

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  12/30/2021
--	---	--	---

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

(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 0000  Bldg. 00	<p>This visit was for the investigation of complaint #IN00368233 and complaint #IN00368243.</p> <p>This visit was in conjunction with the post-certification revisit (PCR) to the pre-determined full recertification and state licensure survey completed on 11/19/21.</p> <p>Complaint #IN00368233: Substantiated, Federal and State deficiencies related to the allegation(s) were cited at W149, W153, W186, and W189.</p> <p>Complaint #IN00368243: Substantiated, Federal and State deficiencies related to the allegation(s) were cited at W149, W186, W189, and W331.</p> <p>Dates of Survey: December 20, 21, 22, 27, and 30, 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. Quality Review of this report completed by #15068 and #39778 on 1/13/22.</p>	W 0000		
W 0149  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 record review and interview for 2 of 2 sampled clients (clients A and B), the facility failed to implement their policies and procedures to prevent a substantiated verbal</p>	W 0149	Staff at this facility will be retrained on preventing abuse and neglect by the Area Director by 01/30/2022. The Program	01/30/2022

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:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>abuse and elopement incident involving client B, to ensure an elopement and verbal abuse allegation involving client B was reported immediately to administration, and to ensure client A received timely medical care after a change in condition.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/20/21 at 11:15 AM.</p> <p>1. A BDDS report dated 11/30/21 indicated the following:</p> <p>- "...Submitted Date: 11/30/21..."</p> <p>- "...Section III - Incident Information."</p> <p>- "Incident Date."</p> <p>- "11/26/21."</p> <p>- "Time."</p> <p>- "9:46 PM."</p> <p>- "Date of knowledge."</p> <p>- "11/29/21..."</p> <p>- "...[Client B] reported to [HM (House Manager) #2] on 11/29/21 that on Friday 11/26/21 the staff person working, [staff #1], had given him a hard time and had slapped consumer [client C] on the face. It was also reported that [staff #1] called the police due to [client B] leaving the house without staff, being out of sight for approximately 5 minutes before returning on his</p>		<p>Coordinator is responsible for generating a monthly staff schedule to ensure that adequate staffing levels are in place for client supervision and needs. It will be verified by the AD to ensure that adequate coverage is scheduled. Professional staff will complete unscheduled pop-in visits three times per week for three weeks to verify that adequate staffing levels are present within the home to support client supervision level and needs. Unannounced visits will titrate down to two times per week for on-going compliance verification. The Sequential Call list policy was updated 01/2022 and employee training was completed. The policy provides more detailed clarification for supervising staff on shift and professional staff regarding notification of appropriate parties and corresponding time frames required. As part of this policy update, the clinical staff will ensure a follow-up for verification of medical treatment to close the communication loop. The agency RN will be trained on the policy update by 01/30/22.</p>	

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  12/30/2021
--	---	--	---

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

(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>own. [Client B] does not have alone time in the community. [Client B] does have a formal behavior plan with target behavior of false reporting. [Client C] was checked for injury/bruising and nothing was found. The police ensured everyone's safety when they arrived and spoke with both staff [staff #1] and consumer [client B]. [Staff #1] has been suspended pending the outcome of an investigation...".</p> <p>An ISF (Investigation Summary Form) dated 12/2/21 indicated the following:</p> <p>-"...On 11/29 (2021) it was reported that [staff #1] hit [client C] and yelled at [client B]. 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: 11-29-21."</p> <p>-"This alleged incident was reported by [HM #2] to this IO on 11-29-21. She reported that [client B] had told her while doing transport that [staff #1] was mean to him yelling and telling him to go to his room. [Client B] also reported that [staff #1] has (sic) slapped [client C] on the face."</p> <p>-"[HM #2]: 11-29-21."</p> <p>-"See written statement attached."</p> <p>-"(handwritten statement by HM #2) [HM #1] called me Friday (11/26/21) telling me to get to [name of group home] because [staff #1] had</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>called the police on [client B]. When I got there the police was (sic) leaving. I had a talk with [client B], then I left. Today I was in the day hab (habilitation) talking to [client B]. He told me the (sic) [staff #1] was giving him a hard time. Then he went on telling me [staff #1] had slapped [client C]. I asked him did he tell anyone. He said he told [staff #2] that same night and he said he told [staff #3] this morning, but she didn't believe him so I told him I was gone (sic) make sure someone would know about it so I reported it to [QIDP #1]..."</p> <p>-"...[HM #2]: 11-29-21."</p> <p>-"IO: You (HM #2) were called to the home on Friday?"</p> <p>-"[HM #2]: Yes, [HM #1] called and asked if I could go and help as [client B] was upset and went outside."</p> <p>-"IO: Where was [client B] when you got there?"</p> <p>-"[HM #2]: He was at the house; I was told that he had just returned, and the Police had just left."</p> <p>-"IO: Why were the police there?"</p> <p>-"[HM #2]: [Staff #1] had called the police as [client B] was upset yelling and threatened to leave. [HM #1] asked me to come over and help as I was closer that she was, she was 45 minutes away."</p> <p>-"IO: Do you know what the police said?"</p> <p>-"[HM #2]: No, they were gone by the time I got there."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>- "IO: Do you know if anyone reported this allegation to anyone?"</p> <p>- "[HM #2]: Not sure, I think [HM #1] knew."</p> <p>- "IO: You didn't call anyone?"</p> <p>- "[HM #2]: [Client B] said he told [staff #2], I got there at 9:30pm. I called [HM #1] as [client B] was upset about getting his evening medication and it was in the med (medication) cup on the med counter. [HM #1] said she had not given it, so I gave it."</p> <p>- "IO: How was [client B] when you got there?"</p> <p>- "[HM #2]: He was calm, so I left after giving him his medications."</p> <p>- "IO NOTE: 11-29-21."</p> <p>- "[FPC (Former Program Coordinator) #1] had reported to this IO that [client B] had taken off on Friday as he was upset about not getting his medications on time. [Client B] had left the property but was in eyesight and had only gone to the neighbors and back. [FPC #1] was asked about police involvement, and she said she was not told that there was any police involvement."</p> <p>- "[Client B]: 11-29-21."</p> <p>- "IO: Tell me what was going on."</p> <p>- "[Client B]: [Staff #1] threatened me to call the police if I didn't (sic) couldn't be quiet. I ran away but I decided to come back on my own. I walked down the street and thought to myself that I should just face my fears and go back to the house."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>- "IO: What happened when you got back to the house?"</p> <p>- "[Client B]: I said I wanted to call the police, but she had already called them and said they were on their way."</p> <p>- "IO: Anything else happen?"</p> <p>- "[Client B]: When I walked into the door, I saw [staff #1] slap [client C] in the face. [Client C] was being loud and yelling and she was just slapped her. [Staff #1] told me to sit down."</p> <p>- "IO: Where was [client C] at?"</p> <p>- "[Client B]: She was in the hallway where her room is at."</p> <p>- "IO: Where was [client D]?"</p> <p>- "[Client B]: She was in her room."</p> <p>- "IO: Where was [client A]?"</p> <p>- "[Client B]: She was in her room."</p> <p>- "IO: Tell me about the police."</p> <p>- "[Client B]: The police came after I got back to the house. I told her I wanted to call them, but she (staff #1) said to sit down and be quiet they were already called and on their way."</p> <p>- "IO: Why were you upset?"</p> <p>- "[Client B]: She kept telling me to be quiet. I just wanted to know about getting my med's (medications). I threw her milkshake at her, and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>she yelled at me to clean it up."</p> <p>-"IO: Did you clean it up?"</p> <p>-"[Client B]: Yes, I did. I got upset as it seemed that she yelled and shouldn't be working in this field. She kept telling me to go to your (sic) room and wait when I asked about my med's. I told her all she cares about is the money. She told me to shut up and go to my room."</p> <p>-"[Client D]: 11-29-21."</p> <p>-"IO: What happened on Friday night with [staff #1]?"</p> <p>-"[Client D]: [Staff #1] hit [client C]."</p> <p>-"IO: Did you see her hit [client C]?"</p> <p>-"[Client D]: She pursed her lips and said yes."</p> <p>-"IO: How did she hit her?"</p> <p>-"[Client D]: She (client D) shrugged her shoulders..."</p> <p>-"...IO: What was going on with [client B]?"</p> <p>-"[Client D]: She (staff #1) was giving him (client B) a hard time..."</p> <p>-"...IO: Why is she (staff #1) a bad girl?"</p> <p>-"[Client D]: [Staff #1] gets on my nerves, she has no patience..."</p> <p>-"...[Staff #1]: 11-29-21."</p> <p>-"See written questions and answers during</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>interview...".</p> <p>-"...(written questions and answers with staff #1) IO: Tell me what happened on Friday (11/26/21)</p> <p>-"[Staff #1]: Friday? With [client B]?"</p> <p>-"IO: Yes."</p> <p>-"[Staff #1]: [HM #1] called me in and I was working. [Client B] had come out of his room. He asked me who was giving meds. I didn't find out until I talked to [HM #2] that [HM #1] had passed all meds but [client B's]. At that point, I understood why [client B] was upset. I just kept telling him I don't know when he kept asking me. He got very mad. I told him I wasn't med (medication) passed, there was nothing I could do....He gets mad and he sits on the couch. You always tell me it's their home and I understand that. But what you aren't going to do is sit three feet from me and yell at me. I told him to go to his room until he calmed down because he wasn't going to talk to me like that. He says he is going to get me fired. I told him okay, please do. He then goes to his room. Comes back. He says he is going to leave. I stand in front of the door, but they have 'f----- three doors in [name of group home]' and he gets out another door. I called [HM #1] and then was like 'nevermind, I should be calling the cops'. And I call (sic) them. [Client C] is also crying because she's 'sh---- and wants to go to bed.' I was all by myself, what was I supposed to do? I can't be my best self if I'm the only person. I didn't raise my voice once or threaten him. Maybe to him I did, I am who I am. But I didn't raise my voice. He threw a shake at me and hit me with a wet mop. The cops can attest to that. I understand he has issues, but I don't think anything I did made him act in that</p>			

