

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G554	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1435 W CONGRESS ST MIDDLETOWN, IN 47356
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W 000 Bldg. 00	<p>This visit was for the pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00156546.</p> <p>Complaint #IN00156546: SUBSTANTIATED, Federal and State deficiency related to the allegations is cited at W140.</p> <p>Dates of Survey: 3/4, 3/5, 3/6, 3/9, 3/10, 3/11, 3/12, and 3/13/2015.</p> <p>Facility Number: 001068 Provider Number: 15G554 AIMS Number: 100239880</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 19, 2015 by Dotty Walton, QIDP.</p>	W 000		
W 140 Bldg. 00	<p>483.420(b)(1)(i) CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p>			

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>Based on record review and interview, for 2 of 4 sampled clients (B and C), the facility failed to ensure the facility implemented its written policy in regard to client finances to ensure accountability of clients' funds for clients B and C.</p> <p>Findings include:</p> <p>On 3/5/15 at 9:45am, the facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed and included the following incidents of financial exploitation for clients B and C:</p> <p>-A 9/12/14 BDDS report for an incident on 9/11/14 at 9:30am for clients B and C, indicated "It was discovered during a scheduled audit that cash from [clients B and C] accounts [at the group home] was not accounted for properly."</p> <p>-The 9/11/14 Investigation indicated clients B and C's personal cash on hand funds at the group home was being audited at the agency's office by the accountant and client B was missing \$160.00 and client C was missing \$120.00. The investigation indicated the agency's accountant was completing the routine audit with Discharged Staff #10. The investigation indicated, on 9/11/14 when the funds were discovered present, then missing, that the agency Area</p>	W 140	<p>After the referenced incident on 9/11/14, agency administration updated and implemented the revised the agency Consumer Accounts Management policy. A copy is attached. The implementation of this policy included the assignment of cashbox responsibility to professional staff. In November 2014 a Consumer Accounts Management protocol was completed and implemented to further clarify how consumer's finances are managed and to detail the audit process. See attached document. All professional staff who have the responsibility for management of consumer finances has been trained on the updated policy and procedure. The administrator oversees the management of consumer finances to ensure the policy and procedure are followed as written. The administrator has a routine presence at monthly audits to ensure compliance with agency policy and procedure by all parties. The administrator will also perform random audits by counting money on site for the residents and verifying the available amount is accurate per the individuals' financial records. Since implementation of the revised policy and procedure there have been no further incidents of mismanagement of consumer funds at the facility or in any other agency facilities.</p> <p>Responsible Party: Area Director</p>	03/31/2015

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	<p>Director (AD) "called the police" when the funds could not be located at the agency office. The investigation indicated "police immediately responded" and interviewed "all" present during the incident on site on 9/11/14. The investigation indicated Discharged Staff #10 counted each of the client cash bags from her lap to the table in front of the agency auditor. After the agency auditor held onto one bag of client funds atop the table, Discharge Staff #10 was not able to shift funds from one cash bag to another, and the client funds were labeled as not accounted for. The investigation indicated "the missing funds for [clients B and C] were never present to be audited. The implication based on the evidence present is that [Discharged Staff #10] showed the same money as belonging to multiple individuals when presented to be counted. [Discharged Staff #10] had physical possession of the money when the alleged discrepancy occurred. [Discharged Staff #10] had excessive cash on hand on behalf of the consumers...[Discharged Staff #10's] employment with DSA should be terminated due to probable criminal activity/definite mismanagement of consumers funds."</p> <p>On 3/6/15 at 10:00am, an interview was conducted with the Area Director (AD)</p>			

