

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 04/06/2016
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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
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W 0000 Bldg. 00	<p>This visit was for a recertification and state licensure survey.</p> <p>Dates of Survey: April 4, 5 and 6, 2016.</p> <p>Facility Number: 001214 AIM Number: 100234330 Provider Number: 15G639</p> <p>These federal deficiencies reflect findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/11/16.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 3 sampled clients (#1, #2, and #3) and three additional clients (#4, #5, and #6), the facility failed to implement written policies and procedures which prohibited staff neglect or abuse of clients.</p> <p>Findings include:</p>	W 0149	<p>Corrective actionstaken:</p> <ul style="list-style-type: none"> ·All county QIDPs were in-serviced on head injury protocol, DSI's ANE policy, incident reporting and investigations on 4/20/16 (Attachment A) ·Group home staff will be in-serviced on client rights, ANE policy & incident reporting. <p>How will we identifyothers:</p> <ul style="list-style-type: none"> ·The Quality assurance director will review all incidents to ensure 	05/06/2016

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>Review of the facility's BDDS/Bureau of Developmental Disabilities Services reports, investigations, internal incidents and medical incident reports on 4/04/16 at 1:30 PM and on 4/05/16 at 9:00 AM indicated the following:</p> <p>A BDDS report dated 3/18/16 indicated an incident of verbal abuse toward clients #1, #2, #3, #4, #5 and #6 on 11/30/15 at 6:00 AM by staff #13. The staff was suspended and ultimately terminated but there was no reproducible investigation of the incident and the allegation was not reported to BDDS.</p> <p>A BDDS report dated 11/03/15 indicated client #3 fell in the bathroom (10/30/15) and hit the side of her face/cheek on the toilet. The client was assessed by the facility's nurse but the incident was not reported to Qualified Intellectual Disabilities professional/QIDP #1 or the administrator according to agency policy. The client's facial injury was not assessed further until 11/03/15 when she was sent to an Immediate Care medical facility and was diagnosed with an eye contusion and was given an orbital CT scan with contrast.</p> <p>A BDDS report dated 11/04/15 indicated client #3 was over medicated on her lamotrigine (Lamictal) seizure</p>		<p>proper reporting and investigations</p> <p>Measures put in place:</p> <ul style="list-style-type: none"> ·Group home observation sheet (Attachment B) ·Group home monthly record review (Attachment C) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> ·QIDP will perform 8 monthly documented observations on all shifts to ensure staff are following client BSPs and IPPs ·The QA for group homes will audit the home monthly to ensure proper incident reporting, follow-up and investigations. The QA manager then sends the audit to the RPM who submits a corrective action report to the county QIDP and director of community living. The QIDP must correct all deficiencies with seven days. ·RPM will review all incident reports to ensure proper follow up and investigation ·All documented observations and audits are forwarded to the agency director of quality for review. 		

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	<p>medication. Client #3 received the incorrect dosage from 10/22/15 until 11/04/15.</p> <p>The client's record (reviewed 4/04/16 at 9:45 AM) indicated a visit to the neurologist on 10/22/15 wherein the lamotrigine was increased to 250 mg/milligrams twice daily. The neurologist sent the facility's pharmacy the new prescription but the pharmacy filled the prescription as 450 mgs. twice daily. The record contained the original prescriptions dated 10/22/15 but no one at the facility had verified the prescriptions with the new pill packages supplied by the pharmacy for the lamotrigine.</p> <p>A BDDS report of 10/08/15 indicated an allegation of substantiated verbal abuse by two staff (#11 and #12) toward clients #1, #2, #3, #4, #5 and #6 on 10/08/15.</p> <p>Review of agency policies and procedures on 4/06/16 at 9:39 AM indicated a Standard Operating Procedure for Identifying and Reporting Suspected Abuse and Neglect dated 4/12/2006. The review indicated the agency prohibited client abuse/neglect/exploitation. Definitions were in the procedure: "2. Verbal/Emotional Abuse: The intentional or willful infliction of physical injury, the unnecessary use of</p>			

