

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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
W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00176260.</p> <p>Complaint #IN00176260: Substantiated, Federal/state deficiencies related to the allegation are cited at W149, W154, W157, W159, W189, W248 and W249.</p> <p>This visit was in conjunction with the Post Certification Revisit to the annual recertification and state licensure survey completed on 12/19/14.</p> <p>Dates of Survey: July 16, 17, 20 and 21, 2015</p> <p>Facility Number: 008879 AIMS Number: 200076390 Provider Number: 15G672</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</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</p>	W 0149	In order to better implement the	08/20/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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>1 of 14 incident/investigative reports reviewed affecting client A, the facility neglected to conduct a thorough investigation and take appropriate corrective actions regarding a fall causing injury to client A.</p> <p>Findings include:</p> <p>On 7/16/15 at 1:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 6/19/15 at 7:30 AM, client A was going up the ramp to the van, slipped and fell backward hitting her head on the asphalt causing a cut on the back of her head. The staff called 911 and client A was transported to the hospital. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 6/19/15, indicated, in part, "I (staff #10) was filling in this morning at the group home assisting another staff person who already works at the group home. We were loading client's (sic) into the van to take them to the workshop when [client A] was starting to come up the ramp she had slipped and fell backwards and hit (sic) head on (sic) ground. [Client A] had fallen due to the ramp being wet from the rain. Staff checked her out and helped her up into the van to sit so that</p>		<p>agency's policy of thorough investigations, the following corrective actions will take place: 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 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. 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. The staff at Rolling Hills will be in-serviced on 8/12/15 regarding the proper implementation of client A's fall</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>we could check her injuries. Only injury was a cut on the back of the head and it was bleeding... I contacted 9-1-1 and another workshop staff came to get the rest of (sic) clients. EMS (emergency medical services) showed up and checked her and took to ER (emergency room) and I followed them there. [Name of doctor] at the [name of hospital] checked her out and said he could put glue on wound instead of staples or stitches. She also had a CAT (computerized tomography) scan and a tetanus shot done (sic) Results from CAT scam (sic) came back normal and was ok to go home...."</p> <p>The follow-up BDDS report, dated 6/23/15, indicated, "Client had fallen walking up wet (rain) ramp into the van. Was taken to ER on 6/19/2015 and was told she was fine. Later on 6/19/2015 bruises were found on clients (sic) back. One was 1 inch in size the other was an inch and a half in size. On 6/20/2015 client was taken back to ER due to acting abnormally. Client is very limited in verbally (sic) communication. ER determined client had a concussion. On 6/19/2015 they didn't think she did, but staff followed the 72 hour rule to see if signs would appear. As of 6/23/2015 client is well. No more symptoms of a concussion and her cut on head and bruises are healing well. Staff is to give</p>		<p>risk plan. 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.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>physical assistance on rainy days to avoid injuries. Client is able to use walker on her own, however on rainy days it will be necessary to intervene for the clients (sic) safety. Staff will continue to make sure client gets well and offer any emotional support that is needed."</p> <p>There was no documentation the facility conducted an investigation. There were no interviews/statements obtained from client A, staff #10, staff #7 and clients B, C, D and E. The BDDS report did not indicate who was working at the time of the fall. The facility's Medical Incident Report, dated 6/19/15, was not part of the information presented to the surveyor when the facility was asked for incident and investigative reports. There was no documentation the facility reviewed client A's Health/Risk Plan for falls to ensure the staff implemented the plan as written. There was no documentation the facility assessed the van's ramp and the client's shoes to ensure they were in good condition. There was no documentation indicating where the staff was located at the time of the fall. There was no documentation in client A's record indicating her risk plan for falls was updated following the incident. There was no documentation the staff was retrained on client A's risk plan for falls following the incident. The facility failed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>to take appropriate corrective action to address client A's fall.</p> <p>A review of Client A's Health/Risk Plan for falls, dated 5/13/15, was conducted on 7/16/15 at 3:02 PM. The plan indicated, in part, "Assessed/Identified Issues Related to Protocol/Diagnosis: History of falls due to unsteadiness and risk of fractures due to osteoporosis... 1. Has had several falls w/o (without) severe injury this year. 2. No incidents of fractures - h/o (history of) osteoporosis. 3. Has short attention span. 4. Uses walker to ambulate but will attempt to walk w/o walker. 5. Uses w/c (wheelchair) when walking distances of 100 ft. (feet) or (greater). 6. Has fallen or slid out of bed several times attempting to get up unassisted... Prescribed Treatments/Medications/Preventative Measures: ...4. Assist client in/out of vehicle...." There was no documentation in client A's record, reviewed on 7/16/15 at 3:59 PM, of an updated Health/Risk Plan for falls since client A's fall on 6/19/15.</p> <p>On 7/17/15 at 3:31 PM, the Quality Assurance/Social Services Manager (QA) emailed a copy of client A's Health/Risk Plan, dated 6/19/15. The Health/Risk Plan indicated the following change from</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>the Health/Risk Plan for falls, dated 5/13/15, in the Prescribed Treatments/Medications/Preventative Measures: "4. Assist client in/out of vehicle. Walk behind her and hold onto her when she is getting in the van. Walk in front of her and hold onto her when she is getting out of the van." The facility was asked to provide documentation the staff was trained on the updated plan on 7/16/15 at 3:32 PM and 7/17/15 at 1:48 PM. The facility did not provide documentation the staff was trained on client A's 6/19/15 Health/Risk Plan for falls.</p> <p>On 7/17/15 at 11:28 AM, the Registered Nurse (RN) indicated when she arrived to the group home on 6/19/15 after client A's fall, the staff was in the van with client A with a wet washcloth on her head. The RN indicated she was told client A fell backward while going up the ramp to get into the van. The RN indicated she did not investigate the fall by assessing the ramp or client A's shoes. The RN indicated she was unsure if the ramp and client A's shoes had been assessed since client A's fall. The RN indicated at the time of client A's fall, the staff should have been with her on the ramp. The RN indicated the staff failed to implement client A's plan as written.