DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090			LDING	ONSTRUCTION 00	(X3) DATE : COMPL 11/22/2	ETED	
	PROVIDER OR SUPPLIER		<u>.</u>	3839 C	ADDRESS, CITY, STATE, ZIP CODE AMELOT LN IBUS, IN47201	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
W0000	Survey Dates: N 18, 21 and 22, 20 Facility Number: Provider Number AIM Number: 1 Surveyor: Steve Surveyor III These deficiencie findings in accor Quality Review of	d state licensure survey. fovember 14, 15, 16, 17, 011. 000630 15G090	W	0000			
W0125	clients. Therefore encourage individual rights as clients of of the United State complaints, and the Based on observative record review for the group home (#6), the facility flad the right to due	nsure the rights of all, the facility must allow and ual clients to exercise their the facility, and as citizens as, including the right to file e right to due process. Action, interview and a 6 of 6 clients living in #1, #2, #3, #4, #5 and a failed to ensure the clients process in regard to the ring chimes attached to the	W	0125	The chimes have been removed from the refrigerator door. QIDP reviewed restriction of client's rig with staff and Client #6's current plan which does not include any such restriction. QIDP or designewill continue to document at leas	hts e	12/22/2011

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

TITLE

000630

(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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

XR7311

Facility ID:

If continuation sheet

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G090	(X2) MU: A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL 11/22/2	ETED
	ROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE AMELOT LN BUS, IN47201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓΕ	(X5) COMPLETION DATE
	Findings include: Observations were on 11/14/11 from 3: 11/15/11 from 6:05 observations, the refarea near the living attached to the hand by side doors). Who wind chimes sounder affected clients #1, and the use of wind chimes to alert staff. A review of client #11/16/11 at 11:19 A documentation in his the use of wind chimes to alert staff. A review of client #11/16/11 at 11:23 A documentation in his the use of wind chimes to alert staff. A review of client #11/16/11 at 12:47 Production of the use of wind chimes to alert staff. A review of client #11/16/11 at 11:13 A documentation in his the use of wind chimes to alert staff.	conducted at the group home 51 PM to 5:56 PM and AM to 8:00 AM. During the frigerator located in the kitchen room had wind chimes le on the refrigerator side (side en the door was opened, the ed an audible alert. This #2, #3, #4, #5 and #6. 1's record was conducted on M. There was no s record indicating he required nes on the refrigerator handle 2's record was conducted on M. There was no s record indicating he required nes on the refrigerator handle 3's record was conducted on M. There was no s record indicating he required nes on the refrigerator handle 4's record was conducted on M. There was no s record indicating he required nes on the refrigerator handle	P		CROSS-REFERENCED TO THE APPROPRIAT	<u> </u>	
	11/16/11 at 12:52 P	5's record was conducted on M. There was no s record indicating he required					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G090	B. WIN			11/22/2	U11
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	ES INC			AMELOT LN IBUS, IN47201		
			ı	l	1000, 11147201		710
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	DATE
		nes on the refrigerator handle					
	to alert staff.	<u> </u>					
	A review of client # 11/16/11 at 12:57 Pl documentation in hi the use of wind chim to alert staff. An interview with d conducted on 11/15 indicated the chimes refrigerator door to was opened. An interview with E 11/14/11 at 5:11 PM chimes were attached client #6's food seek An interview with E 11/15/11 at 6:32 AM chimes were attached refrigerator due to conducted on 11/16/11 at 1:08 use of wind chimes was not part of the conducted in the staff of the staff	s record indicating he required hes on the refrigerator handle lirect care staff (DCS) #8 was /11 at 7:45 AM. DCS #8 were on the handle of the alert the staff when the door DCS #3 was conducted on I. DCS #3 indicated the wind be do to the door handle due to cing. DCS #7 was conducted on M. DCS #7 indicated the ed to the door handle of the lient #6's behavior.					
	9-3-2(a)						
W0126	clients. Therefore individual clients to	ensure the rights of all , the facility must allow o manage their financial hem to do so to the extent s.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	JLTIPLE CO	INSTRUCTION 00	(X3) DATE SUR COMPLETE		
1111212111	or confidence.	15G090	A. BUII			11/22/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				AMELOT LN		
DEVELO	PMENTAL SERVIC	ES INC			IBUS, IN47201		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	re CO	OMPLETION DATE
TAG		review and interview for	137	0126	W126	1	2/22/2011
		ng in the group home	"	0120	QIDP will review each client's	1	.2/22/2011
		f5 and #6), the facility			program plan to ensure goals are i	n	
		he clients accessed their			place for money skills. Staff will be	9	
	petty cash funds.				trained on importance of each clie	nt	
	petty easii runus.				accessing their petty cash funds routinely, at least monthly. QIDP	, .	
	Findings include				designee will audit client petty cas		
		•			reports at least monthly to ensure		
	A review of the o	clients' finances was			compliance in this area.		
	conducted on 11/	/16/11 at 10:10 AM.			Responsible for QA: QIDP		
	-Client #1: On 1	/2/11, the balance in his			Responsible for QA. QIDP		
		29.44. On 1/7/11, the					
	balance was \$40.	.44. The balance					
	remained unchan	iged until 9/22/11 when it					
	was \$10.34. On	10/4/11, the balance was					
	\$10.44. There w	ras no					
	description/docum	mentation to account for					
	the changes in th	e balances.					
	-Client #2: From	n 11/10/10 until 8/4/11,					
		s petty cash was \$3.52.					
		palance was \$2.52. There					
	_	on/documentation to					
		hange in the balance.					
		1/8/10, his petty cash					
		his balance was \$4.56.					
		ained the same until					
	_	en the balance was \$3.56.					
		scription/documentation					
		e change in the balance.					
		/2/11, his petty cash F7. It remained \$5.47					
		n it changed to \$3.47. On nce was \$4.47. There					
	•	on/documentation to					
	was no description	on accumentation to					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090			LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/22/2011		
	PROVIDER OR SUPPLIER			3839 CA	DDRESS, CITY, STATE, ZIP CODE AMELOT LN BUS, IN47201		
				<u> </u>			(715)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	(X5) COMPLETION DATE
TAG				IAG	DEFICIENCE!		DATE
		hanges in the balances.					
		1/8/10, his petty cash					
	balance was \$29						
	_	7/29/11 when it was					
		/11, his balance was					
	\$1.33. There wa						
	_	mentation to account for					
	the changes in th						
		1/23/10, his petty cash					
	balance was \$14						
	1	6/30/11 when it was					
		1/11, the balance was					
		1/11, the balance was					
		11, the balance was					
	\$1.57. There wa						
	_	mentation to account for					
	the changes in th	e balances.					
		th the Director of					
		Living was conducted					
		0:10 AM. The Director					
		ents should be accessing					
		outinely for personal					
		e Director stated one time					
	per month would	l be "reasonable."					
	9-3-2(a)						
W0140	system that assur accounting of clien	establish and maintain a es a full and complete nts' personal funds acility on behalf of clients.					
		review and interview for	W	0140	W140		12/22/2011
		ing in the group home			Each client was reimbursed for th	ne	
					petty cash that was unaccounted		
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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090			LDING	NSTRUCTION 00	CC	ATE SURVEY OMPLETED 22/2011
			B. WIN		DDRESS, CITY, STATE, ZIP CO	ODE	
NAME OF F	PROVIDER OR SUPPLIEF	₹		3839 CA	AMELOT LN		
DEVELO	PMENTAL SERVIC	CES INC		COLUM	BUS, IN47201		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE PPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	for. The finance procedur	oc wore	DATE
		#5 and #6), the facility			reviewed and revised to in		
		an accurate accounting of			nightly auditing by staff. S		
	the clients' petty	casn.			be trained on these proce	dures	
	Findings in alada				which include notification	to the	
	Findings include):			QIDP by the end of the sh		
		1: , 1 6			any discrepancies are four		
		clients' finances was			finance book. Monthly au the Administrative Finance		
		/16/11 at 10:10 AM.			and notification to the QII	•	
		1/2/11, the balance in his			division manager of any		
	1 2	29.44. On 1/7/11, the			discrepancies will continu	e.	
		.44. The balance					
		nged until 9/22/11 when it			Responsible for QA: QIDP	, SGL	
		10/4/11, the balance was			Manager		
	\$10.44. There w						
		mentation to account for					
	the changes in th						
		n 11/10/10 until 8/4/11,					
		s petty cash was \$3.52.					
	-	balance was \$2.52. There					
	_	on/documentation to					
		change in the balance.					
		1/8/10, his petty cash					
	_	his balance was \$4.56.					
		ained the same until					
		en the balance was \$3.56.					
		scription/documentation					
		e change in the balance.					
		1/2/11, his petty cash					
		47. It remained \$5.47					
		n it changed to \$3.47. On					
	•	ince was \$4.47. There					
	_	on/documentation to					
		changes in the balances.					
	-Client #5: On 1	1/8/10, his petty cash					
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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090		LDING	nstruction 00	(X3) DATE (COMPL 11/22/2	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	,	 	DDRESS, CITY, STATE, ZIP CODE		
				AMELOT LN		
DEVELO	PMENTAL SERVIC	CES INC	COLUM	BUS, IN47201		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
TAG	balance was \$29		TAG			DATE
		7/29/11 when it was				
	1	2/11, his balance was				
	\$1.33. There wa	·				
		mentation to account for				
	the changes in th					
		1/23/10, his petty cash				
	balance was \$14					
	unchanged until	6/30/11 when it was				
	\$14.25. On 7/29	/11, the balance was				
	\$14.45. On 7/29	/11, the balance was				
	\$1.45. On 8/24/	11, the balance was				
	\$1.57. There wa					
	_	mentation to account for				
	the changes in th	e balances.				
	An interview we	s conducted with finance				
		loyee #1 on 11/16/11 at				
		sloyee #1 on 11/10/11 at				
	_	e issue with the clients'				
		petty cash. She indicated				
		concerns to the Director				
	_	oup Living on 9/23/11.				
		licated the issues she				
		en addressed and the				
		to be reimbursed for the				
	unaccounted spe	nding.				
	An interview wit	th the Director of				
		Living was conducted				
		0:10 AM. The Director				
		ility should ensure				
	-	hdrawals from the clients'				
	petty cash was d	ocumented. The Director				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090		(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 11/22/2	ETED	
	ROVIDER OR SUPPLIER		B. WIW	STREET A	ADDRESS, CITY, STATE, ZIP CODE AMELOT LN IBUS, IN47201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
W0149	accurate account On 11/16/11 at 1 stated she, "dropp being notified of clients' petty cash 9-3-2(a) The facility must dwritten policies and mistreatment, neg Based on record 1 of 19 incident/i reviewed affecting failed to prevent ensuring a medic immediately to the Bureau of Deservices (BDDS) accordance with investigation was Findings include A review of the fincident/investigation for the fincident/investigation was conducted on 11/1 BDDS report, day the following, "Apsychiatric visit I medication, Abil	evelop and implement d procedures that prohibit lect or abuse of the client. review and interview for investigative reports ag client #5, the facility ineglect of a client by not ation error was reported in administrator and to evelopmental Disabilities within 24 hours, in state law and a thorough is conducted. Cacility's active reports was (14/11 at 1:30 PM. The ted 10/15/11, indicated at [client #5's] last	W	0149	W149 Agency policy and procedures wer reviewed and determined to be appropriate in prohibiting the mistreatment, neglect or abuse of client. Staff were retrained on the policy and procedures for timely reporting of incidents such as med errors. Procedures for reviewing med errors are being revised to include an interview with the individual(s) responsible for the merror in a more timely manner. QIDP's will be responsible for reporting to the SGL Manager monthly information regarding meerrors occurring each month. Responsible for QA: QIDP, SGL Manager	a : ! ed	12/22/2011