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	<p>physical or chemical restraints or isolation, punishment that results in physical harm or pain.</p> <p>4. Neglect: Placing an individual in a situation that may endanger his or her life or health; includes failure to provide appropriate care...or supervision."</p> <p>The policy indicated the suspicion of an individual being the victim of abuse or neglect must be reported to supervisory staff within "one hour" of the discovery. The allegation will be documented within 24 hours. Supervisory staff will report the allegation to the appropriate state agencies and the agency's administrative staff. The allegations will be fully investigated and the results of the investigation will be submitted to the agency's administration (Program Manager, Program Director or designee and Executive Director.</p> <p>An interview with Group Living Division Manager/Administrator #1 was conducted on 04/04/16 at 1:15 PM. The interview indicated the 11/30/15 allegation of staff abuse was reported late. The allegation was investigated and the staff was terminated but there was no reproducible investigation and no report to BDDS at the time (11/30/15) of the incident. The interview indicated the agency's Abuse/Neglect policy and</p>						

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W 0240 Bldg. 00	<p>reporting/investigating procedures should be followed.</p> <p>Interview with QIDP #1 on 4/4/16 at 4:40 PM indicated client #3 fell and hit her head due to being over medicated with her seizure medication, lamotrigine. The interview also indicated staff #3 had neglected to report client #3's facial injury on 10/30/15 as she should have so the client could have received immediate medical care.</p> <p>9-3-2(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure methods for addressing client's refusals/anxiety for medical evaluations were included in program plans.</p>	W 0240	<p>Corrective actions taken:</p> <ul style="list-style-type: none"> ·A goal to help client #2 with her anxiety regarding medical evaluations will be developed, included in the client's IPP, and all staff will be trained. ·Client #2 will be scheduled for a pelvic ultrasound. 	05/06/2016

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	<p>Findings include:</p> <p>Review (04/06/16 9:00 AM) of client #2's record indicated an individual program plan/IPP dated 10/9/15. The record review indicated client #2 refused a pap test on 3/22/16 according to a physician's note on 3/22/16. The note indicated: "Due to extreme fear of heights and apprehension a pap smear was not obtained." The note indicated a pelvic ultrasound had been done in the past but the report and/or the date of the test were not in the client's record. The record contained a dentist's note dated 9/9/15 wherein client #2 underwent dental restorations under a general anesthetic. The client's record contained an order for 1 mg/milligram of alprazolam (anti-anxiety medication) dated 8/27/15 and administered on 9/9/15 prior to the visit for the dental restoration. The client's IPP contained no methods to assist the client with being more comfortable with medical examinations.</p> <p>Interview with Qualified Intellectual Disabilities professional/QIDP #1 on 04/06/16 at 9:20 AM indicated there was no program to assist client #2 with anxiety regarding medical evaluations.</p> <p>9-3-4(a)</p>		<p>How will we identify others:</p> <ul style="list-style-type: none"> The quality assurance manager will audit allhomes on a monthly basis. The audit documents how well each home operates,including checks for active treatment, finances and medication administration. <p>Measures put inplace:</p> <ul style="list-style-type: none"> Group home monthly record review (attachment C) <p>Monitoring ofcorrective action:</p> <ul style="list-style-type: none"> The QA for group homes will audit the homemonthly to ensure proper client supports for medical procedure anxiety. The QAmanager then sends the audit to the RPM who submits a corrective action reportto the county QIDP and director of community living. The QIDP must correct alldeficiencies with seven days. All documented observations and audits areforwarded to the agency director of quality for review. 		

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W 0368 Bldg. 00	<p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 3 sampled clients (#1), and 1 additional client (#5), the facility failed to ensure clients received their medications as prescribed by the physician.</p> <p>Findings include:</p> <p>Review of reportable incidents was done on 4/04/16 at 1:30 PM and on 4/05/16 at 9:00 AM indicated the following medication errors:</p> <p>Client #5 did not receive her clonazepam 2 mg. (for behavior) at 8:00 PM on 4/14/15.</p> <p>Client #1 did not receive her Pioglitizone (diabetes) medication on the morning of 7/17/15. Client #1 did not receive her Prosight vitamin and fenofibrate supplement at 5:00 PM on 11/9/15.</p> <p>On 2/02/16 at 8:00 PM, client #6's medications were given to client #5 by mistake, Risperidone 0.5 mg. (behavior), Venaflaxine 37.5 mg. (behavior), and 10</p>	W 0368	<p>Corrective actionstaken:</p> <ul style="list-style-type: none"> ·All county QIDPs and house staff were in-serviced on the requirement for medication deliveries to be checked upon receipt from the pharmacy and compared against the physician's order and the medication administration record. Any discrepancy will be communicated to the QIDP and the pharmacy immediately on 4/20/16 (Attachment A) ·All house staff will be in-serviced on proper medication administration ·Agency nurses will train staff at any group home when there are multiple med errors in a month <p>How will we identifyothers:</p> <ul style="list-style-type: none"> ·All DSI group homes will be required to checkmedication deliveries upon receipt and compare the medication being deliveredto the physician's orders and the medication administration record. ·The quality assurance manager will audit allhomes monthly to ensure medications are consistent with the medicationadministration record and the physician's orders. ·Every med pass will be 	05/06/2016

