

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G499	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7603 E 10TH ST INDIANAPOLIS, IN 46219
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: April 28, 29, 30, May 1 and 2, 2014.</p> <p>Facility Number: 001013 Provider Number: 15G499 AIM Number: 100245100</p> <p>Surveyor: Susan Reichert, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/12/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.</p> <p>Based upon observation, record review and interview, the facility's outside vocational services failed for 1 of 3 sampled clients (client #3) to ensure his dining plan was implemented as written.</p>	W000120	<p>All of the staff who work with Client #3 at day program have been retrained on his dining plan. The training included a test for competency. (See attachment A) Additionally, a seating chart has been developed and will be utilized to</p>	06/01/2014

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>Observations were completed at day services on 4/29/14 from 9:50 AM to 11:50 AM. At 10:15 AM, client #3 sat in the break room without eating or drinking anything. Client #3 did not consume food or beverage during his break at 10:00 AM. At 11:40 AM, client #3 ate his lunch without direct supervision. Client #3 sat at the end of a table and workshop staff #3 sat at the other end of the table with 2 other clients between herself and client #3.</p> <p>Workshop staff #2 was interviewed on 4/29/14 at 10:05 AM and indicated clients were to bring a snack from home or purchase one at the day services to consume during break time.</p> <p>Workshop staff #2 was interviewed again on 4/29/14 at 10:31 AM and indicated client #3 had not had a snack at break because group home staff had not brought in his lunch but would be bringing his food by lunch time. She stated client #3 had "wet his whistle" at the drinking fountain. When asked if client #3 was able to drink from the drinking fountain, she indicated the client did not drink from the fountain, but had rinsed his mouth and client #3 required his fluids to be prepared to nectar thickened consistency.</p> <p>Client #3's record was reviewed on 4/29/14 at 12:56 PM. A dining plan dated 8/22/13 indicated client #3 was to be supervised during meals.</p> <p>The Area Director was interviewed on 4/29/14 at 3:21 PM. She indicated workshop staff had been trained to provide supervision during meals and when asked if client #1 required 1:1 (one on one) supervision while eating, stated, "Yes." She indicated it was in violation of client #3's dining plan to get water from the drinking fountain.</p>		<p>ensure that the appropriate level of supervision is occurring during meal time at the day program. (See attachment B) Routine observations of meal time at the day program will be completed to ensure that the staff at day program are following the prescribed dining plan as well as ensuring that clients are being supervised at the appropriate levels.</p> <p>Persons Responsible: Residential Director and Area Director</p>	

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W000149	<p>Workshop staff training records were reviewed on 5/1/14 at 10:05 AM and indicated workshop staff #2 and #3 had been trained on 1/8/14 regarding client #3's dining plan which indicated "[Client #3] is to be supervised during meals," and "fluid texture: Honey thickened liquids."</p> <p>9-3-1(a)</p> <p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 3 sampled clients (client #3), the facility neglected to implement policy and procedure to protect client #3 from falls with injury, failed to develop an effective plan of correction to prevent falls with injury, and failed to ensure client #3's food was prepared as prescribed to prevent choking.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on</p>	W000149	The Residential Director for the home will be retrained to ensure that any changes or adaptations which need to be made to risk plans and training on these changes with direct care staff will occur in a timely fashion so as to avoid the potential for future incidents of injury or risk to consumer safety. Routine observations will occur within the home to ensure that staff are preparing meals according to dining plans and achieving the appropriate texture for all consumers involved. (Attachment C) All new staff completing the agency	06/01/2014