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  12/30/2021
--	---	--	---

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

(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>manner."</p> <p>-"IO: When he was upset and yelling at you, what did you say?"</p> <p>-"[Staff #1]: I encouraged him to take a break in his room. When he said he was going to call his guardian and [HM #1], I told him 'please do.' When he called the police, I told him that we weren't going to waste resources, there's already a car on the way. It's their right to use the phone, but I did tell him that we aren't going to call 911 when they're already on their way."</p> <p>-"IO: I know that [client B] talks a lot. Was he really talking to you a lot?"</p> <p>-"[Staff #1]: No, that's the thing. He was sitting in the chair mumbling to himself. I asked him what was wrong and then he got upset and said he wanted to get me fired. I told him I have to be able to see him, but we don't have to be in the same room. I told him I had to be in the living room, but he doesn't need to be in there with me. He chose to sit two feet away from me and have an attitude."</p> <p>-"IO: You said he had an attitude. What was he doing?"</p> <p>-"[Staff #1]: On his phone. He always tells me he doesn't like me. I don't know what it is about me personally but he just literally doesn't like me."</p> <p>-"IO: So the tone of voice you're using with me (a little worked up/raised), is that the tone you used with him?"</p> <p>-"[Staff #1]: No, I used a completely calm tone. I'm extra calm for that reason because they like</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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 say I'm yelling at them."</p> <p>-"IO: What was [client D] doing?"</p> <p>-"[Staff #1]: She came out after the cops left and was wet. I asked her why she was wet and she told me she had just taken a shower."</p> <p>-"IO: Where was [client C]?"</p> <p>-"[Staff #1]: In her room, doing what she does, rolling around."</p> <p>-"IO: What was [client A] doing?"</p> <p>-"[Staff #1]: During the whole thing, [client A] was crying because she was ready to be put in bed. Later I found out she had pooped on herself and smelled like urine. Here's what happened. When I got to the home, [HM #1] told me someone would be there at 8. When I got there, she (client A) didn't smell so I think during that hour when things were happening, she pooped and peed multiple times. This whole time she was crying saying she wanted to get into bed. I was told to just get there (between 6 and 6:15) and just sit until the next person showed up at 8pm. I didn't want to help [client A] get into bed because I didn't want to try to get her in bed and accidentally drop her or snap her shoulder. That's a liability. Then [HM #2] came in and asked me why [client A] was crying. That's when I realized she had defecated on herself. If I hadn't been lied to by [HM #1] and someone was coming in at 8pm, then I would have known and could have done my job. I was put in a really bad situation...I did the best that I could."</p> <p>-"IO: What reason were you called in?"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>-"[Staff #1]: [HM #1] told me she had a family emergency. She told me she was at the hospital with [girl's name]. She told me [HM #2] would be there before her."</p> <p>-"IO: What was going on with (sic) [HM #2] got there?"</p> <p>-"[Staff #1]: She (HM #1) had called her (HM #2) when [client B] went AWOL (leaving the group home without permission). Because I guess that's protocol because someone higher up than me (sic)."</p> <p>-"IO: What time did [client B] leave?"</p> <p>-"[Staff #1]: (looks through phone) I called 911 for the first time at 8:50pm. Mind you I was supposed to get off at 8pm."</p> <p>-"IO: How long was he gone?"</p> <p>-"[Staff #1]: Maybe 10 minutes."</p> <p>-"IO: Did you see him at all?"</p> <p>-"[Staff #1]: yes cause at first he knocked on the neighbor's door and I told him not to bother them. Then he headed north towards a [name of moving truck company]. I told the dispatcher I couldn't leave because I was alone with 3 other consumers inside."</p> <p>-"IO: How long was he gone?"</p> <p>-"[Staff #1]: Maybe 5 minutes. I think he got cold."</p> <p>-"IO: What did police say?"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>-"[Staff #1]: They asked me what I was doing. I told them I was staff. The cops calmed him down. He told them he was upset with their med's (sic). I said I couldn't control that. It's state regulated rules and if I go in that med cabinet, I will lose my job. I can help with anything but medicine, that's out of my hands. For the simple reason of I'm not med passed...that med pass bit, that's like literally the only thing I can't do (sic)."</p> <p>-"IO: Yeah, you can't do med's (sic). Do you have CST (Client Specific Training) for [name of group home]?"</p> <p>-"[Staff #1]: No."</p> <p>-"IO: Next time you're asked to work in a house and you aren't trained, tell them no until they give you CST and site specific (training)."</p> <p>-"[Staff #1]: The whole thing was a set up."</p> <p>-"IO: What do you mean?"</p> <p>-"[Staff #1]: Because she ([HM #1]) knew that [staff #2] wasn't supposed to be in until 10pm. She knew that [client B] didn't have his meds. She knew that I didn't know he didn't have her (sic) meds."</p> <p>-"IO: Why would she set you up?"</p> <p>-"[Staff #1]: Not on purpose. But, she's an RM (Resident Manager), she should have told me these things...".</p> <p>-"...IO: At any point did you put your hands on [client B] or any other consumer?"</p> <p>-"[Staff #1]: No...".</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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 A]: 11-29-21..."</p> <p>-"...IO: Did you see anyone get slapped?"</p> <p>-"[Client A]: No..."</p> <p>-"...[Client B]: 11-29-21 at home."</p> <p>-"IO: [Client B] did you really see [staff #1] slap someone."</p> <p>-"[Client B]: Yes, I was coming in the house from having left and when I walked in I saw her (staff #1) slap [client C]."</p> <p>-"IO: Was [client C] upset or yelling?"</p> <p>-"[Client B]: She was making noise, [staff #1] just walked up to her and slapped her."</p> <p>-"IO NOTE: 11-29-21."</p> <p>-"This IO checked [client C] for any bruising or injuries, none noted. This IO also checked [client A] over for any bruising or injuries as a precaution as [staff #1] said that [client A] was upset and [client C] was not. [Client B] and [client D] said it was [client C] that was yelling and was slapped..."</p> <p>-"...[Staff #3]: 12-1-21."</p> <p>-"IO: Did anyone say anything to you about an incident going on this past weekend?"</p> <p>-"[Staff #3]: [Client B] said things about [staff #1]."</p> <p>-"IO: When did he say something to you?"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>-"[Staff #3]: He said something on Saturday (11/27/21)."</p> <p>-"IO: What did he say?"</p> <p>-"[Staff #3]: He said that [staff #1] was being very mean to him and that he poured water on her."</p> <p>-"IO: Did you report this to anyone?"</p> <p>-"[Staff #3]: No, he said something all weekend. I assumed that everyone knew."</p> <p>-"IO: You can't assume."</p> <p>-"[Staff #3]: [HM #1] told me what happened, so I thought everyone knew."</p> <p>-"IO: Did you hear anything about a consumer being slapped?"</p> <p>-"[Staff #3]: No."</p> <p>-"[HM #1]: 12-1-21."</p> <p>-"IO: You had [staff #1] relieve you?"</p> <p>-"[HM #1]: Yes."</p> <p>-"IO: What time was she supposed to get off?"</p> <p>-"[HM #1]: 8pm when [staff #2] arrived for work."</p> <p>-"IO: [Staff #2] didn't come until 10pm."</p> <p>-"[HM #1]: I just got it changed to 8pm last night."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>- "IO: When were you told about the incident?"</p> <p>- "[HM #1]: I was told a little after 8pm."</p> <p>- "IO: What were you told?"</p> <p>- "[HM #1]: I was told that [client B] ran away and 911 was called. [Staff #1] hung up and then called back to say [client B] was back. I called [HM #2] and had her go over to help out as I was not in town."</p> <p>- "IO: Did [client B] make any allegations to you?"</p> <p>- "[HM #1]: No, I really think it was the way that [staff #1] addressed him, the way she talked to him."</p> <p>- "IO: Who did you report it to?"</p> <p>- "[HM #1]: I reported it to [FPC #1]."</p> <p>- "IO: What did you tell her?"</p> <p>- "[HM #1]: That [client B] ran (sic) only went to neighbors and back was in eyesight."</p> <p>- "IO: Who told you that?"</p> <p>- "[HM #1]: [Staff #1] told me."</p> <p>- "IO: Was [FPC #1] told that the police were involved?"</p> <p>- "[HM #1]: Yes."</p> <p>- "[Staff #2]: 12/2/21."</p> <p>- "IO: How were things when you arrived at work, what was the atmosphere?"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>-"[Staff #2]: Things were calm. [Staff #1] did ask me what time I was supposed to be at work. I told her 10pm. [Staff #1] said that she was supposed to be off at 8pm."</p> <p>-"IO: Was anything going on with the consumers when you arrived?"</p> <p>-"[Staff #2]: No, but that is the day that [client B] ran off."</p> <p>-"IO: Where were all the consumers, were they in bed?"</p> <p>-"[Staff #2]: No, [client A] and [client C] were in bed but [client D] and [client B] were up."</p> <p>-"IO: What was the client's mood (sic)?"</p> <p>-"[Staff #2]: [Client B] was upset about what had gone on."</p> <p>-"IO: Did he say anything?"</p> <p>-"[Staff #2]: He said that he was upset with [staff #1], the police were called...[Client B] states he doesn't like [staff #1], she is mean to him."</p> <p>-"IO: Did he say anything about anyone being hit?"</p> <p>-"[Staff #2]: [Client B] said that [staff #1] hit [client A]."</p> <p>-"IO: Did you see any injury or anything?"</p> <p>-"[Staff #2]: No but I did ask [client A] if anyone was being mean to her, and she said no. I looked at her and there were no marks or injuries that I</p>			

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  12/30/2021
--	---	--	---

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

(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>could see."</p> <p>-"IO: Did you report it to anyone?"</p> <p>-"[Staff #2]: I told [staff #3] when she came in..."</p> <p>-"...Review of Training Data Base for [staff #1]: 12-1-21."</p> <p>-"The following trainings are not recorded on the training data base: C111 (Respect Training), Road Test, CPI (Crisis Prevention Intervention), and site-specific training. She has consumer specific training for [different group home] and CPR (Cardiopulmonary Resuscitation).</p> <p>-"Findings:"</p> <p>-"1. It was not reported to this IO that [client B] had left the property until there was (sic) further allegations made and presented on 11-29-21 which included an allegation of a consumer getting slapped."</p> <p>-"2. [Client B], [client D] state that [staff #1] had slapped [client C] on the face."</p> <p>-"3. This IO checked on [client C] and did not find any injury or bruising present when checked on Monday 11-29-21 and again on Tuesday 11-30-21."</p> <p>-"4. There were no other staff working during the alleged incidents."</p> <p>-"5. [Staff #1] was working from 6:30pish (sic) -10p (PM) when she was relieved, however, she was told she was only working until 8pm."</p> <p>-"6. The police were called to the home by [staff</p>			

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  12/30/2021
--	---	--	---

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

(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]."</p> <p>-"7. [Client B] did leave the premises for approximately 5 minutes; he was not in eyesight."</p> <p>-"8. [Client B] returned to the home on his own."</p> <p>-"9. [Staff #1] called and reported to [FPC #1], according to [FPC #1] that [client B] was upset and had gone outside, not that he left the premises."</p> <p>-"10. [Staff #3] had been told by [client B] that [staff #1] was being mean to him, she did not hear that [client C] may have been slapped."</p> <p>-"11. [Staff #3] said she was also told about what was going on by [HM #1], so she assumed that it was reported."</p> <p>-"12. [Client B] states that [staff #1] was mean to him telling him to go to his room. [Client D] states that [staff #1] was giving [client B] a hard time..."</p> <p>-"14. [Client B] did spill [staff #1's] milkshake, he states that he was yelled at to clean it up..."</p> <p>-"...16. [Staff #1] did state that [client B] was not going to sit three feet from me (staff #1) and yell at me."</p> <p>-"17. [Staff #1] admits that she told him (client B) to go to his room until he was calm."</p> <p>-"18. [Staff #1] claims several times that she didn't raise her voice, however, this IO questioned the tone of her voice in talking with me being the same as when talking to consumers..."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>-"...22. [Staff #1] states that she has not had CST training for [name of group home].</p> <p>-"23. [HM #1] states that she did tell [FPC #1] that the police were called. [HM #1] states that [FPC #1] also knew about him leaving but only to the neighbors and back."</p> <p>-"24. [Staff #2] was told by [client B] that [staff #1] was mean to him, she did not see anything as all was quiet when she arrived for work."</p> <p>-"25. [Staff #2] was told by [client B] that [staff #1] has (sic) slapped [client A], not [client C]."</p> <p>-"26. [Staff #2] did not report the allegations to anyone but the next shift."</p> <p>-"27. This IO reviewed with [staff #2] the importance of reporting and who to report to..."</p> <p>-"...Reviewer Recommendations:..."</p> <p>-"...[Staff #3] must receive verbal counseling on reporting alleged abuse. She received documented training on this."</p> <p>-"[Staff #2] must receive documented training on reportable incidents."</p> <p>-"[Staff #1] must receive Respect Training. Deadline 12/17."</p> <p>-"Staff must not work in a home without Consumer Specific Training and Site Specific Training for that house. This includes BSPs (Behavioral Support Plans) as well."</p> <p>-"(Signature of RD (Regional Director) #1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>-(handwritten by RD) RD #1 Additional Finding:"</p> <p>-"There was not enough information or consistency between individuals to substantiate that [staff #1] hit [client C]."</p> <p>-"[Client B] has a BSP with targeted behaviors of property destruction, verbal aggression, and intimidation. This BSP was not followed nor was [staff #1] trained on it...".</p> <p>An Incident Follow-Up Report dated 12/10/21 indicated the following:</p> <p>-"....Consumer Name: [Client B]...".</p> <p>-"...It was substantiated that [staff #1] was verbally abusive to [client B]...Staff will receive further training on reportable incidents, CST training and training on behavior plans. [Staff #1] will receive the respect training and will not work in that house again...".</p> <p>A review of the ISF dated 12/2/21 indicated client B eloped from the group home. The review indicated verbal abuse from by staff #1 towards client B was substantiated. The review indicated staff #1 had not completed CST or site specific training prior to working in the group home. The review indicated an allegation of verbal abuse was not immediately reported.</p> <p>Client B's record was reviewed on 12/21/21 at 1:32 PM.</p> <p>Client B's BSP (Behavioral Support Plan) dated 6/9/21 indicated the following:</p>			