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>On 7/16/15 at 3:32 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the staff who was working at the time client A fell were staff #7 and staff #10. The QIDP indicated she was told by the staff that client A was starting to walk up the ramp to the van when she slipped and fell backward hitting her head on the ground. The QIDP indicated it was raining at the time of the incident. The QIDP indicated client A's foot slipped causing her to fall down. The QIDP indicated client A was taken to the ER and the doctor indicated client A did not have a concussion. The QIDP stated bruises appeared after the fall on her back and client A started "acting funny." The QIDP indicated client A was waving her arm around and did not want to get out of bed. The QIDP indicated client A may have been in pain or afraid to use the ramp again. The QIDP indicated she did not have documentation of an investigation. The QIDP indicated she spoke to the staff and the nurse. The QIDP indicated the staff was trained to assist client A with two staff when she was getting into and out of the van. The QIDP stated, "she probably does" when asked if client A had a risk plan for falls. The QIDP indicated the interdisciplinary team (IDT) discussed the use of a gait belt but client A may not want one on her and may try to remove a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>gait belt. The QIDP indicated a gait belt had not been tried. The QIDP indicated client A did not have an Occupational or Physical Therapy assessment after the fall. The QIDP indicated the IDT discussed the possibility of getting client A a walker with a seat. The QIDP indicated this was attempted with client A but she did not want to use the walker with a seat. The QIDP indicated she had thought of assessing the ramp (by putting water on it) and client A's shoes but had not done it. The QIDP indicated she would be willing to do it at the time of the interview. On 7/16/15 at 3:47 PM, the QIDP filled a bucket of water and poured it onto the ramp of the van. The ramp had a non-slip coating preventing the surveyor's shoes from slipping on it while wet. The QIDP indicated she could assess client A's shoes. The QIDP and the surveyor assessed client A's shoes. Client A's shoes were in good condition with no issues with the soles of her shoes. The QIDP indicated she had not assessed the ramp and client A's shoes prior to this date.</p> <p>On 7/17/15 at 1:14 PM, staff #10 indicated she was not interviewed about what happened on 6/19/15 by facility administrative staff. Staff #10 indicated prior to submitting the BDDS report, she contacted the Group Home Director to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>ensure he was not filing a BDDS report. Staff #10 indicated when she contacted the GHD, he was not aware of the incident. Staff #10 indicated she informed the GHD of the incident and then she filed the BDDS report. Staff #10 indicated the QIDP did not talk to her about client A's fall. Staff #10 indicated she was not interviewed to give additional information regarding client A's fall. Staff #10 indicated on 6/19/15, she was filling in at the group home for the first time. Staff #10 indicated she was in the back of the van when she observed staff #7 walking out with client A. Staff #10 indicated she continued to assist the other clients and heard client A fall. Staff #10 indicated she did not see client A fall. Staff #10 indicated she did not know if client A slipped and fell or just fell backward. When she turned around to check on client A, staff #7 was inside the van. Staff #10 indicated she told staff #7 that client A fell. Staff #10 indicated staff #7 did not know client A fell until staff #10 told her. Staff #10 indicated staff #7 was not supervising client A at the time she fell. Staff #10 indicated she was not sure why staff #7 got into the van. Staff #10 indicated she was aware client A needed to have assistance getting up the ramp. Staff #10 indicated client A's plan was not implemented as written.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>On 7/17/15 at 2:47 PM, staff #7 indicated on 6/19/15 she was working with a substitute staff. Staff #7 indicated the other staff asked her for help with getting a seatbelt secured. Staff #7 indicated she thought the other staff went down to assist client A. She heard client A fall. Staff #7 was not sure where the other staff was when client A fell. Staff #7 indicated she did not observe client A fall. She was not sure if client A was on the ramp or not when she fell. Staff #7 indicated she was not interviewed by the nurse or management staff following the incident. Staff #7 indicated the regular group home staff never leave client A unsupervised when she was outside. Staff #7 stated "we know better" than to leave client A unsupervised.</p> <p>On 7/17/15 at 1:48 PM, the Quality Assurance/Social Services Manager (QA) indicated an investigation was not conducted. The QA stated the facility thought the incident was "cut and dry" due to the staff observing the fall and writing a report about the fall. The QA indicated an investigation should have been conducted. The QA stated, "I don't know" when asked if the facility had assessed the ramp and client A's shoes. The QA indicated the fall should have been immediately reported to the Group</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>Home Director.</p> <p>A review of the facility's policy on conducting investigations was conducted on 7/16/15 at 1:18 PM. The facility's Protocol for Completing Investigations, dated 1/3/06, indicated, "Any event involving the potential or actual risk of harm to a client served, will be documented, reported, investigated and corrective action taken to alleviate the potential for future risk." The investigation must be initiated within 24 hours and completed within 5 working days." The policy indicated, in part, "...will be investigated immediately and thoroughly." The policy indicated, "1. Instances of suspected violations of rights, abuse or neglect, or inadequate protection of the health and safety of individuals served will be investigated immediately and thoroughly. Examples of inadequate protection of health and safety include but are not limited to: injuries of unknown origin, behavior incidents resulting in client/staff injuries, accidents resulting in the need of medical treatment, incidents caused by possible staff neglect and suspected criminal activity by staff or clients. The investigation must be thorough and shall include the following: a. Review of the incident reports, b. Interview with the client and or guardian and/or advocate, c.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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
