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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G409	A. BUILDING 00 B. WING	10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES	912 N PARKWAY DR ANDERSON, IN 46013

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W 0000 Bldg. 00	This visit was for the investigation of complaints #IN00360527 and #IN00363926. Complaint #IN00360527: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W104, W331 and W368. Complaint #IN00363926: Substantiated, no deficiencies related to the allegation(s) are cited. Dates of Survey: October 4, 5, 6 and 8, 2021. Facility Number: 000923 Provider Number: 15G409 AIMS Number: 100244490 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/21/21.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 2 of 2 sampled clients (A and B), plus 2 additional clients (C and D), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure staff had the proper equipment to document medication administration on client A's electronic MAR (Medication Administration Record). Findings include:	W 0104	A charging station that includes a permanently affixed charger will be installed at the home for the charger. Staff will receive training regarding the frequency at which to charge the tablet in addition to troubleshooting steps in the event that they are unable to access the agency documentation system. The Program Coordinator, or designee, will check the status of	11/07/2021

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	An observation was conducted at the facility on 10/4/21 from 2:55 PM through 5:15 PM. Clients A, B, C and D were observed throughout the observation period. At 4:10 PM staff #1 prepared to administer client A's evening medications. At 4:11 PM RC (Residential Coordinator) #1 was searching for a power cord to charge an electronic device/tablet. RC #1 indicated medications were documented on an electronic MAR called TMP (Task Master Pro). The electronic device/tablet was not charged and staff were not able access the TMP system to document client A's medications. At 4:27 PM RC #1 was trying to pull up client A's MAR on the electronic device/tablet for the surveyor to review. Staff #1 had not been able to administer client A's medications. At 4:40 PM QIDP (Qualified Intellectual Disabilities Professional) #1 was able to access the TMP/electronic MAR for client A on her (QIDP #1's) personal cell phone. QIDP #1 gave staff #1 her cell phone to review client A's MAR and administer client A's 5 PM medications. Staff #2 was interviewed on 10/4/21 at 4:50 PM. Staff #2 was asked if she had problems documenting administered medications on the clients' MARs. Staff #2 stated, "It's the tablets that aren't working." Staff #2 was asked if she had not been able to document on the TMP system due to problems with the electronic device/tablet. Staff #2 stated, "I was able to document on another house's (group home) tablet. Usually we use paper MAR's." Staff #2 indicated the nurse did not bring paper MAR's to the group home for October. QIDP #1 was interviewed on 10/4/21 at 12:40 PM. QIDP #1 was asked what system staff utilize to document the administration of the clients'		the tablet to assure that it is fully operational, and that staff are utilizing it to complete all documentation, to include administration of medications, on a daily basis.	

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	medications. QIDP #1 stated "TMP, Task Master Pro, it pops up that screen on the tablet and says who gets that med at that time." QIDP #1 was asked if the tablets should be charged and available when the clients' medications were being administered. QIDP #1 stated, "Yes." QIDP #1 was asked if staff #1 was able to use the electronic device/tablet to administer client A's 5 PM medications on 10/4/21. QIDP #1 stated, "Nope, because staff failed to make sure they were charged. They did it on my phone." This federal tag relates to complaint #IN00360527. 9-3-1(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 additional client, (FC (Former Client) A), the facility failed to meet the health needs of FC A regarding a delay in notifying EMS (Emergency Medical Services) regarding a medical emergency for FC A. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 10/4/21 at 1:11 PM. A BDDS report dated 8/13/21 indicated, "... [FC A] went into the bathroom and when staff checked on her she was slouched while sitting on the toilet, but responsive. She had a Bowel Movement which she got on herself, she was drooling and she was unable to hold her arm up.	W 0331	The nurse has a new tool to use that she will receive training for “on call triage” that she may reference to guide her actions as necessary. The nurse and all staff will receive additional training regarding notifying EMS of medical emergencies without delay. The Director of Nursing Services will review all nursing on call notes to assure that nursing response was adequate and timely, providing feedback and correction if necessary, to assure that health needs are met for all individuals.	11/07/2021

