STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G090	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICES INC	3839 CAMELOT LN COLUMBUS, IN 47201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	This visit was for a fundamental recertification and state licensure survey. Survey Dates: December 16, 17, and 18, 2013 Facility Number: 000630 Provider Number: 15G090 AIM Number: 100233920 Surveyor: Steven Schwing, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 12/26/13 by Ruth Shackelford, QIDP.	W000000		
W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 3 of 3 clients observed to receive their medications (#2, #4 and #6), the facility failed to ensure the staff	W000249		02/28/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	implemented the clients' medication administration training objectives as written. Findings include: An observation was conducted at the group home on 12/17/13 from 5:50 AM to 7:49 AM. At 7:10 AM, client #4 received his medications from staff #4. Staff #4 obtained a cup of water for client #4's medication administration. Client #4 was not prompted to get his own water. At 7:25 AM, client #6 received his medications from staff #4. Client #6 was not asked to identify the purpose of his medications. At 7:35 AM, client #2 received his medications from staff #4. Client #2 was not asked to stir his medications into his pudding (staff did not crush his medications). A review of client #2's record was conducted on 12/17/13 at 10:13 AM. Client #2's Individual Program Plan (IPP), dated 6/13 - 6/14, indicated he had a medication training objective to assist staff with stirring his crushed medications into pudding. A review of client #4's record was conducted on 12/17/13 at 10:09 AM. Client #4's IPP, dated 6/13 - 6/14, indicated he had a medication training		W249 Staff will be retrained on implementation of each client's individual program plans. Specific training will include but not be limited to the implementation of medication training objectives during each med pass for each client. QIDP or designee will observe at least weekly	

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	objective to get his own water. A review of client #6's record was conducted on 12/17/13 at 10:11 AM. Client #6's IPP, dated 5/13 - 5/14, indicated he had a medication training objective to identify the purpose of his medications. On 12/17/13 at 11:14 AM, the Director of Supported Group Living indicated the clients' medication training objectives should be implemented at each medication administration pass. 9-3-4(a)		for one month then monthly thereafter to ensure compliance in these areas. ADDENDUM: QIDP or Designee will visit the home at least 4 times weekly to observe each client's med pass on various shifts. Each staff in the home will be observed completing a med pass for each client. QIDP will mentor and provide instruction immediately as needed to ensure staff are understanding procedures. These weekly observations will continue for another month and longer if needed until all staff demonstrate competence in procedures. QIDP will continue to conduct observations in each at least monthly to ensure continued compliance. Responsible for QA:	

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			QIDP	
W000312	483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview for 3 of 3 clients in the sample (#1, #3 and #5), the facility failed to ensure the clients' medication reduction plans clearly indicated the psychotropic medication targeted for reduction and the amount of the reduction being identified. Findings include: A review of client #1's record was conducted on 12/17/13 at 9:42 AM. His Behavior Management Program (BMP), dated 7/10/13, indicated he took Lamictal, Haloperidol and Clonazepam	W000312	W312 QIDP will review Behavior Support Plans for all clients. Revisions will be made as determined necessary and specifically for Clients #1, #3, and #5 to include a medication reduction plan which identifies medications targeted for reduction and the	01/17/2014

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	as psychotropic medications. The BMP indicated client #1 moved into the group home in June 2013. The Medication Plan of Reduction section indicated, "Medication reduction will be sought when instances are at or below: This will be determined when he have further information about frequency of behaviors." Client #1 did not have a plan to reduce his psychotropic medications. A review of client #3's record was conducted on 12/17/13 at 10:16 AM. His BMP, dated 6/16/13, indicated he took Paxil and Klonopin as psychotropic medications. The BMP indicated, "Medication reduction will be sought when instances are at or below: Anxiety - 25 instances, 3 months." The plan did not indicate which medication was being targeted for reduction. The plan did not indicate what would be implemented if client #3 had less than 25 instances of anxiety over a 3 month period. A review of client #5's record was conducted on 12/17/13 at 10:39 AM. His BMP, dated 6/1/13, indicated he took Seroquel, Abilify and Trazodone as psychotropic medications. The plan indicated, "Medication reduction will be sought when instances are at or below: physical aggression, 2 instances, 6		amount of the reduction to be sought. QIDP will review behavior tracking data monthly and share results with psychiatrist at least quarterly for review and consideration of medication reductions based on meeting targeted goals. Responsible for QA: QIDP	

