

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2021
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES	STREET ADDRESS, CITY, STATE, ZIP CODE 912 N PARKWAY DR ANDERSON, IN 46013
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W 0000 Bldg. 00	<p>This visit was for the predetermined full recertification and state licensure survey. This visit included a Covid-19 focused infection control survey.</p> <p>Dates of Survey: November 15, 16, 17, and 19, 2021.</p> <p>Facility Number: 000923 Provider Number: 15G409 AIMS Number: 100244490</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #39778 on 12/3/21.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 additional client (client #4), the facility failed to implement their policies and procedures to prevent a substantiated abuse incident involving client #4 and to ensure staff reported an allegation of abuse immediately.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/15/21 at 12:18 PM.</p> <p>1. A BDDS report dated 11/10/21 indicated,</p>	W 0149	<p>All staff will receive additional training regarding their responsibility to prevent, identify and report abuse and neglect. The QIDP will complete visits to the home twice weekly to interview staff and consumers to assess any potential exposure to abuse to confirm that any identified issues have been reported, investigated, and addressed.</p>	12/19/2021

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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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>"...Through the course of an investigation...[client #4] alleged that [FS (Former Staff) #1], DSP (Direct Support Professional), yelled at him. [FS #1] remains on investigative suspension in relation to the other investigation..."</p> <p>An ISF (Investigation Summary Form) dated 11/11/21 indicated the following:</p> <p>"...Upon investigation review, it was found that there were abuse allegations made by [client #4]. He (client #4) stated that [FS #1] yells at him. Investigate to determine the facts and make recommendations to prevent further recurrence..."</p> <p>"...Name of Staff Assigned as IO (Investigation Officer)."</p> <p>"-[QIDP (Qualified Intellectual Disabilities Professional) #1]..."</p> <p>"...IO Note."</p> <p>"During investigation for allegation of sleeping, it was stated by [client #4] that he did not want [FS #1] to yell at him again..."</p> <p>"...[Client #2]..."</p> <p>"...IO: Do the staff yell at anyone?"</p> <p>"[Client #2]: No, but [FS #1] yells at [client #4]..."</p> <p>"...[Client #4]..."</p> <p>"...IO: Remember when we talked the other day about staff sleeping, you mentioned that you did not attempt to wake up staff as you thought they would yell at you, tell me about that."</p>			

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	<p>-"[Client #4]: I thought [FS #1] would yell at me if I woke him up."</p> <p>-"IO: Did he yell at you before?"</p> <p>-"[Client #4]: No, I just thought he would. He told me not to touch him or he would hit me."</p> <p>-"IO: Has he hit you?"</p> <p>-"[Client #4]: No."</p> <p>-"IO: Why do you think he would hit you?"</p> <p>-"[Client #4]: He said if I touched him he would hit me..."</p> <p>-"...IO: When did this happen?"</p> <p>-"[Client #4]: I don't know about two months ago..."</p> <p>-"...[Staff #1]..."</p> <p>-"...IO: Specifically, have you heard a staff person tell a consumer that they would hit the consumer if they touched them?"</p> <p>-"[Staff #1]: No, but [client #4] said that a staff person said they would hit [client #4] if he (client #4) hit him (staff)."</p> <p>-"IO: Who was it?"</p> <p>-"[Staff #1]: [FS #1]."</p> <p>-"IO: When did this occur?"</p> <p>-"[Staff #1]: A couple months ago..."</p>			

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	<p>-"...[Staff #1] 11-10-21."</p> <p>-"See Written Statement..."</p> <p>-"...(handwritten statement from staff #1 dated 11/10/21): Coming into a morning shift one morning [client #4] said to me [FS #1] threatened to hit him back if he were to ever hurt him or any female in the house. [FS #1] then confirmed it saying, 'and I will' in response to [client #4] telling me (staff #1) that. I failed to report it..."</p> <p>-"...[FS #1]..."</p> <p>-"...IO: Did you ever tell a consumer not to touch you?"</p> <p>-"[FS #1]:... in general yes..."</p> <p>-"...IO: Did you ever tell a consumer if they hit you or one of the girls, that you would hit them back."</p> <p>-"[FS #1]: I told the girls, if you all have a problem, call me. I said that in front of that consumer (client #4)."</p> <p>-"IO: When you were talking to the girls, did you say that you would hit someone if they hit you or one of the girls?"</p> <p>-"[FS #1]: I wouldn't say that. No I never said what I would do or what the consequence was, just that they could call me..."</p> <p>-"...IO: Who was the staff present, when you said this to staff in front of the client?"</p> <p>-"[FS #1]: I don't know who it was."</p> <p>-"IO: Do you think consumers could have taken it</p>			