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	<p>4/28/14 at 3:10 PM and indicated the following:</p> <p>1. A BDDS report dated 3/19/14 and submitted by the workshop coordinator indicated client #3 fell backwards while looking at pictures while at day services. Client #3's fall plan "states that he is to use his walker at all times outside of the house. [Client #3's] fall plan also states that he is to wear elbow pads during waking hours to diminish the risk of injury to his elbows if he falls. [Client #3] was not wearing the elbow pads on 3/19/14 which could have prevented injury to his elbow. This writer suggests that a protocol be developed to ensure that [client #3] leaves his home each day with his elbow pads on."</p> <p>An investigation included with the report dated 3/21/14 completed by the workshop coordinator indicated client #3 sustained a dime sized scrape to his elbow (not specified). The workshop staff indicated client #3 wore his elbow pads inconsistently. "The opinion of this writer is that the fall may not have been preventable, but the injury to [client #3's] elbow would have been prevented if client #3 were wearing his elbow pads. I suggest a protocol be planned by [client #3's] team to ensure that he is leaving his home each day with his elbow pads on.</p>		<p>orientation training on meal preparation will receive training to run a fork through foods prepared to a pureed texture to ensure no lumps are present on the mixture. (Attachment D) A formal tracking system and associated protocol has been implemented in which staff acknowledge that Client #3 is wearing his elbow pads daily any time Client #3 is leaving the home. (Attachment E and F)</p> <p>Persons Responsible: Residential Director and Area Director</p>	

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	<p>This protocol could include a sheet initialed by home staff and workshop staff upon [client #3's] arrival to the workshop each day...Alternately, two residential staff could sign a paper at home acknowledging that [client #3] is wearing his elbow pads before leaving the home. A house retraining on [client #3's] plan may be sufficient." There was no evidence of an updated protocol regarding client #3's fall risk plan.</p> <p>A BDDS report dated 4/2/14 indicated client #3 fell backwards at day services "landing on his elbows. His left elbow began bleeding from scabs that were from a previous injury. First aid was administered immediately with the area cleaned and bandaged. Within 45 minutes of the fall, [client #3] had bleed (sic) through the bandages and residential staff (DSA) were contacted again to request that a nurse assess if he needed additional medical care." After residential staff arrived, client #3 was taken to the ER (emergency room). A follow up report dated 4/8/14 indicated client #3 received stitches in the open wound on his elbow and given ointment to be applied to the wound. Client #3 "was not wearing his elbow pads due to staff error and since then staff have been trained on procedures put in place to ensure [client #3] has his elbow pads at all times."</p>			

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	<p>Client #3's record was reviewed on 4/29/14 at 12:56 PM and included interdisciplinary team meeting minutes on 3/19/14 and 4/2/14 indicating "elbow pads in use at all times."</p> <p>The Area Director was interviewed on 4/29/14 at 3:21 PM. She indicated staff did not follow the protocol to ensure client #3 was wearing his elbow pads. She indicated staff had not been trained on the procedure to ensure client #3 wore his elbow pads after client #3's fall on 3/19/14 until 4/3/14 and the facility's interventions did not prevent client #3 from falling again and sustaining injury.</p> <p>Staff training records were reviewed on 5/1/14 at 10:05 AM and indicated on 4/3/14 workshop staff had been trained on client #3's plan to ensure client #3 wore his elbow pads, to prompt client #3 to not lean over his chair, and utilize his walker while prompting client #3 to keep the wheels of his walker on the ground. Group home staff had been trained regarding client #3's fall risk plan between 4/3/14-4/16/14.</p> <p>2. A BDDS report dated 3/18/14 indicated "a portion of bone" was found in client #3's pureed pork stew lunch. "The incident was investigated and it was</p>			

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	<p>determined that the food was pureed in a food processor but the piece was flat enough that it remained under the blades of the food processor...It was further reported that a smaller bone fragment was consumed by [client #3] and he brought that piece back up after his meal...[Client #3] did not seem to suffer any ill effects as a result of this incident." Plan to resolve indicated staff "will be trained to monitor the meat products used in meal preparation to ensure that no other bone fragments find their way into the meals. Additionally, staff will receive training which discusses running a fork or other slotted utensil through any pureed meals to ensure no bone fragments are present. Staff will be trained to purchase boneless meat to further prevent incidents of this nature."</p> <p>An investigation included with the report dated 3/19/14 indicated workshop staff #2 "prepared [client #3's] food and noticed the large bone in his container. She removed it and then noticed he coughed. After lunch he threw up in the hallway and [workshop staff #3] helped clean it up and then noticed the smaller piece of bone that he had eaten." An e-mail dated 3/19/14 from workshop staff #2 to the Residential Director indicated "While preparing lunch I was stirring [client #3's] (sic) and found a large bone.</p>			