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  12/30/2021
--	---	--	---

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

(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>- "...Description of Target Behaviors:"</p> <p>- "Attention Seeking: acting in a way to get attention. This includes, but is not limited to, talking loudly, talking over others, and threatening self-harm..."</p> <p>- "...Verbal Aggression: including yelling, cursing, making threatening statements, etc."</p> <p>- "Intimidation: bullying others; threatening to harm others; etc."</p> <p>- "False reporting: Reporting an incident that did not happen or changing the facts of an incident to get attention, get a certain response, get someone in trouble, etc..."</p> <p>- "...Replacement Behaviors:"</p> <p>- "[Client B] reportedly engages in maladaptive behaviors when he is told no or when he does not get something he wants."</p> <p>- "All replacement behaviors should be documented on TMP (Task Master Professional)."</p> <p>- "Appropriate coping: drawing, taking a walk, taking a shower, laying down in his bed, watching television..."</p> <p>- "...Expression of thoughts and feelings: communicating how he feels when he is upset and what he needs from others to help him feel better..."</p> <p>- "...Approaches:"</p> <p>- "Proactive Approaches:"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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. [Client B] should be provided with clear and consistent expectations and consequences. If there is to be a change in the daily schedule or routine, [client B] should be notified, and changes should be explained."</p> <p>- "2. Staff should provide an explanation for decisions made. Staff should focus on the rationale for the decision and incorporate ways the decision benefits [client B] in the future."</p> <p>- "3. Staff should always frame things positively and avoid using the word 'no.'...".</p> <p>- "...4. All requests should be phrased as questions, and [client B] should be given options when possible...".</p> <p>- "...8. Keep interactions with [client B] positive by encouraging positive behaviors...".</p> <p>- "...Reactive Interventions:"</p> <p>- "Attention Seeking."</p> <p>- "1. Attempt to redirect [client B] to another topic or activity."</p> <p>- "2. If [client B] is speaking very loudly, ask him to lower his voice."</p> <p>- "3. If [client B] is threatening self-harm, tell him 'I can tell you are upset about something. Let's talk about it.' Engage [client B] in a conversation about what is upsetting him and how he can use his coping skills to help him."</p> <p>- "4. If [client B] continues to engage in attention seeking behavior, planned ignore."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>- "a. Do not give him attention until he stops attention seeking."</p> <p>- "b. If [client B] is threatening self-harm, keep him in line of sight in case he tries to follow through with the threat."</p> <p>- "c. Be conscious of your facial expressions and body language; do not react in any way. Make sure to immediately engage him once he stops attention seeking...".</p> <p>- "...Verbal Aggression."</p> <p>- "1. Request that [client B] stop the behavior. Be specific."</p> <p>- "2. Attempt to redirect [client B's] attention to another topic or activity (....drawing, coloring)."</p> <p>- "3. Encourage the use of coping skills and appropriate expression of his thoughts and feelings. Use phrases like 'I can see you are frustrated. Can you tell me why?' or 'I can see you are frustrated. Is there something I can do to help?'"</p> <p>- "4. Explain to [client B] that his current behavior is unacceptable and give him reasons why. If verbal aggression takes place during an activity, explain to [client B] that he will have to leave the current situation if the behavior continues."</p> <p>- "5. If the behavior continues, try to redirect [client B] to a quiet area by himself where he can have the time and space to calm. If you cannot direct him to a quiet are, planned ignore. Do not give him attention until he stops attention seeking. Be conscious of your facial expressions</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>and body language; do not react in any way. Make sure to immediately engage him once he stops the verbal aggression...".</p> <p>"...Intimidation."</p> <p>"1. Request that [client B] stop the behavior. Be specific."</p> <p>"2. Stay neutral. Do not let your body language, tone, or facial expressions show any sign of being intimidated, scared, etc....".</p> <p>"...4. If [client B] is trying to intimidate staff, planned ignore. Do not give him attention until he stops the behavior. Be conscious of your facial expressions and body language; do not react in any way...".</p> <p>"...False Reporting."</p> <p>"1. Never assume a report is false unless you have proof. Ask clarifying questions to [client B] and others involved if you are unsure....".</p> <p>Client B was interviewed on 12/20/21 at 9:38 AM. Client B stated, "A couple of weeks ago [staff #1] was rude with me. I was asking who was going to get my meds and she (staff #1) got mad. I left the house. I didn't go far away. I could see the house from where I was but I didn't go far." Client B was asked if any other staff were there when the incident occurred. Client B stated, "No." Client B stated, "I feel like they are treating me ok now."</p> <p>HM #1 was interviewed on 12/21/21 at 11:12 AM. HM #1 was asked about the evening of 11/26/21. HM #1 indicated she was working but had a family emergency. HM #1 indicated she</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>contacted FPC #1 to inform her of the emergency and for help to find someone to come in and work for her. HM #1 indicated FPC #1 suggested staff #1, so she (HM #1) contacted staff #1. HM #1 was asked if she knew whether or not staff #1 was trained to work at the group home. HM #1 stated, "No." HM #1 indicated at around 8:30-9 PM on 11/26/21 staff #1 called her (HM #1) and said client B had eloped and she (staff #1) was calling 911. HM #1 indicated staff #1 then hung up. HM #1 indicated she tried to call her back and called [FPC #1] and let her (FPC #1) know [client B] had eloped. HM #1 indicated she called the house phone and staff #1 answered and stated client B had returned but 911 was still on the way to the group home. HM #1 was asked about who all she notified of the incident. HM #1 stated, "[FPC #1]." HM #1 was asked if an elopement incident and 911 being called and visiting the home would be considered a reportable incident. HM #1 stated, "Yes."</p> <p>QIDP #1 and RD (Regional Director) #1 were interviewed on 12/27/21 at 11:01 AM. QIDP #1 was asked about the expected staffing ratio at the group home. QIDP #1 indicated there needed to be at least one staff overnight, 2 staff during the day, and at least 2 in the evening. QIDP #1 was asked if the group home was adequately staffed on the evening of 11/26/21. QIDP #1 indicated no. RD #1 was asked what is expected to be completed by all staff prior to working in a group home. RD #1 stated, "They should be trained on CSTs (Client Specific Training's), BSPs if applicable, and have site specific training." RD #1 was asked if any of the client's plans (behavioral or risk) could be followed as written if the staff who is working is not trained on these plans. RD #1 stated, "No." RD #1 stated, "The PC (Program Coordinator) should meet them (staff)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>and do CST and train them to work independently before they start at the group home." QIDP #1 was asked when should an elopement incident with police involvement be reported. QIDP #1 stated, "Immediately to administration and then within 24 hours of the knowledge to BDDS." QIDP #1 was asked if the elopement incident and allegation of verbal abuse involving client B were reported appropriately. QIDP #1 indicated staff did not report the incident in a timely manner. QIDP #1 stated, "I (QIDP #1) am the one who completes the BDDS reports and I was not made aware of the incident until 11/29/21."</p> <p>2. A BDDS report dated 11/30/21 (11:14 AM), indicated, "...[Client A] vomited and had a seizure on 11/29/21. [Client A] did not appear to be fully alert and her skin was pale. She was taken to [name of hospital] ER for precautionary evaluation. [Client A] has a risk plan for seizures which was followed by staff. The ER doctor made no changes to medication...".</p> <p>A BDDS report dated 12/1/21 (2:14 PM) indicated, "...[Client A] was taken to [name of hospital] for continued vomiting. She was given IV (Intravenous) fluids and admitted to the hospital at 8:30pm. She has had a swallow test completed and continues to receive the IV fluids slowly to prevent nausea/vomiting. The hospital plans to introduce foods slowly...".</p> <p>A BDDS report dated 12/1/21 (11:44 AM) indicated, "...An allegation was made that staff did not take [client A] to the ER quickly enough as instructed by the agency nurse. It was also alleged that she was not changed overnight and was not supported to sit in her chair appropriately. These allegations are being investigated to determine the facts and to make</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>recommendations to prevent recurrence...".</p> <p>An ISF dated 12/2/21 indicated the following:</p> <p>- "...Name of Staff Assigned as IO."</p> <p>- "[QIDP #1]..."</p> <p>- "...Investigation Notes for [client A] 11/30/21..."</p> <p>- "...IO NOTE:"</p> <p>- "This IO received information that staff were instructed to take [client A] back to the ER (emergency room) on 11/29/21 and found out on 11/30/21 that she had not been taken. [Client A] was taken to the ER on 11/30/21 where she was then later admitted. (This is a separate investigation into not going as instructed back to the ER on the 29th)..."</p> <p>- "...[Staff #4]: 12/1/21."</p> <p>- "IO: Was [client A] given her medications on Monday night 7p and 8p?"</p> <p>- "[Staff #4]: Let me think that was a couple of days ago. Yes."</p> <p>- "IO: What was going on that evening?"</p> <p>- "[Staff #4]: [Client A] did not get her medications; she was throwing up and I called the nurse. She said to hold the 7p Colace (stool softener) as it could not be crushed. She (client A) got her 4pm medications and I poured water into her mouth, and I thought she was going to choke. I patted her back and had her sit up straighter and she swallowed the medications.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>[LPN (Licensed Practical Nurse) #1] wanted us to crush the pills and put them in applesauce. [LPN #1] wanted to hold the 7pm medication and mouthwash and have her take some Zofran (to prevent nausea/vomiting) and then give her the medications later if the Z ofran helped. When it was time to give the 8pm medications I gave [client A] some applesauce with no medications, and she appeared to not be able to swallow the medications."-"IO: What did you do then?"-"[Staff #4]: [LPN #1] said to give Zofran, but she threw it up. When I called [LPN #1] again, she stated that [client A] was going to the ER. I assumed that since she was going, I was to hold the medications at that time so as not to choke her."-"IO: Do you know who was called for her to go?"-"[Staff #4]: I know [LPN #1] let me know and had called [HM #1] to get it set up. [HM #1] said that she was going to be there by 1am (11/30/21) to take [client A] as she was getting a sitter..."-"...Findings:"-"1. [Client A] did miss medications on the night of the 29th due to vomiting and not keeping anything down."-"2. [Staff #4] thought that [client A] was going to the ER as the nurse had instructed..."-"...6. [Client A] was admitted to the hospital on 11/30/21, after being evaluated in the ER..."</p> <p>"...Reviewer Recommendations:..."-"...If staff notify the nurse directly, the nurse must communicate incident to the PC (Program Coordinator) and QIDP. If a consumer needs to go to the hospital, the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>PC and QIDP must be notified as well. The PC is then responsible for finding a staff member to immediately take the consumer..."-"...Staff must be trained on the chain of command and when to call the next in line due to unresponsiveness or inability to get a hold of the first person."-(signature of RD #1)."An ISF dated 12/10/21 indicated the following: -"..."On 11/30 it was reported that [client A] was not taken to the ER when instructed, was left unchanged all night, and was left sitting in her wheelchair with her bottom where her feet should go. Investigate to determine the facts and make recommendations to prevent further recurrence."-"Name of Staff Assigned as IO: [FAD (Former Area Director) #1] and [QIDP #1]..."-"...IO NOTE: 12-8-21."-"This IO (QIDP #1) was given this investigation to complete as it was turned in by another investigating officer, who is no longer with the company, incomplete. This investigation originally was started on 11-30-21 and was turned in on 12/2/21."-"IO NOTE: 12-8-21."-"See attached investigation (12/2/21 investigation) from previous investigator..."-"...IO (FAD #1) Note: It was reported to this IO (FAD #1) that [HM #1] was to take [client A] to the hospital, and she never did."-"[Staff #4] via phone 11/29/21."-"IO (FAD #1): Tell me what happened with [client A]?"-"[Staff #4]: She was gagging (dry</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>heaving per interview with staff #4 on 12/22/21) and making sounds all night. I couldn't get her to eat. The RM (Resident Manager) was supposed to come in and take her to the ER."-"IO (FAD #1): Did you give her night meds to her?"-"[Staff #4]: No, I was under the impression that the RM was coming to take her to the ER and I couldn't even get her to eat."-"IO (FAD #1): Who came in for you when you left?"-"[Staff #4]: [Staff #6] and I showed him how to take care of her. I was afraid that she would have a seizure so I made sure that he knew how to handle her if she did. He (staff #6) called [HM #1] and she was going to be there at 1 (am), so I went ahead and left."-"[Staff #6] via phone 11/29/21:"-"IO (FAD #1): What happened with [client A]?"-"[Staff #6]: The lady before me said that she had been throwing up and gagging all night..."-"...IO (FAD #1): Did you notify anyone that she was throwing up and gagging?"-"[Staff #6]: Yes, we called the manager, [HM #1] and she said that she was going to be there at 1 am, but she never showed up until after I left the next morning."-"IO (FAD #1): Did you think to call someone else?"-"[Staff #6]: No, I thought she was going to come."-"IO (FAD #1): So you are aware, you should have then called the next step of leadership. That would have been [FPC #1], do you have her number?"-"[Staff #6]: Yes."-"IO (FAD #1): If you feel like it is an emergency you should call 911</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>and then call your PC/PD (Program Director)/AD (Area Director)."-[HM #1] via phone 11/29/21:"-IO (FAD #1): What happened with [client A]?"-[HM #1]: She had been sick and she was supposed to go to the hospital."-IO (FAD #1): Did you take her to the hospital?"-[HM #1]: Yes the next morning, I had been trying to get a hold of you ([FAD #1]) or [FPC #1]."-IO (FAD #1): I know for me you text me and that doesn't wake me up in the night, did you call or text [FPC #1]?"-[HM #1]: I did both. I didn't have a sitter so I couldn't come in."-IO (FAD #1): Did you call [LPN (Licensed Practical Nurse) #1] to let her know?"-[HM #1]: No, but I called [FPC #1]."-[FPC #1]."-IO (FAD #1): What happened (sic) [client A]?"-[FPC #1]: [Client A] was throwing up and [HM #1] never called me. [RD #1] asked to see my call log and she never called me since 8:45 (pm) (sic)."-IO (FAD #1): Did you hear from her after?"-[FPC #1]: No, she never called me again."-Findings:"-1. [Client A] was sick and needed to go to the hospital."-2. The house manager was supposed to take the consumer to the hospital."-3. House manager did not show up."-4. House manager said she tried to call but no one could help her."-5. No one says that the house manager called for help."-6. [Client A] did not go to the ER until the next morning..."-...Also written statement</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>form [HM #1] attached..."-"...(written statement from HM #1) On Monday 11/29 (2021) around 9:30p [staff #4] reported [client A] was still not feeling well vomiting as well as not keeping meds down. I (HM #1) contacted nurse [LPN #1], she said to take her back (to the ER). I let [FPC #1] know I had no one to stay with kids I couldn't take her so (sic) no reply from [FPC #1]. I contacted [FAD #1] to let her know situation. The next morning...I took [client A] to the ER. Stayed with her until around 10 pm when they admitted her."-(signature of HM #1) 12/2/21..."-"...[HM #1]: 12-9-21."-"IO (QIDP #1): In reviewing the notes it says that you texted [FAD #1] and [FPC #1]"-"[HM #1]: Yes, I texted [FAD #1], [FPC #1], and [LPN #1]."-"IO (QIDP #1): Did anyone answer you?"-"[HM #1]: Nothing from [FPC #1]. I texted [FAD #1] at 10:30pm and she texted me back at 6:04am. [FAD #1] told me that she does not hear text messages. [LPN #1] had texted me at 9:34pm and we texted back and forth until 9:40-10pm. [LPN #1] said to make sure they don't release her if she can't eat and keep food down."-"IO (QIDP #1): Did you attempt to call anyone?"-"[HM #1]: No, my phone was off I could only text."-"IO (QIDP #1): Did you try to text anyone else?"-"[HM #1]: [FPC #1]."-"IO (QIDP #1): Did you try to text [RD #1] or [QIDP #1]"-"[HM #1]: No."-"IO (QIDP #1): Did [LPN #1] text</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>you back."-[HM #1]: No, we had talked earlier through text. I had texted [FCP #1] 5 times, but she never texted me back..."</p> <p>-"...[Staff #4]: 12-9-21..."-"...IO (QIDP #1): When you left, she was in her wheelchair?"-[Staff #4]: Yes."-"IO (QIDP #1): Did you get any calls from anyone to get [client A] to (sic) hospital?"-[Staff #4]: No, but [HM #1] said she was coming at 1am as she was looking for a babysitter. Once I left, I didn't hear anything from anyone. I left between 10:45p-11ish."-[FPC #1]: 12-9-21."-"IO: (QIDP #1): Did you receive any texts from [HM #1]?"-[FPC #1]: Remember that I came in the next day and found out that [client A] hadn't gone. I did not receive any text from [HM #1] except on 11/29 (2021) at 10:16pm stating that she was not going to be able to get there until about 1ish (1:00 AM) and then at 10:21pm that she couldn't take her."-"IO (QIDP #1): Did you respond to those texts?"-[FPC #1]: I didn't see the texts until the next morning."-"IO (QIDP #1): I checked the phone and did not see any other text messages from [HM #1]..."-"IO (QIDP #1): When [client A] came home the 1st time on Monday who brought her home?"[FPC #1]: [HM #1]. The hospital had called and said she was ready to come home. I called [HM #1]...She brought her home around 4pm."-"IO (QIDP #1): Do you know if the hospital sent any diapers home with her?"-[FPC</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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]: No, I don't."-IO (QIDP #1): Did you get a report that [client A] was not sitting in her chair appropriately?"-[FPC #1]: The next morning when [HM #1] came in she reported to [FAD #1] that [client A] was not sitting in her chair correctly."-IO (QIDP #1): Did anyone report that they were afraid or having trouble changing [client A]?"-[FPC #1]: No."-IO (QIDP #1): Did [staff #6] or anyone report that [client A] was in her chair not her bed?"-[FPC #1]: No."-[Staff #6]: 12-9-21."-IO (QIDP #1): Did [HM #1] ever call or text you with any plans on what was going on with [client A]?"-[Staff #6]: No, she did text at 4am and said that she would be in in the morning and she was."-IO (QIDP #1): Did you contact anyone?"-[Staff #6]: No."-IO (QIDP #1): Should you have contacted someone?"-[Staff #6]: No."-IO (QIDP #1): Was [client A] in bed?"-[Staff #6]: No."-IO (QIDP #1): She was in her chair all night?"-[Staff #6]: Yes, I thought she was going to the ER, so I left her in her chair."-IO (QIDP #1): How did [client B] slide her butt down from the seat of the chair to the footrest?"-[Staff #6]: I don't know how that happened? She wasn't like that when I was there. I checked on her throughout the night..."-IO (QIDP #1): Do you have consumer specific training?"-[Staff #6]: Yes at [name of different group home]."-IO (QIDP #1): Anywhere</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>else?"-[Staff #6]: No, the lady that was there with me changed [client B] before she left."-IO (QIDP #1): After [HM #1] called at 4 (am), do you think you should have called someone?"-[Staff #6]: I had texted [HM #1] like 7 times. She never answered."-IO (QIDP #1): If you don't get an answer you have to go up the chain of command to talk to someone. It is important that we follow instructions given by the nurse. You should have called [FPC #1], then [FAD #1], then [RD #1]-chain of command."-[Staff #6]: So, I am to follow the chain of command until I get a hold of someone?"-IO (QIDP #1): Yes, for emergencies."-IO (QIDP #1): Do you have training on the Hoyer Lift?"-[Staff #6]: No."-Training Reviewed: 12-9-21..."-[Staff #6]: CST training [different group home] 12-1-18 and C111 12/9/18..."-IO NOTE: 12-9-21."-This IO (QIDP #1) received a text message from the nurse [LPN #1] at 9:55pm on 11/29/21 that she (LPN #1) was sending [client A] to the ER, unable to keep anything down. No other calls or texts received from anyone..."-[LPN #1]: 12-10-21."-See attached written statement..."-(written statement from LPN #1) Nov (November) 29th 7pm, [staff #4] called me and told me that [client A] was having n/v (nausea/vomiting) and she was having trouble getting [client A] to keep any meds down. I encouraged her to hold the 7p</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>meds and give Zofran then if she kept the Zofran down, then try her meds at 8p. [Staff #4] then called back and said that she (client A) couldn't keep anything down. Instructed [staff #4] to call [HM #1] or [FPC #1] and get [client A] to the hospital since she had already had (sic) been seen earlier for seizure activity. I was concerned that her seizures would continue since we weren't getting adequate fluids in her. It wasn't until the next morning in the office that [HM #1] said that she had never taken [client A] to the hospital because she didn't have staff. I asked her if [FPC #1] knew and she (HM #1) said yes and that [FPC #1] hadn't done anything about it to help her."-(signature of LPN #1)..."-[LPN #1]: 12-10-21."-IO (QIDP #1): Who did you contact regarding [client A] to go (sic) to the ER besides [HM #1]?"-[LPN #1]: I did not contact [HM #1]. I was in contact with [staff #4]. I let [DON (Director of Nursing) #1] know what was going on and I sent you (QIDP #1) a text."-IO (QIDP #1): Did [client #4] then call [HM #1]?"-[LPN #1]: She (client #4) made contact with whoever."-IO (QIDP #1): Who were you supposed to contact for [client A] going to the ER?"-[LPN #1]: Staff contacted the Manager, the Manager contacts [FPC #1] or whomever and above. I always contact [DON #1]..."-...Findings:"-1. [Staff #4] states that she changed [client A], [staff #6] did not see</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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
	[client #4] change her and [HM #1] said she had the same diaper/depends was on in the morning."-2. [Staff #6] did not change [client #4] overnight and left her sitting in her wheelchair."-3. [Staff #6] does not know anything about [client A] not being in her chair correctly, she was when he left per him. [HM #1] says that [client A] was not seated correctly when she arrived."-4. [HM #1] did not call anyone as phone was not working only texted [FPC #1], [FAD #1], and did not use chain of command any further up the chain when she did not get a response."-5. [HM #1] was not able to take [client A] to the hospital as she could not find a babysitter but did not call anyone as phone was down, she did attempt to text [FPC #1] and [FAD #1] but did not use chain of command and these texts were made before 11pm."-6. [LPN #1] only contacted [DON #1] (phone), [QIDP #1] (text) and [staff #4] (by phone and text). [LPN #1] did not contact the PC/PD..."A review of the ISF dated 12/10/21 indicated only one staff was working during the overnight shift on 11/29/21. The review indicated staff #6 had not completed CST or site specific training prior to working at the group home. The review indicated staff did not immediately implement instructions given by LPN #1 to have client A taken to the hospital. The review did indicated LPN #1 did not follow up with staff to ensure			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>instructions given to taken client A to the hospital were implemented in a timely manner. Client A's Patient Summary Report dated 12/4/21, was reviewed on 12/22/21 at 10:11 AM. The review indicated client A was admitted to [name of hospital] on 11/30/21 at 2:19 PM. The review indicated client A was diagnosed with acute kidney injury and vomiting. The review indicated the acute kidney injury was likely related to her (client A's) recent vomiting and medication usage. Staff #4 was interviewed on 12/22/21 at 12:03 PM. Staff #4 was asked about the evening events at the the group home on 11/29/21. Staff #4 indicated when she arrived to work on 11/29/21 client A was not home. Staff #4 indicated she was at the hospital due to being sick in the morning. Staff #4 indicated client A returned to the group home sometime between 3-4 PM. Staff #4 indicated she called HM #1 and told her she (staff #4) was having issues with client A taking her 4 PM medications. Staff #4 stated, "[HM #1] was going to call the nurse and I pushed (held) the medications until 4:30 PM and tried to give her (client A) the meds again and she (client A) got them down. I called [HM #1] again she said to call [LPN #1]. [LPN #1] instructed me to give her soft foods and fluids. [LPN #1] told me to hold her 6 PM meds and crush her 8 PM meds." Staff #4 stated, "Every time I tried to give her (client A) her 8 PM meds, she would</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>refuse. I tried to give her dinner and she refused. I called [LPN #1] back and [LPN #1] said best bet would be to take her to the hospital if she (client A) couldn't keep her meds down and was not eating." Staff #4 was asked what communication occurred after the instructions were given for client A to go to the hospital. Staff #4 indicated she had communicated with HM #1 and HM #1 had indicated she (HM #1) was going to be coming in to take client A to the hospital. Staff #4 indicated she told HM #1 she would stay with client A until her relief arrived. Staff #4 was asked if client A had experienced any more vomiting or nausea throughout the evening. Staff #4 indicated she (client A) had only vomited one time between when she (client A) came back to the hospital and when staff #4 left around 11:00 PM. Staff #4 indicated client A was experiencing dry heaving throughout the night and was refusing to allow anything around her mouth. Staff #4 was asked if any other communication was made with LPN #1 after the initial instructions were given for client A to go to the hospital. Staff #4 stated, "No." Staff #4 indicated staff #6 arrived around 10 PM and he (staff #6) called FPC #1 and told FPC #1 client A was sick and FPC #1 indicated HM #1 was coming in at 1 AM to take her (client A) to the hospital. Staff #4 was asked if any communication was made with LPN #1 to discuss the plan for transportation of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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 A to the hospital or if other arrangements needed to be made. Staff #4 indicated no. Staff #4 was asked if any discussion of calling an ambulance to transport client A to the hospital was presented due to HM #1 not being able to come in until at least 1 AM. Staff #4 indicated there was no discussion regarding calling an ambulance. Staff #6 was interviewed on 12/22/21 at 12:58 PM. Staff #6 was asked about the events that occurred on the evening of 11/29/21. Staff #6 indicated when he arrived to work he was told that HM #1 was going to be coming in to take client A to the hospital because she was sick. Staff #6 was asked if he contacted anyone when HM #1 did not arrive at 1 AM to take client A to the hospital. Staff #6 indicated he did not. Staff #6 stated, "I did not have anyone else's number from the home. I just kept trying to call [HM #1]." Staff #6 was asked if he had completed CST for the clients or site specific training for the group home. Staff #6 indicated he had not. Staff #6 stated, "I was informed the same day and same evening about the shift to cover it. [FPC #1] contacted me about working. When I spoke to [FPC #1] I did tell her that was a house I was not trained in. I don't think she said anything back in response to me telling her that I was not trained." Staff #6 was asked how often he checked on client A throughout the night. Staff #6 indicated he checked on her about</p>			