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	<p>as a threat?"</p> <p>-"[FS #1]: A threat as in harming them no, as in them getting in trouble yes..."</p> <p>-"...IO: If you knew a consumer thought this was a threat, what do you think about it?"</p> <p>-"[FS #1]: I don't know. It's how they took it..."</p> <p>-"...IO: At any time in front of a staff did you say if they (consumers) hit you, you would hit them back?"</p> <p>-"[FS #1]: No."</p> <p>-"IO: Why would someone have said that if you hit them you would hit them back?"</p> <p>-"[FS #1]: Whatever their motive is. I challenge the consumers. I challenge the staff as well..."</p> <p>-"...Findings:..."</p> <p>-"...[Client #2] did indicate that [FS #1] had threatened him that if he (client #4) touched him (FS #1), he (FS #1) would hit him (client #4)..."</p> <p>-"...[Staff #1] did state, when asked, that she had heard [client #4] tell her that [FS #1] said he was going to hit him if he touched him. [Staff #1] states that [FS #1] did confirm this by saying 'and I will' when responding to [client #4's] statement..."</p> <p>-"...[Staff #1] did not report this, states when asked that it was about 2 months ago..."</p> <p>-"...[FS #1] denies saying that he would hit anyone who hit him or any of the other staff, but it</p>			

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	<p>could be implied that he was going to do something as he was telling this to staff in front of the consumer (client #4). Knowingly said this in front of a consumer (client #4)...".</p> <p>"...Admin Recommendations."</p> <p>"1. [Staff #1] should receive corrective action for not reporting suspected abuse by another staff member...".</p> <p>"...2. [FS #1] must be terminated for substantiated abuse (intimidation)...Upon review of [FS #1's] training, it was found that he had completed all of his training modules and had received 100% on the Respect module."</p> <p>"([RD (Regional Director) #1] handwritten signature)...".</p> <p>QIDP #1 was interviewed on 11/15/21 at 11:22 AM. QIDP #1 indicated any allegations of ANE (Abuse, Neglect, or Exploitation) were to be reported immediately to administration. QIDP #1 indicated all staff were trained during orientation, annually, and as needed regarding the facility's policy and procedures on abuse, neglect and exploitation. QIDP #1 indicated staff were to follow the facility's policies and procedures and were to prevent any form of ANE against any of the consumers.</p> <p>AD (Area Director) #1 was interviewed on 11/16/21 at 12:02 PM. AD #1 indicated FS #1's employment was terminated due to a substantiated abuse allegation. AD #1 stated, "Any allegation of ANE must be reported immediately."</p> <p>The facility's policy and procedures were</p>			

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W 0153 Bldg. 00	<p>reviewed on 11/17/21 at 10:27 AM. The facility's Preventing Abuse and Neglect policy revised 10/13 indicated, "DSA (Developmental Service Alternatives) prohibits abuse, neglect, exploitation, mistreatment or violation of the rights of consumers it serves. DSA, Inc. (Incorporated) asserts that sensitizing employees to the various forms that abuse and neglect may take is a primary method of prevention. Thus, as part of their Mandatory Initial Training, each staff member shall receive instruction on forms of abuse and neglect... II. Definitions ... B. 'Neglect' means failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 additional client (client #4), the facility failed to ensure staff reported an allegation of abuse to administration immediately upon knowledge.</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/15/21 at 12:18 PM.</p> <p>1. A BDDS report dated 11/10/21 indicated, "...Through the course of an investigation...[client #4] alleged that [FS (Former Staff) #1], DSP (Direct Support Professional), yelled at him. [FS #1] remains on investigative suspension in relation to</p>	W 0153	All staff will receive additional training regarding their responsibility to prevent, identify and report abuse and neglect. The QIDP will complete visits to the home twice weekly to interview staff and consumers to assess any potential exposure to abuse to confirm that any identified issues have been reported, investigated, and addressed.	12/19/2021

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	<p>the other investigation...".</p> <p>An ISF (Investigation Summary Form) dated 11/11/21 indicated the following:</p> <p>-"...Upon investigation review, it was found that there were abuse allegations made by [client #4]. He (client #4) stated that [FS #1] yells at him. Investigate to determine the facts and make recommendations to prevent further recurrence...".</p> <p>-"...Name of Staff Assigned as IO (Investigation Officer)."</p> <p>-"[QIDP (Qualified Intellectual Disabilities Professional) #1]...".</p> <p>-"...IO Note."</p> <p>-"During investigation for allegation of sleeping, it was stated by [client #4] that he did not want [FS #1] to yell at him again...".</p> <p>-"...[Client #2]...".</p> <p>-"...IO: Do the staff yell at anyone?"</p> <p>-"[Client #2]: No, but [FS #1] yells at [client #4]...".</p> <p>-"...[Client #4]...".</p> <p>-"...IO: Remember when we talked the other day about staff sleeping, you mentioned that you did not attempt to wake up staff as you thought they would yell at you, tell me about that."</p> <p>-"[Client #4]: I thought [FS #1] would yell at me if I woke him up."</p> <p>-"IO: Did he yell at you before?"</p>			