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G090		LDING	NSTRUCTION 00	(X3) DATE COMPL 11/22/2	ETED
	PROVIDER OR SUPPLIER			3839 CA	DDRESS, CITY, STATE, ZIP CODE AMELOT LN BUS, IN47201		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	COMPLETION DATE
	the MAR (medic	ordered and was added to eation administration					
	· /	he medication came in g it. However, for some					
		ous order was not onsequently [client #5]					
	was receiving 17	7.5 mg of Abilify. This					
		n from 10/5/11 until it by staff person, [staff #7],					
	on 10/12/11 It	is currently unknown					
		order of Abilify was not I the QA (Qualified					
		ion Professional assistant) ag the change of the					
	medications has	been on vacation this					
		lity did not provide f an investigation into the					
	medication error	." The BDDS report					
	indicated the dat incident was on	e of knowledge of the 10/14/11.					
		th the Qualified Mental					
		Sessional (QMRP) was //16/11 at 12:42 PM. The					
	QMRP indicated	the staff failed to					
		ort this issue to her DS report was submitted					
	late. She indicat	ed her date of knowledge					
		d she reported it to BDDS of being notified.					
		_					
		th the Director of Living was conducted					
		2:42 PM. The Director					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15G090	A. BUILDING B. WING		11/22/2011
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
				AMELOT LN	
	PMENTAL SERVIC			MBUS, IN47201	
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	indicated an inve	estigation was not			
	9-3-2(a)				
W0153	mistreatment, neg injuries of unknow immediately to the officials in accordate established proced. Based on record. I of 19 incident/ir reviewed affecting failed to ensure a reported immediate and to the Bureau Disabilities Servithours, in accordate Findings include. A review of the fincident/investigation conducted on 11/1 BDDS report, dathe following, "A psychiatric visit I medication, Abil 7.5 mg (milligram medication was of the MAR (medic record). When the	review and interview for investigative reports ag client #5, the facility a medication error was ately to the administrator at of Developmental ices (BDDS) within 24 ance with state law. Cacility's active reports was ative reports was ative reports was [client #5's] last this psychotropic ify, was increased from ms) to 10 mg. This ordered and was added to action administration me medication came in	W0153	W153 Agency policy and procedures we reviewed and determined to be appropriate in prohibiting the mistreatment, neglect or abuse of client. Staff were retrained on the policy and procedures for timely reporting of incidents such as med errors. Procedures for reviewing med errors are being revised to include an interview with the individual(s) responsible for the m error in a more timely manner. QIDP's will be responsible for reporting to the SGL Manager monthly information regarding me errors occurring each month. Responsible for QA: QIDP, SGL Manager	a : ! ed
	staff began givin	g it. However, for some			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G090		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/22/2011		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3839 CAMELOT LN COLUMBUS, IN47201				
(X4) ID PREFIX TAG	(EACH DEFICIENC	CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0154	reason, the previous discontinued. Common was receiving 17 dosage was given was discovered by on 10/12/11." The date of known on 10/14/11. An interview with Retardation Professional Conducted on 11/2 QMRP indicated immediately report therefore the BD late. She indicated was 10/14/11 and within 24 hours of 9-3-2(a) The facility must he alleged violations as Based on record in 19 incident/in	ous order was not onsequently [client #5] .5 mg of Abilify. This of from 10/5/11 until it y staff person, [staff #7], he BDDS report indicated ledge of the incident was the Qualified Mental essional (QMRP) was 16/11 at 12:42 PM. The the staff failed to out this issue to her DS report was submitted ed her date of knowledge if she reported it to BDDS of being notified. ave evidence that all are thoroughly investigated. review and interview for investigative reports	W01		W154 Agency policy and procedures were reviewed and determined to be	e	12/22/2011
	failed to thorough	ng client #5, the facility ally investigate a involving a psychotropic			appropriate in prohibiting the mistreatment, neglect or abuse of client. Staff were retrained on the policy and procedures for timely reporting of incidents such as med		
	Findings include: A review of the fincident/investigation	acility's			errors. Procedures for reviewing med errors are being revised to include an interview with the individual(s) responsible for the me error in a more timely manner.	ed	

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NAME OF PROVIDER OR SUPPLIED		STREET ADDRESS, CITY, STATE, ZIP CODE 3839 CAMELOT LN COLUMBUS, IN47201					
DEVELOPMENTAL SERVICE (X4) ID SUMMARY SERVICE TAG REGULATORY OF Conducted on 11 BDDS report, do the following, "A psychiatric visit medication, Abir 7.5 mg (milligramedication was the MAR (medication was the MAR (medication). When the staff began giving reason, the prevential discontinued. On the was receiving 1'd dosage was given was discovered on 10/12/11 If why the original discontinued and Mental Retardate who was handling medications has week." The fact documentation of medication error on 11/16/11 at 1	CES INC TATEMENT OF DEFICIENCIES RCY MUST BE PERCEDED BY FULL RLSC IDENTIFYING INFORMATION) //14/11 at 1:30 PM. The ated 10/15/11, indicated At [client #5's] last his psychotropic lify, was increased from ms) to 10 mg. This ordered and was added to cation administration he medication came in ng it. However, for some fous order was not onsequently [client #5] 7.5 mg of Abilify. This n from 10/5/11 until it by staff person, [staff #7], this currently unknown order of Abilify was not of the QA (Qualified ion Professional assistant) ng the change of the been on vacation this lity did not provide of an investigation into the	B. WIN	STREET A	AMELOT LN	ΤΈ	(X5) COMPLETION DATE	
conducted. 9-3-2(a)							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G090			LDING	NSTRUCTION 00	(X3) DATE COMPL 11/22/2	ETED	
	PROVIDER OR SUPPLIER		D. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE AMELOT LN IBUS, IN47201		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
W0227	The individual prog specific objectives client's needs, as is comprehensive as paragraph (c)(3) of Based on observations interview for 3 of #6), the facility for #2's program plathandheld radio as had training object preparation. Findings include 1) An observation group home on 15:56 PM. At 4:11 client #2 if he was gave client #2 his was seated in the #1, #3, #4 and #5 radio on to a loud held the radio up radio remained left he was prompted out his pajamas for PM, staff #1 turn clients #1 and #3 room with client staff #2 at 4:36 P staff #1 to put on can't hear me with going." At 4:43	gram plan states the necessary to meet the dentified by the sessment required by f this section. ation, record review and f 6 clients (#1, #2 and ailed to ensure: 1) client in addressed the use of a and 2) clients #1 and #6 ctives for meal	W	0227	W227 QIDP will review and revise client #2's program plan to include specinformation addressing the use of his handheld radio and clients #1 and #6's program plan to include training objectives for meal prep. Staff will be trained on all revision to program plans. QIDP or designwill observe at least monthly on a regular basis to ensure program plobjectives are being implemented Responsible for QA: QIDP	s ee lan	12/22/2011

