

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

W 000 Bldg. 00	<p>This visit was for an extended annual recertification and state licensure survey.</p> <p>Dates of Survey: 3/17, 3/18, 3/19, 3/20, 3/23, 3/24, 3/25, 3/26, and 3/27/2015.</p> <p>Facility Number: 000918 Provider Number: 15G404 AIM Number: 100235430</p> <p>Surveyor: Susan Eakright, QIDP</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 4/6/15 by Ruth Shackelford, QIDP.</p>	W 000		
W 149 Bldg. 00	<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 observation, record review, and interview, for 1 of 4 sampled clients (client #8), the facility neglected to provide sufficient staff on duty to supervise client #8 according to her identified needs and neglected to ensure staff were available to provide client #8</p>	W 149	The QIDP is ensuring that appropriate staffing is provided to meet the clients' needs of the home as defined by the IST for all residents of the home. This includes adequate staffing in place to implement client #8's current Behavior Development Program as	04/26/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/27/2015
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>with one on one supervision according to her Behavior Plan.</p> <p>Findings include:</p> <p>On 3/18/15 from 5:40am until 7:45am, client #8 was observed at the group home. From 5:40am until 6:05am, GHS (Group Home Staff) #3 was the one facility staff on duty at the group home with clients #1, #2, #3, #4, #5, #6, #7, and #8. From 5:40am until 6:05am, GHS #3 constantly prompted client #8 to stay within eye sight of staff on the sofa in the living room while clients #5, #6, and #8 sat in the living room. At 5:40am, client #8 and GHS #3 both indicated client #8 slept on the sofa downstairs during the night because there was one staff on duty with eight (8) clients in the home. At 5:40am, GHS #3 indicated client #8 was on Suicide Watch and was to be within eye sight of staff at all times. At 6:05am, the QIDP (Qualified Intellectual Disabilities Professional) and other GHS arrived on duty. At 6:05am, client #8 walked independently up and down the stairs, went into both bathrooms upstairs and downstairs, the kitchen, and accessed the upstairs without staff on the second floor. At 6:05am, when the other staff entered the group home, client #8 jumped up from the sofa, gathered her blankets and pillow, and walked quickly to the</p>		<p>written. The Behavior Program for Client #8 is being reviewed by the IST, including the behavior consultant, to recommend revisions to provide more specific guidelines for staff supervision when client #8 demonstrates suicidal threats or behavior. The behavior program will be updated per the decisions of the IST. The program will be implemented with the required approval of the IST and HRC. Client #8's ISP will be updated to reflect specific information and directives concerning responses to her suicidal behavior, including the needed staffing supervision in these circumstances. The QIPD will ensure that all clients' ISP's reflect their current needs. The QIPD will ensure that unannounced visits in the home occur by a professional staff routinely and when increased monitoring is required following a suicidal threat and/or behavior by client #8 to ensure proper monitoring is being followed per her Behavior Development Program. The QIPD will notify the administrator of any such incidents. The administrator will routinely review electronic time records for staff to ensure proper staffing is provided. Staff will also receive retraining to assess for, report and document all observed injuries. The nurse will review recording of injuries by staff no less than weekly. Professional and nursing staff will complete routine visits in the home</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/27/2015
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>second floor of the home. At 6:05am, client #8 entered a dark bedroom, placed her items on the bed, and began to dress. No facility staff were present on the second floor.</p> <p>On 3/18/15 at 6:16am, GHS #2 asked client #8 to come to the medication room and GHS #2 selected "Mupirocin (Bactroban) Oin. (Ointment) apply to sores 3 times daily for infection." GHS #2 administered client #8's Mupirocin and Flonase medications. At 6:16am, Client #8 rubbed the Mupirocin cream into two red colored two to two and one half inch (2 to 2 1/2 inches) scratches on client #8's left wrist and stated the red scratches were "where I tried to kill myself last week." At 6:30am, GHS #2 indicated client #8 was on fifteen (15) minute checks and that staff needed to know the general location of client #8. GHS #2 stated "Yes, [client #8] was on Suicide Watch" which was 15 minute checks. At 6:30am, client #8 was requested by the QIDP to come into a downstairs bedroom where two other clients lived, and entered the other clients' bedroom walking behind the Lab Technician (LT). Client #8 entered the bedroom with the LT, and had her blood drawn with no staff present. At 6:30am, the LT stated "You may want to look away, this may sting," and held a needle</p>		<p>and will have eyes on the residents and observe for any indication of injuries that may not have been reported or recorded properly. This will include a look at client #8 arms. A protocol for lab draws done in the home will be developed by the administrator. This will include that when client's labs are drawn in the home that this must occur privately in the client's own bedroom or in the medication administration area, ensuring privacy. The staff will also be trained that a staff person must remain with any client when they are having their labs drawn in the home. A professional or nursing staff will be present in the home at the next lab draw that occurs in the home to ensure this protocol is followed. The QIDP will also review the protocol with the lab technician. The protocol will be followed in all agency locations where lab draws are occurring in the home. Responsible Party: QIDP</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>to draw client #8's blood. Client #8 stated "No, I want to watch. I like it." Client #8 exited the other clients' downstairs bedroom, went to the kitchen, and no staff were within eye sight of client #8 until 6:45am, when client #8 walked to the living room. From 6:45am until 7:00am, client #8 sat on the chair in the living room and staff walked in and out of the living room. No one on one staff was present with client #8. At 7:00am, GHS #2 indicated client #8 was to be checked on every fifteen (15) minutes.