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  12/30/2021
--	---	--	---

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

(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>every 15-20 minutes throughout the night. Staff #6 indicated she was kept in her wheelchair throughout the night as he was told she was going to be going to the hospital so they didn't lay her down. Staff #6 was asked if client A had gotten sick during his overnight shift. Staff #6 indicated she had not experienced any vomiting or dry heaving incidents overnight. HM #1 was interviewed on 12/21/21 at 11:12 AM. HM #1 was asked about the events that occurred on the evening of 11/29/21. HM #1 indicated she was contacted by staff #4 who reported client A wouldn't take her medications and couldn't keep them down. HM #1 indicated staff #4 reported client A was gagging when staff #4 would attempt to put the medications up to her mouth. HM #1 stated, "I contacted [FPC #1], [FAD #1], and [LPN #1]. At the time my phone was off so I was using a text app (application)." HM #1 was asked if instructions were given for client A to be taken to the hospital. HM #1 indicated yes. HM #1 indicated she had planned to go in and take client A to the hospital, but had issues with getting some personal arrangements taken care of and was unable to come in. HM #1 indicated she attempted to contact FPC #1, FAD #1, and LPN #1 during the night via text message to let them know she (HM #1) was not going to be able to come in to take client A and she did not receive any responses.</p>			

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  12/30/2021
--	---	--	---

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

(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>HM #1 indicated she went to the group home on the morning of 11/30/21 and took client A to the hospital at around 9:30 AM. HM #1 indicated client A did not vomit at any point in the morning or at the ER. LPN #1 was interviewed on 12/22/21 at 2:15 PM. LPN #1 was asked about the events that occurred on the evening of 11/29/21. LPN #1 indicated she spoke with staff #4 on at least 3 occasions regarding trying different things to help client A keep her meds down. LPN #1 stated, "After the 8 PM meds when she (client A) couldn't keep them down, around 8-8:30 PM the decision was made to take her to the hospital. I told [staff #4] to call [HM #1] and [FPC #1] and she (client A) need to go to the hospital." LPN #1 was asked what the plan was for client A to be transported to the hospital. LPN #1 indicated after the instructions were given for client A to be taken to the hospital she (LPN #1) was not communicated with again by any staff. LPN #1 indicated she had contacted DON (Director of Nursing) alerting her of the situation and attempted to contact QIDP #1 via text message. LPN #1 indicated she was not made aware of client A not going to the hospital until the morning of 11/30/21. LPN #1 was asked if a delay should have occurred in getting client A to the hospital after she (LPN #1) had given the instructions. LPN #1 stated, "No, the expectation is that if a client is instructed</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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
	to be taken to the hospital, then it needs to be done immediately." LPN #1 was asked if she attempted to follow-up with any of the staff at the group home during the night to ensure client A was transported to the hospital. LPN #1 indicated she did not assess client A. QIDP #1 and RD #1 were interviewed on 12/27/21 at 11:01 AM. RD #1 was asked if directions were given from the facility nurse for a client to be taken to the hospital for evaluation, when should this directive be carried out. RD #1 stated, "Should be carried out immediately." QIDP #1 was asked if issues arise and staff are unable to complete tasks instructed for them to do in a timely manner, what communication should occur. QIDP #1 indicated staff should utilize the chain of command calling. QIDP #1 stated, "Staff should be calling and notifying the PC (Program Director) and move up the chain from there." RD #1 was asked if a nurse or supervisor were to give instructions to staff pertaining to the care and/or health and safety of the clients, what expected follow up should occur and in what timeframe should this occur. RD #1 stated, "The nurse should be closing the loop. She (nurse) should be making follow up calls and making sure instructions were followed through." RD #1 was asked if the proper follow up by the nurse occurred on the evening of 11/29/21. RD #1 stated, "No."The facility's policy and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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 0153  Bldg. 00	<p>procedures were reviewed on 12/22/21 at 3:27 PM. 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."This federal tag relates to complaint #IN00368233 and complaint #IN00368243.9-3-2(a) 483.420(d)(2)</p> <p>STAFF TREATMENT OF CLIENTS 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 of 5 investigations reviewed, the facility failed to ensure a verbal abuse and elopement incident involving client B was reported immediately to administration.</p> <p>Findings include:  The facility's BDDS (Bureau of Developmental</p>	W 0153	The Sequential Call list policy was updated 01/2022 and employee training was completed. The policy provides more detailed clarification for supervising staff on shift and professional staff regarding notification of appropriate parties and corresponding time frames	01/18/2022

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  12/30/2021
--	---	--	---

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

(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>Disabilities Services) reports and investigations were reviewed on 12/20/21 at 11:15 AM.</p> <p>A BDDS report dated 11/30/21 indicated the following:</p> <p>- "...Submitted Date: 11/30/21..."</p> <p>- "...Section III - Incident Information."</p> <p>- "Incident Date."</p> <p>- "11/26/21."</p> <p>- "Time."</p> <p>- "9:46 PM."</p> <p>- "Date of knowledge."</p> <p>- "11/29/21..."</p> <p>- "...[Client B] reported to [HM (House Manager) #2] on 11/29/21 that on Friday 11/26/21 the staff person working, [staff #1], had given him a hard time and had slapped consumer [client C] on the face. It was also reported that [staff #1] called the police due to [client B] leaving the house without staff, being out of sight for approximately 5 minutes before returning on his own. [Client B] does not have alone time in the community. [Client B] does have a formal behavior plan with target behavior of false reporting. [Client C] was checked for injury/bruising and nothing was found. The police ensured everyone's safety when they arrived and spoke with both staff [staff #1] and consumer [client B]. [Staff #1] has been suspended pending the outcome of an investigation..."</p>		<p>required. Staff were trained on 12/17/21 by the QIDP regarding incident reporting and proper notification to administration for any allegation of abuse and neglect.</p>	

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  12/30/2021
--	---	--	---

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

(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>A review of the BDDS report dated 11/30/21 indicated the incident occurred on 11/26/21 and was not reported to the administration until 11/29/21.</p> <p>An ISF (Investigation Summary Form) dated 12/2/21 indicated the following:</p> <p>"...On 11/29 it was reported that [staff #1] hit [client C] and yelled at [client B]. 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: 11-29-21."</p> <p>"This alleged incident was reported by [HM #2] to this IO on 11-29-21. She reported that [client B] had told her while doing transport that [staff #1] was mean to him yelling and telling him to go to his room. [Client B] also reported that [staff #1] has (sic) slapped [client C] on the face..."</p> <p>"...Findings:"</p> <p>"1. It was not reported to this IO that [client B] had left the property until there were further allegations made and presented on 11-29-21 which included an allegation of a consumer getting slapped..."</p> <p>"...6. The police were called to the home by [staff #1]."</p> <p>"7. [Client B] did leave the premises for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>approximately 5 minutes; he was not in eyesight."</p> <p>"8. [Client B] returned to the home on his own...".</p> <p>"...10. [Staff #3] had been told by [client B] that [staff #1] was being mean to him, she did not hear that [client C] may have been slapped."</p> <p>"11. [Staff #3] said she was also told about what was going on by [HM #1], so she assumed that it was reported...".</p> <p>"...23. [HM #1] states that she did tell [FPC #1] that the police were called. [HM #1] states that [FPC #1] also knew about him leaving but only to the neighbors and back."</p> <p>"24. [Staff #2] was told by [client B] that [staff #1] was mean to him, she did not see anything as all was quiet when she arrived for work."</p> <p>"25. [Staff #2] was told by [client B] that [staff #1] has (sic) slapped [client A], not [client C]."</p> <p>"26. [Staff #2] did not report the allegations to anyone but the next shift."</p> <p>"27. This IO reviewed with [staff #2] the importance of reporting and who to report to...".</p> <p>"...Reviewer Recommendations:...".</p> <p>"...[Staff #3] must receive verbal counseling on reporting alleged abuse. She received documented training on this."</p> <p>"[Staff #2] must receive documented training on reportable incidents...".</p>			