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	months; SIB (self-injurious behavior) - 10 instances, 6 months; Pacing - 2 instances, 6 months; Yelling - 10 instances, 6 months." The plan did not indicate which medication was being targeted for reduction. The plan did not indicate what would be implemented if client #3 had less than 25 instances of anxiety over a 3 month period. On 12/17/13 at 11:14 AM, the Director of Supported Group Living indicated the clients' medication reduction plans needed to identify the medication and clearly indicate the criteria for reduction. 9-3-5(a)			
W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation and interview for 3 of 3 clients observed to receive their medications (#2, #4 and #6), the facility's nursing services failed to ensure the staff initialed the Medication Administration Record (MAR) after administering the clients' medications. Findings include: An observation was conducted at the	W000331	W331 All staff will be retrained on correct procedures for medication administration to include appropriate documentation procedures such	01/17/2014

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	group home on 12/17/13 from 5:50 AM to 7:49 AM. At 7:10 AM, client #4 received his medications from staff #4. Prior to administering client #4's medications, staff #4 initialed the MAR, dated December 2013, for each medication administered. At 7:25 AM, client #6 received his medications from staff #4. Prior to administering client #6's medications, staff #4 initialed the MAR, dated December 2013, for each medication administered. At 7:35 AM, client #2 received his medications from staff #4. Prior to administering client #2's medications, staff #4 initialed the MAR, dated December 2013, for each medication administered. On 12/17/13 at 11:14 AM, the Director of Supported Group Living indicated the staff should initial the MAR after medications were administered, not before administering the medications. On 12/18/13 at 1:50 PM, the Registered Nurse (RN) indicated the staff were taught to put dots on the MAR as they prepare the medications. After the clients take their medications, the staff then initial the MAR. The RN indicated the staff should initial the MAR after the clients take their medications. 9-3-6(a)		as initialing MAR only after medication has actually been taken by client. QIDP or designee, or Agency nurse will conduct random observations for one week of all staff on at least one med pass after retraining staff to ensure that correct procedures are understood and being followed by each staff person. QIDP or designee, or Agency nurse will continue to observe at least monthly in each home to ensure compliance in this area. Responsible for QA: QIDP, Agency nurse	

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W000368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, interview and record review for 1 of 3 clients (#4) observed to receive medications, the facility failed to ensure the client received his medication as ordered by the physician. Findings include: An observation was conducted at the group home on 12/17/13 from 5:50 AM to 7:49 AM. At 7:10 AM, client #4 received his medications from staff #4. During the medication pass to client #4, staff #4 indicated client #4 had not had a bowel movement in four days. Staff #4 indicated there was no documentation his Physician's Orders to give milk of magnesia were implemented after three days. Staff #4 administered client #4 milk of magnesia. A review of the December 2013 Medication Administration Record (MAR) for client #4 indicated client #4's last bowel movement was on 12/12/13 during the	W000368	W368 Staff will be retrained on appropriate administration per physician's orders of Client #4's milk of magnesia. QIDP or designee, or Agency nurse will, for at least two weeks, monitor documentation of Client #4's bowel movements every 3 days per physician's orders to ensure that the physician's orders to administer milk of magnesia are being implemented as ordered. On-going training and monitoring every 3 days will continue as needed based on these observations until it is evident that staff are clear on how to implement physician orders. QIDP	01/17/2014