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	Staff notified the Residential Coordinator (#1) and 911 (Emergency Services) was called. [FC A] was taken to [Name] Hospital in [Name of City]. A Doppler (Test) was completed and a blood clot was found in her neck on the left side. She was given TPA (Tissue Plasminogen Activator) treatment and sent to [Name] Hospital in [Name of Indianapolis]. She (FC A) had surgery and is currently in the ICU (Intensive Care Unit) in [Name of City]...". -An ISF (Investigation Summary Form) dated 8/13/21 to 8/19/21 indicated the following: -"... [Nurse] #1: 8-18-21" -"[Nurse #1] was asked to go back through the phone calls from Friday, 8/13/21." -"[Nurse #1] stated that [RC #1] called her at 7:57 am but she didn't answer that call." -"[Nurse #1] then stated that she called [RC #1] back and was told that [FC A] was alert and talking." -"[Nurse #1] states that it was a commotion with everyone talking in the background." -"[Nurse #1] states that [RC #1] asked if she should take [FC A] to med check (Urgent Care)." -"[Nurse #1] states that she told [RC #1] no." -"[Nurse #1] was asked if she had asked [staff #3] or [RC #1] about vitals (vital signs)." -"[Nurse #1] stated that she had not as it was chaotic and that she (Nurse #1) asked several questions without an answer."			

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	-"[Nurse #1] states that [RC #1] did ask about [FC A's] appointment with PCP (Primary Care Physician) at 9 am that morning." -"[Nurse #1] states that [RC #1] told her that when she (RC #1) asked [FC A] about waiting for the appointment, [FC A] shook her head yes...". -"[RC #1]: 8-18-21" -"[RC #1] stated that [FC A] was in the bathroom on the toilet when she arrived." -"[FC A] did not answer with words just shook her head and made groaning noises and moving her foot when asked questions when she [RC #1] arrived." -"This IO (Investigating Officer) asked [RC #1] if [FC A] had fallen when she went to the floor. [RC #1] stated that she was not sure, she was already on the floor." -"This IO asked [RC A] what [Nurse #1] had said to her/[staff #3] when [Nurse #1] called. [RC #1] stated that [Nurse #1] said to ask her (FC A) if she could wait until her appointment but just use your best judgement." -"[RC #1] states that she got [FC A] in the wheelchair and to the living room, went to start the van as [RC #1] stated she was taking her to med check, but when [RC #1] came back in [RC #1] stated that [FC A's] mouth was drooping and she couldn't keep her arm up. [RC #1] stated that she called 911 immediately as she knew [FC A] couldn't wait for the appointment at 9 am...". -"[Staff #3]: 8-19-21"			

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-"This IO asked [staff #3] where [FC A] was when she went into the bathroom to check on [FC A]."

-"[Staff #3] states that [FC A] was sitting on the toilet leaned over against the wall. [Staff #3] states that she checked on [FC A] to assure that she was OK, breathing. [Staff #3] states that she unwrapped [FC A] from the blanket she was wrapped inside of (sic). [Staff #3] states that when she did, [FC A] had BM (Bowel Movement) on her and [staff #3] asked [FC A] if she could wipe herself and was given tissue. [Staff #3] states that [FC A] wiped herself with her right hand. [Staff #3] states that [FC A] was sweating and breathing heavy, [staff #3] states that she assisted [FC A] to the floor to lay her on her side and make her more comfortable... [Staff #3] states she then called [RC #1] regarding the situation."

-"Recommendations:"

-"1. Train staff on identifying life-threatening emergencies and assure they can call 911 for them."

-"2. Role-play medical emergencies during monthly staff meetings."

-"3. Train nursing staff on how to take control of a medical emergency when they are contacted over the phone. Since DSP's (Direct Support Professional) are not medical thinkers, the nurse may need to direct them with questions to receive all information to make an informed decisions of situations...".