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  12/30/2021
--	---	--	---

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

(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 0186  Bldg. 00	<p>HM #1 was interviewed on 12/21/21 at 11:12 AM. HM #1 was asked if an elopement incident and 911 being called and visiting the home would be considered a reportable incident. HM #1 stated, "Yes." HM #1 was asked when should an allegation of verbal abuse be reported to administration. HM #1 indicated it should be reported immediately.</p> <p>QIDP #1 and RD (Regional Director) #1 was interviewed on 12/27/21 at 11:01 AM. QIDP #1 was asked when should an allegation of verbal abuse, and an elopement incident with police involvement be reported. QIDP #1 stated, "Immediately to administration and then within 24 hours of the knowledge to BDDS." QIDP #1 was asked if the elopement incident involving client B with police involvement was reported appropriately. QIDP #1 indicated staff did not report the incident in a timely manner to me. QIDP #1 stated, "I (QIDP #1) am the one who completes the BDDS reports and I was not made aware of the incident until 11/29/21."</p> <p>This federal tag relates to complaint #IN00368233.</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>			

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  12/30/2021
--	---	--	---

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

(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>Based on record review and interview for 2 of 2 sampled clients (clients A and B), the facility failed to ensure the group home was adequately staffed during an elopement incident involving client B and during a need for medical intervention involving client A.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/20/21 at 11:15 AM.</p> <p>1. A BDDS report dated 11/30/21 indicated, "... [Client B] reported to [HM (House Manager) #2] on 11/29/21 that on Friday 11/26/21 the staff person working, [staff #1], had given him a hard time and had slapped consumer [client C] on the face. It was also reported that [staff #1] called the police due to [client B] leaving the house without staff, being out of sight for approximately 5 minutes before returning on his own. [Client B] does not have alone time in the community. [Client B] does have a formal behavior plan with target behavior of false reporting. [Client C] was checked for injury/bruising and nothing was found. The police ensured everyone's safety when they arrived and spoke with both staff [staff #1] and consumer [client B]. [Staff #1] has been suspended pending the outcome of the investigation...".</p> <p>An ISF (Investigation Summary Form) dated 12/2/21 indicated the following:</p> <p>"...On 11/29 (2021) it was reported that [staff #1] hit [client C] and yelled at [client B]. Investigate to determine the facts and make recommendations to prevent further recurrence."</p>	W 0186	The Program Coordinator is responsible for generating a monthly staff schedule. It will be verified by the AD to ensure that adequate coverage is scheduled. Professional staff will complete unscheduled pop-in visits three times per week for three weeks to verify that adequate staffing levels are present within the home. Unannounced visits will titrate down to two times per week for on-going compliance verification.	01/30/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>-"Name of Staff Assigned as IO (Investigation Officer)."</p> <p>-"[QIDP (Qualified Intellectual Disabilities Professional) #1]..."</p> <p>-"...IO Note: 11-29-21."</p> <p>-"This alleged incident was reported by [HM #2] to this IO on 11-29-21. She reported that [client B] had told her while doing transport that [staff #1] was mean to him yelling and telling him to go to his room. [Client B] also reported that [staff #1] has (sic) slapped [client C] on the face."</p> <p>-"[HM #2]: 11-29-21."</p> <p>-"See written statement attached."</p> <p>-"(handwritten statement by HM #2) [HM #1] called me Friday (11/26/21) telling me to get to [name of group home] because [staff #1] had called the police on [client B]. When I got there the police was (sic) leaving. I had a talk with [client B], then I left. Today I was in the day hab (habilitation) talking to [client B]. He told me the (sic) [staff #1] was giving him a hard time. Then he went on telling me [staff #1] had slapped [client C]. I asked him did he tell anyone. He said he told [staff #2] that same night and he said he told [staff #3] this morning, but she didn't believe him so I told him I was gone (sic) make sure someone would know about it so I reported it to [QIDP #1]..."</p> <p>-"...[HM #2]: 11-29-21."</p> <p>-"IO: You (HM #2) were called to the home on Friday?"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>-"[HM #2]: Yes, [HM #1] called and asked if I could go and help as [client B] was upset and went outside."</p> <p>-"IO: Where was [client B] when you got there?"</p> <p>-"[HM #2]: He was at the house; I was told that he had just returned, and the Police had just left."</p> <p>-"IO: Why were the police there?"</p> <p>-"[HM #2]: [Staff #1] had called the police as [client B] was upset yelling and threatened to leave. [HM #1] asked me to come over and help as I was closer that she was, she was 45 minutes away."</p> <p>-"IO: Do you know what the police said?"</p> <p>-"[HM #2]: No, they were gone by the time I got there."</p> <p>-"IO: Do you know if anyone reported this allegation to anyone?"</p> <p>-"[HM #2]: Not sure, I think [HM #1] knew."</p> <p>-"IO: You didn't call anyone?"</p> <p>-"[HM #2]: [Client B] said he told [staff #2], I got there at 9:30pm. I called [HM #1] as [client B] was upset about getting his evening medication and it was in the med (medication) cup on the med counter. [HM #1] said she had not given it, so I gave it."</p> <p>-"IO: How was [client B] when you got there?"</p> <p>-"[HM #2]: He was calm, so I left after giving him his medications."</p>			

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  12/30/2021
--	---	--	---

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

(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>- "IO NOTE: 11-29-21."</p> <p>- "[FPC (Former Program Coordinator) #1] had reported to this IO that [client B] had taken off on Friday as he was upset about not getting his medications on time. [Client B] had left the property but was in eyesight and had only gone to the neighbors and back. [FPC #1] was asked about police involvement, and she said she was not told that there was any police involvement."</p> <p>- "[Client B]: 11-29-21."</p> <p>- "IO: Tell me what was going on."</p> <p>- "[Client B]: [Staff #1] threatened me to call the police if I didn't (sic) couldn't be quiet. I ran away but I decided to come back on my own. I walked down the street and thought to myself that I should just face my fears and go back to the house."</p> <p>- "IO: What happened when you got back to the house?"</p> <p>- "[Client B]: I said I wanted to call the police, but she had already called them and said they were on their way."</p> <p>- "IO: Anything else happen?"</p> <p>- "[Client B]: When I walked into the door, I saw [staff #1] slap [client C] in the face. [Client C] was being loud and yelling and she was just slapped her. [Staff #1] told me to sit down."</p> <p>- "IO: Where was [client C] at?"</p> <p>- "[Client B]: She was in the hallway where her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>room is at."</p> <p>-"IO: Where was [client D]?"</p> <p>-"[Client B]: She was in her room."</p> <p>-"IO: Where was [client A]?"</p> <p>-"[Client B]: She was in her room."</p> <p>-"IO: Tell me about the police."</p> <p>-"[Client B]: The police came after I got back to the house. I told her I wanted to call them, but she (staff #1) said to sit down and be quiet they were already called and on their way."</p> <p>-"IO: Why were you upset?"</p> <p>-"[Client B]: She kept telling me to be quiet. I just wanted to know about getting my med's (medications). I threw her milkshake at her, and she yelled at me to clean it up."</p> <p>-"IO: Did you clean it up?"</p> <p>-"[Client B]: Yes, I did. I got upset as it seemed that she yelled and shouldn't be working in this field. She kept telling me to go to your (sic) room and wait when I asked about my med's. I told her all she cares about is the money. She told me to shut up and go to my room."</p> <p>-"[Client D]: 11-29-21."</p> <p>-"IO: What happened on Friday night with [staff #1]?"</p> <p>-"[Client D]: [Staff #1] hit [client C]."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>- "IO: Did you see her hit [client C]?"</p> <p>- "[Client D]: She pursed her lips and said yes."</p> <p>- "IO: How did she hit her?"</p> <p>- "[Client D]: She (client D) shrugged her shoulders..."</p> <p>- "...IO: What was going on with [client B]?"</p> <p>- "[Client D]: She (staff #1) was giving him (client B) a hard time..."</p> <p>- "...IO: Why is she (staff #1) a bad girl?"</p> <p>- "[Client D]: [Staff #1] gets on my nerves, she has no patience..."</p> <p>- "...[Staff #1]: 11-29-21."</p> <p>- "See written questions and answers during interview..."</p> <p>- "...(written questions and answers with staff #1) IO: Tell me what happened on Friday (11/26/21)</p> <p>- "[Staff #1]: Friday? With [client B]?"</p> <p>- "IO: Yes."</p> <p>- "[Staff #1]: [HM #1] called me in and I was working. [Client B] had come (sic) out of his room. He asked me who was giving meds. I didn't find out until I talked to [HM #2] that [HM #1] had passed all meds but [client B's]. At that point, I understood why [client B] was upset. I just kept telling him I don't know when he kept asking me. He got very mad. I told him I wasn't med (medication) passed, there was nothing I could</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>do....He gets mad and he sits on the couch. You always tell me it's their home and I understand that. But what you aren't going to do is sit three feet from me and yell at me. I told him to go to his room until he calmed down because he wasn't going to talk to me like that. He says he is going to get me fired. I told him okay, please do. He then goes to his room. Comes back. He says he is going to leave. I stand in front of the door, but they have 'f----- three doors in [name of group home]' and he gets out another door. I called [HM #1] and then was like 'nevermind, I should be calling the cops'. And I call (sic) them. [Client C] is also crying because she's 'sh---- and wants to go to bed.' I was all by myself, what was I supposed to do? I can't be my best self if I'm the only person. I didn't raise my voice once or threaten him. Maybe to him I did, I am who I am. But I didn't raise my voice. He threw a shake at me and hit me with a wet mop. The cops can attest to that. I understand he has issues, but I don't think anything I did made him act in that manner."</p> <p>-"IO: When he was upset and yelling at you, what did you say?"</p> <p>-"[Staff #1]: I encouraged him to take a break in his room. When he said he was going to call his guardian and [HM #1], I told him 'please do.' When he called the police, I told him that we weren't going to waste resources, there's already a car on the way. It's their right to use the phone, but I did tell him that we aren't going to call 911 when they're already on their way."</p> <p>-"IO: I know that [client B] talks a lot. Was he really talking to you a lot?"</p> <p>-"[Staff #1]: No, that's the thing. He was sitting in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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 chair mumbling to himself. I asked him what was wrong and then he got upset and said he wanted to get me fired. I told him I have to be able to see him, but we don't have to be in the same room. I told him I had to be in the living room, but he doesn't (sic) need to be in there with me. He chose to sit two feet away from me and have an attitude."</p> <p>-"IO: You said he had an attitude. What was he doing?"</p> <p>-"[Staff #1]: On his phone. He always tells me he doesn't like me. I don't know what it is about me personally but he just literally doesn't like me."</p> <p>-"IO: So the tone of voice you're using with me (a little worked up/raised), is that the tone you used with him?"</p> <p>-"[Staff #1]: No, I use a completely calm tone. I'm extra calm for that reason because they like to say I'm yelling at them."</p> <p>-"IO: What was [client D] doing?"</p> <p>-"[Staff #1]: She came out after the cops left and was wet. I asked her why she was wet and she told me she had just taken a shower."</p> <p>-"IO: Where was [client C]?"</p> <p>-"[Staff #1]: In her room, doing what she does, rolling around."</p> <p>-"IO: What was [client A] doing?"</p> <p>-"[Staff #1]: During the whole thing, [client A] was crying because she was ready to be put in bed. Later I found out she had pooped on herself</p>			

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  12/30/2021
--	---	--	---

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

(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>and smelled like urine. Here's what happened. When I got to the home, [HM #1] told me someone would be there at 8. When I got there, she (client A) didn't smell so I think during that hour when things were happening, she pooped and peed multiple times. This whole time she was crying saying she wanted to get into bed. I was told to just get there (between 6 and 6:15) and just sit until the next person showed up at 8pm. I didn't want to help [client A] get into bed because I didn't want to try to get her in bed and accidentally drop her or snap her shoulder. That's a liability. Then [HM #2] came in and asked me why [client A] was crying. That's when I realized she had defecated on herself. If I hadn't been lied to by [HM #1] and someone was coming in at 8pm, then I would have known and could have done my job. I was put in a really bad situation...I did the best that I could."</p> <p>- "IO: What reason were you called in?"</p> <p>- "[Staff #1]: [HM #1] told me she had a family emergency. She told me she was at the hospital with [girl's name]. She told me [HM #2] would be there before her."</p> <p>- "IO: What was going on with (sic) [HM #2] got there?"</p> <p>- "[Staff #1]: She (HM #1) had called her (HM #2) when [client B] went AWOL (leaving the group home without permission). Because I guess that's protocol because someone higher up than me (sic)."</p> <p>- "IO: What time did [client B] leave?"</p> <p>- "[Staff #1]: (looks through phone) I called 911 for the first time at 8:50pm. Mind you I was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>supposed to get off at 8pm."</p> <p>-"IO: How long was he gone?"</p> <p>-"[Staff #1]: Maybe 10 minutes."</p> <p>-"IO: Did you see him at all?"</p> <p>-"[Staff #1]: yes cause at first he knocked on the neighbor's door and I told him not to bother them. Then he headed north towards a [name of moving truck company]. I told the dispatcher I couldn't leave because I was alone with 3 other consumers inside."</p> <p>-"IO: How long was he gone?"</p> <p>-"[Staff #1]: Maybe 5 minutes. I think he got cold."</p> <p>-"IO: What did police say?"</p> <p>-"[Staff #1]: They asked me what I was doing. I told them I was staff. The cops calmed him down. He told them he was upset with their med's (sic). I said I couldn't control that. It's state regulated rules and if I go in that med cabinet, I will lose my job. I can help with anything but medicine, that's out of my hands. For the simple reason of I'm not med passed...that med pass bit, that's like literally the only thing I can't do (sic)."</p> <p>-"IO: Yeah, you can't do med's (sic). Do you have CST (Client Specific Training) for [name of group home]?"</p> <p>-"[Staff #1]: No."</p> <p>-"IO: Next time you're asked to work in a house and you aren't trained, tell them no until they give</p>			