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	<p>He later coughed and it frightened me. I was concerned for him. He continued to eat. After lunch he vomited in the hall way. Vomiting up a smaller bone. I felt badly for him." Workshop staff #3's statement dated 3/19/14 indicated she "witnessed him throwing up in the hall-way by the coat rack. There were 2 puddles on the floor and it looked thick and when I went to clean up the mess I picked up a piece of bone in the mucus like substance on the floor...." A picture of the bone fragments included in the investigation indicated the larger bone fragment was 3 times the length of a nickel pictured with the bone fragments and of the width of a nickel with the exception of one end which was pointed. The smaller fragment was the same length as a nickel and half of the width with sharp edges on either end. Client #3's dining plan dated 8/22/13 indicated he was to receive a pureed diet and "supervised during meals."</p> <p>Client #3's record was reviewed on 4/29/14 at 12:56 PM and indicated he was to receive a pureed diet with honey thickened liquids.</p> <p>The Area Director was interviewed on 4/29/14 at 3:21 PM. She indicated client #3 was to receive a pureed diet and that a new protocol had been developed to</p>			

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	<p>ensure staff check client #3's food before serving it to ensure there were no bones.</p> <p>The facility's Preventing Abuse and Neglect policy dated 10/13 was reviewed on 4/29/14 at 3:00 PM and indicated "DSA, Inc. prohibits abuse, neglect, exploitation, mistreatment or violation of the rights of the consumers it serves...'Abuse' means the following:...Emotional/Verbal abuse including but is not limited to communicating with words or actions in a person's presence with intent to: (a) cause the individual to be placed in fear of retaliation;...cause the individual to be placed in fear of confinement or restraint;...cause the individual to experience emotional distress or humiliation...'Neglect' means failure to provide supervision, training, appropriate care, food, medical care or medical supervision to an individual...Immediately upon learning of an allegation of abuse/neglect, exploitation, sexual abuse and/or sexual exploitation or similar circumstances...."</p> <p>9-3-2(a)</p>			

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W000157	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client #3), the facility failed to develop an effective plan of correction to prevent falls with injury.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 4/28/14 at 3:10 PM and indicated the following:</p> <p>A BDDS report dated 3/19/14 and submitted by the workshop coordinator indicated client #3 fell backwards while looking at pictures while at day services. Client #3's fall plan "states that he is to use his walker at all times outside of the house. [Client #3's] fall plan also states that he is to wear elbow pads during waking hours to diminish the risk of injury to his elbows if he falls. [Client</p>	W000157	<p>The Residential Director for the home will be retrained to ensure that any changes or adaptations which need to be made to risk plans and training on these changes with direct care staff will occur in a timely fashion so as to avoid the potential for future incidents of injury or risk to consumer safety. Routine observations will occur within the home to ensure that staff are preparing meals according to dining plans and achieving the appropriate texture for all consumers involved. (Attachment C) All new staff completing the agency orientation training on meal preparation will receive training to run a fork through foods prepared to a pureed texture to ensure no lumps are present on the mixture. (Attachment D) A formal tracking system and associated protocol has been implemented in which staff acknowledge that Client #3 is wearing his elbow pads daily any time Client #3 is leaving the home.</p>	06/01/2014