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	<p>and the QIDP (Qualified Intellectual Disabilities Professional). The AD stated Discharged Staff #10 was discharged for misappropriation of client B and C's personal funds "believed to be stolen" from their cash on hand money pouches at the group home. The AD indicated, based on the investigation, there was a financial routine audit being completed and Discharged Staff #10 was counting funds from other envelopes, combining funds to equal the ledger amounts, and attempting to cover the shortages in client B and C's funds.</p> <p>On 3/6/15 at 10:45am, a review of the 5/2011 "Individual Financial Record" did not indicate a written dollar amount for each clients' personal cash funds at the group home and did not include random audits completed by the agency's management personnel.</p> <p>On 3/6/15 at 10:45am, a review of the revised policy and procedure 10/2014 "Consumer Accounts Management" indicated "...No more than \$20.00 per consumer will be kept in the cash box at any given time...Staff will count the money that is in the cash box at each shift change." The revised policy and procedure included audits monthly at the agency's office by management personnel and "random" audits in addition.</p>			

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W 157 Bldg. 00	<p>This federal tag relates to complaint #IN00156546.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, for 10 of 36 BDDS (Bureau of Developmental Disabilities Services) reports reviewed for 5 of 6 clients (clients B, C, D, E, and F), the facility failed to implement sufficient corrective actions for client to client physical aggression and ensure staff supervision based on identified client needs for clients B, C, D, E, and F.</p> <p>Findings include:</p> <p>On 3/5/15 at 9:45am, the facility's BDDS (Bureau of Developmental Disabilities Services) Reports, non reportable incident reports, and investigations were reviewed and included the following for clients B, C, D, E, and F:</p> <p>-A 2/14/15 BDDS report for an incident on 2/13/15 at 7:00am, indicated client D was in the medication room, client C</p>	W 157	<p>The agency completed investigations regarding each reported incident. The practice to investigate all incidents of this nature continues. Any future incident of this nature will be reviewed by the Individual Support Team (IST) for each client involved. One aspect of this review will be to determine what corrective action may be needed to prevent recurrence which includes a review of effectiveness of current programming and practices in place to prevent such incidents. The agency has a new Program Quality Coordinator who is responsible for tracking reportable incidents. This professional will be included in IST reviews of Client to Client Physical Aggression incidents and will implement a tracking mechanism to ensure IST reviews are completed following such incidents and that decided corrective actions are made. The Residential Director will also have weekly presence in the home to ensure behavior</p>	04/12/2015

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	<p>"came around the corner and grabbed" client D by her hair. The report indicated an investigation had begun. No corrective action was available for review.</p> <p>-A 1/19/15 BDDS report for an incident on 1/18/15 at 10:30am, indicated client C had physical aggression toward clients D and E, staff intervened, and client D had "scratches on L (left) shoulder." The report indicated an investigation had begun. No corrective action was available for review.</p> <p>-A 1/13/15 BDDS report for an incident on 1/12/15 at 5:30pm, indicated client C pulled client E's hair and staff intervened during the incident. The report indicated an investigation had begun. No corrective action was available for review.</p> <p>-A 12/21/14 BDDS report for an incident on 12/20/14 at 9:00am indicated client C pulled client E's hair. The report indicated an investigation had begun. No corrective action was available for review.</p> <p>-A 12/1/14 BDDS report for an incident on 11/30/14 at 7:45pm, indicated client F "pinched" client D on the arm. No injury was recorded. The report indicated an investigation had begun. No corrective action was available for review.</p>		<p>programs are implemented as written in response to aggressive behavior. Immediate feedback will be provided to home staff regarding their performance in implementation of behavior programs.</p> <p>Responsible Party: Residential Director</p>	

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	<p>-A 11/25/14 BDDS report for an incident on 11/24/14 at 3:30pm indicated client B was "targeted by" an unidentified client "on the van." The report indicated client B was bitten and scratched on his fingers. The report indicated an investigation had begun. No corrective action was available for review.</p> <p>-A 11/22/14 BDDS report for an incident on 11/22/14 at 7:30am indicated client C was physically aggressive toward client E and pulled his hair. The report indicated an investigation had begun. No corrective action was available for review.</p> <p>-A 10/25/14 BDDS report for an incident on 10/25/14 at 11:15pm indicated client F was physically aggressive toward client C at the dining room table. The report indicated no injury was documented. The report indicated an investigation had begun. No corrective action was available for review.</p> <p>-A 10/25/14 BDDS report for an incident on 10/25/14 at 6:30am indicated client B had his hair pulled by client C and client B "bit" client C on his unidentified "pinky finger." The report indicated an investigation had begun. No corrective action was available for review.</p>			