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  12/30/2021
--	---	--	---

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

(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>you CST and site specific (training)."</p> <p>-"[Staff #1]: The whole thing was a set up."</p> <p>-"IO: What do you mean?"</p> <p>-"[Staff #1]: Because she ([HM #1]) knew that [staff #2] wasn't suppose to be in until 10pm. She knew that [client B] didn't have his meds. She knew that I didn't know he didn't have her (sic) meds."</p> <p>-"IO: Why would she set you up?"</p> <p>-"[Staff #1]: Not on purpose. But, she's an RM (Resident Manager), she should have told me these (sic) things...".</p> <p>-"...IO: At any point did you put your hands on [client B] or any other consumer?"</p> <p>-"[Staff #1]: No...".</p> <p>-"...[Client A]: 11-29-21...".</p> <p>-"...IO: Did you see anyone get slapped?"</p> <p>-"[Client A]: No...".</p> <p>-"...[Client B]: 11-29-21 at home."</p> <p>-"IO: [Client B] did you really see [staff #1] slap someone."</p> <p>-"[Client B]: Yes, I was coming in the house from having left and when I walked in I saw her (staff #1) slap [client C]."</p> <p>-"IO: Was [client C] upset or yelling?"</p>			

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  12/30/2021
--	---	--	---

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

(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 B]: She was making noise, [staff #1] just walked up to her and slapped her."</p> <p>-"IO NOTE: 11-29-21."</p> <p>-"This IO checked [client C] for any bruising or injuries, none noted. This IO also checked [client A] over for any bruising or injuries as a precaution as [staff #1] said that [client A] was upset and [client C] was not. [Client B] and [client D] said it was [client C] that was yelling and was slapped...".</p> <p>-"...[Staff #3]: 12-1-21."</p> <p>-"IO: Did anyone say anything to you about an incident going on this past weekend?"</p> <p>-"[Staff #3]: [Client B] said things about [staff #1]."</p> <p>-"IO: When did he say something to you?"</p> <p>-"[Staff #3]: He said something on Saturday (11/27/21)."</p> <p>-"IO: What did he say?"</p> <p>-"[Staff #3]: He said that [staff #1] was being very mean to him and that he poured water on her."</p> <p>-"IO: Did you report this to anyone?"</p> <p>-"[Staff #3]: No, he said something all weekend. I assumed that everyone knew."</p> <p>-"IO: You can't assume."</p> <p>-"[Staff #3]: [HM #1] told me what happened, so I thought everyone knew."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>- "IO: Did you hear anything about a consumer being slapped?"</p> <p>- "[Staff #3]: No."</p> <p>- "[HM #1]: 12-1-21."</p> <p>- "IO: You had [staff #1] relieve you?"</p> <p>- "[HM #1]: Yes."</p> <p>- "IO: What time was she supposed to get off?"</p> <p>- "[HM #1]: 8pm when [staff #2] arrived for work."</p> <p>- "IO: [Staff #2] didn't come until 10pm."</p> <p>- "[HM #1]: I just got it changed to 8pm last night."</p> <p>- "IO: When were you told about the incident?"</p> <p>- "[HM #1]: I was told a little after 8pm."</p> <p>- "IO: What were you told?"</p> <p>- "[HM #1]: I was told that [client B] ran away and 911 was called. [Staff #1] hung up and then called back to say [client B] was back. I called [HM #2] and had her go over to help out as I was not in town."</p> <p>- "IO: Did [client B] make any allegations to you?"</p> <p>- "[HM #1]: No, I really think it was the way that [staff #1] addressed him, the way she talked to him."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>- "IO: Who did you report it to?"</p> <p>- "[HM #1]: I reported it to [FPC #1]."</p> <p>- "IO: What did you tell her?"</p> <p>- "[HM #1]: That [client B] ran (sic) only went to neighbors and back was in eyesight."</p> <p>- "IO: Who told you that?"</p> <p>- "[HM #1]: [Staff #1] told me."</p> <p>- "IO: Was [FPC #1] told that the police were involved?"</p> <p>- "[HM #1]: Yes."</p> <p>- "[Staff #2]: 12/2/21."</p> <p>- "IO: How were things when you arrived at work, what was the atmosphere?"</p> <p>- "[Staff #2]: Things were calm. [Staff #1] did ask me what time I was supposed to be at work. I told her 10pm. [Staff #1] said that she was supposed to be off at 8pm."</p> <p>- "IO: Was anything going on with the consumers when you arrived?"</p> <p>- "[Staff #2]: No, but that is the day that [client B] ran off."</p> <p>- "IO: Where were all the consumers, were they in bed?"</p> <p>- "[Staff #2]: No, [client A] and [client C] were in bed but [client D] and [client B] were up."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>- "IO: What was the client's mood (sic)?"</p> <p>- "[Staff #2]: [Client B] was upset about what had gone on."</p> <p>- "IO: Did he say anything?"</p> <p>- "[Staff #2]: He said that he was upset with [staff #1], the police were called...[Client B] states he doesn't like [staff #1], she is mean to him."</p> <p>- "IO: Did he say anything about anyone being hit?"</p> <p>- "[Staff #2]: [Client B] said that [staff #1] hit [client A]."</p> <p>- "IO: Did you see any injury or anything?"</p> <p>- "[Staff #2]: No but I did ask [client A] if anyone was being mean to her, and she said no. I looked at her and there were no marks or injuries that I could see."</p> <p>- "IO: Did you report it to anyone?"</p> <p>- "[Staff #2]: I told [staff #3] when she came in...".</p> <p>- "...Review of Training Data Base for [staff #1]: 12-1-21."</p> <p>- "The following trainings are not recorded on the training data base: C111 (Respect Training), Road Test, CPI (Crisis Prevention Intervention), and site-specific training. She has consumer specific training for [different group home] and CPR (Cardiopulmonary Resuscitation).</p> <p>- "Findings:"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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. It was not reported to this IO that [client B] had left the property until there was (sic) further allegations made and presented on 11-29-21 which included an allegation of a consumer getting slapped."</p> <p>-"2. [Client B], [client D] state that [staff #1] had slapped [client C] on the face."</p> <p>-"3. This IO checked on [client C] and did not find any injury or bruising present when checked on Monday 11-29-21 and again on Tuesday 11-30-21."</p> <p>-"4. There were no other staff working during the alleged incidents."</p> <p>-"5. [Staff #1] was working from 6:30pish (sic) -10p (PM) when she was relieved, however, she was told she was only working until 8pm."</p> <p>-"6. The police were called to the home by [staff #1]."</p> <p>-"7. [Client B] did leave the premises for approximately 5 minutes; he was not in eyesight."</p> <p>-"8. [Client B] returned to the home on his own."</p> <p>-"9. [Staff #1] called and reported to [FPC #1], according to [FPC #1] that [client B] was upset and had gone outside, not that he left the premises."</p> <p>-"10. [Staff #3] had been told by [client B] that [staff #1] was being mean to him, she did not hear that [client C] may have been slapped."</p> <p>-"11. [Staff #3] said she was also told about what was going on by [HM #1], so she assumed that it</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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 reported."</p> <p>- "12. [Client B] states that [staff #1] was mean to him telling him to go to his room. [Client D] states that [staff #1] was giving [client B] a hard time..."</p> <p>- "14. [Client B] did spill [staff #1's] milkshake, he states that he was yelled at to clean it up..."</p> <p>- "...16. [Staff #1] did state that [client B] was not going to sit three feet from me (staff #1) and yell at me."</p> <p>- "17. [Staff #1] admits that she told him (client B) to go to his room until he was calm."</p> <p>- "18. [Staff #1] claims several times that she didn't raise her voice, however, this IO questioned the tone of her voice in talking with me being the same as when talking to consumers..."</p> <p>- "...22. [Staff #1] states that she has not had CST training for [name of group home].</p> <p>- "23. [HM #1] states that she did tell [FPC #1] that the police were called. [HM #1] states that [FPC #1] also knew about him leaving but only to the neighbors and back."</p> <p>- "24. [Staff #2] was told by [client B] that [staff #1] was mean to him, she did not see anything as all was quiet when she arrived for work."</p> <p>- "25. [Staff #2] was told by [client B] that [staff #1] has (sic) slapped [client A], not [client C]."</p> <p>- "26. [Staff #2] did not report the allegations to anyone but the next shift."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>- "27. This IO reviewed with [staff #2] the importance of reporting and who to report to...".</p> <p>- "...Reviewer Recommendations:...".</p> <p>- "...[Staff #3] must receive verbal counseling on reporting alleged abuse. She received documented training on this."</p> <p>- "[Staff #2] must receive documented training on reportable incidents."</p> <p>- "[Staff #1] must receive Respect Training. Deadline 12/17."</p> <p>- "Staff must not work in a home without Consumer Specific Training and Site Specific Training for that house. This includes BSPs (Behavioral Support Plans) as well."</p> <p>- "(Signature of RD (Regional Director) #1)</p> <p>- "(handwritten by RD) RD #1 Additional Finding:"</p> <p>- "There was not enough information or consistency between individuals to substantiate that [staff #1] hit [client C]."</p> <p>- "[Client B] has a BSP with targeted behaviors of property destruction, verbal aggression, and intimidation. This BSP was not followed nor was [staff #1] trained on it...".</p> <p>An Incident Follow-Up Report dated 12/10/21 indicated the following:</p> <p>- "....Consumer Name: [Client B]...".</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>-"...It was substantiated that [staff #1] was verbally abusive to [client B]...Staff will receive further training on reportable incidents, CST training and training on behavior plans. [Staff #1] will receive the respect training and will not work in that house again..."</p> <p>A review of the ISF dated 12/2/21 indicated the group home was single staffed for a period of 4 hours on the evening of 11/26/21.</p> <p>Client B was interviewed on 12/20/21 at 9:38 AM. Client B was asked if any other staff were there when the incident occurred. Client B stated, "No."</p> <p>2. A BDDS report dated 12/1/21 (11:44 AM) indicated, "...An allegation was made that staff did not take [client A] to the ER quickly enough as instructed by the agency nurse. It was also alleged that she was not changed overnight and was not supported to sit in her chair appropriately. These allegations are being investigated to determine the facts and to make recommendations to prevent recurrence..."</p> <p>An ISF dated 12/2/21 indicated the following:</p> <p>-"...Name of Staff Assigned as IO."</p> <p>-"[QIDP #1]..."</p> <p>-"...Investigation Notes for [client A] 11/30/21..."</p> <p>-"...IO NOTE:"</p> <p>-"This IO received information that staff were instructed to take [client A] back to the ER (emergency room) on 11/29/21 and found out on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>11/30/21 that she had not been taken. [Client A] was taken to the ER on 11/30/21 where she was then later admitted. (This is a separate investigation into not going as instructed back to the ER on the 29th)...".</p> <p>-"...[Staff #4]: 12/1/21."</p> <p>-"IO: Was [client A] given her medications on Monday night 7p and 8p?"</p> <p>-"[Staff #4]: Let me think that was a couple of days ago. Yes."</p> <p>-"IO: What was going on that evening?"</p> <p>-"[Staff #4]: [Client A] did not get her medications; she was throwing up and I called the nurse. She said to hold the 7p Colace (stool softener) as it could not be crushed. She (client A) got her 4pm medications and I poured water into her mouth, and I thought she was going to choke. I patted her back and had her sit up straighter and she swallowed the medications. [LPN (Licensed Practical Nurse) #1] wanted us to crush the pills and put them in applesauce. [LPN #1] wanted to hold the 7pm medication and mouthwash and have her take some Zofran (to prevent nausea/vomiting) and then give her the medications later if the Zofran helped. When it was time to give the 8pm medications I gave [client A] some applesauce with no medications, and she appeared to not be able to swallow the medications."</p> <p>-"IO: What did you do then?"</p> <p>-"[Staff #4]: [LPN #1] said to give Zofran, but she threw it up. When I called [LPN #1] again, she stated that [client A] was going to the ER. I</p>			

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  12/30/2021
--	---	--	---

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

(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>assumed that since she was going, I was to hold the medications at that time so as not to choke her."</p> <p>-"IO: Do you know who was called for her to go?"</p> <p>-"[Staff #4]: I know [LPN #1] let me know and had called [HM #1] to get it set up. [HM #1] said that she was going to be there by 1am (11/30/21) to take [client A] as she was getting a sitter..."</p> <p>-"...Findings:"</p> <p>-"1. [Client A] did miss medications on the night of the 29th due to vomiting and not keeping anything down."</p> <p>-"2. [Staff #4] thought that [client A] was going to the ER as the nurse had instructed..."</p> <p>-"...6. [Client A] was admitted to the hospital on 11/30/21, after being evaluated in the ER..."</p> <p>-"...Reviewer Recommendations:..."</p> <p>-"...If staff notify the nurse directly, the nurse must communicate incident to the PC (Program Coordinator) and QIDP. If a consumer needs to go to the hospital, the PC and QIDP must be notified as well. The PC is then responsible for finding a staff member to immediately take the consumer..."</p> <p>-"...Staff must be trained on the chain of command and when to call the next in line due to unresponsiveness or inability to get a hold of the first person."</p> <p>-"(signature of RD #1)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>An ISF dated 12/10/21 indicated the following:</p> <p>-"...On 11/30 it was reported that [client A] was not taken to the ER when instructed, was left unchanged all night, and was left sitting in her wheelchair with her bottom where her feet should go. Investigate to determine the facts and make recommendations to prevent further recurrence."</p> <p>-"Name of Staff Assigned as IO: [FAD (Former Area Director) #1] and [QIDP #1]..."</p> <p>-"...IO NOTE: 12-8-21."</p> <p>-"This IO (QIDP #1) was given this investigation to complete as it was turned in by another investigating officer, who is no longer with the company, incomplete. This investigation originally was started on 11-30-21 and was turned in on 12/2/21."</p> <p>-"IO NOTE: 12-8-21."</p> <p>-"See attached investigation (12/2/21 investigation) from previous investigator..."</p> <p>-"...IO (FAD #1) Note: It was reported to this IO (FAD #1) that [HM #1] was to take [client A] to the hospital, and she never did."</p> <p>-"[Staff #4] via phone 11/29/21."</p> <p>-"IO (FAD #1): Tell me what happened with [client A]?"</p> <p>-"[Staff #4]: She was gagging (dry heaving per interview with staff #4 on 12/22/21) and making sounds all night. I couldn't get her to eat. The RM (Resident Manager) was supposed to come in and</p>			