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	<p>#3] was not wearing the elbow pads on 3/19/14 which could have prevented injury to his elbow. This writer suggests that a protocol be developed to ensure that [client #3] leaves his home each day with his elbow pads on."</p> <p>An investigation included with the report dated 3/21/14 completed by the workshop coordinator indicated client #3 sustained a dime sized scrape to his elbow (not specified). The workshop staff indicated client #3 wore his elbow pads inconsistently. "The opinion of this writer is that the fall may not have been preventable, but the injury to [client #3's] elbow would have been prevented if client #3 were wearing his elbow pads. I suggest a protocol be planned by [client #3's] team to ensure that he is leaving his home each day with his elbow pads on. This protocol could include a sheet initialed by home staff and workshop staff upon [client #3's] arrival to the workshop each day...Alternately, two residential staff could sign a paper at home acknowledging that [client #3] is wearing his elbow pads before leaving the home. A house retraining on [client #3's] plan may be sufficient." There was no evidence of an updated protocol regarding client #3's fall risk plan.</p> <p>Client #3's record was reviewed on</p>		(Attachment E and F)  Persons Responsible: Residential Director and Area Director				

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	<p>4/29/14 at 12:56 PM and included interdisciplinary team meeting minutes on 3/19/14 and 4/2/14 indicating "elbow pads in use at all times."</p> <p>The Area Director was interviewed on 4/29/14 at 3:21 PM. She indicated staff did not follow the protocol to ensure client #3 was wearing his elbow pads. She indicated staff had not been trained on the procedure to ensure client #3 wore his elbow pads after client #3's fall on 3/19/14 until 4/3/14 and facility interventions did not prevent client #3 from falling again and sustaining injury.</p> <p>Staff training records were reviewed on 5/1/14 at 10:05 AM and indicated on 4/3/14 workshop staff had been trained on client #3's plan to ensure client #3 wore his elbow pads, to prompt client #3 to not lean over his chair, and utilize his walker while prompting client #3 to keep the wheels of his walker on the ground. Group home staff had been trained regarding client #3's fall risk plan between 4/3/14-4/16/14.</p> <p>9-3-2(a)</p>			

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W000192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #3) to ensure staff correctly implemented training protocol for choking as instructed during a choking incident.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 4/28/14 at 3:10 PM. A report dated 2/2/14 indicated client #3 was eating lunch and "staff noticed his eyes were watering and appeared to be choking. The meal was prepared according to his diet. Staff stood him up but did not use the Heimlich maneuver. Staff did gently press on his abdomen and he threw up a small amount. [Client #3] seemed fine afterwards and the nurse was contacted and instructed staff to start a potential aspiration form and vitals checked twice a day." A follow up report dated 2/5/14 indicated staff were trained to ensure they were seated next to client #3.</p> <p>The Residential Director was interviewed</p>	W000192	<p>The staff member involved in the incident has been recertified in Heartsaver First Aid and CPR AED. (Attachment G) She demonstrated at that time that she was knowledgeable of the appropriate and approved method to address a potential choking episode. Staff will routinely be recertified using the Heartsaver First Aid and CPR AED training method or other recognized CPR and First Aid course to ensure that they remain current and abreast of the most current and correct life-saving practices. The Residential Director will be responsible for ensuring that staff remain current in their certification.</p> <p>Persons Responsible: Residential Director and Area Director</p>	06/01/2014