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	<p>mg. of Melatonin (supplement). As a precaution, client #5 was sent to the emergency room for evaluation. The physician removed 3 of client #5's medications from the list to be given that night.</p> <p>Interview with Qualified Intellectual Disabilities professional/QIDP #1 on 04/06/16 at 9:20 AM indicated clients were to receive medications as prescribed by their physicians.</p> <p>9-3-6(a)</p>		<p>required to implement DSI's "buddy check". This is SOP and is a document used by staff to check the other staff's administration of medication.</p> <ul style="list-style-type: none"> · The night auditor for each home will check the medication nightly and look for discrepancies between the MARS, the POs and the actual medication. The night auditor will also ensure buddy checks are being done. · An agency nurse will retrain staff who incur more than one medication error within a 12 month period on Core A and medication administration. <p>Measures put in place:</p> <ul style="list-style-type: none"> · Buddy Check (Attachment D) · Group home monthly record review audit (Attachment C) · Night Audit (Attachment E) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> · The QA for group homes will audit the home monthly to ensure proper medications are on hand. The QA manager then sends the audit to the RPM who submits a corrective action report to the county QIDP and director of community living. The QIDP must correct all deficiencies with seven days. · The QIDPs or team leads are required to review night audits for accuracy and sign off. These night audits will then be reviewed by the RPM on a weekly basis. · All documented observations and audits are forwarded to the agency director of quality for review. 	

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W 0369 Bldg. 00	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 2 of 16 medications observed (client #2), the facility failed to ensure all medications were given without error.</p> <p>Findings include:</p> <p>During observations at the facility on the morning of 4/06/16 at 6:25 AM, client #2 received medications under the direction of staff #5. Client #2 self administered Symbicort (allergy/asthma) one puff, levothyroxine 50 micrograms/mcgs. (thyroid hormone), and a gummy vitamin.</p>	W 0369	<p>An agency nurse will retrain staff who incur more than one med error with a 12 month period on proper medication administration. Agency nurses also monitor physician orders and medication administration records for continuing compliance. Agency nurses sign off on all new medications and discontinuation of medications.</p> <p>Corrective action taken:</p> <ul style="list-style-type: none"> ·All county QIDPs and house staff were in-serviced to ensure they understand the importance of administering medications per physician's orders. (Ex. Levothyroxine is to be administered 30 minutes before other medications; inhaler treatment directions that specify 2 puffs to be given should be followed) on 4/20/16 (Attachment A) ·The county QIDP will make 3 medication administration observations per week for 2 months to ensure staff compliance and training. ·All house staff will be in-serviced on proper medication administration 	05/06/2016

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	<p>Review of client #2's 4/16 medication administration record/MAR at 6:30 AM on 4/6/16 indicated the levothyroxine was supposed to be given at 6:30 AM daily and other medications, including the gummy vitamin, were listed to be given at 7:00 AM. The two puffs of the Symbicort were to be administered daily at 7:00 AM.</p> <p>Interview with staff #5 on 4/06/16 at 8:10 AM indicated client #2 refused to take 2 puffs of the Symbicort and would only apply one puff.</p> <p>An interview with the nurse, RN #10 was conducted on 4/06/16 at 8:35 AM. RN #10 indicated the levothyroxine was to be given at 6:00AM daily on an empty stomach with water only. The other medications were to be given later. The interview indicated the Symbicort dosage was an error. The dosage of the Symbicort should be discussed with the doctor, but until then, two puffs was the correct dosage.</p> <p>9-3-6(a)</p>		<p>·Agency nurses will train staff at any group home when there are multiple med errors in a month</p> <p>How will we identify others:</p> <p>·All QIDPs will utilize their mandatory documented observations on every shift per month to ensure staff are following medication directions as specified by the prescribing physician.</p> <p>·An agency nurse will retrain staff who incur more than one medication error within a 12 month period on Core A and medication administration.</p> <p>·</p> <p>Measures put in place:</p> <p>·Group home observation form (attachment B)</p> <p>Monitoring of corrective action:</p> <p>·The county QIDP will forward her documented medication administration observations to the RPM on a weekly basis.</p> <p>·All documented observations and audits are forwarded to the agency director of quality for review.</p> <p>·An agency nurse will retrain staff who incur more than one med error with a 12 month period on proper medication administration. Agency nurses also monitor physician orders and medication administration records for continuing compliance. Agency nurses sign off on all new medications and discontinuation</p>	