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  12/30/2021
--	---	--	---

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

(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>take her to the ER."</p> <p>-"IO (FAD #1): Did you give her night meds to her?"</p> <p>-"[Staff #4]: No, I was under the impression that the RM was coming to take her to the ER and I couldn't even get her to eat."</p> <p>-"IO (FAD #1): Who came in for you when you left?"</p> <p>-"[Staff #4]: [Staff #6] and I showed him how to take care of her. I was afraid that she would have a seizure so I made sure that he knew how to handle her if she did. He (staff #6) called [HM #1] and she was going to be there at 1 (am), so I went ahead and left."</p> <p>-"[Staff #6] via phone 11/29/21:"</p> <p>-"IO (FAD #1): What happened with [client A]?"</p> <p>-"[Staff #6]: The lady before me said that she had been throwing up and gagging all night..."</p> <p>-"...IO (FAD #1): Did you notify anyone that she was throwing up and gagging?"</p> <p>-"[Staff #6]: Yes, we called the manager, [HM #1] and she said that she was going to be there at 1 am, but she never showed up until after I left the next morning."</p> <p>-"IO (FAD #1): Did you think to call someone else?"</p> <p>-"[Staff #6]: No, I thought she was going to come."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>- "IO (FAD #1): So you are aware, you should have then called the next step of leadership. That would have been [FPC #1], do you have her number?"</p> <p>- "[Staff #6]: Yes."</p> <p>- "IO (FAD #1): If you feel like it is an emergency you should call 911 and then call your PC/PD (Program Director)/AD (Area Director)."</p> <p>- "[HM #1] via phone 11/29/21:"</p> <p>- "IO (FAD #1): What happened with [client A]?"</p> <p>- "[HM #1]: She had been sick and she was supposed to go to the hospital."</p> <p>- "IO (FAD #1): Did you take her to the hospital?"</p> <p>- "[HM #1]: Yes the next morning, I had been trying to get a hold of you ([FAD #1]) or [FPC #1]."</p> <p>- "IO (FAD #1): I know for me you text me and that doesn't wake me up in the night, did you call or text [FPC #1]?"</p> <p>- "[HM #1]: I did both. I didn't have a sitter so I couldn't come in."</p> <p>- "IO (FAD #1): Did you call [LPN (Licensed Practical Nurse) #1] to let her know?"</p> <p>- "[HM #1]: No, but I called [FPC #1]."</p> <p>- "[FPC #1]."</p> <p>- "IO (FAD #1): What happened (sic) [client A]?"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>-"[FPC #1]: [Client A] was throwing up and [HM #1] never called me. [RD #1] asked to see my call log and she never called me since 8:45 (pm) (sic)."</p> <p>-"IO (FAD #1): Did you hear from her after?"</p> <p>-"[FPC #1]: No, she never called me again."</p> <p>-"Findings:"</p> <p>-"1. [Client A] was sick and needed to go to the hospital."</p> <p>-"2. The house manager was supposed to take the consumer to the hospital."</p> <p>-"3. House manager did not show up."</p> <p>-"4. House manager said she tried to call but no one could help her."</p> <p>-"5. No one says that the house manager called for help."</p> <p>-"6. [Client A] did not go to the ER until the next morning...".</p> <p>-"...Also written statement form [HM #1] attached...".</p> <p>-"...(written statement from HM #1) On Monday 11/29 (2021) around 9:30p [staff #4] reported [client A] was still not feeling well vomiting as well as not keeping meds down. I (HM #1) contacted nurse [LPN #1], she said to take her back (to the ER). I let [FPC #1] know I had no one to stay with kids I couldn't take her so (sic) no reply from [FPC #1]. I contacted [FAD #1] to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>let her know situation. The next morning...I took [client A] to the ER. Stayed with her until around 10 pm when they admitted her."</p> <p>-"(signature of HM #1) 12/2/21..."</p> <p>-"...[HM #1]: 12-9-21."</p> <p>-"IO (QIDP #1): In reviewing the notes it says that you texted [FAD #1] and [FPC #1]?"</p> <p>-"[HM #1]: Yes, I texted [FAD #1], [FPC #1], and [LPN #1]."</p> <p>-"IO (QIDP #1): Did anyone answer you?"</p> <p>-"[HM #1]: Nothing from [FPC #1]. I texted [FAD #1] at 10:30pm and she texted me back at 6:04am. [FAD #1] told me that she does not hear text messages. [LPN #1] had texted me at 9:34pm and we texted back and forth until 9:40-10pm. [LPN #1] said to make sure they don't release her if she can't eat and keep food down."</p> <p>-"IO (QIDP #1): Did you attempt to call anyone?"</p> <p>-"[HM #1]: No, my phone was off I could only text."</p> <p>-"IO (QIDP #1): Did you try to text anyone else?"</p> <p>-"[HM #1]: [FPC #1]."</p> <p>-"IO (QIDP #1): Did you try to text [RD #1] or [QIDP #1]?"</p> <p>-"[HM #1]: No."</p> <p>-"IO (QIDP #1): Did [LPN #1] text you back."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>-"[HM #1]: No, we had talked earlier through text. I had texted [FCP #1] 5 times, but she never texted me back..."</p> <p>-"...[Staff #4]: 12-9-21..."</p> <p>-"...IO (QIDP #1): When you left, she was in her wheelchair?"</p> <p>-"[Staff #4]: Yes."</p> <p>-"IO (QIDP #1): Did you get any calls from anyone to get [client A] to (sic) hospital?"</p> <p>-"[Staff #4]: No, but [HM #1] said she was coming at 1am as she was looking for a babysitter. Once I left, I didn't hear anything from anyone. I left between 10:45p-11ish."</p> <p>-"[FPC #1]: 12-9-21."</p> <p>-"IO: (QIDP #1): Did you receive any texts from [HM #1]?"</p> <p>-"[FPC #1]: Remember that I came in the next day and found out that [client A] hadn't gone. I did not receive any text from [HM #1] except on 11/29 (2021) at 10:16pm stating that she was not going to be able to get there until about 1ish (1:00 AM) and then at 10:21pm that she couldn't take her."</p> <p>-"IO (QIDP #1): Did you respond to those texts?"</p> <p>-"[FPC #1]: I didn't see the texts until the next morning."</p> <p>-"IO (QIDP #1): I checked the phone and did not see any other text messages from [HM #1]..."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>- "IO (QIDP #1): When [client A] came home the 1st time on Monday who brought her home?"</p> <p>[FPC #1]: [HM #1]. The hospital had called and said she was ready to come home. I called [HM #1]...She brought her home around 4pm."</p> <p>- "IO (QIDP #1): Do you know if the hospital sent any diapers home with her?"</p> <p>- "[FPC #1]: No, I don't."</p> <p>- "IO (QIDP #1): Did you get a report that [client A] was not sitting in her chair appropriately?"</p> <p>- "[FPC #1]: The next morning when [HM #1] came in she reported to [FAD #1] that [client A] was not sitting in her chair correctly."</p> <p>- "IO (QIDP #1): Did anyone report that they were afraid or having trouble changing [client A]?"</p> <p>- "[FPC #1]: No."</p> <p>- "IO (QIDP #1): Did [staff #6] or anyone report that [client A] was in her chair not her bed?" - "[FPC #1]: No." - "[Staff #6]: 12-9-21." - "IO (QIDP #1): Did [HM #1] ever call or text you with any plans on what was going on with [client A]?" - "[Staff #6]: No, she did text at 4am and said that she would be in in the morning and she was." - "IO (QIDP #1): Did you contact anyone?" - "[Staff #6]: No." - "IO (QIDP #1): Should you have contacted someone?" - "[Staff #6]:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>No."-IO (QIDP #1): Was [client A] in bed?"-[Staff #6]: No."-IO (QIDP #1): She was in her chair all night?"-[Staff #6]: Yes, I thought she was going to the ER, so I left her in her chair."-IO (QIDP #1): How did [client B] slide her butt down from the seat of the chair to the footrest?"-[Staff #6]: I don't know how that happened? She wasn't like that when I was there. I checked on her throughout the night..."-IO (QIDP #1): Do you have consumer specific training?"-[Staff #6]: Yes at [name of different group home]."-IO (QIDP #1): Anywhere else?"-[Staff #6]: No, the lady that was there with me changed [client B] before she left."-IO (QIDP #1): After [HM #1] called at 4 (am), do you think you should have called someone?"-[Staff #6]: I had texted [HM #1] like 7 times. She never answered."-IO (QIDP #1): If you don't get an answer you have to go up the chain of command to talk to someone. It is important that we follow instructions given by the nurse. You should have called [FPC #1], then [FAD #1], then [RD #1]-chain of command."-[Staff #6]: So, I am to follow the chain of command until I get a hold of someone?"-IO (QIDP #1): Yes, for emergencies."-IO (QIDP #1): Do you have training on the Hoyer Lift?"-[Staff #6]: No."-Training Reviewed: 12-9-21..."-[Staff #6]: CST training [different group home] 12-1-18 and C111 12/9/18..."-IO</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>NOTE: 12-9-21."-"This IO (QIDP #1) received a text message from the nurse [LPN #1] at 9:55pm on 11/29/21 that she (LPN #1) was sending [client A] to the ER, unable to keep anything down. No other calls or texts received from anyone..."-"...[LPN #1]: 12-10-21."-"See attached written statement..."-"...(written statement from LPN #1) Nov (November) 29th 7pm, [staff #4] called me and told me that [client A] was having n/v (nausea/vomiting) and she was having trouble getting [client A] to keep any meds down. I encouraged her to hold the 7p meds and give Zofran then if she kept the Zofran down, then try her meds at 8p. [Staff #4] then called back and said that she (client A) couldn't keep anything down. Instructed [staff #4] to call [HM #1] or [FPC #1] and get [client A] to the hospital since she had already had (sic) been seen earlier for seizure activity. I was concerned that her seizures would continue since we weren't getting adequate fluids in her. It wasn't until the next morning in the office that [HM #1] said that she had never taken [client A] to the hospital because she didn't have staff. I asked her if [FPC #1] knew and she (HM #1) said yes and that [FPC #1] hadn't done anything about it to help her."-"(signature of LPN #1)..."-"[LPN #1]: 12-10-21."-"IO (QIDP #1): Who did you contact regarding [client A] to go (sic) to the ER besides [HM #1]?"-"[LPN #1]: I</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>did not contact [HM #1]. I was in contact with [staff #4]. I let [DON (Director of Nursing) #1] know what was going on and I sent you (QIDP #1) a text."-"IO (QIDP #1): Did [client #4] then call [HM #1]?"-"[LPN #1]: She (client #4) made contact with whoever."-"IO (QIDP #1): Who were you supposed to contact for [client A] going to the ER?"-"[LPN #1]: Staff contacted the Manager, the Manager contacts [FPC #1] or whomever and above. I always contact [DON #1]..."</p> <p>"...Findings:"-"1. [Staff #4] states that she changed [client A], [staff #6] did not see [client #4] change her and [HM #1] said she had the same diaper/depends was on in the morning."-"2. [Staff #6] did not change [client #4] overnight and left her sitting in her wheelchair."-"3. [Staff #6] does not know anything about [client A] not being in her chair correctly, she was when he left per him. [HM #1] says that [client A] was not seated correctly when she arrived."-"4. [HM #1] did not call anyone as phone was not working only texted [FPC #1], [FAD #1], and did not use chain of command any further up the chain when she did not get a response."-"5. [HM #1] was not able to take [client A] to the hospital as she could not find a babysitter but did not call anyone as phone was down, she did attempt to text [FPC #1] and [FAD #1] but did not use chain of command and these texts were made before 11pm."-"6. [LPN</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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 0189 Bldg. 00	<p>#1] only contacted [DON #1] (phone), [QIDP #1] (text) and [staff #4] (by phone and text). [LPN #1] did not contact the PC/PD..."A review of the ISF dated 12/10/21 indicated only one staff was working during the evening shift on 11/29/21. QIDP #1 and RD #1 were interviewed on 12/27/21 at 11:01 AM. QIDP #1 was asked about the expected staffing ratio at the group home. QIDP #1 indicated there needed to be at least one staff overnight, 2 staff during the day, and at least 2 staff in the evening. QIDP #1 was asked if the house was adequately staffed on the evenings of 11/26/21 and 11/29/21. QIDP #1 indicated no. RD #1 indicated they normally have it double staffed during the evenings. The federal tag relates to complaint #IN00368233 and complaint #IN00368243.9-3-3(a) 483.430(e)(1) STAFF TRAINING PROGRAM</p> <p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview for 2 of 2 sampled clients (clients A and B), plus 2 additional clients (clients C and D), the facility failed to ensure staff were properly trained prior to working in the group home.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/20/21 at 11:15 AM.</p>	W 0189	Consumer specific trainings were conducted on 10/15/2021 and 12/23/2021. The QIDP will ensure that all staff assigned to this facility have current Consumer Specific Training and Site Specific Training by 01/30/2022. Consumer Specific Training and Site Specific Training is now scheduled into New Hire Orientation week. The Program	01/30/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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. A BDDS report dated 11/30/21 indicated, "... [Client B] reported to [HM (House Manager) #2] on 11/29/21 that on Friday 11/26/21 the staff person working, [staff #1], had given him a hard time and had slapped consumer [client C] on the face. It was also reported that [staff #1] called the police due to [client B] leaving the house without staff, being out of sight for approximately 5 minutes before returning on his own. [Client B] does not have alone time in the community. [Client B] does have a formal behavior plan with target behavior of false reporting. [Client C] was checked for injury/bruising and nothing was found. The police ensured everyone's safety when they arrived and spoke with both staff [staff #1] and consumer [client B]. [Staff #1] has been suspended pending the outcome of an investigation...".</p> <p>An ISF (Investigation Summary Form) dated 12/2/21 indicated the following:</p> <p>- "...On 11/29 it was reported that [staff #1] hit [client C] and yelled at [client B]. 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>- "...[Staff #1]: 11-29-21."</p> <p>- "See written questions and answers during interview..."</p> <p>- "...(written questions and answers with staff #1)</p>		Coordinator will ensure that staff training is completed prior to adding employees to the shift schedule with each new employee hired.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>IO: Tell me what happened on Friday (11/26/21)</p> <p>-"[Staff #1]: Friday? With [client B]?"</p> <p>-"IO: Yes."</p> <p>-"[Staff #1]: [HM #1] called me in and I was working. [Client B] had come out (sic) of his room. He asked me who was giving meds. I didn't find out until I talked to [HM #2] that [HM #1] had passed all meds but [client B's]. At that point, I understood why [client B] was upset. I just kept telling him I don't know when he kept asking me. He got very mad. I told him I wasn't med (medication) passed, there was nothing I could do....He gets mad and he sits on the couch. You always tell me it's their home and I understand that. But what you aren't going to do is sit three feet from me and yell at me. I told him to go to his room until he calmed down because he wasn't going to talk to me like that. He says he is going to get me fired. I told him okay, please do. He then goes to his room. Comes back. He says he is going to leave. I stand in front of the door, but they have 'f----- three doors in [name of group home]' and he gets out another door. I called [HM #1] and then was like 'nevermind, I should be calling the cops'. And I called them. [Client C] is also crying because she's 'sh---- and wants to go to bed.' I was all by myself, what was I supposed to do? I can't be my best self if I'm the only person. I didn't raise my voice once or threaten him. Maybe to him I did, I am who I am. But I didn't raise my voice. He threw a shake at me and hit me with a wet mop. The cops can attest to that. I understand he has issues, but I don't think anything I did made him act in that manner."</p> <p>-"IO: When he was upset and yelling at you, what</p>			