Facility ID:

AND PLAN OF CORRECTION IDE		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL	ETED
		15G090	B. WIN	G		11/22/2	011
NAME OF I	PROVIDER OR SUPPLIEF	\		1	ADDRESS, CITY, STATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	CES INC			AMELOT LN IBUS, IN47201		
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PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Client #2 turned	off his radio at 4:50 PM.					
	At 5:01 PM, clie	ent #2 turned his radio on					
	_	PM, staff #3 indicated to					
	client #3 she would remove his hearing aids so client #2's radio would not bother						
		d calm down a bit. At					
		#2 turned off his radio					
	when it was time	e for dinner.					
	A review of alice	nt #2's record was					
	A review of client #2's record was conducted on 11/16/11 at 11:23 AM. His						
	Behavior Management Program plan,						
	dated 6/5/11, and his Individual Program						
	· ·	-6/12, did not address the					
	•	eld radio. There was no					
	plan in place to a	address client #2 using his					
		not disrupt his peers at					
	the group home.						
		1:32 AM, an interview					
	-	ed Mental Retardation					
	` ~	MRP) was conducted.					
	-	cated there was an					
		l last year to address					
		This radio. The QMRP lendum was not included					
		st recent plans and should					
	be a part of his p	•					
	oc a part or ms p	ταιι.					
	2) Observations	were conducted at the					
	, ·	1/14/11 from 3:51 PM to					
	• •	15/11 from 6:05 AM to					
		1/14/11 at 4:00 PM, client					
		a stool at the island in					

		IDENTIFICATION NUMBER:				00		(X3) DATE COMPL	
		15G090		A. BUIL				11/22/2	
				B. WINC		DDDESS CITY O	STATE, ZIP CODE	l	
NAME OF P	ROVIDER OR SUPPLIER	1				AMELOT LN	TATE, ZIF CODE		
DEVELO	PMENTAL SERVIC	ES INC				IBUS, IN4720	1		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES			ID		'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULI		I	PREFIX	CROSS-REFERE	TIVE ACTION SHOULD BE NCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	N)		TAG	1	DEFICIENCY)		DATE
		e staff #2 unloaded the							
	•	out the dishes away. At							
	-	2 was rinsing dishes and							
	putting them into the dishwasher as client								
	#6 sat at the island. Clients #1, #3 and #4								
	were sitting in the living room and								
		st. At 4:16 PM, staff #2							
	-	ner to open cans for							
		6 was not prompted to							
		M, staff #2 cleaned off							
	_	table. Client #6 was in							
	the area but not asked to assist. At 4:22								
	PM, staff #2 wen	nt into the the living room	Ŀ						
	area to access the	e second refrigerator to							
	get bread. Client	ts #1, #2, #3, #4, #5 and							
	#6 were not aske	ed to assist and were							
	available to assis	t. At 4:28 PM, staff #2							
	was in the kitche	n without the clients							
	cooking dinner.	At 4:41 PM, staff #2							
	breaded the chick	ken; none of the clients							
	assisted or were a	asked to assist. At 4:43							
	PM, staff #2 was	washing dishes without							
		nt. At 4:56 PM, staff #2							
	was cooking with	hout client involvement.							
	_	f #2 stirred the potatoes.							
	· ·	f #3 obtained neck							
	-	lients who wore them							
	•	ne clients to assist. At							
	5:05 PM, staff #2								
		hen took plates out of the							
		7 PM, staff #2 took the							
		e oven. At 5:18 PM,							
		ing up the chicken and							
		ne clients' plates for them.							
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090			LDING	NSTRUCTION 00	(X3) DATE : COMPL 11/22/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					AMELOT LN		
	PMENTAL SERVIC			L	IBUS, IN47201		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION		(X5)
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
		5:24 PM, staff #2 opened					
		At 5:24 PM, staff #2 put					
	the can of peach	*					
	•	35 PM, staff #2 and #3					
	^	chicken. Staff #3 carried					
		, #4, #5 and #6's plates to					
		at the dining room table.					
	On 11/15/11 at 6	5:08 AM, staff #5 was in					
	the kitchen prepa	aring breakfast without					
	client involveme	ent. Clients #1, #2, #3, #5					
	and #6 were sitting in the living room. At						
	6:10 AM, staff #5 asked clients #1 and #6						
	if they wanted co	ereal or oatmeal. At 6:17					
	AM, client #2 si	gned "juice." Staff #7					
	went into the kit	chen, poured a glass of					
	juice and took to	client #2 as he sat on the					
	couch. At 6:21	AM, client #6 pointed to					
	the kitchen. Sta	ff #6 said to client #6,					
	"He's fixing it fo	r you." Staff #5 was in					
		aring breakfast without					
	_	involved. At 6:26 AM,					
		ient #3 if he wanted					
		1. At 6:30 AM, staff #5					
		k sausage and oatmeal					
	•	#2, #3, #4, #5 and #6 sat					
	_	m. At 6:38 AM, staff #5					
	_	At 6:42 AM, staff #5					
		up sausage and the					
		ne living room. At 6:46					
	•	asured and then poured					
		s. At 6:48 AM, staff #5					
		ast was ready. Each plate					
	had food on it. S	Staff #5 served each client					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090			LDING	NSTRUCTION 00	(X3) DATE (COMPL 11/22/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		STREET A	DDRESS, CITY, STATE, ZIP CODE		
	PMENTAL SERVIC				AMELOT LN BUS, IN47201		
(X4) ID		TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	•	food. At 6:55 AM, staff and in the kitchen					
	preparing the cli						
	A review of clien						
	conducted on 11/16/11 at 11:19 AM.						
		idual Program Plan (IPP), indicated his culinary					
		e was to prepare his lunch					
		o. Client #1 did not have					
	a training objective to assist during dinner						
	and breakfast prep.						
	A review of client #6's record was						
		/16/11 at 12:57 PM.					
		dated 5/11-5/12, indicated					
		a culinary training					
	1 "	PP indicated he needed					
		aining however the plan					
		training objective. The					
	_	[Client #6] is able to me meal preparation					
		ver, he can be most					
		heal times by helping with					
		or doing other tasks. He					
		kitchen appliances and					
		ed when in the kitchen to					
	_	He will avoid a hot					
	food."	is attempting to retrieve					
	1000.						
	An interview wit	th the QMRP was					
		/21/11 at 12:12 PM. The					
	QMRP indicated	l clients #1 and #6 should					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/22/2011	
	ROVIDER OR SUPPLIER		STREET 3839 (ADDRESS, CITY, STATE, ZIP CODE CAMELOT LN MBUS, IN47201	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W0240	QMRP indicated participate and the revised to include training. 9-3-4(a) The individual progrelevant intervention toward independed Based on observation record review for clients (#2 and #4 ensure their progression instruction implement their progression in the progression of the progression of the living room onto his left arm belt was not observed.	ation, interview and a 2 of 3 non-sampled 4), the facility failed to ram plans included ons for staff to plans.	W0240	W240 QIDP will review and revise prograplans to include specific instruction for staff on the use of client #2's good belt and client #4's helmet. Staff be trained on these plans and QID or designee will observe weekly for one month and at least monthly of a regular basis to ensure compliant in these areas. Responsible for QA: QIDP	ns ait will P or n

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090				LDING	NSTRUCTION 00		X3) DATE : COMPL 11/22/2	ETED
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>	p. w.:	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	CES INC		COLUM	BUS, IN47201			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	LAN OF CORRECTION TE ACTION SHOULD BE ED TO THE APPROPRIATI ICIENCY)	Ē	(X5) COMPLETION DATE
FORM CMS-2	room; staff #1 di use his gait belt. walked across th his chair. Staff # belt. At 4:16 PM #4 to his room. back of client #4 gait belt was not staff #3 assisted Client #4's gait be staff #3. The ga shirt and staff #3 belt and his shirt was prompted to table to decorate held onto the back belt was not obse #4 stood up and #1 held onto his client #4 entered hallway indepen near him and not holding his gait be A review of clien conducted on 11 Gait Belt Usage indicated the folt to wear the gait be around his waist Staff should wal onto the gait belt	nt #4's record was /16/11 at 11:13 AM. His Instructions, undated, lowing: "1. [Client #4] is belt snugly fastened below his navel. 2. k with their hand holding t keeping constant contact steady [client #4] while he	XR7311	Facility I	D: 000630	If continuation she	eet Pag	ge 19 of 48

