was not prompted to limit her successive drinks to 2-3 at a time. Client #5 was allowed to drink the contents of her drink in a row without prompting from staff.</p> <p>On 7/22/15 at 11:02 AM, a review of client #5's record was conducted. Client #5's Health/Risk Plan for choking, dated 4/4/15, indicated the following in the Prescribed Treatments/Medications/Preventative Measures section: "Supervised during meals. Encourage eating and drinking techniques following ordered eating program. Nectar thick liquids, meds with thickened liquids or applesauce/pudding." There was no documentation client #5's risk plan for</p>			

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	<p>choking was updated since 4/4/15.</p> <p>On 5/7/15, client #5 had a speech therapy evaluation. The evaluation indicated, in part, "Dysphagia therapy is not recommended at this time, however, if pt (patient) demonstrates signs/symptoms of aspiration, we can attempt a modified barium swallow study, recommend pureed diet with nectar-thick liquids, crushed meds. Aspiration precautions include: seating pt as upright as possible during meals; feeding pt slowly, waiting for her to swallow before giving next bite; when allowing pt to hold spouted cup for self-feeding, limit the number of successive drinks to 2-3, temporarily refrain from feeding pt if she coughs during a meal. Leave pt sitting upright for 1-2 hours after meals if possible, to avoid reflux. Provide oral care as pt will tolerate." On the form, the nurse indicated, "Noted 6-11-15 (initials)." There was no documentation in client #5's record indicating the speech therapist's recommendations were incorporated into a plan for client #5.</p> <p>On 7/23/15 at 11:23 AM, the QA indicated the speech therapist's recommendations should have been incorporated into client #5's dining plan.</p> <p>On 7/24/15 at 9:10 AM, the nurse</p>			

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W 0365 Bldg. 00	<p>indicated she did not recall if she incorporated the speech therapist's recommendations into client #5's risk plan for choking. The nurse indicated the recommendations from the speech therapist should be included in client #5's risk plan for choking.</p> <p>9-3-6(a)</p> <p>483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. Based on observation, record review and interview for 2 of 2 clients (#3 and #4) observed to receive their medications during the morning observation, the facility failed to ensure the staff initialed the Medication Administration Record (MAR) after administering the clients' medications.</p> <p>Findings include:</p> <p>On 7/22/15 from 6:08 AM to 7:48 AM, an observation was conducted at the hotel the clients were staying in due to an environmental issue at the group home. At 6:18 AM, client #4 received her medications from staff #5. Prior to administering client #4's medications, staff #5 documented her initials on the</p>	W 0365	An in-service for QIDPs on 8/19/15 and an in-service for Evergreen staff on 8/14/15 will emphasize the importance of initialing MARs entries only after the medication has been properly administered. County QIDPs will utilize their monthly documented observations to ensure that this practice is being followed. County QIDPs will ensure that all staff are up to date on med administration training. QIDP county staff monthly meetings will cover this expectation as well. The QIDP, team lead or quality assurance social services manager will observe medication pass a minimum of 5 times a week for various staff to ensure this process is being followed properly. The house nurse will utilize her monthly house checks to ensure proper MARS	08/23/2015

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	<p>MAR, dated July 2015, as having administered the medications. Staff #5 initialed administering Baclofen (spasticity), Carbamazepine (mood stabilizer), Julivette (dysmenorrhea) and Acidophilus (bad breath) prior to administering the medications.</p> <p>On 7/22/15 at 6:35 AM, client #3 received her medications from staff #5. Prior to administering client #3's medications, staff #5 documented her initials on the MAR, dated July 2015, as having administering the medications. Staff #5 initialed administering Buspirone (depression), Fluoxetine (depression), Lansoprazole (GERD - gastroesophageal reflux disease), Loratadine (sinusitis) and oyster shell with vitamin D (bones) prior to administering the medications.</p> <p>On 7/22/15 at 9:20 AM, the Team Leader (TL) indicated the staff should initial the MAR after the clients' medications were administered.</p> <p>On 7/23/15 at 11:23 AM, the Quality Assurance/Social Services Manager (QA) indicated the staff should initial the MAR after administering the clients' medications.</p> <p>9-3-6(a)</p>		documentation. Nurses will emphasize the need for proper MARS documentation and address and train this issue with the staff.				