</p> <p>On 3/18/15 at 8:50am, client #8's record review was conducted. Client #8's 2/18/15 ISP (Individual Support Plan) and 3/4/14 and 1/2015 revised BDP (Behavior Development Plan) indicated client #8 had the targeted behaviors of SIB (Self Injurious Behavior) of cutting herself and picking her skin, Suicide Threats with 15 minute checks, Vacating, Physical Assault, Verbal Aggression, Resistance, Inappropriate use of Social Media, and Inappropriate Social and Sexual behaviors. Client #8's ISP and BDP indicated the need for locked sharps to prevent injury and door alarms because client #8 leaves the facility AWOL (Absent Without Leave). Client #8's BDP indicated "Suicide Threats/Attempts: If [client #8] threatens</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>suicide, immediately place her under round the clock surveillance. Observe her at all times but do not alter her normal activities...Search all locations where [client #8] spends time for harmful objects...Accompany [client #8] to locations where she typically is alone and unobserved...Document condition every 15 minutes..." Client #8's BDP indicated when client #8 attempted to harm herself or made threats of Suicide that staff should document her skin assessment status every shift. Client #8's skin assessment documentation did not indicate she had an injury, cut, and/or a scratch on her body on 3/16/15, 3/17/15, and 3/18/15. Client #8's BDP indicated when client #8 was on Suicide Watch she was to be on one on one staff supervision level.</p> <p>On 3/17/15 at 1:40pm, the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 10/1/2014 through 3/17/2015 did not indicate any incidents of suicide threats or the following discussions from the IDT meetings.</p> <p>On 3/18/15 at 8:50am, client #8's record indicated IDT (Interdisciplinary Team) Meetings for the following:</p> <p>-On 2/9/15 IDT "Discussion-Summarize</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>following meeting: Discussed that [client #8] had inappropriate pictures on computing equipment. Discussed inappropriate pictures were erased from the computing equipment."</p> <p>-On 10/14/14 IDT "Discussion-Summarize following meeting: Discussed that there have been no...events occurring over the last month. Discussed locking up of sharps due to safety issues and behavior issues of consumers in the home. Discussed that [client #8] is a cutter so for her safety sharps are locked up. Discussed that also a consumer who has in the past left the home with an unknown person, therefore the alarms will alert staff should she attempt to covertly exit the house."</p> <p>-On 10/10/14 IDT "Discussion-Summarize following meeting: Discussed that [client #8] remains eyes on (supervision) at [name of workshop] and we need to discuss if this should continue or not. Discussed that due to [client #8's] interactions with others she should remain eyes on at [name of workshop]. Discussed remaining 15 minute checks at the group home. [Client #8] did attend Special Olympics and did well, had no issues....."</p> <p>-On 9/4/14 IDT "Discussion-Summarize</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>following meeting: Discussed [BDDS] report of interactions between staff and consumers. Discussed that [client #8] was placed on suicide watch."</p> <p>-On 9/4/14 IDT reviewed by the QIDP indicated "Discussion-Summarize following meeting: Discussed [client #8] went on suicide watch on Monday 8/4/14 when she threatened to cut herself. She did nothing the rest of the evening...On Tuesday 8/5/14 evening, [client #8] traded her DS (a computer game system) with her new guy (boyfriend) without anyone's knowledge. On 8/6/14 morning it was found that they both had taken pictures/videos of themselves masturbating and switched the devices back. As per [client #8's] approved behavior plan the device was removed from her possession. [Client #8] then later on 8/6/14 broke her camera, using a piece of it to scratch her left wrist. [Client #8] states that she is now 8/8/14 with her old boyfriend...." The report indicated client #8 "had no issues of suicide threats/attempts, inappropriate sexual behavior or incident of cutting" on 8/7/14 or 8/8/14 and "removed her from suicide watch."</p> <p>-On 8/26/14 IDT meeting indicated client #8 had "one incident which occurred where [client #8] was on suicide watch as well as having used equipment</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>inappropriately."</p> <p>-On 8/8/14 IDT meeting indicated "review of (client #8's) current need to be on suicide watch."</p> <p>-On 6/24/14 IDT meeting indicated client #8 "remains eyes on at [name of workshop] while at the house, she is checked on every 15 minutes."</p> <p>On 3/18/15 at 8:20am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and agency nurse #1 was conducted. The QIDP indicated client #8 was on Suicide Watch and should have had one on one staff supervision. The QIDP indicated client #8 had attempted to cut herself in a Suicide Attempt last week (3/12/15) with a piece of card board at the workshop. The QIDP indicated she was unsure of the staffing pattern for the group home. The QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 were at the group home on 3/18/2015 when one staff was on duty. The QIDP and nurse #1 both stated they were "unaware" client #8 had a left wrist injury. The QIDP indicated no injuries were noted after that incident. The QIDP indicated client #8's ISP and BDP did not contain specific guidelines for one on one staff supervision to clearly define client #8's one on one supervision.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The QIDP indicated she did not know when client #8's new injury to her wrist occurred and did not know how the injury occurred if client #8 was on one on one staff supervision since the 3/12/15 suicide threat. The QIDP indicated no further information was available for review.</p> <p>On 3/18/15 at 9:50am, Nurse #1 stated "I was at the group home on 3/12/15 at 4:00pm after [client #8's] incident at workshop" when client #8 cut her left wrist with card board. Nurse #1 stated client #8 had no injury at that time. "She had a red mark about 1/4" long. What [client #8] has now is new. The one area is about 2 inches and was red." The second area was "a scar" from client #8's previous self injuries of cutting herself. Nurse #1 indicated no staff had contacted her about the new injury, client #8's skin tracking sheets did not indicate the injury, and the staff were not recording the treatment they were providing on client #8's wrist injury. Nurse #1 indicated the staff were recording in client #8's 3/2015 MAR that she was receiving treatment but did not indicate what part of the body the ointment was applied.