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G090	B. WIN			11/22/2	011
NAME OF I	PROVIDER OR SUPPLIEF		•	STREET A	DDRESS, CITY, STATE, ZIP CODE	•	
NAME OF F	ROVIDER OR SUFFLIER			3839 CA	AMELOT LN		
DEVELO	PMENTAL SERVIC			COLUM	BUS, IN47201		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	DEFICIENC!)		DATE
	_	taff should walk to the					
	_	while holding onto the					
	~	hould normally use their					
		o hold the belt but this					
		At the home [client #4]					
		ndependent walking with					
	•	n when in tight quarters					
		en, med room, bathroom,					
		Health/Risk Plan, dated					
		ed the following in the					
	prescribed						
		cations/preventative					
		n, "To wear gait belt, on in					
	AM & off in pm	."					
	An interview wi	th the Supported Group					
	Living Director	was conducted on					
	11/16/11 at 11:3	7 AM. The Director					
	indicated client #	#4's plans should match to					
	ensure staff knov	w when he was to wear					
	his gait belt.						
	An interview wi	th the Qualified Mental					
		essional (QMRP) was					
		/16/11 at 11:43 AM. The					
	QMRP indicated	I the plan may need to					
		pelt was to be worn on the					
	outside of his clo	othes.					
	2) A1	on wood conditional at the					
		on was conducted at the					
	1 0 1	1/14/11 from 3:51 PM to					
		00 PM, client #2 was					
	_	floor of the living room.					
	He sat up on his	knees and hit himself on					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G090	ĺ	LDING	NSTRUCTION 00	(X3) DATE (COMPL 11/22/2	ETED
NAME OF I	PROVIDER OR SUPPLIER			_	DDRESS, CITY, STATE, ZIP CODE		
					AMELOT LN		
DEVELO	PMENTAL SERVIC	CES INC		COLUM	BUS, IN47201		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ΓE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCI)		DATE
	_	his fists four times.					
		ent over and banged his					
	head on the carpeted floor ten times. Staff #2 responded by getting client #2's helmet and assisted client #2 with putting his helmet on. At 4:02 PM, client #2 was told by staff #2 he needed to wear his						
		nutes. At 4:04 PM, staff					
		in his right ear he needed					
		o quit hurting himself.					
	Staff #2 indicated to client #2 his helmet						
	could come off in 15 minutes. At 4:11						
	PM, client #2 took his helmet off and						
		floor. Staff #1 asked					
	staff #2 if client	#2 needed to put his					
	helmet back on.	Staff #2 indicated to staff					
	#1 he could keep	his helmet off. During					
	the remainder of	the observation, client #2					
	was not prompte	d to wear his helmet.					
	A review of clien	nt #2's record was					
	conducted on 11	/16/11 at 11:23 AM.					
		vior Management					
	1 –	5/5/11, indicated he had a					
	_	r of self-injurious					
	behavior. The p						
	_	Behavior - bangs head on					
		rd surface. Client often					
		net when he returns home					
		rogram. However, if he					
		nis head due to agitation					
		his helmet on him					
		protect his head. If he					
	does not begin h	ead banging he should be					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE S COMPL 11/22/20	ETED	
NAME OF I	PROVIDER OR SUPPLIER		J. 17111C	_	DDRESS, CITY, STATE, ZIP CODE		
					MELOT LN		
	PMENTAL SERVIC			_	BUS, IN47201		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION)	'	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	DATE
	allowed a short b	reak of 5-10 minutes and					
	then encouraged	to again wear the helmet					
	for the remainder	r of the evening. Tracking					
	of when the helmet is required will be						
		ridual Program Plan					
	, ,,	-6/12, indicated the					
	<u> </u>	nt #2] may also bang his					
	΄ .	y agitated. He has a					
		to prevent injury to his					
	head when this happens." The IPP did not						
	indicate the staff should prompt client #2						
	to wear his helmet while at the group home when he was not agitated.						
	morne when he w	as not agreated.					
	An interview wit	h the Qualified Mental					
		essional (QMRP) was					
		/16/11 at 11:30 AM. The					
	QMRP indicated	client #2's plans needed					
	to be revised to i	ndicate to staff the					
	expectation for c	lient #2 wearing his					
	helmet.						
	9-3-4(a)						
W0249		erdisciplinary team has				İ	
		t's individual program plan, eceive a continuous active					
	0	n consisting of needed					
	interventions and	services in sufficient					
		ency to support the					
	individual program	e objectives identified in the plan.					
		ation, interview and	W)249	W249		12/22/2011
					QIDP will retrain staff on		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X.	B) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	15G090	A. BUII	LDING	00	,	11/22/2011
		100000	B. WIN				1 1/22/20 1 1
NAME OF I	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP COD	E	
DEVELO	PMENTAL SERVIC	SES INC			AMELOT LN BUS, IN47201		
				<u> </u>	BUS, IN47201		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)	_	TAG	·		DATE
		r 3 of 6 clients living in			implementing program plan providing continuous active		
		(#2, #4 and #5), the			treatment as required to in		
	facility failed to				specific training in the areas		
		client #4's plan for his			the survey report. QIDP or		
	-	nt #5's plan for dysphagia,			will observe in the home at	least	
		, #4 and #5's training			weekly for one month and r	nonthly	
	objectives for m	,			thereafter to ensure compli	ance in	
		#1, #2, #4 and #5's training			this area.		
	objectives for medi	cation administration.			Posnonsible for OA. OID		
					Responsible for QA: QIDP		
	Findings include	: :					
		on was conducted at the					
	group home on 1	1/14/11 from 3:51 PM to					
	5:56 PM. On 11	/14/11 at 3:58 PM, client					
	#4 was prompted	d by staff #1 to put away					
	his laundry. Cli	ent #4 stood up and staff					
	#1 held onto clie	ent #1's right arm at the					
		belt was not observed and					
		1 PM, client #4 returned					
		m with staff #1 holding					
		at the elbow. His gait					
		erved and not used. At					
		#4 was prompted by staff					
		with folding laundry.					
		and walked across the					
	-	id not assist and did not					
	_	At 4:15 PM, client #4					
		e room and sat down in					
		#1 did not use his gait					
		1, staff #3 assisted client					
		Staff #3 held onto the					
		's shirt and pants. His					
	gait belt was not	visible. At 4:21 PM,					
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090		LDING	NSTRUCTION 00	(X3) DATE COMPL 11/22/2	ETED	
	PROVIDER OR SUPPLIER		3839 CA	DDRESS, CITY, STATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	ES INC	COLUM	BUS, IN47201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Client #4's gait be staff #3. The gait shirt and staff #3 belt and his shirt was prompted to table to decorate held onto the back belt was not obse #4 stood up and #1 held onto his client #4 entered hallway independent hallway independent him and not holding his gait belt Usage indicated the foll to wear the gait be around his waist Staff should wall onto the gait belt with the belt to s is walking. 3. S side of [client #4 gait belt. Staff should may vary 8. A can be allowed in close supervision	client #4 to his chair. The twas being held by It belt was on under his It was holding onto the The At 4:34 PM, client #4 It go to the dining room It an ornament. Staff #3 It of his shirt. His gait It erved. At 5:01 PM, client It took 3 steps before staff It gait belt. At 5:27 PM, It the dining room from the It dently. Staff were not It he of the staff were It he belt. It he will be the staff were It will be the staff were It will be the staff were It will be the staff while he It will be the staff while he It will be the staff while he It while holding onto the It hould normally use their It hold the belt but this It the home [client #4] It hold the mome in tight quarters It when in tight quarters It will be the thoom, It will be the thoom, It will be the thoom, It will be the the the the thould normally use their It hold the belt but this It the home [client #4] It when in tight quarters It will be the thoom, It will be the the the the the the the thould normally use their It when in tight quarters It will be the the the the the the the the the th				