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W 0381 Bldg. 00	<p>483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. Based on observation and interview for 5 of 5 clients (#1, #2, #3, #4 and #5), the facility failed to ensure the clients' medications were secured while the clients were staying at a hotel due to an environmental issue at the group home.</p> <p>Findings include:</p> <p>On 7/21/15 from 3:50 PM to 5:35 PM, an observation was conducted at the hotel the clients were staying in. At 4:06 PM, the Team Leader (TL) indicated the clients' medications were not locked up from 7/13/15 until the time of the observation at the hotel. At 4:06 PM, the TL was observed to place the clients' medications into a large plastic storage tote. At 4:32 PM, the TL was trying to get two locks over the handles of a plastic container in order to lock the clients' medication. This affected clients #1, #2, #3, #4 and #5.</p> <p>On 7/22/15 at 7:34 AM, the Team Leader (TL) indicated she knew the medications needed to be locked. The TL indicated she attempted to move the cabinet from the group home but it was too big for her</p>	W 0381	All DSI agency homes provide locked containers for client medication. In the event of a structural emergency that demands clients to be moved to a hotel or other facility other than the home, there will be a written protocol that staff will follow in order to ensure that all medications are secured. On 8/19/15, all county QIDPs will be presented this protocol and trained upon its implementation. The protocol will include the provision of a padlocked tote per home that will facilitate the securing of medication ion in the event of a house evacuation. The county QIDP, team lead and quality assurance social service manager will ensure through 5 visits per week that the houses are keeping these totes in working order.	08/23/2015

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W 0436 Bldg. 00	<p>to move and no one assisted her to move it.</p> <p>On 7/22/15 at 8:42 AM, the Quality Assurance/Social Services Manager (QA) indicated the clients' medications need to be locked up. The QA indicated the clients' medications should have been locked up from the time the group home relocated to the hotel. The QA indicated the TL informed her she had attempted to move the medication cabinet from the home to the hotel but it was too big for her to move. On 7/23/15 at 11:23 AM, the QA indicated the facility should have thought of medication security when the clients were relocated out of the group home to the hotel. The QA indicated the medication security should have been taken care of as soon as the clients moved to a hotel. The QA indicated the facility should have secured the medications prior to 7/21/15.</p> <p>On 7/22/15 at 10:07 AM, the nurse indicated the medications should be locked.</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</p>			

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	<p>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 in the sample (#5) and one additional client (#4), the facility failed to ensure client #5's wheelchair brakes were functioning properly and client #4's communication device was available to her.</p> <p>Findings include:</p> <p>1) On 7/21/15 from 2:36 PM to 3:17 PM, an observation was conducted at the facility-operated day program. At 3:11 PM when client #5 was in her wheelchair and the staff was strapping the wheelchair down, client #5's wheelchair was still able to move. At 3:11 PM, the Team Leader (TL) indicated client #5's brakes were on. The TL asked if the surveyor wanted to check to ensure client #5's brakes were on. The surveyor checked client #5's brakes and both appeared to be on however the left back brake did not hold the wheel from moving. The left back brake was not functioning properly.</p> <p>On 7/22/15 from 6:08 AM to 7:48 AM an observation was conducted at the hotel client #5 was staying in due to an</p>	W 0436	<p>On 8/19/15, county QIDPs will be in-serviced on the need to keep accurate and detailed medical communication logs. This training will enable to QIDPs to set standards for medically related documentation. The evergreen staff will also be trained on 8/14/15. Part of this training will emphasize the need to report damage to adaptive equipment for the clients. They will also be trained to report any failure in client equipment to the QIDP immediately. National seating and mobility will repair client #5's brakes on 8/17/15. The county QIDP, team lead and quality assurance social service manager will ensure through 5 visits per week that client adaptive equipment is in working order and that the medical communication equipment is in working order. No other clients were affected by this deficient practice.</p>	08/23/2015

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	<p>environmental issue at the group home. Upon arrival to the hotel, the TL indicated she had taped the brake to make it hold client #5's left back wheel. When tested, the TL's temporary fix of the brake was working.</p> <p>On 7/22/15 at 11:02 AM, a review of client #5's record was conducted. A 6/10/15 Office Visit/Treatment Plan/Med Order form indicated in the Diagnosis/Patient Observations section, "Wheelchair is not fit for patient." The Comments section indicated, "Patient has older wheelchair that does not meet her needs due to positioning issues. She needs re-eval by PT/OT (physical therapy/occupational therapy) and new chair ordered." There was no documentation in client #5's record her wheelchair was evaluated by PT/OT.</p> <p>On 7/24/15 at 9:11 AM, the nurse indicated she was not aware client #5's wheelchair brake was not functioning properly. The nurse indicated client #5 had been assessed for a new wheelchair. The nurse indicated the TL checked to see if repairs could be done but was told client #5 needed a new wheelchair. The nurse indicated she was not aware of the status of getting client #5 a new wheelchair. The nurse indicated client #5's wheelchair brake needed to function</p>			