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W 227 Bldg. 00	<p>-A 10/12/14 BDDS report for an incident on 10/11/14 at 11:00am indicated client C pulled client E's hair. The report indicated an investigation had begun. No corrective action was available for review.</p> <p>On 3/5/15 at 1:30pm, the facility's corrective actions taken after the continued client to client physical aggression incidents was requested from the QIDP (Qualified Intellectual Disabilities Professional) and the Area Director (AD). No completed corrective actions after the continued incidents of client to client physical aggression was provided for review.</p> <p>On 3/6/15 at 10:45am, an interview was conducted with the QIDP and the Area Director (AD). The QIDP indicated no completed corrective actions were available for review for client B, C, D, E, and F's incidents. The QIDP indicated no further information was available for review.</p> <p>9-3-2(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the</p>			

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	<p>comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, for 2 of 3 sampled clients (clients A and C), the facility failed to develop an active treatment program to address client A's refusals to participate with exit/evacuation of the facility during drills and for client C's incontinence needs.</p> <p>Findings include:</p> <p>1. On 3/4/15 at 3:00pm, the facility's evacuation drills for the period of 3/2014 through 3/13/2015 was completed with QIDP (Qualified Intellectual Disabilities Professional). The review of the evacuation drill records (Fire Drill Records and Tornado Drill Records) indicated the following for client A's refusals to participate and client A's failure to respond.</p> <p>-On 2/24/15 at 4:47pm, 10 minutes duration, and client A "refused" to participate.</p> <p>-On 12/8/14 at 5:12pm, 3 minutes duration, and client A "refused" to participate.</p> <p>-On 10/28/14 at 6:15am, 20 seconds duration, and client A "refused" to participate.</p> <p>-On 3/12/14 at 4:05pm, 2 minutes 10 seconds duration, and client A "refused"</p>	W 227	<p>A formal goal will be developed and implemented for Client A in order to teach him how to identify and know the importance of responding to emergency situations, including fires. The QIDP will monitor his progress with the goal each month in conjunction with his compliance with completed drills. The QIDP reviews of progress will be recorded and available for IST review. Agency QIDP's will receive training to ensure they are monitoring client compliance with and ability to complete fire drills. The training will include a review of their responsibility to ensure implement programming for any clients who demonstrate non-compliance with drills. The agency Program Quality Coordinator will receive and track all fire drill reports. An aspect of this tracking will be to ensure that recorded non-compliance is addressed with programming to improve compliance.</p> <p>The current Behavior Development Program for client C does include a timed toileting component. See attached plan for reference.</p> <p>Client C's Individual Support Plan will be updated to include accurate information about his incontinence and the programming that is in place to address this. The nurse will also be trained to ensure this is addressed in her notes. All agency QIDP's and nursing staff will be trained to</p>	04/12/2015

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	<p>to participate.</p> <p>-On 3/12/15 at 3:58pm, 1 minute 16 seconds, and client A "refused" to participate.</p> <p>On 3/5/15 at 1:30pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated client A did not have a goal/objective to exit during evacuation drills. The QIDP indicated client A did not possess the skill for pedestrian safety or to exit during an emergency.</p> <p>Client A's record was reviewed on 3/5/15 at 11:15am. Client A's 5/23/14 Individual Support Plan (ISP) did not include an exit/evacuation drill objective.</p> <p>2. During observations at the group home on 3/4/15 from 3:20pm until 6:30pm and on 3/5/15 from 5:30am until 7:15am, client C was observed to wear adult briefs for his incontinence of urine and bowel. Client C was prompted and physically assisted by the facility staff to go to the bathroom.</p> <p>On 3/5/15 at 12:10pm, client C's record review was conducted. Client C's 10/16/14 ISP (Individual Support Plan) indicated he wore "Pull Ups" (adult incontinent briefs) and did not include an objective to address his incontinence of</p>		<p>ensure any incontinence issues are properly addressed and how the issue is addressed is to be recorded properly.</p> <p>Responsible Party: Residential Director</p>				

