

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G093	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/22/2011
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3514 GREENBRIAR DR COLUMBUS, IN47203
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W0000	<p>This visit was for a full recertification and state licensure survey.</p> <p>Dates of Survey: November 14, 15, 16, 17, 18, 21 and 22, 2011</p> <p>Facility Number: 000633 AIMS Number: 100233950 Provider Number: 15G093</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/1/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0125	<p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and record review for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure the clients had the right to due process in regard to wind chimes hanging on the back door handle.</p>	W0125	<p>W125 The windchimes have been removed from the backdoor. QIDP reviewed restriction of client's rights with staff and the revised plan of Client #1 which no longer included this restriction. QIDP or designee will</p>	12/09/2011

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>Findings include:</p> <p>Observations were conducted at the group home on 11/17/11 from 3:57 PM to 5:24 PM and 11/18/11 from 5:55 AM to 7:55 AM. During the observations, a set of wind chimes was hanging from the back door doorknob. This affected clients #1, #2, #3, #4 and #5.</p> <p>A review of client #1's record was conducted on 11/21/11 at 9:58 AM. There was no documentation in her record in regard to the use of wind chimes on the back door doorknob.</p> <p>A review of client #2's record was conducted on 11/21/11 at 10:24 AM. There was no documentation in her record in regard to the use of wind chimes on the back door doorknob.</p> <p>A review of client #3's record was conducted on 11/21/11 at 12:05 PM. There was no documentation in her record in regard to the use of wind chimes on the back door doorknob.</p> <p>A review of client #4's record was conducted on 11/21/11 at 11:48 AM. There was no documentation in her record in regard to the use of wind chimes on the back door doorknob.</p> <p>A review of client #5's record was conducted on 11/21/11 at 11:23 AM. There was no documentation in her record in regard to the use of wind chimes on the back door doorknob.</p> <p>An interview with Direct Care Staff #2 was conducted on 11/17/11 at 5:13 PM. Staff #2 indicated the bells were decorative but good to have on the door knob in case client #1 went out the door.</p>		<p>continue to document at least monthly observations in the home and will retrain staff in any area of client rights restrictions that are observed.</p> <p>Responsible for QA: QIDP</p>		

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W0140	<p>An interview with Direct Care Staff #4 was conducted on 11/18/11 at 7:10 AM. Staff #4 indicated the bells on the back door were in place for client #1's elopement behavior.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/18/11 at 9:35 AM. The QMRP indicated there was no purpose for the chimes on the back door. The QMRP indicated the chimes used to be included in client #1's plan however when the plan was revised, the chimes were not removed.</p> <p>9-3-2(a)</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 3 of 3 clients in the sample (#1, #2 and #5), the facility failed to ensure an accurate accounting of the clients' petty cash.</p> <p>Findings include:</p> <p>A review of the clients' finances was conducted on 11/18/11 at 9:01 AM.</p> <p>-Client #1: On 2/14/11, the balance in her petty cash was \$3.64. The balance remained the same until 7/7/11 when the balance was \$89.38. On 8/4/11, the balance was \$89.39. There was no documentation of deposits into her petty cash to account for the change in balance.</p> <p>-Client #2: On 9/2/11, the balance in her petty cash was \$35.92. On 9/7/11, the balance was \$34.92. The note on 9/7/11 indicated, "\$1.00 missing." There was no documentation accounting</p>	W0140	<p>W140</p> <p>Client's #2 was reimbursed \$1.00 for the petty cash that was unaccounted for. Client #5 was reimbursed \$2.00 for the petty cash that was unaccounted for. The finance procedures were reviewed and revised to include nightly auditing by staff. Staff will be trained on these procedures which include notification to the QIDP by the end of the shift when any discrepancies are found in any finance book. Monthly auditing by the Administrative Finance Specialist and notification to the QIDP and SGL division manager of any discrepancies will continue.</p>	12/22/2011