W 0154 Bldg. 00	<p>Interview of all staff involved including whenever possible. The policy indicated, "The investigative report should include the following information as applicable: a. Description of the concern, b. Review and summary of any documentation, c. Listing and summary of personal interviews, d. Review of agency policies, e. A summary of findings/conclusions investigation has discovered, f. Resolution/outcome, and g. Suggestive Corrective Action to prevent further issues from reoccurring."</p> <p>This federal tag relates to complaint #IN00176260. 9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 14 incident/investigative reports reviewed affecting client A, the facility failed to conduct a thorough investigation regarding a fall causing injury. Findings include:</p>	W 0154	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	08/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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>On 7/16/15 at 1:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 6/19/15 at 7:30 AM, client A was going up the ramp to the van, slipped and fell backward hitting her head on the asphalt causing a cut on the back of her head. The staff called 911 and client A was transported to the hospital. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 6/19/15, indicated, in part, "I (staff #10) was filling in this morning at the group home assisting another staff person who already works at the group home. We were loading client's (sic) into the van to take them to the workshop when [client A] was starting to come up the ramp she had slipped and fell backwards and hit (sic) head on (sic) ground. [Client A] had fallen due to the ramp being wet from the rain. Staff checked her out and helped her up into the van to sit so that we could check her injuries. Only injury was a cut on the back of the head and it was bleeding... I contacted 9-1-1 and another workshop staff came to get the rest of (sic) clients. EMS (emergency medical services) showed up and checked her and took to ER (emergency room) and I followed them there. [Name of doctor] at the [name of hospital] checked</p>		<p>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 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</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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>her out and said he could put glue on wound instead of staples or stitches. She also had a CAT (computerized tomography) scan and a tetanus shot done (sic) Results from CAT scam (sic) came back normal and was ok to go home...."</p> <p>The follow-up BDDS report, dated 6/23/15, indicated, "Client had fallen walking up wet (rain) ramp into the van. Was taken to ER on 6/19/2015 and was told she was fine. Later on 6/19/2015 bruises were found on clients (sic) back. One was 1 inch in size the other was an inch and a half in size. On 6/20/2015 client was taken back to ER due to acting abnormally. Client is very limited in verbally (sic) communication. ER determined client had a concussion. On 6/19/2015 they didn't think she did, but staff followed the 72 hour rule to see if signs would appear. As of 6/23/2015 client is well. No more symptoms of a concussion and her cut on head and bruises are healing well. Staff is to give physical assistance on rainy days to avoid injuries. Client is able to use walker on her own, however on rainy days it will be necessary to intervene for the clients (sic) safety. Staff will continue to make sure client gets well and offer any emotional support that is needed."</p> <p>There was no documentation the facility</p>		<p>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 documentation. 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.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>conducted an investigation. There were no statements obtained from client A, staff #10 and staff #7. The BDDS report did not indicate who was working at the time of the fall. The facility's Medical Incident Report, dated 6/19/15, was not part of the information presented to the surveyor when the facility was asked for incident and investigative reports. There was no documentation the facility reviewed client A's Health/Risk Plan for falls to ensure the staff implemented the plan as written. There was no documentation the facility assessed the van's ramp and the client's shoes to ensure they were in good condition. There was no documentation indicating where the staff was located at the time of the fall.</p> <p>A review of Client A's Health/Risk Plan for falls, dated 5/13/15, was conducted on 7/16/15 at 3:02 PM. The plan indicated, in part, "Assessed/Identified Issues Related to Protocol/Diagnosis: History of falls due to unsteadiness and risk of fractures due to osteoporosis... 1. Has had several falls w/o (without) severe injury this year. 2. No incidents of fractures - h/o (history of) osteoporosis. 3. Has short attention span. 4. Uses walker to ambulate but will attempt to walk w/o walker. 5. Uses w/c (wheelchair) when walking distances of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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>100 ft. (feet) or (greater). 6. Has fallen or slid out of bed several times attempting to get up unassisted... Prescribed Treatments/Medications/Preventative Measures: ...4. Assist client in/out of vehicle...." There was no documentation in client A's record, reviewed on 7/16/15 at 3:59 PM, of an updated Health/Risk Plan for falls since client A's fall on 6/19/15.</p> <p>On 7/17/15 at 11:28 AM, the Registered Nurse (RN) indicated when she arrived to the group home on 6/19/15 after client A's fall, the staff was in the van with client A with a wet washcloth on her head. The RN indicated she was told client A fell backward while going up the ramp to get into the van. The RN indicated she did not investigate the fall by assessing the ramp or client A's shoes. The RN indicated she was unsure if the ramp and client A's shoes had been assessed since client A's fall. The RN indicated at the time of client A's fall, the staff should have been with her on the ramp. The RN indicated the staff failed to implement client A's plan as written.</p> <p>On 7/16/15 at 3:32 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the staff who was working at the time client A fell were</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>staff #7 and staff #10. The QIDP indicated she was told by the staff that client A was starting to walk up the ramp to the van when she slipped and fell backward hitting her head on the ground. The QIDP indicated it was raining at the time of the incident. The QIDP indicated client A's foot slipped causing her to fall down. The QIDP indicated client A was taken to the ER and the doctor indicated client A did not have a concussion. The QIDP stated bruises appeared after the fall on her back and client A started "acting funny." The QIDP indicated client A was waving her arm around and did not want to get out of bed. The QIDP indicated client A may have been in pain or afraid to use the ramp again. The QIDP indicated she did not have documentation of an investigation. The QIDP indicated she spoke to the staff and the nurse. The QIDP indicated the staff was trained to assist client A with two staff when she was getting into and out of the van. The QIDP stated, "she probably does" when asked if client A had a risk plan for falls. The QIDP indicated the interdisciplinary team (IDT) discussed the use of a gait belt but client A may not want one on her and may try to remove a gait belt. The QIDP indicated client A did not have an Occupational or Physical Therapy assessment after the fall. The QIDP indicated the IDT discussed the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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>possibility of getting client A a walker with a seat. The QIDP indicated this was attempted with client A but she did not want to use the walker with a seat.</p> <p>On 7/17/15 at 1:14 PM, staff #10 indicated she was not interviewed about what happened on 6/19/15 by facility administrative staff. Staff #10 indicated prior to submitting the BDDS report, she contacted the Group Home Director to ensure he was not filing a BDDS report. Staff #10 indicated when she contacted the GHD, he was not aware of the incident. Staff #10 indicated she informed the GHD of the incident and then she filed the BDDS report. Staff #10 indicated the QIDP did not talk to her about client A's fall. Staff #10 indicated she was not interviewed to give additional information regarding client A's fall. Staff #10 indicated on 6/19/15, she was filling in at the group home for the first time. Staff #10 indicated she was in the back of the van when she observed staff #7 walking out with client A. Staff #10 indicated she continued to assist the other clients and heard client A fall. Staff #10 indicated she did not see client A fall. Staff #10 indicated she did not know if client A slipped and fell or just fell backward. When she turned around to check on client A, staff #7 was inside the van. Staff #10 indicated she</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>told staff #7 that client A fell. Staff #10 indicated staff #7 did not know client A fell until staff #10 told her. Staff #10 indicated staff #7 was not supervising client A at the time she fell. Staff #10 indicated she was not sure why staff #7 got into the van. Staff #10 indicated she was aware client A needed to have assistance getting up the ramp. Staff #10 indicated client A's plan was not implemented as written.