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W 317 Bldg. 00	<p>bowel or bladder. Client C's ISP did not indicate he was incontinent. Client C's 3/14, 12/14, 9/14, and 6/14 Nursing Quarterly reviews did not indicate client C's incontinence or the reasons for his incontinence. Client C's record did not indicate evidence of training to address client C's incontinence.</p> <p>On 3/6/15 at 8:30am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client C was incontinent and wore adult briefs. The QIDP indicated client C's identified incontinence needs had not been addressed or objectives developed. The QIDP indicated no further information was available for review.</p> <p>9-3-4(a)</p> <p>483.450(e)(4)(ii) DRUG USAGE</p> <p>Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. Based on record review and interview, for 1 of 3 sampled clients (client B) who received psychotropic medications, the facility failed to evaluate client B's status for an annual decrease of psychotropic</p>	W 317	At his next psychiatry review, the provider will be presented with information to evaluate for medication reduction. The Behavior Consultant develops a	04/12/2015

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	<p>medication or provide evidence to contraindicate an attempted decrease.</p> <p>Findings include:</p> <p>Client B's record was reviewed on 3/5/15 at 1:35pm. Client B's 1/14/15 ISP (Individual Support Plan), 2/4/14 BSP (Behavior Support Plan), and 2/2015 Physician's Orders indicated client B received "Oxcarbazepine tab 300mg (milligrams) give 1 tab by mouth twice daily Diagnosis: Behavior," "Quetiapine tab 200mg, give 1 tab by mouth every morning Diagnosis: Behavior," "Sertraline tab 100mg, give 1 tab by mouth twice daily, Diagnosis: Behavior," and "Modafinil tab 200mg, give one and one half tabs (to equal) 300mg by mouth every morning" for behaviors. Client B's psychiatric medication reviews on 2/5/15, 11/6/14, 8/7/14, 7/3/14, 5/15/14, and 3/15/14 indicated the use of each of the listed medications without a documented change or contraindication for dosage change recorded. Client A's record did not indicate a current year medication change or contraindication for a dosage change. No behavior data was provided for review.</p> <p>Interview with the AD (Area Director) and the QIDP (Qualified Intellectual</p>		<p>medicationreduction plan and tracks frequency of behavior problems and mental illnessymptoms that are intended to be reduced by prescribed psychotropic medicationsfor each client in the facility. The behavior consultant will provide report tothe psychiatry provider at each visit regarding the client's status. No lessthan annually the team will discuss with the psychiatry provider the need toevaluate for a decrease of psychotropic medications. When the psychiatryprovider determines that a decrease would be contraindicated for the clientthis will be recorded by the provider and this information will be included inthe client record. The BehaviorConsultant will ensure that a discussion and evaluation of a decrease coincideswith the annual update of the behavior program for the client. An administrator does oversee the process ofpsychiatry evaluations and will develop a tracking mechanism to ensure eachclient who is prescribed psychotropic medications is evaluated for a decreasein medications no less than annually. Responsible Party: Behavior Consultant</p>	

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W 369 Bldg. 00	<p>Disabilities Professional) was conducted on 3/6/15 at 1:30pm. The AD and QIDP both indicated client B's psychiatric medication had not been changed in over a year and no contraindication for an attempt of drug withdrawal client B's psychiatric medication had been documented. The AD indicated client B had no documented evidence that a medication change had been considered or a medication reduction attempted.</p> <p>9-3-5(a)</p> <p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation, record review, and interview, for 2 of 9 medications administered during the morning medication administration (client C), the facility failed to ensure medications were given without error.</p> <p>Findings include:</p> <p>On 3/5/15 at 6:12am, client C was asked by GHS (Group Home Staff) #1 to come into the medication room. At 6:12am, GHS #1 unlocked the medication cabinet, retrieved client C's medication of</p>	W 369	<p>The staff in the home include the staff who was responsible for the cited medication errors will receive re-training on agency policies to ensure medications are administered as prescribed. This training will include a review of the need to closely review the Medication Administration Record and to follow all specific directions of how a medication is to be administered. This training will include an observation of each staff administering medications by a professional staff to ensure medications are administered per physician's orders. Ongoing</p>	04/12/2015