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	<p>properly.</p> <p>On 7/24/15 at 11:26 AM, the Quality Assurance/Social Services Manager (QA) indicated in email, "[Nurse] told me you were asking about [client #5's] wheelchair and the brake and that it was no longer holding. I spoke to the OT at [name of hospital] that [Team Leader] has been working with on [client #5's] chair. She said she is working with [name of company] to get the brake replaced and also to get her a new seating system to make it more functional for her. The frame itself is good, so the parts are what need replaced. She has a call in to the tech who is supposed to be in town next week. What I am understanding is they were waiting on insurance approval to for the parts. I told her that for the brake if that is all they are waiting on then we will just pay for it whatever it is. She is calling them back again after she finishes with a patient and will call me back one way or the other. For the immediate problem with the brake though I have talked with a technician at [name of company] in [city] who might possibly be able to look at it today and I also just talked with our maintenance man who can fix anything and he is going to let me know if can take a look at it and see if he can do some kind of adjustment to make it hold."</p>			

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	<p>2) On 7/21/15 from 2:36 PM to 3:17 PM, an observation was conducted at the facility-operated day program. At 2:42 PM when client #4 was introduced to the surveyor, client #4 attempted to verbally communicate with the surveyor and the Day Program Manager. Client #4 was unable to communicate verbally and appeared (by facial expressions) upset and frustrated she was unable to communicate. Client #4 was asked if she had a communication device or board and she responded "yes." Client #4 did not locate her communication board.</p> <p>On 7/21/15 at 2:43 PM, the DPM indicated client #4 had a communication board at one time. The DPM did not know where client #4's communication board was located. The DPM did not attempt to locate client #4's communication device.</p> <p>On 7/21/15 from 3:50 PM to 5:35 PM, an observation was conducted at the hotel client #4 was staying due to an environmental issue at the group home. At 4:02 PM when client #4 attempted to communicate with the surveyor, she was prompted to get her communication device. Client #4 did not attempt to locate her communication device. At 4:46 PM, client #4 attempted to</p>			

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	<p>communicate to the surveyor. The surveyor was unable to understand what client #4 was attempting to communicate. At 4:55 PM when client #4 was asked by the Bureau of Developmental Disabilities Services Coordinator if she had her communication device client #4 shook her head "no." At 4:59 PM, the TL indicated client #4's communication device was present at the hotel. The TL prompted client #4 to find her communication device. At 5:19 PM, the TL prompted client #4 to find her communication device. During the observation the staff was not observed to assist client #4 in locating her communication device.</p> <p>On 7/22/15 from 6:08 AM to 7:48 AM, an observation was conducted at the hotel. At 6:32 AM, client #4 was prompted by staff #5 to locate her communication device. Client #4 was not assisted to locate her communication device.</p> <p>On 7/22/15 at 11:47 AM, a review of client #4's Individual Program Plan, dated 8/14 to 8/15, indicated, in part, "Communication remains a primary goal for [client #4]. [Client #4] is able to sign, has a 'talk box,' and has several pictorial guides. [Client #4] also can state a few one to two syllable words, such as yes</p>			

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	<p>and no, or the names of family or friends; however, [client #4] often chooses not to communicate with others with assistance, and will point or make whispering sounds to communicate. Staff must prompt [client #4] to sign, use her 'talk box,' or pictorial guides for communication." The plan indicated, "[Client #4] is a very social young woman and is so friendly. She truly enjoys meeting people and is always smiling. [Client #4] is able to sign, but chooses to do so infrequently (although is prompted to daily). [Client #4] has a 'talk box', but she does not like this device and refuses to use it for communication as well. Staff must encourage her to use this as well as her pictorial communication guide. [Client #4] attempts to verbalize her wants and needs, although her verbalizations are difficult to understand overall. [Client #4] will gesture to indicate her needs and is able to verbalize some words. [Client #4] also has a pictorial guide available for her use for communication."</p> <p>On 7/23/15 at 11:23 AM, the Quality Assurance/Social Services Manager (QA) indicated the staff should have assisted client #4 to locate her communication device. The QA indicated client #4's communication device should be available to her at all times.</p>			