</p> <p>On 7/17/15 at 2:47 PM, staff #7 indicated on 6/19/15 she was working with a substitute staff. Staff #7 indicated the other staff asked her for help with getting a seatbelt secured. Staff #7 indicated she thought the other staff went down to assist client A. She heard client A fall. Staff #7 was not sure where the other staff was when client A fell. Staff #7 indicated she did not observe client A fall. She was not sure if client A was on the ramp or not when she fell. Staff #7 indicated she was not interviewed by the nurse or management staff following the incident. Staff #7 indicated the regular group home staff never leave client A unsupervised when she was outside. Staff #7 stated "we know better" than to leave client A unsupervised.</p> <p>On 7/17/15 at 1:48 PM, the Quality Assurance/Social Services Manager (QA)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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			
W 0157 Bldg. 00	<p>indicated an investigation was not conducted. The QA stated the facility thought the incident was "cut and dry" due to the staff observing the fall and writing a report about the fall. The QA indicated an investigation should have been conducted.</p> <p>This federal tag relates to complaint #IN00176260.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 1 of 14 incident/investigative reports reviewed affecting client A, the facility failed to take appropriate corrective action to address client A's fall on 6/19/15.</p> <p>Findings include: On 7/16/15 from 2:57 PM to 3:18 PM an observation was conducted at the facility-operated day program. At 2:57 PM, client A's record was reviewed. The Health/Risk Plan for falls was dated 5/13/15. Client A's record did not include the current risk plan for falls for</p>	W 0157	<p>Any change to a client's plan, including changes to health risk plans, will be addressed with staff immediately by the QIDP. The staff will sign a training form in order to document their acknowledgement of the change. The staff of the facility will be in-serviced on all current health risk plans on 8/12/15. In order to better protect clients, 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</p>	08/20/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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>client A. At 3:12 PM when client A walked out of the day program to the group home van, the day program staff held onto the back of her pants. Client A was not wearing a gait belt.</p> <p>On 7/16/15 at 3:15 PM, three day program staff indicated client A did not have a gait belt but needed one so staff could assist her while she ambulated. The staff indicated they held onto the back of her pants to ensure she did not fall.</p> <p>On 7/16/15 at 1:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 6/19/15 at 7:30 AM, client A was going up the ramp to the van, slipped and fell backward hitting her head on the asphalt causing a cut on the back of her head. The staff called 911 and client A was transported to the hospital. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 6/19/15, indicated, in part, "I (staff #10) was filling in this morning at the group home assisting another staff person who already works at the group home. We were loading client's (sic) into the van to take them to the workshop when [client A] was starting to come up the ramp she</p>		<p>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 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 discover any possible root cause. 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. On 8/19, all county QIDPs will receive an in-service that will include direction for ensuring IPPs and other related documents are shared will all relevant program managers. An IPP scheduler has been created to help facilitate communication for when IPPs are due. 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</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>had slipped and fell backwards and hit (sic) head on (sic) ground. [Client A] had fallen due to the ramp being wet from the rain. Staff checked her out and helped her up into the van to sit so that we could check her injuries. Only injury was a cut on the back of the head and it was bleeding... I contacted 9-1-1 and another workshop staff came to get the rest of (sic) clients. EMS (emergency medical services) showed up and checked her and took to ER (emergency room) and I followed them there. [Name of doctor] at the [name of hospital] checked her out and said he could put glue on wound instead of staples or stitches. She also had a CAT (computerized tomography) scan and a tetanus shot done (sic) Results from CAT scam (sic) came back normal and was ok to go home...."</p> <p>The follow-up BDDS report, dated 6/23/15, indicated, "Client had fallen walking up wet (rain) ramp into the van. Was taken to ER on 6/19/2015 and was told she was fine. Later on 6/19/2015 bruises were found on clients (sic) back. One was 1 inch in size the other was an inch and a half in size. On 6/20/2015 client was taken back to ER due to acting abnormally. Client is very limited in verbally (sic) communication. ER determined client had a concussion. On 6/19/2015 they didn't think she did, but</p>		are following proper procedures.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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>staff followed the 72 hour rule to see if signs would appear. As of 6/23/2015 client is well. No more symptoms of a concussion and her cut on head and bruises are healing well. Staff is to give physical assistance on rainy days to avoid injuries. Client is able to use walker on her own, however on rainy days it will be necessary to intervene for the clients (sic) safety. Staff will continue to make sure client gets well and offer any emotional support that is needed."</p> <p>There was no documentation the facility reviewed client A's Health/Risk Plan for falls to ensure the staff implemented the plan as written. There was no documentation the facility assessed the van's ramp and the client's shoes to ensure they were in good condition. There was no documentation the staff was retrained on client A's risk plan for falls following the incident.</p> <p>A review of Client A's Health/Risk Plan for falls, dated 5/13/15, was conducted on 7/16/15 at 3:02 PM. The plan indicated, in part, "Assessed/Identified Issues Related to Protocol/Diagnosis: History of falls due to unsteadiness and risk of fractures due to osteoporosis... 1. Has had several falls w/o (without) severe injury this year. 2. No incidents of fractures - h/o (history of) osteoporosis.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>3. Has short attention span. 4. Uses walker to ambulate but will attempt to walk w/o walker. 5. Uses w/c (wheelchair) when walking distances of 100 ft. (feet) or (greater). 