

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G639	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/07/2011
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 426 E MONTGOMERY RD. GREENSBURG, IN47240
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W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: October 3, 4, 5, 6 and 7, 2011.</p> <p>Surveyor: Dotty Walton, Medical Surveyor III</p> <p>Facility Number: 001214 AIM Number: 100234330 Provider Number: 15G639</p> <p>The following deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/18/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		
W0249	<p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure the client's dining program was implemented.</p>	W0249	QIDP will work with morning staff to structure morning routine so that the dining plan for Client #1 will be implemented appropriately. QIDP or designee will observe the	11/06/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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	<p>Findings include:</p> <p>During observations at the facility on 10/05/11 from 5:50 AM until 7:37 AM, client #1's breakfast was observed. Client #1 was observed to consume dry cereal with milk on 10/05/11 at 6:45 AM until 7:00 AM without staff supervision. Staff #7 was observed to be administering medications to clients #2 and #4, assisted client #2 with making her lunch and was checking on clients #3 and #5 to ensure they were up and dressed for the day.</p> <p>Review of client #1's record on 10/05/11 at 2:30 PM indicated a speech assessment dated 9/13/11 which indicated she was at risk for choking and her meat should be ground. The review indicated a 9/11 dining plan which indicated client #1 required supervision to take small bites of food and small sips of liquid during meals. The dining plan indicated the client's meat should be finely chopped to prevent swallowing difficulty and she should be verbally cued by staff during meals.</p> <p>Interview with Administrator #1 on 10/05/11 at 3:00 PM indicated staff #7 should have structured the morning routine/medication pass so that she could monitor clients during breakfast.</p>		<p>morning routine at least weekly for one month to ensure compliance. Random observations at least monthly will be on-going to ensure continue program implementation.</p> <p>Responsible for QA: QIDP 11/6/2011</p>		

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W0368	<p>9-3-4(a)</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure the client's medications were given according to the physician's orders.</p> <p>Findings include:</p> <p>The facility's medication administration record/MAR for 10/11 was reviewed on 10/05/11 at 10:00 AM. Client #2's 10/11 MAR indicated she received the following medications at 8:00 PM/bedtime: 5 mg. of metclopamide (digestive/elimination aide), 2 mg. of clonazepam (for anxiety), 200 mg. of docusate sodium (laxative), ranitidine 150 mg. (used for gastro esophageal reflux disease/GERD), trazodone 100 mg. (antidepressant), and Zyprexa 7.5 mg. (antipsychotic). The review of the MAR indicated staff had not signed the medications as having been administered on the previous evening of 10/04/11.</p> <p>Interview with Administrator #1 on 10/05/11 at 10:30 AM indicated staff #8</p>	W0368	<p>It is expected that all physician orders are implemented timely and as ordered. QIDP will retrain all staff on the importance of timeliness and accuracy in implementing all physician orders. Overnight staff review MAR's and medications to ensure that proper documentation is complete and meds were administered. Staff are expected to complete a medication error report should errors be identified. QIDP is responsible for ensuring agency policies are followed in addressing all medication errors and retraining is completed when required.</p> <p>Responsible for QA: QIDP 11/6/2011</p>	11/06/2011			

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W0369	<p>had neglected to administer client #2's 8:00 PM medications to her on 10/04/11.</p> <p>9-3-6(a)</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review and interview for 3 of 26 medications observed (clients #1, #2 and #4), the facility failed to ensure the medications were given according to the physician's orders.</p> <p>Findings include:</p> <p>During observations at the facility on 10/05/11, client #4 was observed to receive omeprazole 20 mg./milligrams (used for gastro esophageal reflux disease/GERD) at 6:23 AM. Client #4 was observed to prepare cereal and milk for breakfast at 6:30 AM and was eating at 6:40 AM.</p> <p>During observations at the facility on 10/05/11 at 6:15 AM, client #2 was observed to eat cereal milk and coffee for breakfast. At 6:30 AM, client #2 was observed to receive her medications which included metclopamide 5 mg.</p>	W0369	<p>QIDP will retrain staff specifically on administering the medications as ordered by physician for Clients #1, 2, and 4. QIDP will retrain all staff on the importance of accuracy in administering medications. QIDP or designee will observe at least weekly for one month to ensure compliance. Random observations at least monthly will be on-going to ensure continued compliance.</p> <p>Responsible for QA: QIDP 11/6/2011</p>	11/06/2011	

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	<p>(medication to aide with digestion and elimination) from staff #7. Client #1 was observed to consume breakfast of milk and dry cereal at 6:45 AM on 10/05/11. Client #1 was given her medication levothyroxine (thyroid hormone) 0.025 mg. at 7:19 AM by staff #7 after she had eaten.</p> <p>The facility's medication administration record/MAR for 10/11 was reviewed on 10/05/11 at 10:00 AM. Client #1's 10/11 MAR indicated she was to receive levothyroxine 0.025 mg. at 6:30 AM daily on an empty stomach. Client #2's 10/11 MAR indicated she received 5 mg. of metclopamide four times (before meals and at bedtime) daily. Client #4's 10/11 MAR review indicated she had a physician's order to take omeprazole 20 mg. 30 minutes before food in the morning.</p> <p>Interview with RN #9 on 10/05/11 at 3:30 PM and 5:00 PM indicated client #2's metclopamide and client #4's omeprazole should be taken 30 minutes before meals for best results.</p> <p>9-3-6(a)</p>				