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	<p>"Nasonex, Spr (spray) 50mcg (microgram), give 2 sprays in each nostril daily Diagnosis: Seasonal Allergies." GHS #1 indicated and was observed to administer one (1) spray into each of client C's nostrils. At 6:12am, GHS #1 administered client C's "Chlorhex sol. (solution) for Peridex, rinse mouth with 1 tablespoon (or) 15ml (milliliters) twice daily after breakfast and before bedtime, Diagnosis: Antiseptic (for oral care)" on an oral swab and applied the rinse to the inside of client C's mouth. For both medications observed administered to client C, GHS #1 matched each medication to client C's 3/2015 MAR (Medication Administration Record) and administered client C's medications. Client C took the medications with his ensure drink and left the medication area. From 6:27am until 7:15am, client C was verbally prompted and encouraged to eat his breakfast meal.</p> <p>On 3/5/15 at 12:10pm, Client C's 3/2015 MAR (Medication Administration Record) and 2/23/15 Physician's Order both indicated "Nasonex, Spr (spray) 50mcg, give 2 sprays in each nostril daily Diagnosis: Seasonal Allergies" and "Chlorhex sol. (solution) for Peridex, rinse mouth with 1 tablespoon (or) 15ml (milliliters) twice daily after breakfast and before bedtime, Diagnosis: Antiseptic</p>		<p>professionalstaff will complete routine observations of administration of medications to ensurethey are administered per agency policy and physicians orders. Responsible Party: Residential Director</p>	

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	<p>(for oral care)."</p> <p>On 3/6/15 at 10:00am, a record review was completed of the facility's policy and procedures, 10/2013 "Medication Administration by Staff" indicated "Check the information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage, site of instillation, and the time...Check the medication listed on the medication administration record with the medication label three times...." The policy and procedure indicated staff should administer client medications according to physician's orders and the pharmacy instructions should be followed.</p> <p>On 3/6/15 at 10:00am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow physician orders and the pharmacy instructions.</p> <p>On 3/5/15 at 10:45am, an interview with the agency nurse and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The agency nurse and QIDP both indicated staff should administer</p>			

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W 382 Bldg. 00	<p>medications according to physician's orders. The agency nurse indicated staff did not follow the medication administration policy and procedure when medications were not administered according to physician's orders. The agency nurse stated the facility staff should have administered client C's oral rinse after breakfast and not before breakfast. The agency nurse indicated the staff should have administered two sprays of nasal medication spray and not one per nostril. The agency nurse indicated the facility staff did not follow the policy and procedure to administer medication according to physician's orders.</p> <p>9-3-6(a)</p> <p>483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation, record review, and interview, for 1 additional client (client D), the facility failed to ensure client D's injectable seizure medication was kept secured when not being administered.</p> <p>Findings include:</p>	W 382	All staff in the home will receive retraining to ensure that the black combination box that stores client D's injectable seizure medication remains secured. This training will include demonstration by each staff on how to secure the box properly. This will be included in the home's medication	04/12/2015

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	<p>On 3/5/15 from 5:30am until 7:15am, client D was observed at the group home and her back pack was hung on the back of her wheelchair. At 6:15am, client D sat with her open backpack hanging on the back of client D's wheelchair at the dining room table. Client D's back pack was unzipped and inside the backpack was a hard shell black combination box with the lock set to open. The unsecured black combination box was clicked open by the surveyor to expose client D's injectable seizure medication inside.</p> <p>On 3/5/15 at 8:30am, client D sat at a table inside the classroom at the local high school. Client D's backpack was unzipped exposing the black box with client D's one syringe of 12.5mg (milligrams) Diazepam for seizure medication. At 8:30am, the classroom teacher indicated she could open the container because it was not locked or secured. The teacher indicated client D had seizures and needed the as needed Diazepam medication available for use in the classroom. The teacher indicated the box should have been locked or secured and was not.</p> <p>On 3/6/15 at 10:00am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated medications should</p>		<p>administration training for any newemployees in the home. During routine observations in the home, the QIDP willcheck this box to ensure it is secured properly. This check will be recorded ona home visit report that is submitted to the administrative team for review.</p> <p>Responsible Party: Residential Director</p>	