6. Has fallen or slid out of bed several times attempting to get up unassisted... Prescribed Treatments/Medications/Preventative Measures: ...4. Assist client in/out of vehicle...." There was no documentation in client A's record at the group home, reviewed on 7/16/15 at 3:59 PM, of an updated Health/Risk Plan for falls since client A's fall on 6/19/15.</p> <p>On 7/17/15 at 11:28 AM, the Registered Nurse (RN) indicated she was unsure if the ramp and client A's shoes had been assessed since client A's fall.</p> <p>On 7/17/15 at 2:47 PM, staff #7 indicated on 6/19/15 she was working with a substitute staff. Staff #7 indicated the other staff asked her for help with getting a seatbelt secured. Staff #7 indicated she thought the other staff went down to assist client A. She heard client A fall. Staff #7 was not sure where the other staff was when client A fell. Staff #7 indicated she did not observe client A fall. She was not sure if client A was on the ramp or not when she fell. Staff #7 indicated she was not interviewed by the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>nurse or management staff following the incident. Staff #7 indicated the regular group home staff never leave client A unsupervised when she was outside. Staff #7 stated "we know better" than to leave client A unsupervised. Staff #7 indicated if there were changes made to client A's risk plan after the incident, she was not trained on the changes.</p> <p>On 7/16/15 at 3:32 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the staff was trained to assist client A with two staff when she was getting into and out of the van. The QIDP stated, "she probably does" when asked if client A had a risk plan for falls. The QIDP indicated the interdisciplinary team (IDT) discussed the use of a gait belt but client A may not want one on her and may try to remove a gait belt. The QIDP indicated a gait belt had not been tried. The QIDP indicated client A did not have an Occupational or Physical Therapy assessment after the fall. The QIDP indicated the IDT discussed the possibility of getting client A a walker with a seat. The QIDP indicated this was attempted with client A but she did not want to use the walker with a seat. The QIDP indicated she had thought of assessing the ramp (by putting water on it) and client A's shoes but had not done it. The QIDP indicated she would be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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
W 0159 Bldg. 00	<p>willing to do it at the time of the interview. On 7/16/15 at 3:47 PM, the QIDP filled a bucket of water and poured it onto the ramp of the van. The ramp had a non-slip coating preventing the surveyor's shoes from slipping on it while wet. The QIDP indicated she could assess client A's shoes. The QIDP and the surveyor assessed client A's shoes. Client A's shoes were in good condition with no issues with the soles of her shoes. The QIDP indicated she had not assessed the ramp and client A's shoes prior to this date.</p> <p>On 7/17/15 at 1:48 PM, the Quality Assurance/Social Services Manager (QA) stated, "I don't know" when asked if the facility had assessed the ramp and client A's shoes.</p> <p>This federal tag relates to complaint #IN00176260.</p> <p>9-3-2(a)</p> <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.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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>Based on record review and interview for 1 of 14 incident/investigative reports reviewed affecting client A, the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor client A's program plans following a fall with injury.</p> <p>Findings include:</p> <p>On 7/16/15 at 1:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 6/19/15 at 7:30 AM, client A was going up the ramp to the van, slipped and fell backward hitting her head on the asphalt causing a cut on the back of her head. The staff called 911 and client A was transported to the hospital. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 6/19/15, indicated, in part, "I (staff #10) was filling in this morning at the group home assisting another staff person who already works at the group home. We were loading client's (sic) into the van to take them to the workshop when [client A] was starting to come up the ramp she had slipped and fell backwards and hit (sic) head on (sic) ground. [Client A] had fallen due to the ramp being wet from the rain. Staff checked her out and</p>	W 0159	<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 8/12/15 upon prompting clients to help them fully utilize client health risk plans. 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 at Rolling Hills will be in-serviced on 8/12/15 regarding the proper implementation of client health risk plans. 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. 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</p>	08/20/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>helped her up into the van to sit so that we could check her injuries. Only injury was a cut on the back of the head and it was bleeding... I contacted 9-1-1 and another workshop staff came to get the rest of (sic) clients. EMS (emergency medical services) showed up and checked her and took to ER (emergency room) and I followed them there. [Name of doctor] at the [name of hospital] checked her out and said he could put glue on wound instead of staples or stitches. She also had a CAT (computerized tomography) scan and a tetanus shot done (sic) Results from CAT scam (sic) came back normal and was ok to go home...."</p> <p>The follow-up BDDS report, dated 6/23/15, indicated, "Client had fallen walking up wet (rain) ramp into the van. Was taken to ER on 6/19/2015 and was told she was fine. Later on 6/19/2015 bruises were found on clients (sic) back. One was 1 inch in size the other was an inch and a half in size. On 6/20/2015 client was taken back to ER due to acting abnormally. Client is very limited in verbally (sic) communication. ER determined client had a concussion. On 6/19/2015 they didn't think she did, but staff followed the 72 hour rule to see if signs would appear. As of 6/23/2015 client is well. No more symptoms of a concussion and her cut on head and</p>		<p>lead, QIDP, Quality assurance social services manager or regional program manager will follow up with at least 5 weekly observations, every week, 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>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2015
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(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>bruises are healing well. Staff is to give physical assistance on rainy days to avoid injuries. Client is able to use walker on her own, however on rainy days it will be necessary to intervene for the clients (sic) safety. Staff will continue to make sure client gets well and offer any emotional support that is needed."</p> <p>There was no documentation the QIDP conducted an investigation. There were no statements obtained from client A, staff #10 and staff #7. The BDDS report did not indicate who was working at the time of the fall. The facility's Medical Incident Report, dated 6/19/15, was not part of the information presented to the surveyor when the facility was asked for incident and investigative reports. There was no documentation the facility reviewed client A's Health/Risk Plan for falls to ensure the staff implemented the plan as written. There was no documentation the QIDP assessed the van's ramp and the client's shoes to ensure they were in good condition. There was no documentation indicating where the staff was located at the time of the fall.