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	<p>on 4/29/14 at 3:21 PM. She indicated it was not part of the protocol for first aid emergency procedures for staff to press on client #3's abdomen if he appeared to be choking.</p> <p>The Heartsaver First Aid CPR AED student workbook dated 2011 was reviewed on 5/1/14 at 11:28 AM. The procedures for choking indicated staff were to determine if someone had "mild or severe choking" by using the criteria of: "If someone can make sounds or cough loudly, the block in the airway is Mild and you should stand by and let her cough. If worried about her breathing, phone your emergency response number (911). If someone cannot breathe or has a cough that has no sound or cannot talk or make a sound or makes the choking sign (holding the neck with one or both hands), the block in the airway is Severe and you should act quickly, follow the steps to help a choking adult. When someone has severe choking, give thrusts above the belly button. These thrusts are sometimes called the Heimlich maneuver...." The procedures did not include staff pressing gently on the abdomen to address a potential choking episode.</p> <p>9-3-3(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G499	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7603 E 10TH ST INDIANAPOLIS, IN 46219
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W000289	<p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart.</p> <p>Based upon record review and interview for 3 of 3 sampled clients (clients #1, #2, and #3), the facility failed to ensure physical techniques to manage behavior were specifically identified and a hierarchy of their use was included in their behavior plans.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 4/29/14 at 2:30 PM. Client #1's Behavior Management Plan (BMP) dated 9/12/13 included targeted behaviors of property misuse/destruction and physical assault. The techniques to address property misuse/destruction and physical assault</p>	W000289	<p>The behavior consultant has developed a hierarchy for the use of physical interventions which will be added to the HRC approved behavior development program of the involved clients. The staff working in the home will be trained on the approved hierarchy to be utilized with the involved clients. (Attachment H) On-going the behavior consultant will ensure that the Behavior Development Programs contain the hierarchy sheet to identify the physical techniques used to manage techniques.</p> <p>Persons Responsible: Behavior Consultant, Residential Director, and Area Director</p>	06/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G499	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
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	<p>included "Use the minimum amount of physical guidance necessary to stop the aggression. Use the techniques taught in Aggression Management Training Series (AMTS)." The type of physical techniques or the hierarchy for their use was not included in the plan.</p> <p>Client #2's record was reviewed on 4/29/14 at 2:00 PM. Client #2's BMP dated 5/22/13 included a targeted behaviors of suicide threats/attempts and pica (eating cigarette butts). The techniques to address suicide threat and pica included "Use the minimum amount of physical guidance necessary to stop the aggression. (Use the techniques taught in AMTS)." The type of physical techniques or the hierarchy for their use was not included in the plan.</p> <p>Client #3's record was reviewed on 4/29/14 at 12:56 PM. A BMP dated 7/11/13 included a targeted objective of physical assault. The plan included the use of physical techniques to address physical aggression. The techniques to address physical assault included "Use the minimum amount of physical guidance necessary to stop the aggression. Use the techniques taught in AMTS." The type of physical techniques or the hierarchy for their use was not included in the plan.</p>			

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	<p>The Area Director was interviewed on 4/29/14 at 3:21 PM. She indicated staff were to use the least restrictive method as necessary to address client behaviors and the specific methods and hierarchy for their use was not spelled out in client plans.</p> <p>The facility's behavior intervention techniques training was reviewed on 4/29/14 at 4:00 PM. The techniques included a baskethold technique (physical hold to prevent movement) and escort (physical guidance to move a client).</p> <p>9-3-5(a)</p>						
W000323	<p>483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based upon record review and interview, the facility failed for 1 of 4 sampled clients (client #1) to ensure a vision screening was completed annually.</p>	W000323	<p>The Program Nurse and the Area Director will routinely review client charts to ensure that all clients receive at a minimum an annual vision and hearing exam. The</p>	06/01/2014			

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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICE ALTERNATIVES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 7603 E 10TH ST INDIANAPOLIS, IN 46219			
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W000331	<p>Findings include:</p> <p>Client #1's record was reviewed on 4/29/14 at 2:30 PM. There was no evidence of a vision exam in the record.</p> <p>The Area Director (AD) was interviewed on 4/29/14 at 3:21 PM. She indicated she would need to check in purged records to obtain a vision exam for client #1.</p> <p>An undated note from client #1's eye doctor was reviewed on 5/2/14 at 9:00 AM. The note indicated client #1 was seen on 6/26/12 for a "full examination..." There was no information regarding the results of the examination. There was no other evidence of a vision examination provided.</p> <p>The AD was interviewed again on 5/2/14 at 10:10 AM and indicated there was no other evidence of an examination of client #1's vision.</p> <p>9-3-6(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p>		<p>programnurse and Residential Director will receive retraining to ensure that annualscreenings for vision and hearing occur. The vision exam for client #1 is scheduled to occur on June 26, 2014.</p> <p>Persons Responsible: Program Nurse and Area Director</p>				