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W0227	<p>for the missing \$1.00.</p> <p>-Client #5: On 8/2/11, the balance in her petty cash was \$9.16. On 8/3/11, the balance was \$62.04. There was no documentation accounting for the change in balance. On 8/3/11, there were three withdrawals totaling \$79.48; the balance indicated \$-.32. An undated entry below the 8/3/11 entries indicated \$16.16 was returned from vacation. The balance was \$15.84. On 8/24/11, the balance was \$25.32 with no documentation accounting for the change in the amount. On 8/25/11, the balance was \$20.32 after \$5.00 was sent with client #5 during a home visit. On 9/7/11, the balance indicated there was \$20.83 with no documentation indicating the reason for the change in balance. On 9/15/11, the balance was \$20.83. On 9/16/11, \$18.00 was deposited. On 9/16/11, she spent \$13.20 and the balance was \$25.63. The note on this date indicated, "returned more cash and receipts (sic), than took funds again." The balance was \$38.33. On 10/16/11, the balance was \$18.71 (correct after additional transactions). On 10/19/11, the balance was \$16.71. There was no documentation for the \$2.00 discrepancy.</p> <p>An interview with the Director of Supported Group Living was conducted on 11/18/11 at 9:18 AM. The Director indicated the facility should account for, to the penny, the clients' petty cash.</p> <p>9-3-2(a)</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview for 4 of 5 clients living in the</p>	W0227	<p>Responsible for QA: QIDP, SGL Manager</p> <p>W227 A plan for accessing knives will be developed for clients #2, 3, 4, and 5. Staff will</p>	12/22/2011	

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	<p>group home (#2, #3, #4 and #5), the facility failed to ensure: 1) clients #2, #3, #4 and #5 had plans to access knives and 2) client #2 had plans addressing her slow response/refusal to participate in evacuation drills and medical appointments.</p> <p>Findings include:</p> <p>1) Observations were conducted at the group home on 11/17/11 from 3:57 PM to 5:24 PM and 11/18/11 from 5:55 AM to 7:55 AM. During the observations, the sharp knives in the group home were locked.</p> <p>A review of client #1's record was conducted on 11/21/11 at 9:58 AM. Her Behavioral Support Plan (BSP), dated 8/11/11, indicated the following, "Knives are to be locked up at all times: [client #1] has used a knife to break into the med room and get the phone. She has also acted aggressively within the past 6 months, so having access to knives presents a danger to [client #1] and others. Therefore, the team has agreed that it is in the best interest of [client #1] to lock up the knives in the house, restricting he access to them."</p> <p>A review of client #2's record was conducted on 11/21/11 at 10:24 AM. There was no documentation in her record indicating she had : plan to access the sharp knives.</p>		<p>be trained on these plans. QIDP will document observations in the home at least monthly ensuring these plans are being followed. Client #2's program plan will be revised to include objectives addressing her slow response or refusal to participate in evacuation drills and to comply with medical appointments/procedures. Staff will be trained on this revised plan. Monthly documentation of progress on these objectives will be monitored by the QIDP.Addendum: QIDP or designee will observe at least weekly for one month to ensure compliance and continue to document at least monthly observations for continued compliance. Responsible for QA: QIDP</p>		

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	<p>A review of client #3's record was conducted on 11/21/11 at 12:05 PM. There was no documentation in her record indicating she had plan to access the sharp knives.</p> <p>A review of client #4's record was conducted on 11/21/11 at 11:48 AM. There was no documentation in her record indicating she had plan to access the sharp knives.</p> <p>A review of client #5's record was conducted on 11/21/11 at 11:23 AM. There was no documentation in her record indicating she had plan to access the sharp knives.</p> <p>An interview with the Director of Supported Group Living was conducted on 11/21/11 at 12:21 PM. The Director indicated clients #2, #3 #4 and #5 did not have plans to access the sharp knives and the restriction did not pertain to them The Director indicated the knives were locked due to client #1's behavior.</p> <p>2) A review of the facility's evacuation drills was conducted on 11/18/11 at 8:34 AM. Day shift (7:00 AM - 3:00 PM): On 1/29/11 at 2:09 PM, client #2 took 6 minutes to evacuate. On 7/19/11 at 7:05 AM, client #2 refused to participate in the drill. Evening shift (3:00 PM - 11:00 PM): On 2/23/11 at 5:15 PM, client #2 took 8 minutes to evacuate. On 5/9/11 at 4:45 PM, client #2 took 4 minutes to</p>			