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	<p>-"[Client #4]: No, I just thought he would. He told me not to touch him or he would hit me."</p> <p>-"IO: Has he hit you?"</p> <p>-"[Client #4]: No."</p> <p>-"IO: Why do you think he would hit you?"</p> <p>-"[Client #4]: He said if I touched him he would hit me...".</p> <p>-"...IO: When did this happen?"</p> <p>-"[Client #4]: I don't know about two months ago...".</p> <p>-"...[Staff #1]...".</p> <p>-"...IO: Specifically, have you heard a staff person tell a consumer that they would hit the consumer if they touched them?"</p> <p>-"[Staff #1]: No, but [client #4] said that a staff person said they would hit [client #4] if he (client #4) hit him (staff)."</p> <p>-"IO: Who was it?"</p> <p>-"[Staff #1]: [FS #1]."</p> <p>-"IO: When did this occur?"</p> <p>-"[Staff #1]: A couple months ago...".</p> <p>-"...[Staff #1] 11-10-21."</p> <p>-"See Written Statement...".</p>			

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W 0369 Bldg. 00	<p>-"...(handwritten statement from staff #1 dated 11/10/21): Coming into a morning shift one morning [client #4] said to me [FS #1] threatened to hit him back if he were to ever hurt him or any female in the house. [FS #1] then confirmed it saying, 'and I will' in response to [client #4] telling me (staff #1) that. I failed to report it..."</p> <p>A review of the ISF dated 11/11/21 indicated staff #1 was made aware of an allegation of abuse against FS #1 two months prior to it being reported. The review indicated staff #1 did not report the allegation immediately to administration.</p> <p>QIDP #1 was interviewed on 11/15/21 at 11:22 AM. QIDP #1 indicated any allegations of ANE (Abuse, Neglect, or Exploitation) were to be reported immediately to administration. QIDP #1 indicated all staff were trained during orientation, annually, and as needed regarding the facility's policy and procedures on abuse, neglect and exploitation.</p> <p>AD (Area Director) #1 was interviewed on 11/16/21 at 12:02 PM. AD #1 stated, "Any allegation of ANE must be reported immediately."</p> <p>9-3-2(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 1 of 2 sampled clients (client #2), the facility failed to ensure staff administered client #2's prescribed medications as ordered.</p>	W 0369	All staff will receive additional training regarding their responsibility to administer medications without error in	12/19/2021

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	<p>Findings include:</p> <p>An observation was conducted at the group home on 11/16/21 from 6:10 AM through 8:09 AM. At 7:06 AM, client #1 was administered her morning medications. Client #1 was administered Milk of Magnesia. The medication label for client #1's Milk of Magnesia indicated client #1 was to take 15 ML (milliliters) by mouth every night at bedtime. Upon review of the medication label with staff #2, staff #2 indicated the label did indicate to give the medication at bedtime. Staff #2 reviewed client #2's November 2021 MAR (Medication Administration Record) and indicated the MAR also indicated to administer the medication at bedtime. Staff #2 stated, "Well that's a med (medication) error."</p> <p>The facility's BDDS reports were reviewed on 11/17/21 at 1:20 PM.</p> <p>A BDDS report dated 11/17/21 indicated, "... [Staff #2], DSP, administered [client #2's] evening dose of Milk of Magnesia along with her other morning medications. Another staff member present had advised [staff #2] that [client #2's] physician had verbally stated that [client #2] could have the medication in the morning as well as at night; however, there are no written orders that reflect that. The evening dose of Milk of Magnesia was held and [client #2] suffered no resulting ill effect from the error. Staff will receive additional training regarding the requirement that staff are only to administer medications in accordance with the written physician's order".</p> <p>Client #1's record was reviewed on 11/16/21 at 11:02 AM. Client #1's PO (Physician Order) dated</p>		<p>accordance with physician's order, agency policy and regulation. The QIDP, or designee will observe medication administration three times weekly to assure staff technique remains appropriate and in accordance with their Core A/B training and fade to weekly upon the approval of the Regional Director that staff competence is being demonstrated.</p>	

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

PRINTED: 12/21/2021

FORM APPROVED

OMB NO. 0938-039

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	<p>11/2021 indicated client #1 was to be administered Milk of Magnesia Susp (Suspension) - 437 ML. The PO indicated client #1 was to receive her Milk of Magnesia by mouth every night at bedtime.</p> <p>LPN (Licensed Practical Nurse) #1 was interviewed on 11/16/21 at 1:23 PM. LPN #1 indicated client medications should be administered in accordance with their PO/MAR.</p> <p>9-3-6(a)</p>			