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	<p>Based upon observation, record review, and interview, the facility's nursing services failed for 1 of 3 sampled clients (client #3) to develop a protocol to promote healing for a wound to his elbow.</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 4/28/14 at 3:10 PM. A report dated 4/2/14 indicated client #3 fell backwards "landing on his elbows. His left elbow began bleeding from scabs that were from a previous injury. First aid was administered immediately with the area cleaned and bandaged. Within 45 minutes of the fall, [client #3] had bleed (sic) through the bandages and residential staff (DSA) were contacted again to request that a nurse assess if he needed additional medical care." After residential staff arrived, client #3 was taken to the ER (emergency room). A follow up report dated 4/8/14 indicated client #3 received stitches in the open wound on his elbow and given ointment to be applied to the wound. Client #3 "was not wearing his elbow pads due to staff error and since then staff have been trained on procedures put in place to ensure [client #3] has his elbow pads at all times."</p>	W000331	<p>The program nurse will receive retraining which focuses on the need to develop formal protocols for wound care and ensure that staff receive training on the execution of these protocols. Additionally, a formal protocol has been developed for the wound care of Client #3's wound and all staff working with this client will be trained on this protocol. (Attachment I)</p> <p>Persons Responsible: Program Nurse, Residential Director, and Area Director</p>	06/01/2014			

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W000340	<p>Observations were completed at day services on 4/29/14 from 9:50 AM to 11:50 AM. At 10:15 Client #3's outer sweatshirt was removed by workshop staff #2 at 10:25 AM. Workshop staff #2 noted client #3's shirt was wet at the elbow from wet elbow pads. She indicated client #3 had a wound underneath the elbow pad from "falling backward." Workshop staff #3 stated client #2 had arrived at the workshop with an adult brief tied around the wound "last week" and "they (group home staff) don't know how to take care of it."</p> <p>Client #3's record was reviewed on 4/29/14 at 12:56 PM. There was no evidence in the record of a protocol to address the healing of client #3's wound to his elbow.</p> <p>The group home nurse was interviewed on 5/1/14 at 11:52 AM. She indicated there was no protocol to provide instruction to staff regarding client #3's wound. She indicated it was not appropriate to use an adult brief around client #3's elbow.</p> <p>9-3-6(a)</p> <p>483.460(c)(5)(i) NURSING SERVICES</p>						

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	<p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. Based on record review and interview, the facility failed for 1 additional client (client #5) to implement training to administer and to document medication administration as per facility medication administration procedures.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 4/28/14 at 4:48 PM to 6:30 PM. At 5:05 PM, client #5 received Metronidazole (antibiotic) 5 ml (milliliters), and inhaled Flovent HFA (asthma). The label on the Flovent indicated "swab mouth with mouthwash after use." Client #5 was given a dry paper towel to wipe his mouth out after inhaling the medication.</p> <p>Client #5's MAR (medication administration record) for April, 2014 was reviewed on 4/28/14 at 5:15 PM. The MAR indicated client #5's Metronidazole had not been documented at 7:00 AM on 4/27/14 and 4/28/14. Client #3's Clarithromycin (antibiotic) 250 mg (milligrams) was not documented at 7:00 AM on 4/27/14 or 4/28/14. The</p>	W000340	<p>The program nurse will ensure that the instructions for administration of medications and treatments is written clearly in the Medication Administration Record. The staff will receive retraining on the administration of Client #5's Flovent to ensure they are following the instructions set forth in the Medication Administration Record. (Attachment J) Additionally, staff will receive retraining on the necessity to document the administration of all medication to all clients served.</p> <p>Persons Responsible: Program Nurse, Residential Director and Area Director</p>	06/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G499		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014	
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W000391	<p>MAR indicated for Flovent "swab mouth with mouthwash after use."</p> <p>The Residential Coordinator was interviewed on 4/28/14 at 5:35 PM and indicated medications should be documented when they were administered. She indicated client #5 was not to receive any fluids by mouth and was not to rinse his mouth with mouthwash after inhaling the Flovent.</p> <p>The group home nurse was interviewed on 5/1/14 at 11:52 AM. She indicated staff were to document the administration of medication as trained to do in the facility's medication administration procedures. She was unaware of a change to the procedures for client #5 as indicated in the MAR to swab his mouth with mouthwash after using Flovent, and staff were to follow the instructions indicated in the MAR and on the medication labels.</p> <p>9-3-6(a)</p> <p>483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing</p>						