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W 0391 Bldg. 00	<p>483.460(m)(2)(ii) DRUG LABELING</p> <p>The facility must remove from use drug containers with worn, illegible, or missing labels.</p> <p>Based on observation and interview for 1 of 3 sampled clients (#2), the facility failed to label her medications.</p> <p>Findings include:</p> <p>During observations at the facility on the morning of 4/06/16 at 6:25 AM, client #2 received medications under the direction of staff #5. Client #2's medications were stored in a lock box which she accessed. Her clotrimazole lotion (anti-fungal) and Symbicort (allergy/asthma) and a package of unknown plastic vials (said to be allergy/asthma medication) had no pharmacy labels with the client's name, name of medication or dosage on them.</p> <p>An interview with the nurse, RN #10 was conducted on 4/06/16 at 8:35 AM. RN #10 indicated all medications were to have a pharmacy label.</p> <p>9-3-6(a)</p>	W 0391	<p>of medications.</p> <p>.</p> <p>Corrective actions taken:</p> <ul style="list-style-type: none"> ·The illegible label for the medication has beenreplaced with a new label ·Staff will be in-serviced on recognizing missing or illegiblemedication labels on <p>How we will identifyothers:</p> <ul style="list-style-type: none"> ·Night auditors will ensure all medication hasclean and legible labeling ·The group home quality assurance manager willensure that all medication has legible labeling during her monthly documentedaudits. <p>Measures put inplace:</p> <ul style="list-style-type: none"> ·Group home monthly record review (Attachment C) ·Night auditor sheet (Attachment E) <p>Monitoring ofcorrective action:</p> <ul style="list-style-type: none"> ·The group home regional program manager willreceive all QIDP documented observations and quality assurance manager audits.The regional program manager will ensure all deficiencies found are addressedin the form of training or appropriate disciplinary action. ·All documented observations 	05/06/2016

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W 0440 Bldg. 00	<p>483.470(i)(1) EVACUATION DRILLS</p> <p>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), and 3 additional clients (#4, #5 and #6), the facility failed to ensure sleeptime evacuation drills were conducted at least quarterly.</p> <p>Findings include:</p> <p>Fire evacuation drills from 4/15/15 through 4/05/16 with clients #1, #2, #3, #4, #5 and #6 as participants were reviewed on 4/05/16 at 2:45 PM. The review indicated no sleeptime fire drills (11:00 PM until 5:00 AM) for the second quarter of 2015 (April, May, and June).</p> <p>Interview with Qualified Intellectual Disabilities professional/QIDP #1 on 04/05/16 at 2:45 PM indicated no more drills for review.</p> <p>9-3-7(a)</p>	W 0440	<p>and audits are forwarded to the agency director of quality for review.</p> <ul style="list-style-type: none"> All county QIDPs will review night auditorsheets and their findings on a daily basis <p>Corrective actions taken:</p> <ul style="list-style-type: none"> The fire evacuation drill sheet has been revised to reflect that all sleep time drills must be conducted between the hours of 1am and 4am. Staff will be in-serviced on the new expectation of the sleep time drills <p>How we will identify others:</p> <ul style="list-style-type: none"> The group home quality assurance manager will ensure that all drills have been conducted during the proper time during her monthly documented audits. All group home night auditors ensure during their nightly audits that scheduled drills have been completed. Sleep time drills will be conducted by the night auditor. <p>Measures put in place:</p> <ul style="list-style-type: none"> Revised fire evacuation drill sheet (attachment F) Group home monthly record review (Attachment C) Night auditor sheet (Attachment E) <p>Monitoring of corrective action:</p> <ul style="list-style-type: none"> The group home regional program manager will receive all 	05/06/2016

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 04/06/2016
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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
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			<p>QIDP documented observations and quality assurance manager audits. The regional program manager will ensure all deficiencies found are addressed in the form of training or appropriate disciplinary action.</p> <ul style="list-style-type: none"> · All documented observations and audits are forwarded to the agency director of quality for review. · All county QIDPs will review night auditor sheets and their findings on a daily basis · The agency safety coordinator receives all fire drills on a monthly basis to ensure proper compliance to standards. 	