</p> <p>A review of Client A's Health/Risk Plan for falls, dated 5/13/15, was conducted on 7/16/15 at 3:02 PM. The plan indicated, in part, "Assessed/Identified Issues</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>Related to Protocol/Diagnosis: History of falls due to unsteadiness and risk of fractures due to osteoporosis... 1. Has had several falls w/o (without) severe injury this year. 2. No incidents of fractures - h/o (history of) osteoporosis. 3. Has short attention span. 4. Uses walker to ambulate but will attempt to walk w/o walker. 5. Uses w/c (wheelchair) when walking distances of 100 ft. (feet) or (greater). 6. Has fallen or slid out of bed several times attempting to get up unassisted... Prescribed Treatments/Medications/Preventative Measures: ...4. Assist client in/out of vehicle...." There was no documentation in client A's record, reviewed on 7/16/15 at 3:59 PM, of an updated Health/Risk Plan for falls since client A's fall on 6/19/15.</p> <p>On 7/17/15 at 11:28 AM, the Registered Nurse (RN) indicated when she arrived to the group home on 6/19/15 after client A's fall, the staff was in the van with client A with a wet washcloth on her head. The RN indicated she was told client A fell backward while going up the ramp to get into the van. The RN indicated she did not investigate the fall by assessing the ramp or client A's shoes. The RN indicated she was unsure if the ramp and client A's shoes had been</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>assessed since client A's fall. The RN indicated at the time of client A's fall, the staff should have been with her on the ramp. The RN indicated the staff failed to implement client A's plan as written.</p> <p>On 7/16/15 at 3:32 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the staff who was working at the time client A fell were staff #7 and staff #10. The QIDP indicated she was told by the staff that client A was starting to walk up the ramp to the van when she slipped and fell backward hitting her head on the ground. The QIDP indicated it was raining at the time of the incident. The QIDP indicated client A's foot slipped causing her to fall down. The QIDP indicated client A was taken to the ER and the doctor indicated client A did not have a concussion. The QIDP stated bruises appeared after the fall on her back and client A started "acting funny." The QIDP indicated client A was waving her arm around and did not want to get out of bed. The QIDP indicated client A may have been in pain or afraid to use the ramp again. The QIDP indicated she did not have documentation of an investigation. The QIDP indicated she spoke to the staff and the nurse. The QIDP indicated the staff was trained to assist client A with two staff when she was getting into and out of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>the van. The QIDP stated, "she probably does" when asked if client A had a risk plan for falls. The QIDP indicated the interdisciplinary team (IDT) discussed the use of a gait belt but client A may not want one on her and may try to remove a gait belt. The QIDP indicated client A did not have an Occupational or Physical Therapy assessment after the fall. The QIDP indicated the IDT discussed the possibility of getting client A a walker with a seat. The QIDP indicated this was attempted with client A but she did not want to use the walker with a seat.</p> <p>On 7/17/15 at 1:14 PM, staff #10 indicated she was not interviewed about what happened on 6/19/15 by facility administrative staff. Staff #10 indicated prior to submitting the BDDS report, she contacted the Group Home Director to ensure he was not filing a BDDS report. Staff #10 indicated when she contacted the GHD, he was not aware of the incident. Staff #10 indicated she informed the GHD of the incident and then she filed the BDDS report. Staff #10 indicated the QIDP did not talk to her about client A's fall. Staff #10 indicated she was not interviewed to give additional information regarding client A's fall. Staff #10 indicated on 6/19/15, she was filling in at the group home for the first time. Staff #10 indicated she</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>was in the back of the van when she observed staff #7 walking out with client A. Staff #10 indicated she continued to assist the other clients and heard client A fall. Staff #10 indicated she did not see client A fall. Staff #10 indicated she did not know if client A slipped and fell or just fell backward. When she turned around to check on client A, staff #7 was inside the van. Staff #10 indicated she told staff #7 that client A fell. Staff #10 indicated staff #7 did not know client A fell until staff #10 told her. Staff #10 indicated staff #7 was not supervising client A at the time she fell. Staff #10 indicated she was not sure why staff #7 got into the van. Staff #10 indicated she was aware client A needed to have assistance getting up the ramp. Staff #10 indicated client A's plan was not implemented as written.</p> <p>On 7/17/15 at 2:47 PM, staff #7 indicated on 6/19/15 she was working with a substitute staff. Staff #7 indicated the other staff asked her for help with getting a seatbelt secured. Staff #7 indicated she thought the other staff went down to assist client A. She heard client A fall. Staff #7 was not sure where the other staff was when client A fell. Staff #7 indicated she did not observe client A fall. She was not sure if client A was on the ramp or not when she fell. Staff #7</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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
W 0189 Bldg. 00	<p>indicated she was not interviewed by the nurse or management staff following the incident. Staff #7 indicated the regular group home staff never leave client A unsupervised when she was outside. Staff #7 stated "we know better" than to leave client A unsupervised.</p> <p>On 7/17/15 at 1:48 PM, the Quality Assurance/Social Services Manager (QA) indicated an investigation was not conducted. The QA stated the facility thought the incident was "cut and dry" due to the staff observing the fall and writing a report about the fall. The QA indicated an investigation should have been conducted. The QA indicated client A's updated risk plan for falls should have been in her group home and day program records for staff to review.</p> <p>This federal tag relates to complaint #IN00176260.</p> <p>9-3-3(a)</p> <p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview for</p>	W 0189	Any change to a client's plan,	08/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>1 of 3 clients in the sample (A), the facility failed to ensure staff was trained on client A's updated risk plan for falls.</p> <p>Findings include:</p> <p>On 7/16/15 at 1:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 6/19/15 at 7:30 AM, client A was going up the ramp to the van, slipped and fell backward hitting her head on the asphalt causing a cut on the back of her head. The staff called 911 and client A was transported to the hospital. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 6/19/15, indicated, in part, "I (staff #10) was filling in this morning at the group home assisting another staff person who already works at the group home. We were loading client's (sic) into the van to take them to the workshop when [client A] was starting to come up the ramp she had slipped and fell backwards and hit (sic) head on (sic) ground. [Client A] had fallen due to the ramp being wet from the rain. Staff checked her out and helped her up into the van to sit so that we could check her injuries. Only injury was a cut on the back of the head and it was bleeding... I contacted 9-1-1 and</p>		<p>including changes to health risk plans, will be addressed with staff immediately by the QIDP. The staff will sign a training form in order to document their acknowledgement of the change. The staff of the facility will be in-serviced on all current health risk plans on 8/12/15. The team lead, QIDP, Quality assurance social services manager or regional program manager will follow up with at least 5 weekly observations, every week, to ensure these measures are being followed. The QIDP or RPM will utilize the mandated 3in house documented observations and 4 mandated video surveillance observations to ensure that staff are following proper procedures. If staff are observed to fail to perform any duty outlined in a client's plan, the QIDP will provide the staff with any relevant training and hold the staff accountable through the previously mentioned observations and site visits. The observations, whether documented or not, will be conducted every week by either the team lead, QIDP or quality assurance social service manager.