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W000436	<p>labels.</p> <p>Based on observation, record review and interview for 1 additional client (client #5) of 4 clients who received medications, the facility failed to ensure all medications had a label with dispensing instructions.</p> <p>Findings include:</p> <p>Observations were completed at the group home on 4/28/14 at 4:48 PM to 6:30 PM. At 5:05 PM, client #5 received Clobetasol .05% solution to his scalp. The manufactures instructions on the bottle indicated "See package insert for full prescribing information." There was not an additional label on the medication to indicate the instructions to administer the medication.</p> <p>The April, 2014 MAR (medication administration record) was reviewed on 4/28/14 at 5:15 PM and indicated for Clobetasol, "Apply to scalp daily to twice daily."</p> <p>The group home nurse was interviewed on 5/1/14 at 11:52 AM. She indicated there should be a label with instructions for dispensing on all medications.</p> <p>9-3-6(a)</p> <p>483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make</p>	W000391	<p>The program nurse will ensure that all of the medication containers have legible and present labels which includes client name, medication name, and dispensing instructions. The program nurse will routinely audit the medications to ensure that these labels remain in place. If it is discovered that a medication does not have a present and legible label, a replacement will be obtained from the pharmacy.</p> <p>Persons Responsible: Program Nurse</p>	06/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G499	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
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W000440	<p>informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Based upon observation, record review and interview, the facility failed for 2 of 3 sampled clients (clients #2 and #3) to encourage them to wear glasses.</p> <p>Findings include:</p> <p>During observations at the group home on 4/28/14 from 4:48 PM until 6:30 PM and on 4/29/14 from 6:24 AM until 7:35 AM, clients #2 and #3 did not wear glasses. During observations at the workshop on 4/29/14 from 9:50 AM until 11:50 AM, clients #2 and #3 did not wear glasses.</p> <p>Client #2's record was reviewed on 4/29/14 at 2:00 PM. A vision examination dated 8/19/13 indicated client #2 was given new glasses to wear.</p> <p>Client #3's record was reviewed on 4/29/14 at 12:56 PM . A vision exam dated 2/21/12 indicated client #3 had been prescribed glasses, but they were lost.</p> <p>The Area Director was interviewed on 4/29/14 at 3:21 PM and indicated clients #2 and #3 normally wore their glasses and staff should prompt them to wear their glasses.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS</p>	W000436	<p>Staff will receive retraining on ensuring that Clients #2and #3, as well as all clients are prompted to wear their glasses on a daily basis. Formal goals are in place to ensure the consumers are additionally prompted to wear their glasses daily. (Attachment K) The effectivenessof the programming goal will be reviewed monthly by the Residential Director. Persons Responsible: Residential Director</p>	06/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G499	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  05/02/2014
NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICE ALTERNATIVES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 7603 E 10TH ST INDIANAPOLIS, IN 46219		
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W000440	<p>The facility must hold evacuation drills at least quarterly for each shift of personnel. Based upon record review and interview, the facility failed for 3 of 3 sampled clients (clients #1, #2 and #3), and for 3 additional clients (clients #4, #5 and #6) to conduct quarterly evacuation drills for the 7:00 AM to 3:00 PM shift and for the 3:00 PM to 11:00 PM shift.</p> <p>Findings include:</p> <p>The facility's evacuation drills were reviewed on 4/29/14 at 3:05 PM. The review indicated the facility had failed to conduct evacuation drills for clients #1, #2, #3, #4, #5 and #6 for the 7:00 AM to 3:00 PM shift from 1/14/13 to 6/2/13 and and for the 3:00 PM to 11:00 PM shift from 2/14/13 to 6/28/13.</p> <p>The Area Director (AD) was interviewed on 5/1/14 at 11:11 AM and indicated there were no drills for the missing time periods.</p> <p>9-3-7(a)</p>		<p>Staff will be in-serviced on completing drills in compliance with regulations. The Residential Director will be responsible to schedule specific staff to complete drills at a frequency which is compliant with regulations. This schedule will be placed in the site. The drills and schedule will be monitored by the Residential Director and Area Director to assure compliance. Additionally, Area Director will track the completion of the drills and provide periodic reports to the Residential Director who will assure compliance. Person responsible: Residential Director and Area Director</p>	06/01/2014	