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W0386	<p>The facility must, on a sample basis, periodically reconcile the receipt and disposition of all controlled drugs in schedules II through IV (drugs subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C. 801 et seq., as implemented by 21 CFR Part 308).</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure the disposition/receipt of the client's controlled drug was documented.</p> <p>Findings include:</p> <p>During observations at the facility on 10/05/11 at 6:30 AM client #2 was observed to receive 2 mg/milligrams of clonazepam (used for seizures or panic disorders) from staff #7. Staff #7 did not count the medication or document the number of the clonazepam disbursed or remaining.</p> <p>The facility's medication administration record/MAR for 10/11 was reviewed on 10/05/11 at 10:00 AM. Client #2's 10/11 MAR indicated she received 2 mg. of clonazepam twice daily at 7:00 AM and 8:00 PM. The MAR contained no documentation of the number of the clonazepam pills or information regarding their disbursement (no descending count sheets). Review of the Food and Drug Administration's website on 10/06/11 at</p>	W0386	<p>Staff were retrained on the documentation procedures for controlled medications. Appropriate documentation was implemented for Client #2's medication as identified in survey report. QIDP or designee will check at least weekly for one month to ensure documentation is continuing. Agency nurse will review documentation at least monthly.</p> <p>Responsible for QA: QIDP 11/6/2011</p>	11/06/2011	

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W0440	<p>3:00 PM indicated the medication clonazepam was a schedule IV controlled drug.</p> <p>Interview with staff #1 on 10/05/11 at 10:30 AM indicated client #2's clonazepam was not counted and quantities of it were not documented as it was dispensed twice daily at the facility.</p> <p>9-3-6(a)</p> <p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), and 2 additional clients (#4 and #5), the facility failed to ensure day shift, evening shift sleeptime evacuation drills were conducted at least quarterly.</p> <p>Findings include:</p> <p>Fire evacuation drills from 9/10 to 10/11 with clients #1, #2, #3, #4 and #5, as participants were reviewed on 10/05/11 at 2:00 PM. The review indicated no sleeptime fire drill (11:00 PM until 5:00 AM) for the fourth quarter of 2010 (October, November and December), or the first quarter of 2011 (January, February and March), or the third quarter of 2011 (July, August and September).</p>	W0440	<p>QIDP will retrain staff on requirements for regular evacuation drills. A schedule will be posted in the home to ensure drills are performed as required for each shift. QIDP will review this monthly at house meetings to ensure compliance.</p> <p>Responsible for QA: QIDP 11/6/2011</p>	11/06/2011			

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W0460	<p>The review indicated no daytime (7:00 AM to 3:00 PM) drills for the fourth quarter of 2010 (October, November and December), or the first quarter of 2011 (January, February and March), or the second quarter of 2011 (April, May and June), or the third quarter of 2011 (July, August and September). There was no evening shift (3:00 PM to 11:00 PM) drill for the third quarter of 2011 (July, August and September).</p> <p>Interview with Administrative staff #1 on 10/05/11 at 2:15 PM indicated no additional drill records for the facility.</p> <p>9-3-7(a)</p> <p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview for 2 of 3 sampled clients (#1 and #2), and two additional clients (#4 and #5), the facility failed to ensure the clients' menu was followed.</p> <p>Findings include: During observations at the facility on 10/05/11 from 5:50 AM until 7:37 AM, breakfast was observed. Client #2 was observed to eat cereal with</p>	W0460	<p>QIDP will retrain staff on ensuring clients receive a well-balanced diet by following menus and specific diet orders. QIDP or designee will do random observations at least weekly for one month and at least monthly thereafter to ensure compliance.</p> <p>Responsible for QA: QIDP 11/6/2011</p>	11/06/2011	

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	<p>milk and coffee for breakfast at 6:15 AM. Client #4 was observed to prepare cereal and milk for breakfast at 6:30 AM and was eating at 6:40 AM. Client #1 was observed to consume breakfast of milk and dry cereal at 6:45 AM. Client #5 was observed to make toaster waffles and eat them with syrup and no beverage on 10/5/11 at 7:15 AM. Clients were not prompted by staff #7 to follow the menu of cereal, milk, yogurt, apple juice and toast.</p> <p>Review of the breakfast menu for 10/05/11 on 10/05/11 at 11:00 AM indicated clients had a choice of dry or cooked cereal, a cup of milk, 1/2 cup of apple juice, four ounces of yogurt and toast with jelly/margarine.</p> <p>Interview with Administrator #1 on 10/05/11 at 11:30 AM indicated staff #7 should have ensured clients were offered juice and yogurt along with the cereal and milk for breakfast.</p> <p>9-3-8(a)</p>				