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W 390 Bldg. 00	<p>be kept locked and secured when not being administered. The QIDP indicated the facility followed "Living in the Community" Core A/Core B procedures for medication administration.</p> <p>Client D's 3/2015 MAR (Medication Administration Record) was reviewed on 3/5/15 at 10am. Client D's 2/2015 Physician's Order and 3/2015 MAR both indicated "Diazepam for Diastat Acudial, insert 12.5mg rectally as directed as needed for seizures, flag each syringe with label."</p> <p>On 3/6/15 at 10:00am, a record review of the facility's undated "Living in the Community" Core A/Core B training for medication administration indicated in "Core Lesson 3: Principles of Administering Medication" medications should be kept secured when not being administered.</p> <p>9-3-6(a)</p> <p>483.460(m)(2)(i) DRUG LABELING The facility must remove from use outdated drugs. Based on observation, record review, and interview, for 1 additional client (client B), the facility failed to remove client B's outdated medication container from use.</p>	W 390	The staff in the home including the staff who was responsible for administering the expired medication will receive re-training on agency policies to ensure	04/12/2015

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	<p>Findings include:</p> <p>On 3/4/15 at 4:35pm, GHS (Group Home Staff) #2 selected client B's "Clindamycin Pad 1% for: Cleocin-T, apply to face daily for acne," GHS #2 applied the cream to client B's face, and the container had a manufacturer's expiration date of 1/2015 stamped on the side of the container. After GHS #2 administered client B's Clindamycin cream to his face, GHS #2 indicated the expiration date was 1/2015 on the side of the container. At 4:45pm, client B's 3/2015 MAR (Medication Administration Record) indicated "Clindamycin Pad 1% for: Cleocin-T, apply to face daily for acne."</p> <p>On 3/5/15 at 1:35pm, client B's record was reviewed. Client B's 2/2015 Physician's Order indicated "Clindamycin Pad 1% for: Cleocin-T, apply to face daily for acne."</p> <p>On 3/6/15 at 10:00am, a record review was completed of the facility's policy and procedures, 10/2013 "Medication Administration by Staff" indicated "Check the information on the pharmacy medication label by comparing it to the medication administration record and the physician's order, for the individual's name, medication ordered, dosage, site of</p>		<p>medications that are administered have not expired. This training will include a review of the need to review all medication packaging prior to administration to ensure it has not expired. Staff will be trained to immediately notify the nurse if they find a medication that has expired. This training will include an observation of each staff administering medications by a professional staff to ensure medications are administered per physician's orders. During this observation the professional staff will require the staff to demonstrate how they check and identify expiration dates on medications. The agency nurse will also receive retraining to ensure that any expired medications are removed from the home supply when she completes weekly audits of medications. There is a staff who works in the home who has also been trained to review medication supplies routinely and to report the need for replacing medications that are due for expiration to the agency nurse and/or for the need to dispose of expired medications. Responsible Party: Residential Director</p>	

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W 436 Bldg. 00	<p>instillation, and the time...Check the medication listed on the medication administration record with the medication label three times...." The policy and procedure indicated staff should administer client medications according to physician's orders and the pharmacy instructions should be followed.</p> <p>On 3/5/15 at 10:45am, an interview with the agency nurse and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The agency nurse indicated staff did not follow the medication administration policy and procedure when client B's topical medication was administered from an expired medication container. The agency nurse indicated the facility staff should have ensured client B's topical medication was not expired. The agency nurse indicated the medication should have been removed from use.</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 informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary</p>			