</p> <p>On 3/27/15 at 4:00pm, an interview with the Area Director (AD) was conducted. The AD indicated no further information</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was available for review.</p> <p>On 3/18/15 at 1:04pm, a record review was conducted of the 10/2005 "Bureau of Developmental Disabilities Services Policy and Guidelines." The BDDS policy and procedure indicated "...Abuse, Neglect, and Mistreatment of Individuals...it is the policy of the company to ensure that individuals are not subjected to physical, verbal, sexual, or psychological abuse or exploitation by anyone including but not limited to: facility staff...other individuals, or themselves." The policy indicated "Neglect, the failure to supply an individual's nutritional, emotional, physical, or health needs although sources of such support are available and offered and such failure results in physical or psychological harm to the individual." The BDDS policy indicated each allegation of abuse, neglect, and/or mistreatment should be immediately reported.</p> <p>On 3/18/15 at 1:04pm, the facility's 10/13 "Preventing Abuse and Neglect" policy and procedure indicated "Abuse means the following: 1. Intentional or willful infliction of physical injury...7. Corporal Punishment which includes forced physical (sic), hitting, pinching, application of painful or noxious stimuli,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 186 Bldg. 00	<p>use of electric shock, and the infliction of physical pain...9. Violation of individual rights....Neglect means failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual." The policy and procedure indicated "all" allegations of abuse and/or neglect should be immediately reported to the administrator and to BDDS in accordance with State Law and should be thoroughly investigated.</p> <p>9-3-2(a)</p> <p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #8), the facility failed to provide sufficient staff on duty to supervise client #8 according to her needs.</p> <p>Findings include:</p>	W 186	<p>The QIDP is ensuring that appropriate staffing is provided to meet the clients' needs of the home as defined by the IST for all residents of the home. This includes adequate staffing in place to implement client #8's current Behavior Development Program as</p>	04/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 3/18/15 from 5:40am until 7:45am, client #8 was observed at the group home. From 5:40am until 6:05am, GHS (Group Home Staff) #3 was the one facility staff on duty at the group home with clients #1, #2, #3, #4, #5, #6, #7, and #8. From 5:40am until 6:05am, GHS #3 constantly prompted client #8 to stay within eye sight of staff on the sofa in the living room while clients #5, #6, and #8 sat in the living room. At 5:40am, client #8 and GHS #3 both indicated client #8 slept on the sofa downstairs during the night because there was one staff on duty with eight (8) clients in the home. At 5:40am, GHS #3 indicated client #8 was on Suicide Watch and was to be within eye sight of staff at all times. At 6:05am, the QIDP (Qualified Intellectual Disabilities Professional) and other GHS arrived on duty. At 6:05am, client #8 walked independently up and down the stairs, went into both bathrooms upstairs and downstairs, the kitchen, and accessed the upstairs without staff on the second floor. At 6:05am, when the other staff entered the group home, client #8 jumped up from the sofa, gathered her blankets and pillow, and walked quickly to the second floor of the home. At 6:05am, client #8 entered a dark bedroom, placed her items on the bed, and began to dress. No facility staff were present on the</p>		<p>written. The Behavior Program for Client #8 is being reviewed by the IST, including the behavior consultant, to recommend revisions to provide more specific guidelines for staff supervision when client #8 demonstrates suicidal threats or behavior. The behavior program will be updated per the decisions of the IST. The program will be implemented with the required approval of the IST and HRC. The QIDP will ensure that unannounced visits in the home occurs by a professional staff routinely and when increased monitoring is required following a suicidal threat and/or behavior by client #8 to ensure proper monitoring is being followed per her Behavior Development Program. The QIDP will notify the administrator of any such incidents. The administrator will routinely review electronic time records for staff to ensure proper staffing is provided. Responsible Party: QIDP</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>second floor.</p> <p>On 3/18/15 at 6:16am, GHS #2 asked client #8 to come to the medication room and GHS #2 selected "Mupirocin (Bactroban) Oin. (Ointment) apply to sores 3 times daily for infection." GHS #2 administered client #8's Mupirocin and Flonase medications. At 6:16am, Client #8 rubbed the Mupirocin cream into two red colored two to two and one half inch (2 to 2 1/2 inches) scratches on client #8's left wrist and stated the red scratches were "where I tried to kill myself last week." At 6:30am, GHS #2 indicated client #8 was on fifteen (15) minute checks and that staff needed to know the general location of client #8. GHS #2 stated "Yes, [client #8] was on Suicide Watch" which was 15 minute checks. At 6:30am, client #8 was requested by the QIDP to come into a downstairs bedroom belonging to two other clients who lived in the group home. Client #8 walked behind the the Lab Technician (LT) to enter the downstairs bedroom. Client #8 entered the bedroom, with the LT, with no staff present and had her blood drawn. At 6:30am, the LT stated "You may want to look away, this may sting," and held a needle to draw client #8's blood. Client #8 stated "No, I want to watch. I like it."