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	11:00 PM to 7:00 AM shift. There was no documentation on the December 2013 MAR indicating staff administered milk of magnesia on 12/16/13. Staff #4 indicated client #4 should have received milk of magnesia, per Physician's Orders, on 12/16/13. A review of client #4's record was conducted on 12/17/13 at 10:09 AM. Client #4's most recently signed Physician's Orders, dated 11/5/13, indicated client #4 had an order to administer milk of magnesia if there was no recorded bowel movement after three days. On 12/17/13 at 11:14 AM, the Director of Supported Group Living indicated, after reviewing client #4's December 2013 MAR, client #4 should have received milk of magnesia on 12/16/13 per his physician's orders. On 12/18/13 at 1:50 PM, the Registered Nurse (RN) indicated client #4 should have received milk of magnesia per physician's orders. The RN indicated it was a medication error. The RN indicated the staff needed to implement the physician's orders as written. 9-3-6(a)		or designee, or Agency nurse will review MAR's at least monthly to ensure continued compliance in this area and provide retraining as needed. Responsible for QA: QIDP, Agency nurse	

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W000369	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, interview and record review for 1 of 3 clients (#2) observed to receive their medications, the facility failed to ensure the client received his medication in the form ordered by the physician. Findings include: An observation was conducted at the group home on 12/17/13 from 5:50 AM to 7:49 AM. At 7:35 AM, client #2 received his medications from staff #4. Client #2 received the following medications whole during the morning medication administration: Cetirizine (chronic sinusitis), Hydroxychloroquine (rheumatoid arthritis), Nexium (hiatal hernia), and Risperidone. Staff #4 administered client #2's medications whole. Staff #4 did not crush client #2's medications. On 12/17/13 at 7:47 AM, staff #4 indicated if client #2's medications were crushed, the medications stay on his	W000369	W369 All staff have been retrained on medication administration for Client #2 as ordered by physician. QIDP or	02/28/2014

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	tongue and end up on his shirt after his medication pass. Staff #4 indicated she was aware client #2 had a physician's order to crush his medications. Staff #4 indicated client #2 could safely take his medications whole due to not having an issue with swallowing them. A review of client #2's record was conducted on 12/17/13 at 10:13 AM. Client #2's December 2013 MAR indicated, "How does client take medications: crushed in pudding." Client #2 ' s Physician ' s Orders, dated 11/5/13, indicated, " " How does client take medications: crushed in pudding. " Client #2's Individual Program Plan (IPP), dated 6/13 - 6/14, indicated he had a medication training objective to assist staff with stirring his crushed medications into pudding. On 12/17/13 at 11:14 AM, the Director of Supported Group Living indicated client #2's medications should have been administered per physician's orders. The Director indicated client #2's medications should have been crushed. On 12/18/13 at 1:50 PM, the Registered Nurse (RN) indicated the staff should have implemented client #2's physician's orders as written by ensuring client #2's medications were crushed. The RN		designee, or Agency nurse will conduct random observations for one week of all staff on at least one med pass after retraining staff to ensure that correct procedures are understood and being followed by each staff person. QIDP or designee, or Agency nurse will continue to observe at least monthly in each home to ensure compliance in this area.	

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	indicated client #2 was on a pureed diet due to dysphagia. The RN indicated the staff was not qualified to indicate it was safe for client #2 to take his medications whole. The RN indicated this was a medication error due to staff not implementing the physician's orders as written. 9-3-6(a)		ADDENDUM: QIDP or Designee will visit the home at least 4 times weekly to observe each client's med pass on various shifts. Each staff in the home will be observed completing a med pass for each client. QIDP will mentor and provide instruction immediately as needed to ensure staff are understanding procedures. These weekly observations will continue for another month and longer if needed until all staff demonstrate competence in procedures. QIDP will continue to conduct observations in each at least monthly to ensure continued compliance.	