-A review of the ISF dated 8/13/21 to 8/19/21 indicated FC A was found in the bathroom by

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	staff #3. The review indicated staff #3 found FC A leaning over on the toilet in the bathroom. The review indicated staff #3 indicated FC A was groaning and communicated by nodding. The review indicated FC A was incontinent of bowel. The review indicated staff #3 called RC #1 for assistance. The review indicated RC #1 called Nurse #1 for instructions. The review indicated Nurse #1 told RC #1 not to take FC A to Med Check/Urgent Care but to attempt to wait for a scheduled appointment with FC A's PCP at 9 AM. The review indicated RC #1 called 911 for emergency transport to the Hospital. RC #1 was interviewed on 10/4/21 at 4:02 PM. RC #1 was asked if staff had called her to report a medical problem with FC A. RC #1 stated, "She called me and she said [FC A] was laying on the ground and she wanted help getting her up." RC #1 was asked what she saw when she arrived on the group home on 8/13/21. RC #1 stated, "[FC A] was on the floor leaning up on her arm. I asked [FC A] if she wanted me to help her up, she was just nodding. We got her in a wheelchair. I just said I'm going to take her to the ER (Emergency Room). Then I noticed her (FC A's) face started to droop, so I called 911." Nurse #1 was interviewed on 10/5/21 at 12:21 PM. Nurse #1 was asked if staff had called her regarding a medical problem with FC A on 8/13/21. Nurse #1 stated, "Yes, that she was sitting on the toilet, she was incontinent of stool and she was leaning to the left." Nurse #1 was asked if she instructed RC #1 to call 911. Nurse #1 stated, "I did not instruct them to call 911." This federal tag relates to complaint #IN00360527.			

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	9-3-6(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure client A received her prescription medications as ordered. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 10/4/21 at 1:11 PM. 1. A BDDS report dated 9/24/21 indicated on 9/23/21, "... [Client A] had three seizures (sic) first one lasted 4 minutes, second one 5 minutes so Diastat (seizures) given and then she (client A) went into a third one. 911 (Emergency Services) was called and she was still seizing. She was taken to [name] Hospital ED (Emergency Department) where she received IV (Intravenous) fluids, her medications were adjusted...". 2. A BDDS report dated 9/24/21 indicated, "... It was discovered on 9/24/21 audit of medications that [client A] did not receive her morning medications on 9/22 or 9/23. [Client A] did have a seizure and was taken to the ED on 9/23/21. The medications that she did not receive include: Levetiracetam (seizures) 500 MG (Milligrams), Levetiracetam 1000 MG, Oxcarbazepine (seizures) 750 MG, PEG 3350 Powder (constipation), Chlorhexidine Gluconate Rinse (mouthwash), Clonidine (sedative) 0.1 MG,	W 0368	The nurse and all staff will receive additional training regarding the responsibility to ensure that all clients receive prescription medications as ordered. Training will include notification of the nurse when supply is running low. Additionally, training for the nurse will include her responsibility to act and follow up to assure that medications are received in the home as quickly as possible without interruption in treatment for consumers. The Director of Nursing will review with the nurse three times weekly to assure and confirm that any potential medication supply issues have been identified and addressed.	11/07/2021

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	Fluticasone Propionate (nasal spray), Lisinopril (Hypertension) 20 MG... and Vimpat (seizures). An investigation will be completed to determine the facts of the missed medications and how to prevent this from reoccurring...". A review of the BDDS report dated 9/24/21 indicated client A did not receive her morning medications on 9/22/21 and 9/23/21. The review indicated client A sustained breakthrough seizures on 9/23/21 and was sent to the ED on 9/23/21 for treatment. Client A's record was reviewed on 10/5/21 at 11:30 AM. Client A's PO's (Physician's Orders) dated 10/5/21 indicated, "... Levetiracetam Tab 1000 MG... Take 1 tablet twice daily for seizures... Levetiracetam Tab 500 MG... Take 1 tablet twice daily for seizures... Vimpat Tab 200 MG... Take 1 tablet by mouth twice daily... Oxcarbazepine Tab 600 MG Take 1 tablet by mouth three times daily...". Nurse #1 was interviewed on 10/5/21 at 12:21 PM. Nurse #1 indicated client A did not receive her AM prescription medications as ordered on 9/22/21 or 9/23/21. Nurse #1 was asked if client A sustained breakthrough seizures on 9/23/21. Nurse #1 stated, "Yes." Nurse #1 indicated client A should have received her prescription medications as ordered by the physician. This federal tag relates to complaint #IN00360527. 9-3-6(a)			