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA				(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		15G090	B. WIN	G		11/22/2	011
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	CES INC			AMELOT LN 1BUS, IN47201		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
IAG	An interview wi Retardation Profice conducted on 11 QMRP indicated the use of his gaimplement the part of the use	th the Qualified Mental Ressional (QMRP) was /16/11 at 11:43 AM. The I client #4 had a plan for it belt and staff should lan as written. The Supported Group was conducted on 3 AM. The Director mould implement the plan were conducted at the 11/14/11 from 3:51 PM to /15/11 from 6:05 AM to 11/14/11 at 5:39 PM, At 5:40 PM, client #5 had aking large, fast bites of at #5 held one side of his right hand and scooped and into his mouth with his 11 PM, client #5 in the same manner. At 3 stated in regard to 5, "These two are having a 12 M, client #5 finished his 13 the staff (#1, #2 and #3) #5 to slow down, take sit upright. None of the wed to prompt client #5 to		IAU	DEFICIENCI		DATE
		dry swallows. On					
	11/13/11 at 6:33	AM, breakfast started.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090			LDING	NSTRUCTION 00	(X3) DATE COMPL 11/22/2	ETED			
	F PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 3839 CAMELOT LN COLUMBUS, IN47201						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	At 6:53 AM, click his plate up with scooped/shoveled lowered mouth of finished his breat of the staff (#5, #1) client #5 to slow to sit upright. No observed to promous successive dry so the staff was a review of client conducted on 11 Dysphagia Care indicated client #1 take small bites a down when eating sit upright in characteristic upright in characteristic was a successive dry so the staff were to promous successive dry so the staff was an interview with Retardation Professional Conducted on 11 QMRP indicated implement client was a supported Group on 11/18/11 at 8 indicated client #1 implemented as a supplemented as a supplemented as a supplemented with the staff was a supplemented as	ent #5 held the corner of his right hand and d large bites into his quickly. Client #5 kfast at 6:55 AM. None #6 and #7) prompted down, take small bites or one of the staff were inpt client #5 to take wallows. Int #5's record was /16/11 at 12:52 PM. His Plan, dated 5/4/11, #5 was to receive cues to and sips and to slow ing fast. Client #5 was to air for meals and snacks. In the Qualified Mental dessional (QMRP) was /18/11 at 9:40 AM. The lathe staff should at #5's plan as written. In the Director of the Living was conducted at 4.54 AM. The Director #5's plan should be							

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090			MULTIPLE CO JILDING ING	NSTRUCTION 00		X3) DATE COMPL 11/22/2	ETED		
			B. W.		DDRESS, CITY, STA	ATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	R		3839 CAMELOT LN					
DEVELO	PMENTAL SERVIC	CES INC		COLUM	BUS, IN47201				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	S	ID	PROVIDER'S P	LAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY		PREFIX	CROSS-REFERENCE	E ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION	
TAG		R LSC IDENTIFYING INFORMA		TAG	DEFI	ICIENCY)		DATE	
		11/14/11 from 3:51 PN							
		/15/11 from 6:05 AM							
		1/14/11 at 4:00 PM, cl							
		n a stool at the island in							
		e staff #2 unloaded the							
		put the dishes away. A							
	· ·	2 was rinsing dishes an							
	1 0	o the dishwasher as cli							
		nd. Clients #1, #3 and	. #4						
	_	ne living room and							
		st. At 4:16 PM, staff #	2						
	used the can ope	ener to open cans for							
	dinner. Client #	6 was not prompted to							
	assist. At 4:21 P	PM, staff #2 cleaned of	f						
	the dining room	table. Client #6 was i	n						
	the area but not a	asked to assist. At 4:2	2						
	PM, staff #2 wer	nt into the the living ro	oom						
	area to access the	e second refrigerator to	0						
	get bread. Clien	nts #1, #2, #3, #4, #5 au	nd						
	#6 were not aske	ed to assist and were							
	available to assis	st. At 4:28 PM, staff #	¹ 2						
	was in the kitche	en without the clients							
	cooking dinner.	At 4:41 PM, staff #2							
	breaded the chic	ken; none of the client	s						
	assisted or were	asked to assist. At 4:4	13						
	PM, staff #2 was	s washing dishes with	out						
	client involveme	ent. At 4:56 PM, staff	#2						
	was cooking wit	thout client involvement	nt.						
	_	ff #2 stirred the potato							
		ff #3 obtained neck							
	· ·	clients who wore them							
	•	ne clients to assist. At							
	5:05 PM, staff #								
		then took plates out of	the						
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090		ĺ	ILDING	NSTRUCTION 00		X3) DATE : COMPL 11/22/2	ETED			
NAME OF L	DDOMNED OD GUDDI IEI		В. WII		DDRESS, CITY, STA	TE, ZIP CODE				
	PROVIDER OR SUPPLIEF			3839 CAMELOT LN						
DEVELO	PMENTAL SERVIC	CES INC		COLUM	BUS, IN47201					
(X4) ID		STATEMENT OF DEFICIENCIES		ID		AN OF CORRECTION E ACTION SHOULD BE		(X5)		
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCE	E ACTION SHOULD BE ED TO THE APPROPRIATE CIENCY)	E	COMPLETION DATE		
1710		77 PM, staff #2 took the		1710				DITTE		
		he oven. At 5:18 PM,								
		ting up the chicken and								
	put food on all the clients' plates for them.									
	-	5:24 PM, staff #2 opened								
		At 5:24 PM, staff #2 put								
	the can of peach	_								
	processor. At 5:	:35 PM, staff #2 and #3								
	were cutting up	chicken. Staff #3 carried								
	client #1, #2, #3,	, #4, #5 and #6's plates to								
	them as they sat	at the dining room table.								
	At 5:46 PM, staff #2 cut up client #3's									
	chicken for him.	. At 5:48 PM, client #5								
	was prompted tw	wo times by staff #2 to								
	carry his plate to	the kitchen. At 5:49								
		ompted client #5 to carry								
	plate to kitchen.	Staff #2 then took client								
		picked up his plate and								
		At 5:50 PM, staff #2								
	1	is drink. At 5:52 PM,								
		client #6's cup to the sink.								
		ent #1's cup to the sink.								
	1	ff #3 started washing								
	dishes.									
	On 11/15/11 at 6	6:08 AM, staff #5 was in								
		aring breakfast without								
		ent. Clients #1, #2, #3, #5								
		ing in the living room. At								
		#5 asked clients #1 and #6								
	1	ereal or oatmeal. At 6:17								
	1	gned "juice." Staff #7								
		chen, poured a glass of								
		o client #2 as he sat on the								
FORM CMS-2	2567(02-99) Previous Versi		XR7311	Facility I	D: 000630	If continuation she	eet Pac	ge 28 of 48		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090			LDING	NSTRUCTION 00	(X3) DATE COMPL 11/22/2	ETED	
	PROVIDER OR SUPPLIER		<u> </u>	3839 CA	DDRESS, CITY, STATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	EES INC		COLUM	BUS, IN47201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the kitchen. Staf "He's fixing it fo the kitchen prepa the clients being staff #5 asked cli cereal or oatmea continued to coo while clients #1, in the living roor cut the sausage. continued to cut clients were in th AM, staff #5 me the clients' drink indicated breakfa had food on it. S their plates with #2 was at the isla preparing the clie client #5 was giv juice by staff #5 client #5 to take and get his drink was washing dis #5 took a glass o client #6. At 7:0 client #2 orange Staff #5 then star loaded the dishw #5 washed dishe A review of client	nt #2's record was					
	conducted on 11.	/16/11 at 11:23 AM.					

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Event ID:

XR7311

Facility ID:

000630

If continuation sheet

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 15G090	A. BUI	LDING	00	COMPL 11/22/2	
		130090	B. WIN			11/22/2	011
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE AMELOT LN		
DEVELO	PMENTAL SERVIC	CES INC			IBUS, IN47201		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDE DEFICIENCY)		TE	COMPLETION DATE
TAG	Client #2's IPP, dated 6/11-6/12, indicated			TAG			DATE
	his training objective for meals was to pour liquids and to clear his place setting. A review of client #3's record was						
		/16/11 at 11/16/11 at					
		nt #3's IPP, dated					
	6/11-6/12, indica	·					
		to put silverware away					
	and to clear the t	table of dishes after					
	meals.						
	A review of client #4's record was						
	conducted on 11	/16/11 at 11:13 AM.					
	Client #4's IPP,	dated 6/11-6/12, indicated					
	his culinary train	ning objective was to clear					
	dishes off the tab	ole and wipe off the table.					
	A review of clien	nt #5's record was					
		/16/11 at 11:13 AM.					
		dated 6/11-6/12, indicated					
		ning objective was to clear					
		ripe the table off after					
	meals.						
	An interview wi	th the QMRP was					
		/21/11 at 12:15 PM. The					
		I the clients' training					
		d be implemented as					
	written.	•					
	4) An observation	was conducted at the group					
		From 6:05 AM to 8:00 AM. At					
	7:20 AM, client #4	received his medications					