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 3/18/15 at 8:50am, client #8's record review was conducted. Client #8's 2/18/15 ISP (Individual Support Plan) and 3/4/14 and 1/2015 revised BDP (Behavior Development Plan) indicated client #8 had the targeted behaviors of SIB (Self Injurious Behavior) of cutting herself and picking her skin, Suicide Threats with 15 minute checks, Vacating, Physical Assault, Verbal Aggression, Resistance, Inappropriate use of Social Media, and Inappropriate Social and Sexual behaviors. Client #8's ISP and BDP indicated the need for locked sharps to prevent injury and door alarms because client #8 leaves the facility AWOL (Absent Without Leave). Client #8's BDP indicated "Suicide Threats/Attempts: If [client #8] threatens suicide, immediately place her under round the clock surveillance. Observe her at all times but do not alter her normal activities...Search all locations where [client #8] spends time for harmful objects...Accompany [client #8] to locations where she typically is alone and unobserved...Document condition every 15 minutes..." Client #8's BDP indicated when client #8 was on Suicide Watch she was to be on one on one staff supervision level.</p> <p>On 3/18/15 at 8:20am, an interview with the QIDP (Qualified Intellectual</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/27/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W 210 Bldg. 00	<p>Disabilities Professional) and agency nurse #1 was conducted. The QIDP indicated client #8 was on Suicide Watch and should have had staff one on one supervision. The QIDP indicated client #8 had attempted to cut herself in a Suicide Attempt last week (3/12/15) with a piece of card board at the workshop. The QIDP indicated she was unsure of the staffing pattern for the group home. The QIDP indicated clients #1, #2, #3, #4, #5, #6, #7, and #8 were at the group home on 3/18/2015 when one staff was on duty.</p> <p>9-3-3(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview, for 1 of 4 sampled clients (client #4), the facility failed to ensure client #4's assessments were completed within 30 days of admission.</p> <p>Findings include:</p>	W 210	Client #4 has been scheduled to have both a hearing and vision assessment completed. The nurse will be trained that annual vision and hearing assessments are required for all facility clients. The nurse will implement a tracking system to monitor the scheduling and completion of	04/26/2015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/27/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W 227 Bldg. 00	<p>Client #4's record was reviewed on 3/19/15 at 12:20pm. Client #4's record indicated she was admitted on 11/20/1995. Client #4's record indicated 8/22/13, 9/18/14, 1/15/15, and 3/23/14 Physician's review of client #4's History and Physical but did not include hearing and visual assessments.</p> <p>On 3/25/15 at 3:58pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #4 was admitted 11/20/1995. The QIDP indicated client #4 had no hearing and no visual assessments available for review.</p> <p>9-3-4(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 comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #3), the facility failed to develop a program to address client #3's identified incontinence need.</p> <p>Findings include:</p>			W 227	<p>allrequired medical and health related assessments for all clients in thefacility. The completion of all such assessments is recorded in an electronicrecord that will be accessed by the administrator to routinely review to ensurerequired assessments are completed. Responsible Party: Facility nurse</p> <p>Client #3 does have incontinence due to a diagnosed medicalcondition and is routinely evaluated by her urologist. The nurse will developand implement a protocol regarding the incontinence and steps that staff are tofollow to support her regarding this condition. The nursing staff will ensurethat appropriate protocols</p>		04/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/27/2015
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>On 3/18/15 from 3:10pm until 5:30pm, and on 3/19/15 from 5:40am until 7:45am, observations and interviews were conducted at the group home. During both observation periods client #3 was assisted by the facility staff to use her walker. Staff held onto client #3 at the waist with a gait belt, and staff assisted client #3 to walk to and from the bathroom. During both observation periods staff stayed inside the bathroom with client #3. On 3/18/15 at 3:40pm, Group Home Staff (GHS) #1 assisted client #3 to rise up from a seated position, observed client #3's pants were wet in the front and back, and walked with client #3 to the bathroom. On 3/18/15 at 3:40pm, GHS #1 indicated client #3 was incontinent and wore adult briefs.</p> <p>On 3/18/15 at 12:30pm, client #3's record was reviewed. Client #3's 1/7/15 ISP (Individual Support Plan) did not include an objective to address her incontinence of bowel or bladder. Client #3's ISP did not indicate she was incontinent and wore adult briefs. Client #3's record did not indicate evidence of training to address client #3's incontinence. Client #3's 1/2015 "Programming Guide" indicated in the area of "Toileting: Is not independent in this area. Needs assistance in toileting. Does not mind</p>		<p>are developed and implemented for any other clients who may have incontinence related to a medical condition. Client #3's ISP will be updated to specify her incontinence need and the associated plan. This will also be done for any other clients as needed. The QDP will ensure programming is in place to address incontinence for any clients for which there is not a determined medical cause for the incontinence. The administrator will provide oversight to ensure appropriate protocols are completed and implemented.</p> <p>Responsible Party: Facility nurse</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 240 Bldg. 00	<p>going to restroom with assistance."</p> <p>On 3/25/15 at 3:58pm, an interview with the QIDP (Qualified Intellectual Disabilities Professional) was conducted. The QIDP indicated client #3 was incontinent and wore adult briefs. The QIDP indicated client #3's identified incontinence needs had not been addressed or an objective developed. The QIDP indicated no further information was available for review.</p> <p>9-3-4(a)</p> <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #8), the facility failed to develop behavioral guidelines for staff to follow for client #8's one on one (1:1) supervision needs.