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			Responsible for QA: QIDP, Agency nurse	
W000440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility failed to conduct quarterly evacuation drills for the day shift (7:00 AM to 3:00 PM) and night shift (11:00 PM to 7:00 AM). Findings include:	W000440	W440 QIDP will retrain staff on the requirements for regular evacuation drills. A schedule of the drills will be posted in the	01/17/2014

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	A review of the facility's evacuation drills was conducted on 12/16/13 at 4:02 PM. The day shift did not have a drill from 3/27/13 to 7/5/13. The night shift did not have drills conducted from 1/11/13 to 6/10/13 and 8/24/13 to 12/16/13. This affected clients #1, #2, #3, #4, #5 and #6. On 12/17/13 at 6:23 AM, staff #4 indicated she had worked on the overnight shift for four months. Staff #4 indicated she had not conducted an evacuation drill. On 12/17/13 at 11:14 AM, the Director of Supported Group Living indicated there should be one evacuation drill completed each shift each quarter. 9-3-7(a)		home. Staff will turn in monthly documentation to the QIDP of the evacuation drills completed that month. QIDP will compare with the drill schedule to ensure compliance in this area. QIDP will report monthly to SGL Manager the dates of drills conducted that month for tracking to ensure compliance. Responsible for QA: QIDP, SGL Manager	
W000488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. Based on observation and interview for 6 of 6 clients living at the group home (#1, #2, #3, #4, #5 and #6), the facility failed to ensure the clients were involved with meal preparation and serving themselves.	W000488		02/28/2014

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	Findings include: Observations were conducted at the group home on 12/16/13 from 3:43 PM to 5:37 PM and 12/17/13 from 5:50 AM to 7:49 AM. On 12/16/13 at 4:25 PM, client #6 asked staff #8 for a drink. Staff #8 informed staff #1 that client #6 wanted a drink. Staff #1 got out a cup and orange juice, poured the orange juice and gave the cup to client #6. At 4:28 PM, staff #8 opened four cans of apricots without prompting the clients to assist. At 4:45 PM, staff #8 poured peas from a pot into a strainer and into a serving bowl. At 4:53 PM, staff #8 put the serving bowl of peas onto the table as well as ketchup and barbeque sauce. At 5:01 PM, staff #8 cut pork chops into 1/2 inch pieces. At 5:02 PM, staff #8 pureed pork chops in a food processor. At 5:07 PM, staff #1 put the clients' drinks, already poured, onto the table. At 5:09 PM, staff #8 pureed dinner rolls. Client #1 drank his milk and staff #1 poured client #1 another cup of milk. At 5:18 PM, staff #1 served client #3 bread. On 12/17/13 at 5:58 AM staff #9 was in the kitchen making oatmeal while clients #2, #4, #5 and #6 were sitting in		W488 Staff will be retrained on implementation of each client's individual program plans. Specific training will include but not be limited to client's objectives for meal prep, serving themselves with assistance as needed, and clean up after	

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(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
	the living room. Staff #9 poured water into a bowl, added oatmeal and put the bowl into the microwave. At 5:59 AM, staff #9 obtained and opened a box of cereal bars. At 6:04 AM, staff #9 stated to the clients in the living regarding breakfast, "I'm working on it." At 6:08 AM, staff #9 removed the oatmeal from the microwave, stirred and put the bowl back into the microwave. Staff #9 removed eggs from the refrigerator. Staff #9 poured thickener into a mixing bottle. Staff #9 stated to client #5, "I'm going to make you my famous eggs this morning." Staff #9 cracked eggs into a bowl. Staff #9 stirred the eggs. Staff #9 removed the oatmeal from the microwave, stirred and put the eggs into the microwave to cook. At 6:18 AM, staff #9 poured sugar into the oatmeal and stirred. At 6:23 AM, staff #9 stirred the eggs. Staff #9 poured juice concentrate into a container, added water, stirred and added ice. Clients #1, #2, #3, #4, #5 and #6 were awake and available to assist. None of the clients was prompted to assist. Staff #9 poured a glass of orange juice and put the glass on the table. Staff #9 put a bottle of prune juice on the table. At 6:30 AM, staff #9 took the eggs out of the microwave and put a frozen sausage patty into the microwave. At 6:39 AM, staff #9 served client #2's eggs and staff		meals. QIDP or designee will conduct observations on various shifts at least weekly for one month and at least monthly thereafter to ensure compliance in this area. ADDENDUM: QIDP or Designee will visit the home at least 4 times weekly to observe meal prep, meal time, and clean up on various shifts. QIDP will mentor and provide	