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	<p>evacuate.</p> <p>A review of client #2's record was conducted on 11/21/11 at 10:24 AM. A review of her medical records indicated client #2's most recent mammogram was conducted on 2/26/09. There was no documentation in her record indicating client #2 refused to cooperate with her mammograms in 2010 and 2011. Client #2's Behavioral Support Plan, dated 8/24/11, indicated she had the following targeted behaviors: <u>Self-injurious behavior</u>- biting forearm, picking at scabs. <u>Physical Aggression</u> - hitting and smacking others, spitting. <u>Property destruction</u> - throwing and hitting items, slamming doors. <u>Disrobing</u> - removes items of clothing in public areas. <u>Verbal Aggression</u> - yelling and cursing at others. There was no documentation in her plan indicating refusals were a targeted behavior. There was no documentation addressing her slow response to evacuation drills.</p> <p>An interview with the nurse was conducted on 11/21/11 at 12:34 PM. The nurse indicated client #2 refused to cooperate with her annual mammograms.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/21/11 at 12:36 PM. The</p>			

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W0295	<p>QMRP indicated there was no plan to address client #2's refusals to cooperate with her annual mammograms. On 11/18/11 at 9:35 AM, the QMRP indicated client #2 did not have a plan addressing her slow response/refusal to participate in evacuation drills.</p> <p>9-3-4(a)</p> <p>The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied. Based on observation, interview and record review for 1 of 3 clients in the sample (#1), the facility failed to ensure her behavior plan included the interventions to use for physical intervention.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 11/21/11 at 9:58 AM. Her Behavioral Support Plan (BSP), dated 8/11/11, indicated the following, "PHYSICAL AGGRESSION: hitting, kicking, spitting at, pinching, or grabbing others with the intent of harming them. 1. Direct [client #1] verbally to 'stop.' 2. BLOCK all aggressive moves by [client #1], maintaining the safety for you, her and others in the environment. If [client #1] is not</p>	W0295	<p>W295 Client #1's Behavioral Support Plan was revised to identify specifically the non-violent crisis intervention techniques approved for use as a last resort during incidents involving physical aggression by the client. Staff are trained annually on the techniques identified in the plan. Addendum: Staff have been retrained on the revised plan. QIDP reviews incident reports as they are received. Staff document on the internal incident reports strategies outlined in BSP that were implemented during the behavior. Retraining with staff occurs should BSP not be implemented as originally trained. The IDT will meet within 24 hours of incident requiring use of non-violent crisis intervention to review the incident and the</p>	11/30/2011			

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	<p>able to be redirected, and she is not calmed down fairly quickly, be preventative by directing others out of her immediate environment to protect their safety. 3. REDIRECT: Offer [client #1] another activity to get involved with that is away from whatever is upsetting her. If you are upsetting her, you may get another staff to assist with intervention as this will minimize the behavior from getting worse. Offer her activities that are calming to her, such as listening to music in her bedroom. DO NOT tell her what to do-no one wants to be TOLD what to do. 4. RETURN TO TRAINING toward teaching [client #1] to better express her feelings in positive ways. Remind her to use her anger management/calming techniques that are outlined for her on note cards, when she is upset. 5. PHYSICAL INTERVENTION: If the above interventions are not effective, proceed with physical intervention, as outlined in your training provided by DSI. 6. Document the behavior on documentation sheets." The plan did not indicate what steps were included in "physical intervention."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/21/11 at 12:21 PM. The QMRP indicated the plan should include the interventions within the plan for staff to implement.</p>		<p>appropriateness of the plan.Responsible for QA: QIDP</p>				