</p> <p>Findings include:</p> <p>On 3/18/15 from 5:40am until 7:45am, client #8 was observed at the group home. From 5:40am until 6:05am, GHS (Group Home Staff) #3 was the one facility staff on duty at the group home</p>	W 240	The Behavior Program for Client #8 is being reviewed by the IST, including the behavior consultant, to recommend revisions to provide more specific guidelines for staff supervision when client #8 demonstrates suicidal threats or behavior. The behavior program will be updated per the decisions of the IST. The program will be implemented with the required approval of the IST and HRC. Client #8's ISP will be updated to reflect specific information and directives concerning responses to her suicidal behavior, including the needed staffing supervision in these	04/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/27/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>with clients #1, #2, #3, #4, #5, #6, #7, and #8. From 5:40am until 6:05am, GHS #3 constantly prompted client #8 to stay within eye sight of staff on the sofa in the living room while clients #5, #6, and #8 sat in the living room. At 5:40am, client #8 and GHS #3 both indicated client #8 slept on the sofa downstairs during the night because there was one staff on duty with eight (8) clients in the home. At 5:40am, GHS #3 indicated client #8 was on Suicide Watch and was to be within eye sight at all times. At 6:05am, the QIDP (Qualified Intellectual Disabilities Professional) and other GHS arrived on duty. At 6:05am, client #8 walked independently up and down the stairs, went into both bathrooms upstairs and downstairs, the kitchen, and accessed the upstairs without staff on the second floor. At 6:05am, when the other staff entered the group home, client #8 jumped up from the sofa, gathered her blankets and pillow, and walked quickly to the second floor of the home. At 6:05am, client #8 entered a dark bedroom, placed her items on the bed, and began to dress. No facility staff were present on the second floor.</p> <p>On 3/18/15 at 6:16am, GHS #2 asked client #8 to the medication room and GHS #2 selected "Mupirocin (Bactroban) Oin. (Ointment) apply to sores 3 times</p>		<p>circumstances. The QIPD will ensure that allclients ISP's reflect their current needs. Responsible Party: QIDP</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>daily for infection." GHS #2 administered client #8's Mupirocin and Flonase medications. At 6:16am, Client #8 rubbed the Mupirocin cream into two red colored two to two and one half inch (2 to 2 1/2 inches) scratches on client #8's left wrist and stated the red scratches were "where I tried to kill myself last week." At 6:30am, GHS #2 indicated client #8 was on fifteen (15) minute checks and that staff needed to know the general location of client #8. GHS #2 stated "Yes, [client #8] was on Suicide Watch" which was 15 minute checks. At 6:30am, client #8 was requested by the QIDP to come into a downstairs bedroom where two other clients lived in the group home. Client #8 walked behind the Lab Technician (LT) to enter the bedroom. Client #8 entered the bedroom, with the LT, with no staff present and had her blood drawn. At 6:30am, the LT stated "You may want to look away, this may sting," and held a needle to draw client #8's blood. Client #8 stated "No, I want to watch. I like it."</p> <p>On 3/18/15 at 8:50am, client #8's record review was conducted. Client #8's 2/18/15 ISP (Individual Support Plan) and 3/4/14 and 1/2015 revised BDP (Behavior Development Plan) indicated client #8 had the targeted behaviors of SIB (Self Injurious Behavior) of cutting</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>herself and picking her skin, Suicide Threats with 15 minute checks, Vacating, Physical Assault, Verbal Aggression, Resistance, Inappropriate use of Social Media, and Inappropriate Social and Sexual behaviors. Client #8's ISP and BDP indicated the need for locked sharps to prevent injury and door alarms because client #8 leaves the facility AWOL (Absent Without Leave). Client #8's BDP indicated "Suicide Threats/Attempts: If [client #8] threatens suicide, immediately place her under round the clock surveillance. Observe her at all times but do not alter her normal activities...Search all locations where [client #8] spends time for harmful objects...Accompany [client #8] to locations where she typically is alone and unobserved...Document condition every 15 minutes..." Client #8's BDP indicated when client #8 was on Suicide Watch she was to be on one on one staff supervision level.</p> <p>On 3/18/15 at 8:20am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and agency nurse #1 was conducted. The QIDP indicated client #8 was on Suicide Watch and should have had staff one on one supervision. The QIDP and nurse #1 both stated they were "unaware" client #8 had a left wrist injury. The QIDP</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 249 Bldg. 00	<p>indicated client #8 had attempted to cut herself in a Suicide Attempt last week with a piece of card board at the workshop. The QIDP indicated no injuries were noted after that incident. The QIDP indicated client #8's ISP and BDP did not contain specific guidelines for one on one staff supervision. The QIDP indicated no further information was available for review.</p> <p>9-3-4(a)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, for 1 of 4 sampled clients (client #8), the facility failed to ensure client #8's ISP (Individual Support Plan) and BDP (Behavior Development Plan) were implemented with opportunities existed.</p> <p>Findings include:</p> <p>On 3/18/15 from 5:40am until 7:45am, client #8 was observed at the group</p>	W 249	The QIDP is ensuring that appropriate staffing is provided to meet the clients' needs of the home as defined by the IST for all residents of the home. This includes adequate staffing in place to implement client #8's current Behavior Development Program as written. The Behavior Program for Client #8 is being reviewed by the IST, including the behavior consultant, to recommend revisions to provide more specific guidelines for staff supervision when client #8	04/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/27/2015	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>home. From 5:40am until 6:05am, GHS (Group Home Staff) #3 was the one facility staff on duty at the group home with clients #1, #2, #3, #4, #5, #6, #7, and #8. From 5:40am until 6:05am, GHS #3 constantly prompted client #8 to stay within eye sight of staff on the sofa in the living room while clients #5, #6, and #8 sat in the living room. At 5:40am, client #8 and GHS #3 both indicated client #8 slept on the sofa downstairs during the night because there was one staff on duty with eight (8) clients in the home. At 5:40am, GHS #3 indicated client #8 was on Suicide Watch and was to be within eye sight at all times. At 6:05am, the QIDP (Qualified Intellectual Disabilities Professional) and other GHS arrived on duty. At 6:05am, client #8 walked independently up and down the stairs, went into both bathrooms upstairs and downstairs, the kitchen, and accessed the upstairs without staff on the second floor. At 6:05am, when the other staff entered the group home, client #8 jumped up from the sofa, gathered her blankets and pillow, and walked quickly to the second floor of the home. At 6:05am, client #8 entered a dark bedroom, placed her items on the bed, and began to dress. No facility staff were present on the second floor.