W000460	483.480(a)(1) FOOD AND NUTRITION SERVICES				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G499	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7603 E 10TH ST INDIANAPOLIS, IN 46219
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	<p>Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets.</p> <p>Based upon record review and interview, the facility failed to provide the prescribed food consistency for 1 of 3 sampled clients (client #3).</p> <p>Findings include:</p> <p>The facility's reportable incidents to the Bureau of Developmental Disabilities Services (BDDS) were reviewed on 4/28/14 at 3:10 PM and indicated the following:</p> <p>A BDDS report dated 3/18/14 indicated "a portion of bone" was found in client #3's pureed pork stew lunch. "The incident was investigated and it was determined that the food was pureed in a food processor but the piece was flat enough that it remained under the blades of the food processor...It was further reported that a smaller bone fragment was consumed by [client #3] and he brought that piece back up after his meal...[Client #3] did not seem to suffer any ill effects as a result of this incident." Plan to resolve indicated staff "will be trained to monitor the meat products used in meal preparation to ensure that no other bone fragments find their way into the meals. Additionally, staff will receive training which discusses running a fork</p>	W000460	<p>All staff have been trained on the requirements for a pureed diet including the requirements for preparing food to a correct puree consistency and will demonstrate this knowledge. (Attachment L) Observations of the staff will occur routinely to ensure that they continue to prepare food to the correct puree consistency. (Attachment C)</p> <p>Persons Responsible: Residential Director and Area Director</p>	06/01/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G499	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
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	<p>or other slotted utensil through any pureed meals to ensure no bone fragments are present. Staff will be trained to purchase boneless meat to further prevent incidents of this nature."</p> <p>An investigation included with the report dated 3/19/14 indicated workshop staff #2 "prepared [client #3's] food and noticed the large bone in his container. She removed it and then noticed he coughed. After lunch he threw up in the hallway and [workshop staff #3] helped clean it up and then noticed the smaller piece of bone that he had eaten." An e-mail dated 3/19/14 from workshop staff #2 to the Residential Director indicated "While preparing lunch I was stirring [client #3's] (sic) and found a large bone. He later coughed and it frightened me. I was concerned for him. He continued to eat. After lunch he vomited in the hall way. Vomiting up a smaller bone. I felt badly for him." Workshop staff #3's statement dated 3/19/14 indicated she "witnessed him throwing up in the hall-way by the coat rack. There were 2 puddles on the floor and it looked thick and when I went to clean up the mess I picked up a piece of bone in the mucus like substance on the floor...." A picture of the bone fragments included in the investigation indicated the larger bone fragment was 3 times the length of a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G499	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  05/02/2014
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NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 7603 E 10TH ST INDIANAPOLIS, IN 46219
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	<p>nickel pictured with the bone fragments and of the width of a nickel with the exception of one end which was pointed. the smaller fragment was the same length as a nickel and half of the width with sharp edges on either end. Client #3's dining plan dated 8/22/13 indicated he was to receive a pureed diet and "supervised during meals."</p> <p>Client #3's record was reviewed on 4/29/14 at 12:56 PM and indicated he was to receive a pureed diet with honey thickened liquids.</p> <p>The Area Director was interviewed on 4/29/14 at 3:21 PM. She indicated client #3 was to receive a pureed diet and that a new protocol had been developed to ensure staff check client #3's food before serving it to ensure there were no bones.</p> <p>9-3-8(a)</p>			