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W0312	<p>9-3-5(a)</p> <p>Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview for 3 of 3 clients in the sample (#1, #2 and #5), the facility failed to ensure the clients' plans included a medication reduction plan for each psychotropic medication.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 11/21/11 at 9:58 AM. Her Behavioral Support Plan (BSP), dated 8/11/11, indicated she took Abilify and Zoloft as psychotropic medications. The Plan for Reduction indicated the following, "Our goal is to have [client #1] on the least amount of medication while promoting the greatest potential for continued learning. This must be balanced by monitoring side effects and continually monitoring the risks versus benefits profile of her medication regimen. This is done in conjunction with [client #1's] interdisciplinary team and her psychiatrist. [Psychiatrist's names] will work with [client #1's] team to determine</p>	W0312	<p>W312 Client's #1, 2, and 5 behavior support plans will be revised to include specific criteria for reducing each psychotropic medication. QIDP will review behavior plans at least annually to ensure that reduction plans are included in each behavior support plan. Addendum: QIDP reviews tracking data monthly to see if criteria has been met for med reduction. QIDP revises or notifies the BC of the need for revision of BSP to include med reduction plan each time a psychotropic med is prescribed or increased for all clients Responsible for QA: QIDP</p>	12/22/2011	

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	<p>the best approach for any medication reductions. [Client #1] appears to be relatively stable on the current medications prescribed. Her progress, and any medication adjustments, will be reviewed with the team at least quarterly." There was not a specific plan of reduction for each medication.</p> <p>A review of client #2's record was conducted on 11/21/11 at 10:24 AM. Her BSP, dated 8/24/11, indicated she took Tegretol, Lexapro and Seroquel as psychotropic medications. The plan indicated the following, "[Client #2] had been prescribed a variety of psychotropic medications to address her mental health issues. Tegretol was recently added to her prescriptions, although she has taken it in the past. Her prescription for Buspar was recently discontinued. [Client #2's] brothers are actively involved in monitoring the effectiveness of her medications and request changes they deem necessary. Due to her psychiatric needs, behavioral strategies alone have not been effective in managing her behavior. Any suggestion from [client #2's] team to her psychiatrist that a medication change be considered should be carefully contemplated. The team and family feel that the benefits of psychotropic medication outweigh the possible risks of side effects. If [client</p>				

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	<p>#2] is meeting behavioral objectives, her team will consider a discussion with her psychiatrist regarding medication reduction." There was not a specific plan of reduction for each medication.</p> <p>A review of client #5's record was conducted on 11/21/11 at 11:23 AM. Her Behavior Management Program, dated 9/13/11, indicated she took Risperdal and Trazadone as psychotropic medications. The plan indicated the following for medication reduction, "Medication reduction/ will be sought in conjunction with guardian, psychiatric review, and consultations." There was not a specific plan of reduction for each medication.</p> <p>On 11/21/11 at 12:21 PM, an interview with the Qualified Mental Retardation Professional (QMRP) was conducted. The QMRP indicated the facility was aware the clients' behavior plans needed to include specific medication reduction plans for each medication.</p> <p>9-3-5(a)</p>				