</p> <p>On 3/18/15 at 6:16am, GHS #2 asked</p>		<p>demonstrates suicidal threats or behavior. The behavior program will be updated per the decisions of the IST. The program will be implemented with the required approval of the IST and HRC. Client #8's ISP will be updated to reflect specific information and directives concerning responses to her suicidal behavior, including the needed staffing supervision in these circumstances. The QIPD will ensure that all clients' ISP's reflect their current needs. The QIPD will ensure that unannounced visits in the home occur by a professional staff routinely and when increased monitoring is required following a suicidal threat and/or behavior by client #8 to ensure proper monitoring is being followed per her Behavior Development Program. The QIPD will notify the administrator of any such incidents. The administrator will routinely review electronic time records for staff to ensure proper staffing is provided. Staff will also receive retraining to assess for, report and document all observed injuries. The nurse will review recording of injuries by staff no less than weekly. Professional and nursing staff will complete routine visits in the home and will have eyes on the residents and observe for any indication of injuries that may not have been reported or recorded properly. A protocol for lab draws done in the home will be developed by the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>client #8 to come to the medication room and GHS #2 selected "Mupirocin (Bactroban) Oin. (Ointment) apply to sores 3 times daily for infection." GHS #2 administered client #8's Mupirocin and Flonase medications. At 6:16am, Client #8 rubbed the Mupirocin cream into two red colored two to two and one half inch (2 to 2 1/2 inches) scratches on client #8's left wrist and stated the red scratches were "where I tried to kill myself last week." At 6:30am, GHS #2 indicated client #8 was on fifteen (15) minute checks and that staff needed to know the general location of client #8. GHS #2 stated "Yes, [client #8] was on Suicide Watch" which was 15 minute checks. At 6:30am, client #8 was requested by the QIDP to come into a downstairs bedroom where two other clients lived in the group home. Client #8 walked with the Lab Technician (LT) into the other clients bedroom. Client #8 entered the bedroom, with the LT, with no staff present and had her blood drawn. At 6:30am, the LT stated "You may want to look away, this may sting," and held a needle to draw client #8's blood. Client #8 stated "No, I want to watch. I like it." Client #8 exited the other clients' downstairs bedroom, went to the kitchen, and no staff were within eye sight of client #8 until 6:45am, when client #8 walked to the living room. From 6:45am</p>		<p>administrator. This will include that when client's slabs are drawn in the home that this must occur privately in the client's own bedroom or in the medication administration area, ensuring privacy. The staff will also be trained that a staff person must remain with any client when they are having their labs drawn in the home. A professional or nursing staff will be present in the home at the next lab draw that occurs in the home to ensure this protocol is followed. The QIDP will also review the protocol with the lab technician. The protocol will be followed in all agency locations where lab draws are occurring in the home. Responsible Party: QIDP</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>until 7:00am, client #8 sat on the chair in the living room and staff walked in and out of the living room. No one on one staff was present with client #8. At 7:00am, GHS #2 indicated client #8 was to be checked on every fifteen (15) minutes.</p> <p>On 3/18/15 at 8:50am, client #8's record review was conducted. Client #8's 2/18/15 ISP (Individual Support Plan) and 3/4/14 and 1/2015 revised BDP (Behavior Development Plan) indicated client #8 had the targeted behaviors of SIB (Self Injurious Behavior) of cutting herself and picking her skin, Suicide Threats with 15 minute checks, Vacating, Physical Assault, Verbal Aggression, Resistance, Inappropriate use of Social Media, and Inappropriate Social and Sexual behaviors. Client #8's ISP and BDP indicated the need for locked sharps to prevent injury and door alarms because client #8 leaves the facility AWOL (Absent Without Leave). Client #8's BDP indicated "Suicide Threats/Attempts: If [client #8] threatens suicide, immediately place her under round the clock surveillance. Observe her at all times but do not alter her normal activities...Search all locations where [client #8] spends time for harmful objects...Accompany [client #8] to locations where she typically is alone and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>unobserved...Document condition every 15 minutes..." Client #8's BDP indicated when client #8 attempted to harm herself or made threats of Suicide that staff should document her skin assessment status every shift. Client #8's skin assessment documentation did not indicate she had an injury, cut, and/or a scratch on her body on 3/16/15, 3/17/15, and 3/18/15. Client #8's BDP indicated when client #8 was on Suicide Watch she was to be on one on one staff supervision level.