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>another workshop staff came to get the rest of (sic) clients. EMS (emergency medical services) showed up and checked her and took to ER (emergency room) and I followed them there. [Name of doctor] at the [name of hospital] checked her out and said he could put glue on wound instead of staples or stitches. She also had a CAT (computerized tomography) scan and a tetanus shot done (sic) Results from CAT scam (sic) came back normal and was ok to go home...."</p> <p>The follow-up BDDS report, dated 6/23/15, indicated, "Client had fallen walking up wet (rain) ramp into the van. Was taken to ER on 6/19/2015 and was told she was fine. Later on 6/19/2015 bruises were found on clients (sic) back. One was 1 inch in size the other was an inch and a half in size. On 6/20/2015 client was taken back to ER due to acting abnormally. Client is very limited in verbally (sic) communication. ER determined client had a concussion. On 6/19/2015 they didn't think she did, but staff followed the 72 hour rule to see if signs would appear. As of 6/23/2015 client is well. No more symptoms of a concussion and her cut on head and bruises are healing well. Staff is to give physical assistance on rainy days to avoid injuries. Client is able to use walker on her own, however on rainy days it will be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>necessary to intervene for the clients (sic) safety. Staff will continue to make sure client gets well and offer any emotional support that is needed."</p> <p>There was no documentation the staff was retrained on client A's risk plan for falls following the incident.</p> <p>A review of Client A's Health/Risk Plan for falls, dated 5/13/15, was conducted on 7/16/15 at 3:02 PM. The plan indicated, in part, "Assessed/Identified Issues Related to Protocol/Diagnosis: History of falls due to unsteadiness and risk of fractures due to osteoporosis... 1. Has had several falls w/o (without) severe injury this year. 2. No incidents of fractures - h/o (history of) osteoporosis. 3. Has short attention span. 4. Uses walker to ambulate but will attempt to walk w/o walker. 5. Uses w/c (wheelchair) when walking distances of 100 ft. (feet) or (greater). 6. Has fallen or slid out of bed several times attempting to get up unassisted... Prescribed Treatments/Medications/Preventative Measures: ...4. Assist client in/out of vehicle...." There was no documentation in client A's record, reviewed on 7/16/15 at 3:59 PM, of an updated Health/Risk Plan for falls since client A's fall on 6/19/15.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>On 7/17/15 at 3:31 PM, the Quality Assurance/Social Services Manager (QA) emailed a copy of client A's Health/Risk Plan, dated 6/19/15. The Health/Risk Plan indicated the following change from the Health/Risk Plan for falls, dated 5/13/15, in the Prescribed Treatments/Medications/Preventative Measures: "4. Assist client in/out of vehicle. Walk behind her and hold onto her when she is getting in the van. Walk in front of her and hold onto her when she is getting out of the van."</p> <p>The facility was asked to provide documentation the staff was trained on the updated plan on 7/16/15 at 3:32 PM and 7/17/15 at 1:48 PM. The facility did not provide documentation the staff was trained on client A's 6/19/15 Health/Risk Plan for falls.</p> <p>On 7/17/15 at 11:28 AM, the Registered Nurse (RN) indicated she thought staff #2 printed out the updated risk plan and informed the staff at the group home of the change to the plan.</p> <p>On 7/16/15 at 3:32 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the staff was trained to assist client A with two staff when she was getting into and out of the van after</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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			
W 0248 Bldg. 00	<p>the fall on 6/19/15.</p> <p>On 7/17/15 at 1:14 PM, staff #10 indicated she was not trained on client A's risk plan for falls after her fall on 6/19/15.</p> <p>On 7/17/15 at 2:47 PM, staff #7 indicated she was not trained on client A's risk plan for falls after her fall on 6/19/15. Staff #7 stated, "If there was a change in the plan, I wasn't informed."</p> <p>This federal tag relates to complaint #IN00176260.</p> <p>9-3-3(a)</p> <p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on record review and interview for 1 of 3 clients in the sample (A), the facility failed to ensure the client's updated risk plan for falls was at the group home and facility-operated day program for direct care staff to review.</p> <p>Findings include:</p>	W 0248	In order to ensure that visitors are aware of client D's behavior of stealing keys from visitors, staff will advise visitors to secure their personal belongings due to a client's behavior. Staff will also be in-serviced upon the need to inform visiting staff or visitors to secure their belongings on 8/12/15. All staff will be retrained on client D's behavior support	08/20/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>A review of Client A's Health/Risk Plan for falls, dated 5/13/15, was conducted on 7/16/15 at 3:02 PM at the facility-operated day program. The plan indicated, in part, "Assessed/Identified Issues Related to Protocol/Diagnosis: History of falls due to unsteadiness and risk of fractures due to osteoporosis... 1. Has had several falls w/o (without) severe injury this year. 2. No incidents of fractures - h/o (history of) osteoporosis. 3. Has short attention span. 4. Uses walker to ambulate but will attempt to walk w/o walker. 5. Uses w/c (wheelchair) when walking distances of 100 ft. (feet) or (greater). 6. Has fallen or slid out of bed several times attempting to get up unassisted... Prescribed Treatments/Medications/Preventative Measures: ...4. Assist client in/out of vehicle...."</p> <p>There was no documentation in client A's record at the group home, reviewed on 7/16/15 at 3:59 PM, of an updated Health/Risk Plan for falls since client A's fall on 6/19/15.</p> <p>On 7/17/15 at 11:28 AM, the Registered Nurse (RN) indicated she updated the risk plan after client A's fall on 6/19/15. The RN indicated she updated the plan and emailed the plan to the Qualified</p>		<p>plan in order to further address her behavior. On 8/19, all county QIDPs will receive an in-service that will include direction for ensuring IPPs and other related documents are shared with all relevant program managers. An IPP scheduler has been created to help facilitate communication for when IPPs are due. 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>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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
