STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G182	A. BUILDING 00 B. WING	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DEVELOPMENTAL SERVICE ALTERNATIVES	2326 BERWICK DR SHELBYVILLE, IN 46176

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0000 Bldg. 00	This visit was for a focused fundamental recertification and state licensure survey. Dates of Survey: February 26, 27, 28, and 29, 2024. Facility Number: 000715 Provider Number: 15G182 Aims Number: 100234640 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 3/15/24.	W 0000		
W 0130 Bldg. 00	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview for 1 of 3 sampled clients (#3), plus 1 additional client (#4), the facility failed to ensure client privacy during medication administration. Findings include: An observation was conducted at the group home on 2/27/24 from 6:15 AM through 8:03 AM. At 7:18 AM, client #4 was prompted to the medication area to take his morning medication. The medication area was located in the northwest corner of the kitchen in the home. Client #4 walked to the medication area to receive his morning medications. As client #4 arrived at the medication area, client #3 also walked into the kitchen and walked up to the medication cabinet. Staff #2	W 0130	Caregiver-DSA will install a curtain to apply in the medication area to ensure each client has privacy when taking medication. The Residential Service Director or QIDP will train staff on how to utilize the curtain by 3/29/2024.	03/29/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jenna Metcalfe	Director of Quality Assurance	04/12/2024

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	proceeded to greet client #3 and stated, "well since you're (client #3) here we will go ahead and do your morning meds." Staff #2 proceeded to ask client #3 why he took his Risperidone (depression) medication. Client #3 did not respond and staff #2 stated, "It's for your depression." The entire time staff #2 was communicating with and administering client #3's medications, client #4 continued to stand directly behind staff #2 waiting his turn to take his medications. No barrier was present nor was there any prompting to clear the area for privacy. Staff #2 was interviewed on 2/27/24 at 7:41 AM. Staff #2 was asked when passing medications, should anyone else be in the medication area except for the client whose meds you are currently administering. Staff #2 stated, "No." Staff #2 was asked why other clients should not be in the area. Staff #2 stated, "For privacy." Staff #2 was asked if other clients came into the medication area while she was passing meds what was she expected to do. Staff #2 stated, "We are to redirect them away from the medication area." Staff #2 was asked if she redirected client #4 away from the medication area when she decided to pass client #3's medications. Staff #2 stated, "No, I should have." LPN (Licensed Practical Nurse) #1 was interviewed on 2/28/24 at 11:45 AM. LPN #1 was asked how staff were expected to ensure each client's privacy was maintained during medication administration. LPN #1 stated, "The individual receiving meds should be the only client in the med area during med pass." LPN #1 was asked if other clients should be around the med cabinet. LPN #1 stated, "No." LPN #1 was asked if a staff calls a client to the medication area to take their medication and then decides to pass a different client's medications what should staff do. LPN #1			

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	stated, "They should send the other client to another area and call them back when it is their turn." LPN #1 indicated client #4 should not have been allowed to wait in the med area while client #3 was administered his medication. 9-3-2(a)			
W 0327 Bldg. 00	483.460(a)(3)(iv) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure clients #1, #2 and #3 had current Mantoux screenings. Findings include: 1. Client #1's record was reviewed on 2/27/24 at 9:43 AM. Client #1's record indicated a Mantoux test dated 2/11/22. The Mantoux test indicated client #1 had a Mantoux screening completed on 2/11/22. Client #1's record did not indicate documentation of a a current Mantoux screening. 2. Client #2's record was reviewed on 2/27/24 at 10:40 AM. Client #2's record indicated a Mantoux test dated 8/27/22. The Mantoux test indicated client #2 had a Mantoux screening completed on 8/27/22. Client #2's record did not indicate documentation of a current Mantoux screening. 3. Client #3's record was reviewed on 2/28/24 at	W 0327	The nurse will create and schedule to have TB test done January 17 and June 17. This timeframe will ensure every consumer has gotten their TB test, this will also be beneficial for the consumers we have coming in whether it's at the beginning of the year or the middle of the year. The Area Director or designee will check in with the nurse by April 24, 2024, to see the progress made on the chart.	03/29/2024

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	9:30 AM. Client #3's record indicated a Mantoux test dated 8/20/22. The Mantoux test indicated client #3 had a Mantoux screening completed on 8/20/22. Client #3's record did not indicate documentation of a current Mantoux screening. LPN (Licensed Practical Nurse) #1 was interviewed on 2/28/24 at 11:45 AM. LPN #1 was asked how often clients should receive Mantoux screenings. LPN #1 stated, "Annually." LPN #1 was asked if the facility had current Mantoux screenings for clients #1, #2 or #3. LPN #1 indicated they did not have current screenings. 9-3-6(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure client #2's medication was administered as ordered. Findings include: An observation was conducted at the group home on 2/26/24 from 4:10 PM through 6:05 PM. At 4:18 PM, client #2 was prompted to come to the medication cabinet to take his 5 PM medications. Staff #1 administered client #2's medications. Client #2 was given Metformin Tab (tablet) 1000mg (milligrams) (diabetes). Client #2's Metformin medication had administration directions that indicated, "give one tablet by mouth 2x daily with meals." Staff #1 completed client #2's medication administration and client #2	W 0369	Staff 1 will be retrained and will be monitored during drug administration until 4/12/24; During this time either the Residential Service Director or the QIDP will ensure medications are administered as ordered.	03/29/2024

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	then began to assist with meal preparation. At 5:30 PM, the evening meal preparation was completed and the clients were prompted to the kitchen table to begin eating dinner. Client #2 sat down at the kitchen table and began eating his evening meal. Client #2's record was reviewed on 2/27/24 at 10:40 AM. Client #2's PO (Physician Order) dated February 2024 indicated the following: -"...Metformin Tab 1000mg give 1 tab by mouth twice daily with meals...". Staff #1 was interviewed on 2/26/24 at 4:24 PM. Staff #1 was asked if all client medications should be given as ordered. Staff #1 stated, "Yes." Staff #1 was asked if client #2 was supposed to eat right after he took his Metformin medication. Staff #1 stated, "Yes, usually I give him his meds right at the time they eat, just as they start to eat but today because we were cooking multiple things that take a little time we did meds early to start cooking." Staff #1 was asked when the evening meal should be ready. Staff #1 stated, "In about an hour or so." LPN (Licensed Practical Nurse) #1 was interviewed on 2/28/24 at 11:45 AM. LPN #1 was asked if all client medications should be administered in accordance with the medication administration instructions. LPN #1 stated, "Yes." LPN #1 was asked if a client was to take a medication and the administration instructions indicated to take the medication with meal, when should the medication be given. LPN #1 stated, "Usually within 30 minutes of the meal." LPN #1 was asked if client #2 should have been given his			

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	Metformin medication over an hour before he ate his next meal. LPN #1 stated, "No." 9-3-6(a)			