000630

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		15G090	B. WIN	IG		11/22/2	011
NAME OF F	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					AMELOT LN		
DEVELO	PMENTAL SERVIC	CES INC		COLUM	1BUS, IN47201		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
	, ,	trigine, Levetiracetam,					
	Topiramate, Vitamin C, Fiber Powder, Chlorhexidine, and Saline Mist) from staff #7. Staff #7 did not implement medication training to client #4. Client #4 did not obtain his own water for the med pass.						
	Am alama setti ii						
	An observation was	nior day program on 11/15/11					
		12:05 PM. At 11:57 AM,					
		is medication (Lithium					
		y program staff #1. Client #1					
		entify his medication, name					
	side effects, med time or to identify the medication by color. At 11:58 AM, client #4 received his medication (Saline nasal spray) from staff #1.						
		rovided medication training.					
	enema i was not p	i o vi u o u i o u i o u i o u i o u i o u i o u i o u i o u i o u i o u i o u i o u i o u i o u i o u i o u i					
		11/16/11 at 12:15 PM at the					
		y program, client #2 received					
		done) from day program staff					
		not provided training. At 12:19 wed his medication (Lithium					
		#2 was not provided training					
		s. At 12:23 PM, client #5					
		ation (Saline nasal spray and					
		nt #5 was not provided training					
	during the med pass	3.					
	A review of client ±	1's record was conducted on					
		M. His Individual Program					
		/11-5/12, indicated he had a					
	training objective to	increase his					
		of medications. The training					
		dentify med by name, identify					
	·	learn medication times, and					
	identify meds by co	nor.					
	A review of client #	[‡] 2's record was conducted on					
		AM. His IPP, dated 6/11-6/12,					

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		15G090	B. WING	G		11/22/2	011
NAME OF F	PROVIDER OR SUPPLIEF	\			DDRESS, CITY, STATE, ZIP CODE		
DEVELO	DMENTAL CEDVIC	NEC INIC			AMELOT LN		
	PMENTAL SERVIC			l	BUS, IN47201		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION SHOULD IN			(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			COMPLETION DATE
TAG		raining objective to increase		TAG	Birtelinery		DATE
		on of medications. His					
		were to get a glass of water for					
	his evening medications and staff would review his medication side effects.						
	A raviany of aliant +	4's record was conducted on					
		M. His IPP, dated 6/11-6/12,					
		raining objective to increase					
		on of medications. The					
		was to get water for his evening					
	medications.						
	A review of client #	45's record was conducted on					
	11/16/11 at 12:52 P	M. His IPP, dated 6/11-6/12,					
		raining objective to increase					
		ion of medications. His IPP,					
		licated he had a training e his self-administration of					
		aining objectives were to get					
		ening medications, identify the					
	drawer where his m	eds were stored, and clean his					
	pill crusher daily.						
	An interview with t	he Supported Group Living					
		cted on 11/18/11 at 8:47 AM.					
		ted the clients should receive					
	training during each	n med pass.					
	9-3-4(a)						
W0331	The facility must p	provide clients with nursing					
	services in accord	lance with their needs.					
	Based on observ	ation, record review and	W	0331	W331		12/22/2011
	interview for 2 o	of 6 clients living in the			The DON reviewed the medication	1	
					error affecting client #5 with the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	ILDING	00	COMPLETED
		15G090	B. WIN	NG		11/22/2011
NAME OF F	PROVIDER OR SUPPLIER	 {			ADDRESS, CITY, STATE, ZIP CODE	
					AMELOT LN	
	PMENTAL SERVIC			COLUM	BUS, IN47201	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	 	LISC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	,	and #5), the nurse failed			agency nursing staff and retrained	
	· · · · · · · · · · · · · · · · · · ·	ent #5's medication			specifically the nurse responsible to not removing the one order on the	
		ecord (MAR) was revised			MAR for client #5 which resulted i	
	_	ge in a medication and 2)			the medication error. QIDP or	
		cation was scheduled to be			agency nurse will retrain staff	
	given according	to the instructions on the			specifically on administering the	
	bottle.				medication as ordered by physicia	n
					for client #4. QIDP will retrain all	
	Findings include	»:			staff on the importance of accurac	cy
					in administering medications per	99
	1) A review of the	he facility's			medication labels. QIDP or design will observe at least weekly for on	
	· 1	gative reports was			month to ensure compliance.	
	_	/14/11 at 1:30 PM. The			Random observations at least	
		ated 10/15/11, indicated			monthly will be on-going to ensure	e
	•	At [client #5's] last			continued compliance.	
	psychiatric visit l					
		lify, was increased from			Responsible for QA: QIDP, DON,	
	•	ms) to 10 mg. This			Agency nurse	
		ordered and was added to				
		cation administration				
	` `					
	· ·	he medication came in				
		ng it. However, for some				
		ous order was not				
		onsequently [client #5]				
		7.5 mg of Abilify. This				
		n from 10/5/11 until it				
		by staff person, [staff #7],				
	on 10/12/11."					
	An interview wit	th the nurse was				
		/21/11 at 10:38 AM. The				
	nurse indicated a	a fill-in nurse added the				
	new order for Ab	bilify but did not ensure				
		er for Abilify was removed				
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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G090		LDING	NSTRUCTION 00	(X3) DATE : COMPL 11/22/2	ETED
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	P. 1111		DDRESS, CITY, STATE, ZIP CODE		
					AMELOT LN		
DEVELO	PMENTAL SERVIC	CES INC		COLUM	IBUS, IN47201		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710	from the MAR.	LEGE IDENTIFIEND IN ORGANITORY		1710			DITTE
	An interview with the Director of Nursing						
	` ′	lucted on 11/21/11 at					
		DON indicated the nurse					
	_	in for the regular nurse					
	Abilify from the	the original order for					
	Adminy from the	IVIAIN,					
	2) An observation	on of client #4 receiving					
	, ·	was conducted on					
	11/15/11 at 7:20	AM. Staff #7					
	administered the	medications. Client #4's					
	Fiber Powder (M	letamucil) bottle had a					
	sticker on it that	indicated the following,					
	` '	plenty of water 2 hours					
		r meds." Client #4					
		dine, Lamotrigine,					
		Copiramate, Vitamin C					
		nasal spray at the same					
	time he took the	river rowder.					
	A review of clies	nt #4's record was					
		/16/11 at 11:13 AM. His					
		vember 2011, indicated,					
	•	y of water 2 hrs (hours)					
	_	s aft (after) other meds."					
	An interview wit						
		/21/11 at 10:38 AM. The					
		the did not check the					
		e for instructions on how					
		he nurse indicated it was					
	technically a me	d error since the					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CON	STRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	15G090	A. BUILD	ING	00	11/22/2	
		100000	B. WING	amp promite	ADDRESS CHANGE CONT.	11/22/21	J 1 1
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	ES INC			MELOT LN BUS, IN47201		
(X4) ID		FATEMENT OF DEFICIENCIES	1	ID		I	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PI	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	directions for adr	ministering the					
	medication were	not followed.					
W0365	An interview with (DON) was conditional to the medication error MAR and bottle written. 9-3-6(a) An individual medimust be maintaine Based on observation at the program, the facility medication Adm (MAR) was present administration of Findings include. An observation with facility-operated from 12:05 PM to PM, client #1 recognitional to the program. After medication, day produced the program indicated she did document client in the program indicated she did document client in the program in the	h the Director of Nursing flucted on 11/21/11 at DON indicated it was a that the directions on the were not implemented as different for each client. Attion and interview for 1 observed to receive a facility-operated day illity failed to ensure a inistration Record ent to document the finis noon medication. Evas conducted at the day program on 11/16/11 or 12:25 PM. At 12:19 beived Lithium and administering the program staff #1 not have a MAR to #1's med pass. Staff #1 are was left at the new	W03	365	W365 Group home QIDP and Day prograt QIDP reviewed this citation and stawer retrained on appropriate medication administration includir presence of MAR for all medication administration. Day program QIDF will ensure that MAR provided by group home is present at the appropriate day program site prior to any medication administration. QIDP or designee will observe at least monthly on a regular basis to ensure compliance. Responsible for QA: QIDP	aff ng n	12/22/2011
	progre						
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AND PLAN OF CORRECTION IDENTIFICA		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		NSTRUCTION 00	(X3) DATE : COMPL	ETED
		15G090	B. WING			11/22/2	011
	ROVIDER OR SUPPLIER PMENTAL SERVIC			3839 CA	DDRESS, CITY, STATE, ZIP CODE AMELOT LN BUS, IN47201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
W0381	Retardation Profection of Conducted on 11/2 QMRP indicated an extra MAR at brought the MAF day program to describe the facility must seconditions of secure Based on observation of 2 clients who a facility-operated the facility failed medications were Findings include: An observation of facility-operated 11/15/11 from 10/2 At 11:55 AM, day opened the middle client #1 and #4's did not use a key the drawer. Client Lithium Carbona #1 took from the administered Salina in the sa	attended the day program (#1 and #4), to ensure the clients' e secured.	W0	0381	W381 Day program QIDP was notified of this failure to follow policy. Staff have been retrained on keeping medications secure as required. QIDP or designee will observe at least monthly on a regular basis to ensure compliance. Responsible for QA: QIDP		12/22/2011

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Event ID:

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Facility ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
THIE TENT	or conduction	15G090	A. BUILDING B. WING		11/22/2011	
				ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER			AMELOT LN		
DEVELO	PMENTAL SERVIC	ES INC	COLUM	IBUS, IN47201		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
W0440	conducted on 11/QMRP indicated be locked at the farmed program. An interview with Living Director with 11/16/11 at 11:56 indicated the medicated the medicated at the facility must be facility must be facility for each Based on record 6 of 6 clients living (#1, #2, #3, #4, #4 failed to ensure of were conducted for Findings include A review of the facility was conducted on There were no draight shift (11:00 6/3/11 until the triangle of the facility. The drill of 6:50 AM did not	review and interview for ng in the group home 5 and #6), the facility quarterly evacuation drills for each shift.	W0440	W440 QIDP will retrain staff on requirements for regular evacuation drills and varied times for night shind trills. 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. Responsible for QA: QIDP	ift	

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Event ID: XR7311

Facility ID:

000630

If continuation sheet

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		NSTRUCTION 00	(X3) DATE :	ETED
		15G090	B. WIN	G		11/22/2	U11
	ROVIDER OR SUPPLIER PMENTAL SERVIC			3839 CA	DDRESS, CITY, STATE, ZIP CODE MELOT LN BUS, IN47201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
W0441 FORM CMS-2	Group Living wa at 11:05 AM. The evacuation drill of indicated the time. The Director indicated the time. The facility must have varied conditions. Based on record 6 of 6 clients living (#1, #2, #3, #4, #failed to ensure indicated the time. The facility were varied. Findings include the following draws a conducted on the following draws are drill on 1/4/2 evacuate was not a frire drill on 3/20 minutes to conducted on the facility of the	old evacuation drills under review and interview for ng in the group home is and #6), the facility hight shift evacuation drills in 11/15/11 at 7:40 AM. Fills were conducted shift: //11 at 6:50 AM (time to a documented). //11 at 6:35 AM took 4 leet. //11 at 6:30 AM to 3 leet. //12 AM the Director of a Living was conducted	W ¹	0441 Facility II	W441 QIDP will retrain staff on requirements for regular evacuation drills and varied times for night shind 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. Responsible for QA: QIDP	ft y	12/22/2011

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
THE TENT	or condection	15G090	A. BUILDING B. WING		11/22/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER		3839 C	AMELOT LN	
DEVELO	PMENTAL SERVIC	ES INC	COLUM	1BUS, IN47201	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
TAG		50 AM. The Director	TAG		DATE
		es of the drills should be			
	varied.				
	9-3-7(a)				
11/0440	The facility must in	nvestigate all problems with			
W0448	•	ncluding accidents.			
	Based on record	review and interview for	W0448	W448	12/22/2011
	6 of 6 clients livi	ng in the group home		QIDP's will be trained on the	
	(#1, #2, #3, #4, #	5 and #6), the facility		regulation requiring investigation of issues noted during drills. Drill reports have been revised to include	of
	failed to ensure is	ssues noted during			de
	evacuation drills	were investigated.		documentation of issues and	
				reporting of issues to the QIDP.	
	Findings include	:		Staff have been trained on these reports. QIDP reviews drills month	alv
	A	Sanilitada arra arratiana dailla		at house meetings to ensure	ny
		Cacility's evacuation drills n 11/15/11 at 7:40 AM.		compliance.	
		cumentation the facility			
	investigated issue			Responsible for QA: QIDP	
	following evacua				
	-	Irills conducted during			
		1:00 PM to 7:00 AM)			
	from 6/3/11 until	the time of review of the			
	drills.				
	-The drill conduc	eted on 3/20/11 at 6:35			
	AM took 4 minu	•			
		eted on 2/25/11 at 5:10			
		ninutes to complete.			
		eted on 1/4/11 at 6:50			
		eate the amount of time it			
	took for the clien				
	- The drill conduc	eted on 12/10/10 at 5:25			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ	(X2) MULTIPLE CONSTRUCTION (X3) DATE S A DEPURITY OF COMPLETED COMPLICATION COMPLETED COMPLETED COMPLETED COMPLETED COMPLETED COMPLICATION COMPLETED COMPLETED COMPLETED COMPLETED COMPLETED COMPLICATION COMPLETED COMPLICATION COMP				
		15G090	A. BUILD			11/22/2	
			B. WING		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				MELOT LN		
DEVELO	PMENTAL SERVIC	ES INC			BUS, IN47201		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	Pl	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ate the amount of time it					
	took for the clien	ts to evacuate.					
	-The drill conduc	ted on 11/15/10 at 7:05					
	AM did not indic	ate the amount of time it					
	took for the clien	ts to evacuate.					
	An interview with	h the Director of Support					
	Group Living wa	s conducted on 11/16/11					
		e Director indicated the					
	evacuation drill d	locumentation should					
	indicated the time	e it took to evacuate.					
	The Director indi	cated the targeted time					
		was being discussed.					
		cated she thought it was					
	between 3 and 4	· ·					
	between 5 and 4	iiiiiucs.					
	9-3-7(a)						
W0460	Each client must re	eceive a nourishing,					
		including modified and					
	specially-prescribe		****	460			10/00/0011
		ntion and interview for 6	W02	460	W460 QIDP will retrain staff on ensi	ıring	12/22/2011
	_	g in the group home (#1,			clients receive a well-balance		
		d #6), the facility failed			diet by following menus and		
		ovided/offered the clients			specific diet orders to include		
	their drinks durin	g the meal.			beverages as indicated on th menu. QIDP or designee wil		
					random observations at least		
	Findings include:				weekly for one month and at		
					monthly thereafter to ensure		
		re conducted at the group			compliance.		
		1 from 3:51 PM to 5:56			Responsible for QA: QIDP		
	PM and 11/15/11	from 6:05 AM to 8:00			Mesholisinie ini MA. MIDL		
	AM. On 11/14/1	1 at 5:39 PM, dinner					
FORM CMS-2	567(02-99) Previous Versio	ns Obsolete Event ID: X	<u> </u>	Facility II	D: 000630 If continuation sh	eet Da	ne 40 of 48

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X	2) MULTIPLE CO			(X3) DATE COMPL		
AND PLAN	OF CORRECTION	15G090	A.	BUILDING	00		11/22/2	
		130090	В.	WING			11/22/2	UII
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, ST	ATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	CES INC			AMELOT LN BUS, IN47201			
					200, 11477201			OVE.
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX		PLAN OF CORRECTION VE ACTION SHOULD BE		(X5) COMPLETION
TAG	``	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENC	CED TO THE APPROPRIAT FICIENCY)	E	DATE
		#1, #2, #3, #4, #5 and #6	$\neg \dagger$					
		ed or offered drinks until						
	•	ed with their meal. At						
		lient #5 finished his						
		ompted him to take his						
		nen and get his drink. At						
	_	#5 was prompted again to						
	· ·	the kitchen in order to get						
		49 PM, client #1 indicated						
		ilk; staff gave client #1						
		#6 carried his plate to the						
		drink. Client #4, at 5:50						
	PM, was prompt	ted to go back to the table						
		is drink. At 5:54 PM,						
	_	ven his drink. At the end						
	_	on, client #3 was still						
		and had not received his						
	_	7/11 at 6:53 AM, breakfast						
		#1, #2, #3, #4, #5 and #6						
		ed or offered drinks. At						
	•	#5 was given his orange						
	ĺ	ing his breakfast. At 6:59						
	-	as given a glass of milk						
	•	after finishing his meal.						
		ent #2 was given milk,						
		Ensure. At 7:03 AM,						
		4 were given orange juice.						
		ed his drink at 7:03 AM.						
	A review of the 1	menu, dated 1996-1997						
	Fall/Winter, was	s conducted on 11/14/11						
	at 4:40 PM. The	e menu indicated the						
	following was to	be served for dinner: 3						
	_	chicken, 1/2 cup mashed						
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	XR73	311 Facility I	D: 000630	If continuation sh	eet Pa	ge 41 of 48