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	<p>team as needed by the client.</p> <p>Based on observation, record review, and interview, for 1 of 1 sampled client (client C) with adaptive communication equipment, the facility failed to teach, encourage, and have available client C's augmented communication device at the group home.</p> <p>Findings include:</p> <p>On 3/4/15 from 3:20pm until 6:30pm, and on 3/5/15 from 5:30am until 7:15am, observation and interviews were conducted at the group home. During both observations, client C did not have a communication system available for his use and was not taught or encouraged to use a system to communicate his wants and needs to the facility staff. During both observation periods client C pulled staff by the hand and responded to his name when staff spoke client C's name. No other requests were made to client C from the staff.</p> <p>On 3/5/15 from 8:00am until 8:45am, client C was observed at the school and used an augmented communication device to tell his teacher the weather report outside was "cloudy" and "cold." Client C communicated he was "hungry" and asked if it was "time for lunch yet." Client C counted to five on his</p>	W 436	<p>The augmented communication device that belongs to client Cis functioning properly now. There is a formal training goal in place in whichhis staff work with him to use the device to communicate. The staff will be trained to report to the RD any concerns with the functioning of the device.</p> <p>A communication book will also be developed that uses pictures consistent withthose on the device that will be available for use should the device notfunction properly for some reason in the future. The QIDP completes visits noless than weekly in the home. During these observations the QIDP will ensurethe device is used properly with client C and will train staff as needed inproper use. These observations will be recorded on the home visit report thatis provided to the administrator for review. Agency QIDP's will be trained ontheir responsibility to ensure that the facility furnishes, maintains in goodrepair, and teaches clients to use and make informed choices regarding the use of any assistive (includingthose for communication) devices.</p> <p>Responsible Party: Residential Director</p>	04/12/2015

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	<p>communication board and identified the day of the week correctly. Client C identified people in his classroom, staff, and clients by their names.</p> <p>On 3/5/15 at 12:10pm, client C's record was reviewed. Client C's 1/14/15 ISP (Individual Support Plan) and 2/2015 FA (Functional Assessment) indicated client C was "being assessed" to use an augmented communication device. Client C's ISP indicated a goal/objective for client C to communicate with staff to answer a question. Client C's 6/9/14 "Audiology" assessment indicated client C was unable to speak. Client C's 10/22/14 and 6/11/14 speech therapy assessments indicated client C was recommended for an augmented communication device.</p> <p>On 3/6/15 at 10:00am, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and the AD. The QIDP indicated client C had an augmented communication system and the device was not functioning at this time. The QIDP indicated she did not know where the device was and stated she "thought it was gone for repair or at the group home." The QIDP indicated client C should have been taught and encouraged to use his communication device during formal and informal</p>			

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W 454 Bldg. 00	<p>opportunities.</p> <p>On 3/6/15 at 1:30pm, the QIDP indicated client C's communication device had been located, the power cord adjusted, and now client C's communication device was working.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections.</p> <p>Based on observation, record review, and interview, for 2 of 9 medications administered during the morning medication administration (client C), the facility failed to implement and teach sanitary methods during medication administration.</p> <p>Findings include:</p> <p>On 3/5/15 at 6:12am, client C was asked by GHS (Group Home Staff) #1 to come into the medication room. At 6:12am, GHS #1 did not wash his hands and did not wash the top of the washer/dryer where medications were being administered on the top. At 6:12am, GHS #1 unlocked the medication cabinet, retrieved client C's medication of</p>	W 454	<p>The staff in the home including the staff who was responsible for failing to implement sanitary methods during medication administration will receive retraining on requirements to ensure proper sanitation steps are followed during each medication administration. This training will include an observation of each staff administering medications by a professional staff to ensure medications are administered in a manner that a proper sanitary environment is provided. Ongoing professional staff will complete routine observations of administration of medications to ensure that a sanitary environment is provided when medications are administered.</p> <p>Responsible Party: Residential Director</p>	04/12/2015