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	#10 served client #2's oatmeal. At 6:41 AM, staff #9 served eggs to clients #1 and #3. Staff #9 served eggs to clients #4 and #5. Staff #10 served oatmeal to clients #1, #4 and #5. At 6:43 AM, staff #9 cut up client #6's sausage patty. At 6:48 AM, staff #9 poured client #4's grape juice. Staff #4 poured client #3's prune juice and client #2's grape juice. Staff #9 poured client #1's milk. Staff #10 poured client #5's juice. Staff #10 served clients #5 and #6 a second serving of oatmeal. At 6:59 AM, staff #9 poured client #2's milk. Staff #4 poured client #3's juice. On 12/17/13 at 11:14 AM, the Director of Supported Group Living indicated the clients should all serve themselves in a manner consistent with the assistance they require. The Director indicated the clients should be involved in all aspects of meal preparation including pouring, stirring and carrying items to the table. The Director indicated the staff should involve the clients as much as possible. 9-3-8(a)		instruction immediately as needed to ensure staff are implementing each client's goals for meal time. These weekly observations will continue for another month and longer if needed until all staff demonstrate competence in this area. QIDP will continue to conduct observations at least monthly to ensure continued compliance. Responsible for QA: QIDP	

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W009999	State Findings The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: 460 IAC 9-3-1(a) Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: A fall resulting in injury, regardless of the severity of the injury. This state rule was not met as evidenced by: Based on record review and interview for 4 of 21 incident reports reviewed affecting clients #1, #4 and #5, the facility failed to ensure falls with injury were reported to the Bureau of Developmental Disabilities Services (BDDS) within 24 hours. Findings include:	W009999	W9999 Clarification on the definition of fall was reviewed with the QIDP. Further incidents of such as those identified in the survey report will be reported per guidelines to BDDS. Responsible for QA: QIDP, SGL Manager	01/17/2014

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	A review of the facility's incident/investigative reports was conducted on 12/16/13 at 12:45 PM and indicated the following: 1) On 9/5/13 at 5:00 AM, client #4 was in the restroom. The Medical Incident Report, dated 9/5/13, indicated, "Was having [client #4] stand up from toilet to wipe his bottom he let go of the handle and fell back on the toilet lip... it was red and could tell it scraped his back as it went down his back." The Measurement of Injury section indicated, "1 inch tall maybe 2 inches wide." The What Injury Resulted section indicated, "Scrape on back/may bruise later (right) middel (sic)." The fall with injury was not reported to BDDS. 2) On 9/5/13 at 5:10 AM, client #1 had a seizure. The Medical Incident Report, dated 9/5/13, indicated, "He had a seizure in bathroom and hit knees on cabnit (sic), he had a previous injury of the knee. He was going down to the floor during a seziure (sic). I was able to protect his head from hitting and slapping as he went down but was not able to protect his head and legs at same time." The Measurement of Injury section indicated, "1 inch." There was no description of the injury. The fall with injury was not reported to BDDS.			

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	3) On 9/23/13 at 5:45 PM, client #5 was outside. The Medical Incident Report, dated 9/23/13, indicated, "We were walking he started to run and lost balance forward and hit (right) knee." Client #5 had a quarter size red spot with a 1 inch scrape on his right knee. A note on the report indicated, "IR (incident report) done 9/25/13 when Q (Qualified Intellectual Disabilities Professional) got this report." The incident was reported to BDDS on 9/25/13. 4) On 10/17/13 at 2:21 PM, client #1 was in the restroom. The Medical Incident Report, dated 10/17/13, indicated, "Staff assisted when falling to the floor onto knees. The report indicated client #1 had a 1 centimeter/2 centimeter bruise circle on his left knee. The fall with injury was not reported to BDDS. On 12/17/13 at 11:14 AM, the Director of Supported Group Living indicated falls with injury should be reported to BDDS within 24 hours. 9-3-1(b)			