

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G670	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/10/2013
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4918 MICHAEL ST ANDERSON, IN 46011
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W0000	<p>This visit was a post-certification revisit (PCR) to the fundamental annual recertification and state licensure survey conducted on October 31, 2012.</p> <p>Dates of survey: January 7, 8, 9 and 10, 2013.</p> <p>Facility Number: 001224 Provider Number: 15G670 AIMS Number: 100239540</p> <p>Surveyor: Claudia Ramirez, RN/Public Health Nurse Surveyor III/QMRP</p> <p>This federal deficiency also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 1/17/13 by Tim Shebel, Medical Surveyor III.</p>	W0000		

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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W0331	<p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview, the facility failed for 2 of 3 sampled clients (clients #1 and #2) by not ensuring clients received nursing services according to their medical needs, by not ensuring medications were administered as ordered and by not ensuring medication orders were carried out after being discharged from the hospital.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 01/09/13 at 1:20 PM and contained the following dated documents:</p> <p>12/14/12: A BDDS (Bureau of Developmental Disabilities Services) Report for an incident dated 12/14/12 at 10:00 AM indicated, "On 12/14/12, [client #1] was seen in the emergency room after staff noticed her tongue was extremely swollen. The physician began treating [client #1] with Benadryl, Pepcid, and Solu-Medrol for a possible allergic reaction. [Client #1] currently has no known allergies. [Client #1] was admitted to the ICU (Intensive Care Unit) for continued monitoring. At this time, [client #1] is receiving fluids and</p>	W0331	<p>W331 Staff will receive very detailed, specific training with regard to following medication orders. The medication administration procedure for the home has been organized in such a manner as to facilitate complete compliance with following medication orders to include multiple reviews of the orders. Professional staff will continue to complete routine oversight of medication administration. Staff who commit any type of error will be prohibited from completing any further medication passes until the nurse has indicated that they are competent to do so. The agency policy regarding new medication orders will be reviewed with staff at each routine staff meeting.</p>	02/09/2013			

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	<p>medication via IV (intravenous) in the ICU unit. Further follow up will be submitted."</p> <p>12/20/12: A BDDS Follow-Up Report indicated, "[Client A] remains in ICU. It was determined that she developed Angioedema (the rapid swelling of the dermis, subcutaneous tissue, mucosa and submucosal tissues) in her tongue resulting in the swelling. The physician ordered a swallow study on 12/15, but [client #1] was not able to participate due to the swelling. An ENT (ears, nose and throat) consultation was requested. On 12/19, [client #1] had a CT (computed tomography) scan completed. After reviewing the scan, the physician believes the root cause of the Angioedema is likely an infection in [client #1's] sinus cavity. She has started antibiotic treatment. On 12/20, [client #1] had another swallow study completed and she was able to participate. Results of the swallow study are not available at this time. Further follow up will be submitted."</p> <p>12/28/12: A BDDS Follow-Up Report indicated, "[Client #1] was discharged on 12/25/12 with orders to schedule appointments with her primary care physician and ENT. She is to have a chest xray (sic) prior to attending the appointments. She also had short term orders for an antibiotic and steroid. [Agency] will continue to monitor [client</p>			

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	<p>#1's] health and safety and follow any other physician recommendations."</p> <p>12/27/12: A BDDS Report for an incident dated 12/25/12 at 3:00 PM indicated, "[Client #1] was discharged from the hospital on 12/25/12. Upon return to the group home, [staff #1] failed to contact the nurse to advise her that [client #1] had been released and had orders for two new medications. The medications were ordered on 12/26/12 and received late that evening (due to inclement weather). [Client #1] missed one dose of Prednisone (steroid) and two doses of Clindamycin (antibiotic). [Client #1's] physician has been notified and we await his feedback. [Client #1] is not receiving medications as ordered. [Staff #1] had been suspended pending investigation. Staff will closely monitor [client #1] as she continues to recuperate. Further follow up to be submitted."</p> <p>01/04/13: A BDDS Follow-Up Report indicated, "The physician did not offer any feedback after being notified of this incident. [Client #1] has continued to recuperate and is doing very well. She has her follow up appointments on 1/7/13 and 1/17/13. [Client #1] has returned to work and resumed normal day to day activity. The outcome of the investigation determined that [staff #1] failed to notify the nurse of the new orders upon [client</p>			

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	<p>#1's] release from the hospital. All staff have received very specific training with regard to notifying the nurse of any change in health status (to include immediate notification of new orders upon release from the hospital). [Staff #1] has received corrective action."</p> <p>The facility Investigation Summary Form dated 12/26/12 contained the following information: "On 12/26/12, it was discovered that [client #1] had been discharged from the hospital on 12/25/12 and nursing staff were unaware and new orders were not processed...Findings: 1. [Staff #1] did not notify any nurse that [client #1] had been discharged. It was only by chance that the on-call RD (Residential Director) was notified that [client #1] had been discharged from the hospital. 2. [Staff #1] did not communicate to anyone that [client #1] had new orders, although she did tell [staff #2] that she had 'papers' from the hospital...4. All professional staff involved assumed that the other appropriate professional staff had been advised that [client #1] had been released from the hospital but did not verify. 5. [Client #1] did not receive one dose of Prednisone and two doses of Clindamycin due to the lack of communication and then further due to the delay in delivery due to the inclement weather..."</p>						

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	<p>The Investigation Summary contained the following interviews dated 12/27/12: Staff #1: "This is the first time I've been at the hospital with someone. I didn't really know what to do...".</p> <p>On 01/09/13 at 3:30 PM an interview with the Area Director (AD) was conducted. The AD indicated staff #1 should have contacted the nurse on call and the RD on call when client #1 was discharged from the hospital. The AD indicated the staff failed to provide the proper medical care to client #1 as she missed doses of medications that should have been continued from the hospital course of treatment for her infection. The AD indicated staff training has recently been completed on this same issue and staff should have know what to do and should have called the on call nurse and RD.</p> <p>2. Client #2's record was reviewed on 01/09/13 at 2:20 PM and contained the following dated documents:</p> <p>12/29/12: A BDDS Report for an incident dated 12/28/12 at 7:00 PM indicated, "On 12/29/12, it was discovered that staff (staff #3) failed to administer [client #2's] Remeron (antidepressant) on 12/28/12...".</p>			

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	<p>On 01/09/13 at 3:30 PM an interview with the Area Director (AD) was conducted. The AD indicated staff #3 should have given client #2's medication as ordered. The AD indicated the staff failed to provide the proper medical care to client #2 as she missed the dose of the medication. The AD indicated staff training has recently been completed on this same issue and client #2 should have received her medication as ordered.</p> <p>This deficiency was cited on 08/31/2012. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-6(a)</p>			
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