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLE	
		15G090	B. WIN			11/22/20)
NAME OF P	PROVIDER OR SUPPLIER	R			DDRESS, CITY, STATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	CES INC			AMELOT LN BUS, IN47201		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				<u> </u>		1	(W5)
PREFIX				ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	potatoes, 2 ounc	es of gravy, 1/2 cup of					
	green beans, roll	/margarine, 1/2 cup of					
	peaches and 1 cu	up of milk.					
		breakfast menu, dated					
		Winter, was conducted on					
		AM. The menu					
		lowing was to be served:					
		4 cup cold cereal, 1 thin					
		if desired, and 1 cup of					
	milk.						
	An interview wi	th the Qualified Mental					
		fessional (QMRP) was					
		/16/11 at 11:30 AM. The					
		d the clients should					
	,	nks at the start of their					
		cated she did not know					
	why the staff we	ere not providing the					
	drinks until the o	clients finished their					
	meals.						
		th the Director of					
	**	p Living was conducted					
		:19 PM. The Director					
		vas no reason the clients					
		e their drinks at the start					
	of the meal.						
	0.2.9(a)						
	9-3-8(a)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G090			(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 11/22/2	ETED
DEVELO	PROVIDER OR SUPPLIER	ES INC		STREET A 3839 CA COLUM	AMELOT LN IBUS, IN47201		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
W0484	chairs, eating uten meet the developm Based on observations of 6 clients living #2, #3, #4, #5 and to ensure the clie condiments, fork meals. Findings include Observations we home on 11/14/1 PM and 11/15/11 AM. On 11/14/1 started. The client mashed potatoes, peaches. Clients were not provide knives. The client offered salt, pepp condiments during at 6:53 AM, breat were served cere. Clients #1, #2, #2 provided or offer clients were not pepper, ketchup of during the meal. An interview with Retardation Professional Retardation Profession of the clients were not pepper, ketchup of during the meal.	quip areas with tables, sils, and dishes designed to nental needs of each client. ation and interview for 6 in the group home (#1, d #6), the facility failed ints were provided is and knives during. The conducted at the group 1 from 3:51 PM to 5:56 from 6:05 AM to 8:00 1 at 5:39 PM, dinner into the were served chicken, gravy, green beans and #1, #2, #3, #4, #5 and #6 do or offered forks and into the were not provided or over, ketchup or other ing the meal. On 11/15/11 kfast started. The clients all, toast, milk and juice. B, #4, #5 and #6 were not red forks and knives. The provided or offered salt, for other condiments. The Qualified Mental resional (QMRP) was 16/11 at 12:55 PM. The	W	0484	W484 QIDP will retrain staff on the appropriate table service for group home that meets the developmental needs of thes clients and provision of appropriate condiments durir meals. QIDP or designee wi random observations at least weekly for one month and at monthly thereafter to ensure compliance. Responsible for QA: QIDP	e ng II do	12/22/2011

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G090	(X2) MU A. BUII B. WIN	DING	NSTRUCTION 00	(X3) DATE COMPL 11/22/2	ETED		
	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 3839 CAMELOT LN COLUMBUS, IN47201					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE		
W0488	provided forks an On 11/18/11 at 9 indicated condim during each meal. An interview with Supported Group on 11/18/11 at 8: indicated condim during each meal. 9-3-8(a) The facility must a in a manner consist developmental lev. Based on observation of 6 clients living #2, #3, #4, #5 and to ensure the client meal preparation themselves and emeals. Findings include Observations we home on 11/14/1 PM and 11/15/11 AM. On 11/14/1 was seated on a sea	ch the Director of Director and Sam. The Director and Sam. Sam. Sam. Sam. Sam. Sam. Sam. Sam.	W(0488	W488 QIDP will retrain staff on ensclients receive a well-balance diet by following menus and specific diet orders. QIDP or designee will do random observations at least weekly one month and at least mont thereafter to ensure compliant Responsible for QA: QIDP	for hly nce.	12/22/2011		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2	2) MULTIPLE CO			X3) DATE : COMPL		
AND PLAN	OF CORRECTION	15G090	A. 1	BUILDING	00		11/22/2	
		100000	В. У	WING			1112212	011
NAME OF P	ROVIDER OR SUPPLIER	R			DDRESS, CITY, ST	ATE, ZIP CODE		
DEVELO	PMENTAL SERVIC	SES INC			MELOT LN BUS, IN47201			
					BO3, 11147201			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX		PLAN OF CORRECTION VE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENC	CED TO THE APPROPRIAT FICIENCY)	E	DATE
		put the dishes away. At						21112
	_	2 was rinsing dishes and						
	· ·	o the dishwasher as client						
		nd. Clients #1, #3 and #4						
		ne living room and						
	_	st. At 4:16 PM, staff #2						
		ener to open cans for						
	•	6 was not prompted to						
		PM, staff #2 cleaned off						
		table. Client #6 was in						
	•	asked to assist. At 4:22						
		nt into the the living room						
	•	e second refrigerator to						
		ats #1, #2, #3, #4, #5 and						
	_	ed to assist and were						
		st. At 4:28 PM, staff #2						
		en without the clients						
		At 4:41 PM, staff #2						
	_	ken; none of the clients						
		asked to assist. At 4:43						
		s washing dishes without						
		ent. At 4:56 PM, staff #2						
		hout client involvement.						
	_	ff #2 stirred the potatoes.						
	· ·	ff #3 obtained neck						
	·	clients who wore them						
	*	e clients to assist. At						
	5:05 PM, staff #2							
		then took plates out of the						
		7 PM, staff #2 took the						
		ne oven. At 5:18 PM,						
		ing up the chicken and						
		he clients' plates for them.						
	-	5:24 PM, staff #2 opened						
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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G090		LDING	NSTRUCTION 00	(X3) DATE COMPL 11/22/2	ETED
	PROVIDER OR SUPPLIER		D. WIIV	STREET A	ODDRESS, CITY, STATE, ZIP CODE AMELOT LN BUS, IN47201	1	
				<u> </u>			<i>a</i> un
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		At 5:24 PM, staff #2 put					
	the can of peach	•					
	_	35 PM, staff #2 and #3					
		chicken. Staff #3 carried					
		, #4, #5 and #6's plates to					
		at the dining room table.					
	1	f #2 cut up client #3's					
		At 5:48 PM, client #5					
	was prompted tw	vo times by staff #2 to					
	carry his plate to	the kitchen. At 5:49					
	PM, staff #2 pro	mpted client #5 to carry					
	plate to kitchen.	Staff #2 then took client					
	#5 his drink and	picked up his plate and					
	took to the sink.	At 5:50 PM, staff #2					
	gave client #1 hi	s drink. At 5:52 PM,					
	staff #3 carried c	elient #6's cup to the sink.					
	Staff #2 took clie	ent #1's cup to the sink.					
	At 5:53 PM, staf	f #3 started washing					
	dishes. The clien	nts did not serve					
	themselves food	or drinks during the					
	meal. There wer	re no serving bowls or					
	pitchers on the ta	able.					
		5:08 AM, staff #5 was in					
		aring breakfast without					
		ent. Clients #1, #2, #3, #5					
		ng in the living room. At					
	·	5 asked clients #1 and #6					
	1	ereal or oatmeal. At 6:17					
		gned "juice." Staff #7					
		chen, poured a glass of					
	1 *	client #2 as he sat on the					
		AM, client #6 pointed to					
	the kitchen. Stat	ff #6 said to client #6,					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/27/2011 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL		
		15G090		LDING		11/22/2	
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				AMELOT LN		
DEVELO	PMENTAL SERVIC	ES INC			BUS, IN47201		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		r you." Staff #5 was in		TAG	BEHREIMET		DATE
		aring breakfast without					
		involved. At 6:26 AM,					
	I -	ient #3 if he wanted					
		l. At 6:30 AM, staff #5					
		k sausage and oatmeal					
		#2, #3, #4, #5 and #6 sat					
		n. At 6:38 AM, staff #5					
	_	At 6:42 AM, staff #5					
		up sausage and the					
		ne living room. At 6:46					
		asured and then poured					
		s. At 6:48 AM, staff #5					
		ast was ready. Each plate					
		Staff #5 served each client					
	their plates with	food. At 6:55 AM, staff					
	_	and in the kitchen					
	preparing the clie	ents' drinks. At 6:58 AM,					
	client #5 was giv	en his cup of orange					
	juice by staff #5	after staff #6 prompted					
	client #5 to take	his plate to the kitchen					
		. At 6:59 AM, staff #5					
	was washing disl	hes. At 7:00 AM, staff					
	#5 took a glass o	f milk and orange juice to					
		1 AM, staff #5 took					
	1	juice, milk and Ensure.					
		rted washing dishes and					
		rasher. At 7:07 AM, staff					
		s. The clients did not					
		s food or drinks during					
		were no serving bowls or					
	pitchers on the ta	able.					
	An interview wit	th staff #5 was conducted					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G090	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	TE SURVEY SPLETED S/2011		
PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3839 CAMELOT LN COLUMBUS, IN47201					
SUMMARY S' (EACH DEFICIEN REGULATORY OR on 11/15/11 at 7: indicated client # putting out napk: and cutting toast could wipe off th indicated none o involved with co microwave). An interview wit Retardation Prof conducted on 11. QMRP indicated involved in all as and clean-up. Th	EES INC TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) 45 AM. Staff #5 66 could assist with ins, wiping off the table . He indicated client #1 ne table. Staff #5 f the clients were oking (using stove or the Qualified Mental dessional (QMRP) was /16/11 at 11:52 AM. The I the clients should be spects of meal preparation the QMRP indicated the rive themselves family	STREET A 3839 CA	AMELOT LN	ORRECTION N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		