

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/22/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: November 4, 5, 6 and 22, 2013.</p> <p>Surveyor: Dotty Walton, QIDP.</p> <p>Facility Number: 003184 AIM Number: 100368720 Provider Number: 15G697</p> <p>The following deficiencies reflect findings in accordance with 460 IAC 9. Quality Review completed 12/5/13 by Ruth Shackelford, QIDP.</p>	W000000			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/22/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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 achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2, and #3), the facility failed to ensure staff implemented program plan objectives during formal and informal times of opportunity.</p> <p>Findings include:</p> <p>During observations at the facility on the evening of 11/4/13 from 3:50 PM until 5:45 PM client #3's medications were administered by staff #2 at 4:00 PM. No training was offered by staff.</p> <p>Observations were conducted at the facility on 11/5/13 from 6:00 AM until 8:10 AM. Client #1 was given his medications by staff #4 at 6:13 AM. Staff #4 did not offer medication side effects training to client #1. Client #2's medications were administered by staff #4 at 6:55 AM. No training was offered by staff #4 to client #2.</p>	W000249	<p>W249</p> <p>Staff will be retrained on implementation of each client's individual program plans. Specific training will include but not be limited to the implementation of medication training objectives during each med pass for each client. QIDP or designee will observe at least weekly for one month then monthly thereafter to ensure compliance in these areas.</p>	12/22/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/22/2013
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>When asked about medication side effects training for clients on 11/5/13 at 7:10 AM, staff #4 indicated he did not do training during the medication administration with clients.</p> <p>Review of client #1's Individual Program Plan (IPP) dated 2/13 through 2/14 on 11/5/13 at 9:15 AM indicated he had an objective to identify side effects of medications with verbal prompting.</p> <p>Review of client #2's Individual Program Plan (IPP) dated 2/13 through 2/14 on 11/5/13 at 10:00 AM indicated he had an objective to identify side effects of medications with verbal prompting.</p> <p>Review of client #3's Individual Program Plan (IPP) dated 2/13 through 2/14 on 11/5/13 at 11:30 AM indicated he had an objective to identify the possible side effects of medications.</p> <p>Interview with Administrator #1 on 11/5/13 at 11:00 AM indicated staff were to do program plan training with all clients during times of opportunity.</p> <p>9-3-4(a)</p>		Responsible for QA: QIDP		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/22/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000317	<p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. Based on record review and interview for 1 of 3 sample clients receiving medications to control maladaptive behaviors (client #1), the facility failed to provide evidence an annual medication reduction had been attempted or specific contraindications as to why an attempt was not made.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 11/05/13 at 9:00 AM. Client #1's BMP/Behavior Management Program dated 7/06/13 indicated client #1 had the following targeted behaviors for which data was to be recorded by staff and the incident rates targeted for meeting a medication reduction: Hitting, two incidents for a six month time period. Stealing, one incident for six months. Self injurious behavior, zero incidents for six months. Leaving boundaries, zero incidents for six months. Threats to leave, three incidents for six</p>	W000317	<p>W317</p> <p>QIDP will review data with Client #1's psychiatrist at his visit this month and discuss medication reduction plans. QIDP will review all clients BSP's and current medication in regards to medication reductions. Medication reductions will be sought from the psychiatrist according to BSP criteria and input from the IDT. QIDP will review behavior plans and behavior data at least annually to ensure that reductions are sought according to BSP criteria.</p>	12/22/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/22/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>months. Threat of physical aggression, five incidents for six months.</p> <p>Behavior data for the last 7 months, April 2013 through October 2013, indicated: Hitting, zero. Stealing, six. Self injurious behavior, zero. Leaving boundaries, one. Threats to leave, one. Threat of physical aggression, one.</p> <p>The record review indicated client #1 received the following drugs for behavior: olanzapine (antipsychotic) 10 mg. (milligrams) in the morning 20 mg. at night, risperadone 3 mg.(antipsychotic) twice daily and sertraline (antidepressant) 100 mg. daily. The record review indicated client #1 had taken the same behavior medications with no changes in dosage since 7/09/12 according to a psychiatric consult of the same date. No medication had been identified as the first to be withdrawn. There was no evidence an attempt at a gradual reduction of one of client #1's behavior medications had been attempted since 7/12.</p> <p>Administrator #1 was interviewed on 11/05/13 at 11:00 AM. The interview indicated the facility was to track relevant behavior data for each client according to</p>		<p>Responsible for QA: QIDP</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>their BMPs. The interview indicated no evidence to contraindicate an attempt of an annual gradual withdrawal of a behavior medication for client #1.</p> <p>9-3-5(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/22/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W009999	<p>STATE FINDINGS</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-2(c)(3) Resident Protections</p> <p>(c) The residential provider shall demonstrate that its employee practices assure that no staff person would be employed where there is:</p> <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, the facility failed for 3 of 4 employee records reviewed (staff #3, #7 and #5), to obtain 3 complete references prior to staff working with clients #1, #2, #3, #4, #5, and #6.</p>	W009999	<p>W9999</p> <p>Observations have been noted and reviewed with the HR department. Appropriate references will be sought for each new employee.</p> <p>Responsible for QA: HR, SGL Manager</p>	12/22/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G697		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/22/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 4251 RIVER RD COLUMBUS, IN 47203			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>Findings include:</p> <p>Employee records were reviewed on 11-04-13 at 10:30 AM. A review of the records failed to show 3 references were obtained which contained more than verification of employment dates for staff #3, two references, staff #7, two references and staff #5, one reference which met the state rule.</p> <p>Administrative staff #10 indicated on 11/04/13 at 11:00 AM three references with more than employment dates had not been done for facility staff prior to working in the facility with clients #1, #2, #3, #4, #5, and #6.</p> <p>9-3-2(c)(3)</p>						