</p> <p>On 3/18/15 at 8:20am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and agency nurse #1 was conducted. The QIDP indicated client #8 was on Suicide Watch and should have had staff one on one supervision. The QIDP indicated client #8 had attempted to cut herself in a Suicide Attempt last week (3/12/15) with a piece of card board at the workshop. The QIDP indicated she was unsure of the staffing pattern for the group home. The QIDP indicated client #8 was at the group home on 3/18/2015 when one staff was on duty with seven additional clients. The QIDP and nurse #1 both stated they were "unaware" client #8 had a left wrist injury. The QIDP indicated client #8 had attempted to cut herself in a Suicide Attempt last week on 3/12/15 with a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>piece of card board at the workshop. The QIDP indicated no injuries were noted after that incident. The QIDP indicated client #8's ISP and BDP indicated client #8 was to have one on one supervision and did not contain guidelines for staff to implement one on one staff supervision. The QIDP indicated she did not know when client #8's new injury to her wrist occurred and did not know how the injury occurred if client #8 was one on one staff supervision since the 3/12/15 suicide threat. The QIDP indicated no further information was available for review.</p> <p>On 3/18/15 at 9:50am, Nurse #1 stated "I was at the group home on 3/12/15 at 4:00pm after [client #8's] incident at workshop" when client #8 cut her left wrist with card board. Nurse #1 stated client #8 had no injury at that time. "She had a red mark about 1/4" long. What [client #8] has now is new. The one area is about 2 inches and was red." The second area was "a scar" from client #8's previous self injuries of cutting herself. Nurse #1 indicated no staff had contacted her regarding client #8's injury, client #8's skin tracking sheets did not indicate the injury, and the staff were not recording the treatment they were providing on client #8's wrist injury. Nurse #1 indicated the staff were recording in client #8's 3/2015 MAR that she was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 331 Bldg. 00	<p>receiving treatment but did not indicate what part of the body the ointment was applied.</p> <p>On 3/27/15 at 4:00pm, an interview with the Area Director (AD) was conducted. The AD indicated no further information was available for review.</p> <p>9-3-4(a)</p> <p>483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #8), the nursing services failed to ensure staff accurately documented client #8's skin assessments.</p> <p>Findings include:</p> <p>On 3/18/15 at 6:16am, GHS (Group Home Staff) #2 asked client #8 to the medication room and GHS #2 selected "Mupirocin (Bactroban) Oin. (Ointment) apply to sores 3 times daily for infection." GHS #2 administered client #8's Mupirocin and Flonase medications. At 6:16am, Client #8 rubbed the Mupirocin cream into two red colored two to two and one half inch (2 to 2 1/2</p>	W 331	<p>Staff will receive retraining to assess for, report and document all observed injuries. The nurse will review recording of injuries by staff no less than weekly. Professional and nursing staff will complete routine visits in the home and will have eyes on the residents and observe for any indication of injuries that may not have been reported or recorded properly. This will include a look at client #8 arms.</p> <p>Documentation of skin assessments and assessments for injury are recorded electronically by staff and the nursing staff. The administrator will routinely review these records to ensure documentation is completed as required. Should an injury be noted that was not properly</p>	04/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>inches) scratches on client #8's left wrist and stated the red scratches were "where I tried to kill myself last week."</p> <p>On 3/18/15 at 8:50am, client #8's record review was conducted. Client #8's 2/18/15 ISP (Individual Support Plan) and 3/4/14 and 1/2015 revised BDP (Behavior Development Plan) indicated client #8 had the targeted behaviors of SIB (Self Injurious Behavior) of cutting herself and picking her skin, Suicide Threats with 15 minute checks, Vacating, Physical Assault, Verbal Aggression, Resistance, Inappropriate use of Social Media, and Inappropriate Social and Sexual behaviors. Client #8's ISP and BDP indicated the need for locked sharps to prevent injury and door alarms because client #8 leaves the facility AWOL (Absent Without Leave). Client #8's BDP indicated "Suicide Threats/Attempts: If [client #8] threatens suicide, immediately place her under round the clock surveillance. Observe her at all times but do not alter her normal activities...Search all locations where [client #8] spends time for harmful objects...Accompany [client #8] to locations where she typically is alone and unobserved...Document condition every 15 minutes..." Client #8's BDP indicated when client #8 attempted to harm herself or threats of Suicide that staff should</p>		<p>reported or documented the administrator will ensure the completion of an investigation and corrective action.</p> <p>Responsible Party: Facility Nurse</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>document her skin assessment status every shift. Client #8's 3/2015 Skin Assessment Sheet did not include documentation for client #8's injury on her left wrist. No assessment was available for review to determine client #8's left wrist injury had been documented.</p> <p>On 3/18/15 at 8:20am, an interview with the QIDP (Qualified Intellectual Disabilities Professional) and agency nurse #1 was conducted. The QIDP and nurse #1 both stated they were "unaware" client #8 had a left wrist injury. The QIDP indicated client #8 had attempted to cut herself in a Suicide Attempt last week with a piece of card board at the workshop. The QIDP indicated no injuries were noted after that incident. The QIDP indicated she did not know how or when client #8's new injury occurred. The QIDP indicated no further information was available for review.</p> <p>On 3/18/15 at 9:50am, Nurse #1 stated "I was at the group home on 3/12/15 at 4:00pm after [client #8's] incident at workshop" when client #8 cut her left wrist with card board. Nurse #1 stated client #8 had no injury at that time. "She had a red mark about 1/4" long. What [client #8] has now is new. The one area is about 2 inches and was red. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 391 Bldg. 00	<p>second area was "a scar" from client #8's previous self injuries of cutting herself. Nurse #1 indicated no staff had contacted her about the new injury, client #8's 3/2015 skin tracking sheets did not indicate the new injury, and the staff were not recording the treatment they were providing on client #8's wrist injury. Nurse #1 indicated the staff were recording in client #8's 3/2015 MAR that she was receiving treatment but did not indicate what part of the body the ointment was applied.