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	<p>"Levothyroxine 25mcg (microgram), 1 tab daily for Hypothyroidism (and) Risperidone 1mg (milligram) 1 tab twice a day for behaviors." GHS #1 popped the medications out of the medication bubble package, dropped the medications on the unwashed top of the dryer, and the pills became commingled with papers and debris on the dryer top. GHS #1 located each tablet, picked up the tablets with his fingers, placed them into a medication cup, placed the medications into a pill crusher, crushed the tablets, added the crushed soiled medications to client C's ensure drink, and administered each of the dropped medications to client C. Client C consumed the mixture.</p> <p>On 3/5/15 at 12:10pm, Client C's 3/2015 MAR (Medication Administration Record) and 2/23/15 Physician's Order both indicated "Levothyroxine 25mcg, 1 tab daily for Hypothyroidism (and) Risperidone 1mg (milligram) 1 tab twice a day for behaviors."</p> <p>On 3/5/15 at 10:45am, an interview with the agency nurse and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The agency nurse and QIDP both indicated staff should have washed the top counter areas before medication administration.</p>			

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W 455 Bldg. 00	<p>On 3/6/15 at 10:00am, an interview was conducted with the AD. The AD indicated client C should have washed the top of the washer/dryer area before medication administration. The AD indicated the agency trained the staff to follow "Universal Precautions" for sanitation in Core A/Core B medication administration training.</p> <p>On 3/6/15 at 10:00am, the undated Core A/Core B Medication Administration training manual page 3 indicated "Universal precautions" included washing hands before medication administration, before eating, and after using the restroom.</p> <p>9-3-7(a)</p> <p>483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation, record review, and interview, for 1 of 3 sampled clients (client C), the facility failed to encourage and teach handwashing during medication administration.</p> <p>Findings include: On 3/5/15 at 6:12am, client C was asked</p>	W 455	All group home staff will receive retraining on therequirement to ensure that the staff administering the medications must washtheir hands before administering medications. They will also receive retrainingto ensure that each client is encouraged and taught to wash their hands beforetaking their medications. Each staffwill be observed to administer medications	04/12/2015

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	<p>by GHS (Group Home Staff) #1 to come into the medication room. At 6:12am, GHS #1 did not wash his hands and did not wash the top of the washer/dryer where medications were being administered on the top. At 6:12am, GHS #1 unlocked the medication cabinet, retrieved client C's medication of "Levothyroxine 25mcg (microgram), 1 tab daily for Hypothyroidism (and) Risperidone 1mg (milligram) 1 tab twice a day for behaviors." GHS #1 popped the medications out of the medication bubble package, dropped the medications on the unwashed top of the dryer, and the pills became commingled with papers and debris on the dryer top. GHS #1 located each tablet, picked up the tablets with his fingers, placed them into a medication cup, placed the medications into a pill crusher, crushed the tablets, added the crushed soiled medications to client C's ensure drink, and administered each of the dropped medications to client C. Client C consumed the mixture.</p> <p>On 3/5/15 at 10:45am, an interview with the agency nurse and the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The agency nurse and QIDP both indicated staff and clients should wash their hands before handling medications.</p>		<p>by a professional staff to ensure proper hand washing technique is followed before administering medications and to ensure each client is encouraged and provided any needed training to wash their hands properly before taking their medications. Ongoing professional staff will complete routine observations of administration of medications to ensure that staff wash their own hands and encourage and teach each client to wash their hands before medications are administered.</p> <p>Responsible Party: Residential Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G554	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/13/2015
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1435 W CONGRESS ST MIDDLETOWN, IN 47356
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	<p>On 3/6/15 at 10:00am, an interview was conducted with the AD. The AD indicated client C should have had his hands washed before medication administration. The AD indicated the agency trained the staff to follow "Universal Precautions" for teaching clients to wash their hands in Core A/Core B medication administration training.</p> <p>On 3/6/15 at 10:00am, the 2004 "Core A/Core B Medication Training" indicated "Lesson 3 Principles of Administering Medications." The Core A/Core B policy and procedure indicated the facility should follow universal precautions during medication administration.</p> <p>On 3/6/15 at 10:00am, the undated Core A/Core B Medication Administration training manual page 3 indicated "Universal precautions" included washing hands before medication administration, before eating, and after using the restroom.</p> <p>9-3-7(a)</p>			