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W 0440 Bldg. 00	<p>9-3-7(a)</p> <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 5 of 5 clients (#1, #2, #3, #4 and #5), the facility failed to conduct quarterly evacuation drills for each shift.</p> <p>Findings include:</p> <p>On 7/22/15 at 8:47 AM, a review of the facility's evacuation drills was conducted and indicated the following: During the day shift (7:00 AM to 3:00 PM) there were no evacuation drills conducted from 8/18/14 to 1/14/15. During the evening shift (3:00 PM to 11:00 PM) there were no evacuation drills conducted from 2/9/15 to 6/28/15. During the night shift (11:00 PM to 7:00 AM) there were no evacuation drills conducted from 3/5/15 to 7/22/15. This affected clients #1, #2, #3, #4 and #5.</p> <p>On 7/22/15 at 8:53 AM, the Quality Assurance/Social Services Manager (QA) indicated the facility should conduct one evacuation per shift per quarter.</p> <p>9-3-7(a)</p>	W 0440	In order to ensure that drills are held on a timely basis, county QIDPs will post drill schedules in the homes and remind staff to perform them in the days up to the drill. The agency safety manager will also receive monthly drill records in order to ensure continuing compliance. The team lead, quality assurance social service manager or the county QIDP will inspect drill books and calendars on a bi-weekly basis in order to follow up on scheduled drill times.	08/23/2015

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W 0488 Bldg. 00	<p>483.480(d)(4) DINING AREAS AND SERVICE</p> <p>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 5 of 5 clients (#1, #2, #3, #4 and #5), the facility failed to ensure the clients were involved with breakfast and dinner preparation.</p> <p>Findings include:</p> <p>On 7/21/15 from 3:50 PM to 5:35 PM, an observation was conducted at the hotel the clients were staying in due to an environmental issue at the group home. At 4:43 PM, staff #1 and #2 microwaved containers with the clients' food in it. None of the clients was involved. At 4:46 PM, staff #1 used the food processor to puree client #3, #4 and #5's food. None of the clients were involved or asked to assist. At 4:48 PM, staff #1 was trying to get the food processor to work (there was too much food in it). Client #2 was observing. At 4:59 PM, staff #1 used the food processor. None of the clients was involved in preparing their dinner.</p> <p>On 7/22/15 from 6:08 PM to 7:48 AM, an observation was conducted at the</p>	W 0488	<p>In order to ensure that staff are adequately aware of the expectations of providing clients meals that are in line with their menu, an in-service will be held on 8/14/2015. The staff will be instructed to ensure that the clients are offered everything that is listed on each day's menu. The house lead and the QIDP will make use of documented observations in order to ensure staff are following the menu. The staff will also be instructed to avoid serving the meals in a custodial manner. The in-service instructed them to allow clients to serve themselves as their functioning level would allow. Clients who need help serving themselves will be provided hand over hand assistance from the staff. The QA will assist staff with following the menu on a daily and weekly basis. The RPM expects all county QIDPs to ensure, through documented and undocumented observations that meals are being served in accordance with each facility's menu and that clients are engaging in family style meals within their functioning levels. If staff are seen to be confused or unable to</p>	08/23/2015

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W 9999 Bldg. 00	<p>hotel. At 7:16 AM, the Team Leader used the food processor to puree the client #3, #4 and #5's breakfast. None of the clients were involved or asked to assist. At 7:16 AM, client #5 was given eggs by staff #5. Staff #5 told client #5 her oatmeal was coming. Staff #5 stated, "She's making it." At 7:17 AM, the Team Leader gave clients #3 and #4 oatmeal. At 7:21 AM, staff #5 got up to get client #5's drink.</p> <p>On 7/23/15 at 11:23 AM, the Quality Assurance/Social Services Manager (QA) indicated the clients should be involved with meal preparation.</p> <p>9-3-8(a)</p> <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>1) 460 IAC 9-3-1 Governing Body</p> <p>(b) The residential provider shall report the following circumstances to the</p>	W 9999	<p>follow the menu or unable to ensure that each client eats in a manner consistent with their functioning level, the county QIDP will offer more focused training regarding adherence to the menu. Monthly house meetings will include the importance of having family style meals and client participation in meal prep and while serving the meal. The team lead, QIDP or quality assurance social service manager will observe at least 4 meals a week in order to ensure that this standard is being met.</p> <p>The initiation of a fall investigation will no longer be at the QIDP's discretion. Every fall will be documented by staff will include a cursory investigation form that will identify if the fall warrants a more in depth investigation. The initial investigation form will be attached to the incident form along with any applicable state report or fall risk plan. The regional program manager will also receive a copy of the forms within 24 hours. The regional</p>	08/23/2015			