</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 labels. Based on observation, record review, and interview, for 1 of 4 sampled clients (client #8), the facility failed to remove from use 2 of 14 medication containers without labels and/or illegible labels from the supply on 3/18/15.</p> <p>Findings include: On 3/18/15 at 6:16am, GHS (Group Home Staff) #2 selected "Mupirocin (Bactroban) Oin. (Ointment) apply to</p>	W 391	The staff in the home including the staff who was responsible for administering the medication that was not clearly labeled will receive re-training on agency policies to ensure medications that are administered have a clear and legible pharmacy label. This training will include a review of the need to review all medication packaging prior to administration to ensure it is properly labeled. Staff will be trained to immediately notify the nurse if they find a medication that	04/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>sores 3 times daily for infection (and) Fluticasone (Flonase) Spr (Spray) 50mcg (micrograms) give 1 spray in each nostril daily for Seasonal Allergies." On both medication containers GHS #2 stated the ink on each label "was faded and could not be read" the client's name, the name of the medication, or the directions for use. GHS #2 administered client #8's Mupirocin and Flonase medications. At 6:16am, Client #8 rubbed the Mupirocin cream into two red colored two to two and one half inch (2 to 2 1/2 inches) scratches on client #8's left wrist.</p> <p>At 6:30am, client #8's 3/2015 MAR (Medication Administration Record) indicated "Mupirocin (Bactroban) Oin. (Ointment) apply to sores 3 times daily for infection (and) Fluticasone (Flonase) Spr (Spray) 50mcg (micrograms) give 1 spray in each nostril daily for Seasonal Allergies."</p> <p>On 3/18/15 at 8:50am, client #8's 1/2015 "Physician's Order" indicated "Mupirocin (Bactroban) Oin. (Ointment) apply to sores 3 times daily for infection (and) Fluticasone (Flonase) Spr (Spray) 50mcg (micrograms) give 1 spray in each nostril daily for Seasonal Allergies."</p> <p>On 3/18/15 at 8:20am, an interview with agency's nurse #1 was conducted. Nurse</p>		<p>is not labeled legibly. There will beroutine observations by professional and nursing staff in the home of themedication administration process to ensure medications that are administeredare properly labeled. During thisobservation the professional staff will require the staff to demonstrate howthey check and identify that medications are properly labeled. The agency nursewill also receive retraining to ensure that any medications that are notproperly labeled are removed from the homes supply when she completes weeklyaudits of medications. There is a staffwho works in the home who has also been trained to review medication suppliesroutinely and to report the need for replacing medications that are notproperly labeled to the agency nurse and/or for the need to dispose of expiredmedications. Responsible Party: Facility nurse</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>#1 stated "all" medications administered by the group home staff to clients living in the group home should have a "legible pharmacy label." Nurse #1 indicated the label should include the client name and directions for the medication use. Nurse #1 indicated the facility followed the Core A/Core B training for medication administration and the facility's policy and procedure for medication administration. Nurse #1 indicated staff did not follow the medication administration policy and procedure when client #8's topical cream and nasal spray medications were administered from a container without legible labels. Nurse #1 indicated the medications should have been removed from use.</p> <p>On 3/18/15 at 8:30am, a review of the 2004 "Living in the Community" medication administration training manual, Core Lesson 2: Responsibilities in the Area of Medication Administration indicated medications should be labeled.</p> <p>On 3/18/15 at 8:30am, 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</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 436 Bldg. 00	<p>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>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 team as needed by the client. Based on observation, record review, and interview, for 1 of 3 sampled clients (client #3) with adaptive equipment, the facility failed to teach and encourage client #3 to wear her prescribed eye glasses at the group home.</p> <p>Findings include: On 3/17/15 from 3:10pm until 5:30pm and on 3/18/15 from 5:40am until 7:45am, observations were conducted with client #3 at the group home. During</p>	W 436	A training objective has been implemented to teach client #3to wear her eyeglasses as prescribed. The required prompting for her to wearher glasses is recorded each day electronically by the staff working with her.This documentation will be reviewed by the QIDP no less than monthly toevaluate for progress and/or need for revision. The QIDP will also updateclient #3 ISP's to include the objective for her to wear her glasses asprescribed. Agency QIDP's will receiveretraining to ensure training	04/26/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/27/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN 46016
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>both observations client #3 did not wear her prescribed eye glasses. During both observation periods client #3 watched television, looked at a magazine, walked with a walker, completed medication administration, consumed meals, and cleaned her bedroom.</p> <p>On 3/18/15 at 12:40pm, client #3's record was reviewed. Client #3's 1/7/15 ISP (Individual Support Plan) indicated client #3 wore prescribed eye glasses and did not include a goal/objective to teach client #3 to wear her eye glasses at the group home. Client #3's ISP indicated an objective to use picture cards to communicate her wants/needs. Client #3's 10/18/13 visual assessment indicated client #3 wore prescribed eye glasses to see.</p> <p>On 3/20/15 at 12:00pm, an interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional). The QIDP indicated client #3 wore prescribed eye glasses to see. The QIDP indicated client #3 should have been taught and encouraged to wear her prescribed eye glasses during formal and informal opportunities.</p> <p>9-3-7(a)</p>		<p>objectives are in place for any resident whoneeds prompts to use any adaptive equipment as prescribed. The administratorwill routinely review electronic programming records to ensure neededobjectives are in place.</p> <p>Responsible Party: Residential Director</p>	