W 0249 Bldg. 00	<p>Intellectual Disabilities Professional with instructions to print the plan out and put it in the client's record. The RN indicated the direct care staff should have access to the client's current plan.</p> <p>On 7/16/15 at 3:59 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated she thought she had client A's current risk plan for falls on her computer. The QIDP indicated the direct care staff did not have access to her computer. The QIDP indicated she thought the nurse put the plan into the client's record.</p> <p>On 7/17/15 at 1:48 PM, the Quality Assurance/Social Services Manager (QA) indicated the client's current risk plan should be at the group home and the day program for staff to review.</p> <p>This federal tag relates to complaint #IN00176260.</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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>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 record review and interview for 1 of 3 clients in the sample (A), the facility failed to ensure staff implemented client A's risk plan for falls, as written, to prevent a fall with injury.</p> <p>Findings include:</p> <p>On 7/16/15 at 1:03 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 6/19/15 at 7:30 AM, client A was going up the ramp to the van, slipped and fell backward hitting her head on the asphalt causing a cut on the back of her head. The staff called 911 and client A was transported to the hospital. The Bureau of Developmental Disabilities Services (BDDS) incident report, dated 6/19/15, indicated, in part, "I (staff #10) was filling in this morning at the group home assisting another staff person who already works at the group home. We were loading client's (sic) into the van to take them to the workshop when [client A] was starting to come up the ramp she had slipped and fell backwards and hit (sic) head on (sic) ground. [Client A]</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 8/12/15 upon the clients' falls risk plans help them fully utilize client health risk plans, which will include the proper protocol for assisting client A into the van. Staff will be instructed to not move a client unnecessarily after a fall. 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. Any staff from another facility will be trained on all risk plans including fall risk plans in order to provide clients' adequate supports. 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. Any head injury will be followed up at the facility with monitoring. The team lead, QIDP, Quality assurance social services manager or</p>	08/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265			
(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>had fallen due to the ramp being wet from the rain. Staff checked her out and helped her up into the van to sit so that we could check her injuries. Only injury was a cut on the back of the head and it was bleeding... I contacted 9-1-1 and another workshop staff came to get the rest of (sic) clients. EMS (emergency medical services) showed up and checked her and took to ER (emergency room) and I followed them there. [Name of doctor] at the [name of hospital] checked her out and said he could put glue on wound instead of staples or stitches. She also had a CAT (computerized tomography) scan and a tetanus shot done (sic) Results from CAT scam (sic) came back normal and was ok to go home...."</p> <p>The follow-up BDDS report, dated 6/23/15, indicated, "Client had fallen walking up wet (rain) ramp into the van. Was taken to ER on 6/19/2015 and was told she was fine. Later on 6/19/2015 bruises were found on clients (sic) back. One was 1 inch in size the other was an inch and a half in size. On 6/20/2015 client was taken back to ER due to acting abnormally. Client is very limited in verbally (sic) communication. ER determined client had a concussion. On 6/19/2015 they didn't think she did, but staff followed the 72 hour rule to see if signs would appear. As of 6/23/2015</p>		<p>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>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>client is well. No more symptoms of a concussion and her cut on head and bruises are healing well. Staff is to give physical assistance on rainy days to avoid injuries. Client is able to use walker on her own, however on rainy days it will be necessary to intervene for the clients (sic) safety. Staff will continue to make sure client gets well and offer any emotional support that is needed."</p> <p>A review of Client A's Health/Risk Plan for falls, dated 5/13/15, was conducted on 7/16/15 at 3:02 PM. The plan indicated, in part, "Assessed/Identified Issues Related to Protocol/Diagnosis: History of falls due to unsteadiness and risk of fractures due to osteoporosis... 1. Has had several falls w/o (without) severe injury this year. 2. No incidents of fractures - h/o (history of) osteoporosis. 3. Has short attention span. 4. Uses walker to ambulate but will attempt to walk w/o walker. 5. Uses w/c (wheelchair) when walking distances of 100 ft. (feet) or (greater). 6. Has fallen or slid out of bed several times attempting to get up unassisted... Prescribed Treatments/Medications/Preventative Measures: ...4. Assist client in/out of vehicle...."</p> <p>On 7/17/15 at 11:28 AM, the Registered</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/21/2015
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265		
(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>Nurse (RN) indicated at the time of client A's fall, the staff should have been with her on the ramp. The RN indicated the staff failed to implement client A's plan as written.</p> <p>On 7/17/15 at 1:14 PM, staff #10 indicated that on 6/19/15, she was filling in at the group home for the first time. Staff #10 indicated she was in the back of the van when she observed staff #7 walking out with client A. Staff #10 indicated she continued to assist the other clients and heard client A fall. Staff #10 indicated she did not see client A fall. Staff #10 indicated she did not know if client A slipped and fell or just fell backward. When she turned around to check on client A, staff #7 was inside the van. Staff #10 indicated she told staff #7 that client A fell. Staff #10 indicated staff #7 did not know client A fell until staff #10 told her. Staff #10 indicated staff #7 was not supervising client A at the time she fell. Staff #10 indicated she was not sure why staff #7 got into the van. Staff #10 indicated she was aware client A needed to have assistance getting up the ramp. Staff #10 indicated client A's plan was not implemented as written.</p> <p>On 7/17/15 at 2:47 PM, staff #7 indicated on 6/19/15 she was working with a substitute staff. Staff #7 indicated the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G672	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/21/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 W PRIVATE RD 385 N NORTH VERNON, IN 47265
--	--

(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>other staff asked her for help with getting a seatbelt secured. Staff #7 indicated she thought the other staff went down to assist client A. She heard client A fall. Staff #7 was not sure where the other staff was when client A fell. Staff #7 indicated she did not observe client A fall. She was not sure if client A was on the ramp or not when she fell. Staff #7 indicated the regular group home staff never leave client A unsupervised when she was outside. Staff #7 stated "we know better" than to leave client A unsupervised.</p> <p>On 7/17/15 at 1:48 PM, the Quality Assurance/Social Services Manager (QA) indicated the staff did not implement client A's risk plan for falls as written. The QA indicated the staff should have implemented the plan as written by being with her on the ramp. The QA indicated the staff did not follow the plan.</p> <p>This federal tag relates to complaint #IN00176260.</p> <p>9-3-4(a)</p>			