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	<p>division by telephone no later than the first business day followed by written summaries as requested by the division: 15. A fall resulting in injury, regardless of the severity of the injury.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 2 non-sampled clients (#4), the facility failed to submit an incident report to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours, in accordance with state law, for a fall resulting in an injury.</p> <p>Findings include:</p> <p>On 7/21/15 at 1:37 PM, a review of the facility's incident/investigative reports was conducted and indicated the following: On 6/25/15 at 12:00 PM at the facility-operated day program, client #4 was running to the kitchen to get her medication. Client #4 tripped and fell causing scrapes on her knees. Staff used first aid to treat the scrapes. There was no documentation the facility reported the fall with injury to BDDS.</p> <p>On 7/22/15 at 8:35 AM, the Quality Assurance/Social Services Manager (QA) indicated the fall with injury should have</p>		<p>program manager or quality assurance social services manager will then make a final determination and root cause analysis. If the RPM or QASSM will then determine if a more in depth investigation should occur. An in-service on 8/19/15 for the county QIDPs will address this procedure. A staff in -service will occur on 8/14/15 that will emphasize the importance of reporting and documenting falls properly. The county QIDPs will receive training needs on a monthly basis. The QIDPs will then schedule their staff for the appropriate training for the next available training session. Any needed driver's license or Insurance information will be expected before the staff works their next shift. TB tests are available to staff every Friday at the regional office. Staff who need a TB test will be scheduled by their QIDP for the next Friday. Tests are then read at regional the following Monday. The regional program manager, QIDP, team lead or quality assurance social services manager will be given the training needs of all staff monthly and will follow up with staff daily until the staff are in compliance.</p>	

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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 830 EVERGREEN DRIVE SEYMOUR, IN 47274
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	<p>been reported to BDDS.</p> <p>2) 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 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 2 of 3 employee (staff #4 and #5) files reviewed, the facility failed to ensure an annual Mantoux (5TU, PPD) tuberculosis (TB) screening was conducted.</p> <p>Findings include:</p> <p>On 7/22/15 at 1:47 PM, a review of the</p>			

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	<p>employee's files was conducted and indicated the following:</p> <p>Staff #4's most recent TB screening was conducted on 2/11/14. There was no documentation in her file indicating she had a TB screening since 2/11/14.</p> <p>Staff #5's most recent TB screening was conducted on 7/21/14. There was no documentation in her file indicating she had a TB screening since 7/21/14.</p> <p>On 7/22/15 at 2:03 PM, the Human Resources Program Secretary (HRPS) indicated the facility staff should have annual TB screenings conducted. The HRPS indicated there was a report the HR department ran monthly on the status of the employees status for their TB tests. The HRPS indicated the report was disseminated to the employee's supervisor for follow up.</p> <p>On 7/23/15 at 11:23 AM, the QA indicated the staff should have annual TB tests.</p> <p>3) 460 IAC 9-3-2 Resident Protections</p> <p>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is:</p>				

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	<p>(3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5, and three (3) 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 for 3 of 3 employee files reviewed (#3, #4 and #5), the facility failed to ensure the employees' driver's licenses were valid after completing the initial bureau of motor vehicles record upon hire.</p> <p>Findings include:</p> <p>On 7/22/15 at 1:47 PM, a review of the employees' files was conducted and indicated the following:</p> <p>Staff #3's Bureau of Motor Vehicle check, dated 1/12/15, indicated her license expired on 5/18/15. There was no documentation in her record indicating the facility ensured staff #3 renewed her license. The facility did not have</p>			

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	<p>documentation staff #3 had a valid driver's license.</p> <p>Staff #4's Bureau of Motor Vehicle check, dated 5/7/15, indicated her license expired on 7/2/15. There was no documentation in her record indicating the facility ensured staff #4 renewed her license. The facility did not have documentation staff #4 had a valid driver's license.</p> <p>Staff #5's Bureau of Motor Vehicle check, dated 9/11/12, indicated her license expired on 5/29/15. There was no documentation in her record indicating the facility ensured staff #5 renewed her license. The facility did not have documentation staff #5 had a valid driver's license.</p> <p>On 7/22/15 at 2:03 PM, the Human Resources Program Secretary (HRPS) indicated the staff were supposed to bring in a copy of their renewed license once they obtain one. The supervisor is supposed to conduct employee file reviews to ensure the employee's information was current. The supervisor receives a report monthly indicating the status of their driver's license. The HRPS indicated she did not have documentation staff #3, #4 and #5 had valid driver's licenses.</p>			

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	<p>On 7/23/15 at 11:23 AM, the QA indicated the staff was supposed to provide a copy of their renewed driver's licenses to the facility when obtained. The QA indicated staff #3, #4 and #5 transport the clients in the group home van and the facility should have documentation of their current licenses.</p> <p>9-3-1(b) 9-3-3(e) 9-3-2(c)</p>				