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W0336	<p>Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#1), the facility failed to ensure a quarterly nursing exam was conducted.</p> <p>Findings include:</p> <p>A review of client #1's record was conducted on 11/21/11 at 9:58 AM. Client #1 had quarterly nursing exams conducted on 12/9/10, 3/1/11, 7/30/11 and 10/4/11. There was no documentation a quarterly exam was conducted between 3/1/11 and 7/30/11.</p> <p>An interview with the nurse was conducted on 11/21/11 at 11:38 AM. The nurse indicated she was off during the timeframe and another nurse was covering her homes. The nurse indicated quarterly exams should be conducted every 90 days or so.</p> <p>An interview with the Director of Nursing (DON) was conducted on 11/21/11 at 11:03 AM. The DON indicated the nurse was off during the time period between 3/1/11 and 7/30/11. The DON indicated the nurse who was filling in must have missed a quarterly. The DON indicated</p>	W0336	<p>W336 SGL Manager, QIDP, DON, and nursing staff reviewed the criteria for quarterly assessments. The team will ensure in the future that each client is assessed quarterly by a nurse. The DON will review nursing notes monthly to ensure compliance in this area.</p> <p>Responsible for QA: DON, nursing staff, QIDP, SGL Manager</p>	12/22/2011

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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3514 GREENBRIAR DR COLUMBUS, IN47203
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W0440	<p>nursing quarterlies should be conducted every 90 days or so.</p> <p>9-3-6(a)</p> <p>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 living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure quarterly evacuation drills were conducted.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 11/18/11 at 8:34 AM. This affected clients #1, #2, #3, #4 and #5.</p> <p>-Day shift (7:00 AM - 3:00 PM): There were no drills conducted between 1/29/11 and 7/19/11.</p> <p>-Evening shift (3:00 PM - 11:00 PM): There were no drills conducted since 8/5/11. The drills conducted on 12/10/10 and 8/5/11 did not indicate how long the drill took to conduct.</p> <p>-Night shift: (11:00 PM - 7:00 AM): There were no drills conducted between 11/15/10 and 3/25/11. The drills conducted on 11/15/10, 4/15/11 and 8/30/11 did not indicate how long the drills took to conduct.</p>	W0440	<p>W440</p> <p>QIDP will retrain staff on requirements for regular evacuation drills. A schedule will be posted in the home to ensure drills are performed as required for each shift. QIDP will review this monthly at house meetings to ensure compliance.</p> <p>Responsible for QA: QIDP</p>	12/22/2011

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W0448	<p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/21/11 at 12:21 PM. The QMRP indicated there should be one drill per shift per quarter.</p> <p>An interview with the Director of Supported Group Living was conducted on 11/21/11 at 12:21 PM. The Director indicated the drills should include the duration of time to conduct the drills. The Director indicated there should be one drill per shift per quarter.</p> <p>9-3-7(a)</p> <p>The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview for 5 of 5 clients living in the group home (#1, #2, #3, #4 and #5), the facility failed to ensure issues noted during drills were investigated.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills was conducted on 11/18/11 at 8:34 AM. This affected clients #1, #2, #3, #4 and #5.</p> <p>-Day shift (7:00 AM - 3:00 PM): On 1/29/11 at 2:09 PM, client #2 took 6</p>	W0448	<p>W448</p> <p>QIDP's will be trained on the regulation requiring investigation of issues noted during drills. Drill reports have been revised to include documentation of issues and reporting of issues to the QIDP. Staff have been trained on these reports. QIDP reviews drills monthly at house meetings to ensure compliance.</p> <p>Responsible for QA: QIDP</p>	12/22/2011	

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	<p>minutes to evacuate. On 7/19/11 at 7:05 AM, client #2 refused to participate in the drill. There was no documentation the facility investigated the issues.</p> <p>-Evening shift (3:00 PM - 11:00 PM): On 2/23/11 at 5:15 PM, client #2 took 8 minutes to evacuate. On 5/9/11 at 4:45 PM, client #2 took 4 minutes to evacuate. There was no documentation the facility investigated the issues.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 11/21/11 at 12:21 PM. The QMRP indicated issues noted during evacuation drills should be investigated.</p> <p>An interview with the Director of Supported Group Living was conducted on 11/21/11 at 12:21 PM. The Director indicated issues noted during evacuation drills should be investigated.</p> <p>9-3-7(a)</p>				