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  12/30/2021
--	---	--	---

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

(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>did you say?"</p> <p>-"[Staff #1]: I encouraged him to take a break in his room. When he said he was going to call his guardian and [HM #1], I told him 'please do.' When he called the police, I told him that we weren't going to waste resources, there's already a car on the way. It's their right to use the phone, but I did tell him that we aren't going to call 911 when they're already on their way."</p> <p>-"IO: I know that [client B] talks a lot. Was he really talking to you a lot?"</p> <p>-"[Staff #1]: No, that's the thing. He was sitting in the chair mumbling to himself. I asked him what was wrong and then he got upset and said he wanted to get me fired. I told him I have to be able to see him, but we don't have to be in the same room. I told him I had to be in the living room, but he didn't need to be in there with me. He chose to sit two feet away from me and have an attitude."</p> <p>-"IO: You said he had an attitude. What was he doing?"</p> <p>-"[Staff #1]: On his phone. He always tells me he doesn't like me. I don't know what it is about me personally, but he just literally doesn't like me."</p> <p>-"IO: So the tone of voice you're using with me (a little worked up/raised), is that the tone you used with him?"</p> <p>-"[Staff #1]: No, I use a completely calm tone. I'm extra calm for that reason because they like to say I'm yelling at them."</p> <p>-"IO: What was [client D] doing?"</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>-"[Staff #1]: She came out after the cops left and was wet. I asked her why she was wet and she told me she had just taken a shower."</p> <p>-"IO: Where was [client C]?"</p> <p>-"[Staff #1]: In her room, doing what she does, rolling around."</p> <p>-"IO: What was [client A] doing?"</p> <p>-"[Staff #1]: During the whole thing, [client A] was crying because she was ready to be put in bed. Later I found out she had pooped on herself and smelled like urine. Here's what happened. When I got to the home, [HM #1] told me someone would be there at 8. When I got there, she (client A) didn't smell so I think during that hour when things were happening, she pooped and peed multiple times. This whole time she was crying saying she wanted to get into bed. I was told to just get there (between 6 and 6:15) and just sit until the next person showed up at 8pm. I didn't want to help [client A] get into bed because I didn't want to try to get her in bed and accidentally drop her or snap her shoulder. That's a liability. Then [HM #2] came in and asked me why [client A] was crying. That's when I realized she had defecated on herself. If I hadn't been lied to by [HM #1] and someone was coming in at 8pm, then I would have known and could have done my job. I was put in a really bad situation...I did the best that I could."</p> <p>-"IO: What reason were you called in?"</p> <p>-"[Staff #1]: [HM #1] told me she had a family emergency. She told me she was at the hospital with [girl's name]. She told me [HM #2] would be</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>there before her."</p> <p>-"IO: What was going on with (sic) [HM #2] got there?"</p> <p>-"[Staff #1]: She (HM #1) had called her (HM #2) when [client B] went AWOL (leaving the group home without permission). Because I guess that's protocol because someone higher up than me (sic)."</p> <p>-"IO: What time did [client B] leave?"</p> <p>-"[Staff #1]: (looks through phone) I called 911 for the first time at 8:50pm. Mind you I was supposed to get off at 8pm."</p> <p>-"IO: How long was he gone?"</p> <p>-"[Staff #1]: Maybe 10 minutes."</p> <p>-"IO: Did you see him at all?"</p> <p>-"[Staff #1]: Yes, because at first he knocked on the neighbor's door and I told him not to bother them. Then he headed north towards [name of moving truck company]. I told the dispatcher I couldn't leave because I was alone with 3 other consumers inside."</p> <p>-"IO: How long was he gone?"</p> <p>-"[Staff #1]: Maybe 5 minutes. I think he got cold."</p> <p>-"IO: What did police say?"</p> <p>-"[Staff #1]: They asked me what I was doing. I told them I was staff. The cops calmed him down. He told them he was upset with the meds. I said I</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>couldn't control that. It's state regulated rules and if I go in that med cabinet, I will lose my job. I can help with anything but medicine, that's out of my hands. For the simple reason of I'm not med passed...that med pass bit, that's like literally the only thing I can't do (sic)."</p> <p>-"IO: Yeah, you can't do meds. Do you have CST (Client Specific Training) for [name of group home]?"</p> <p>-"[Staff #1]: No."</p> <p>-"IO: Next time you're asked to work in a house and you aren't trained, tell them no until they give you CST and site specific (training)."</p> <p>-"[Staff #1]: The whole thing was a set up."</p> <p>-"IO: What do you mean?"</p> <p>-"[Staff #1]: Because she ([HM #1]) knew that [staff #2] wasn't suppose to be in until 10 (pm). She knew that [client B] didn't have his meds. She knew that I didn't know he didn't have her (sic) meds."</p> <p>-"IO: Why would she set you up?"</p> <p>-"[Staff #1]: Not on purpose. But, she's an RM (Resident Manager), she should have told me these (sic) things..."</p> <p>-"...IO: At any point did you put your hands on [client B] or any other consumer?"</p> <p>-"[Staff #1]: No..."</p> <p>-"...Review of Training Data Base for [staff #1]: 12-1-21."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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 following training are not recorded on the training data base: C111 (Respect Training), Road Test, CPI (Crisis Prevention Intervention, and site-specific training. She has consumer specific training for [different group home] and CPR (Cardiopulmonary Resuscitation)...".</p> <p>- "...Findings:...".</p> <p>- "...22. [Staff #1] states that she has not had CST training for [name of group home]...".</p> <p>2. A BDDS report dated 12/1/21 indicated, "...An allegation was made that staff did not take [client A] to the ER quickly enough as instructed by the agency nurse. It was also alleged that she was not changed overnight and was not supported to sit in her chair appropriately. These allegations are being investigated to determine the facts and to make recommendations to prevent recurrence...".</p> <p>An ISF dated 12/10/21 indicated the following:</p> <p>- "...On 11/30 (2021) it was reported that [client A] was not taken to the ER when instructed, was left unchanged all night, and was left sitting in her wheelchair with her bottom where her feet should go. Investigate to determine the facts and make recommendations to prevent further recurrence...".</p> <p>- "...[Staff #6]: 12-9-21."</p> <p>- "IO (QIDP #1): Did [HM #1] ever call or text you with any plans on what was going on with [client A]?"</p> <p>- "[Staff #6]: No, she did text at 4am and said that she would be in, in the morning and she was."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>- "IO (QIDP #1): Did you contact anyone?"</p> <p>- "[Staff #6]: No."</p> <p>- "IO (QIDP #1): Should you have contacted someone?"</p> <p>- "[Staff #6]: No."</p> <p>- "IO (QIDP #1): Was [client A] in bed?"</p> <p>- "[Staff #6]: No."</p> <p>- "IO (QIDP #1): She was in her chair all night?"</p> <p>- "[Staff #6]: Yes, I thought she was going to the ER, so I left her in her chair..."</p> <p>- "...IO (QIDP #1): Do you have consumer specific training?"</p> <p>- "[Staff #6]: Yes at [name of different group home]."</p> <p>- "IO (QIDP #1): Anywhere else?"</p> <p>- "[Staff #6]: No, the lady that was there with me changed [client B] before she left."</p> <p>- "IO (QIDP #1): After [HM #1] called at 4, do you think you should have called someone?"</p> <p>- "[Staff #6]: I had texted [HM #1] like 7 times. She never answered."</p> <p>- "IO (QIDP #1): If you don't get an answer you have to go up the chain of command to talk to someone, it is important that we follow instructions given by the nurse. You should have</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>called [FPC #1], then [FAD #1], then [RD #1] -chain of command."</p> <p>-"[Staff #6]: So, I am to follow the chain of command until I get a hold of someone?"</p> <p>-"IO (QIDP #1): Yes, for emergencies."</p> <p>-"IO (QIDP #1): Do you have training on the Hoyer Lift?"</p> <p>-"[Staff #6]: No."</p> <p>-"Training Reviewed: 12-9-21..."</p> <p>-"...[Staff #6]: CST training [different group home] 12-1-18 and C111 12/9/18..."</p> <p>Staff #6 was interviewed on 12/22/21 at 12:58 PM. Staff #6 was asked about the evening of 11/29/21. Staff #6 stated, "When I got there, staff started telling me about [client A] being sick and I told them I wasn't trained and didn't know anything about her." Staff #6 was asked about who contacted him to work the shift on the evening of 11/29/21. Staff #6 indicated FPC (Former Program Coordinator) #1 had contacted him about working. Staff #6 stated, "When I spoke to [FPC #1] I did tell her that was a house I was not trained in. They did not tell me about [client A's] condition. I don't think she (FPC #1) said anything back in response to me telling her I was not trained."</p> <p>QIDP #1 and RD (Regional Director) #1 were interviewed on 12/27/21 at 11:01 AM. RD #1 was asked what is expected to be completed by all staff prior to working in a group home. RD #1 stated, "They should be trained on CSTs (Client Specific Trainings), BSPs if applicable, and have</p>			

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  12/30/2021
--	---	--	---

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

(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 0331 Bldg. 00	<p>site specific training." RD #1 was asked if any of the clients plans (behavioral or risk) could be followed as written if the staff who is working is not trained on these plans. RD #1 stated, "No." RD #1 stated, "The PC (Program Coordinator) should meet them (staff) and do CST and train them to work independently before they start at the group home."</p> <p>This federal tag relates to complaint #IN00368233 and complaint #IN00368243.</p> <p>9-3-3(a) 483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 2 sampled clients (client A), the facility's nursing services failed to ensure proper follow up was completed following the nurse giving instructions for client A to be taken to the ER (emergency room), resulting in a delay of medical treatment for client A.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/20/21 at 11:15 AM.</p> <p>A BDDS report dated 12/1/21 (11:44 AM) indicated, "...An allegation was made that staff did not take [client A] to the ER (emergency room) quickly enough as instructed by the agency nurse. It was also alleged that she was not changed overnight and was not supported to sit in her chair appropriately. These allegations are being investigated to determine the facts and to make</p>	W 0331	The Sequential Call list policy was updated 01/2022. The policy provides more detailed clarification for supervising staff on shift and professional staff regarding notification of appropriate parties and corresponding time frames required. As part of this policy update, the clinical staff will ensure a follow-up for verification of medical treatment to close the communication loop. The agency RN will be trained on the policy update by 01/30/22.	01/30/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>recommendations to prevent recurrence...".</p> <p>An ISF (Investigation Summary Form) dated 12/2/21 indicated the following:</p> <p>- "...Name of Staff Assigned as IO (Investigation officer)."</p> <p>- "[QIDP #1]..."</p> <p>- "...Investigation Notes for [client A] 11/30/21..."</p> <p>- "...IO NOTE:"</p> <p>- "This IO received information that staff were instructed to take [client A] back to the ER (emergency room) on 11/29/21 and found out on 11/30/21 that she had not been taken. [Client A] was taken to the ER on 11/30/21 where she was then later admitted. (This is a separate investigation into not going as instructed back to the ER on the 29th..."</p> <p>- "...[Staff #4]: 12/1/21."</p> <p>- "IO: Was [client A] given her medications on Monday night 7p and 8p?"</p> <p>- "[Staff #4]: Let me think that was a couple of days ago. Yes."</p> <p>- "IO: What was going on that evening?"</p> <p>- "[Staff #4]: [Client A] did not get her medications; she was throwing up and I called the nurse. She said to hold the 7p Colace (stool softener) as it could not be crushed. She (client A) got her 4pm medications and I poured water into her mouth, and I thought she was going to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>choke. I patted her back and had her sit up straighter and she swallowed the medications. [LPN (Licensed Practical Nurse) #1] wanted us to crush the pills and put them in applesauce. [LPN #1] wanted to hold the 7pm medication and mouthwash and have her take some Zofran (to prevent nausea/vomiting) and then give her the medications later if the Zofran helped. When it was time to give the 8pm medications I gave [client A] some applesauce with no medications, and she appeared to not be able to swallow the medications."</p> <p>"IO: What did you do then?"</p> <p>"[Staff #4]: [LPN #1] said to give Zofran, but she threw it up. When I called [LPN #1] again, she stated that [client A] was going to the ER. I assumed that since she was going, I was to hold the medications at that time so as not to choke her."</p> <p>"IO: Do you know who was called for her to go?"</p> <p>"[Staff #4]: I know [LPN #1] let me know and had called [HM #1] to get it set up. [HM #1] said that she was going to be there by 1am (11/30/21) to take [client A] as she was getting a sitter..."</p> <p>"...Findings:"</p> <p>"1. [Client A] did miss medications on the night of the 29th due to vomiting and not keeping anything down."</p> <p>"2. [Staff #4] thought that [client A] was going to the ER as the nurse had instructed..."</p> <p>"...6. [Client A] was admitted to the hospital on 11/30/21, after being evaluated in the ER..."</p>			

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  12/30/2021
--	---	--	---

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

(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>- "...Reviewer Recommendations:...".</p> <p>- "...If staff notify the nurse directly, the nurse must communicate incident to the PC (Program Coordinator) and QIDP. If a consumer needs to go to the hospital, the PC and QIDP must be notified as well. The PC is then responsible for finding a staff member to immediately take the consumer...".</p> <p>- "...Staff must be trained on the chain of command and when to call the next in line due to unresponsiveness or inability to get a hold of the first person."</p> <p>-(signature of RD #1).</p> <p>An ISF dated 12/10/21 indicated the following:</p> <p>- "...On 11/30 it was reported that [client A] was not taken to the ER when instructed, was left unchanged all night, and was left sitting in her wheelchair with her bottom where her feet should go. Investigate to determine the facts and make recommendations to prevent further recurrence."</p> <p>- "Name of Staff Assigned as IO: [FAD (Former Area Director) #1] and [QIDP #1]...".</p> <p>- "...IO NOTE: 12-8-21."</p> <p>- "This IO (QIDP #1) was given this investigation to complete as it was turned in by another investigating officer, who is no longer with the company, incomplete. This investigation originally was started on 11-30-21 and was turned in on 12/2/21."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>-"IO NOTE: 12-8-21."</p> <p>-"See attached investigation (12/2/21 investigation) from previous investigator...".</p> <p>-"...IO (FAD #1) Note: It was reported to this IO (FAD #1) that [HM #1] was to take [client A] to the hospital, and she never did."</p> <p>-"[Staff #4] via phone 11/29/21."</p> <p>-"IO (FAD #1): Tell me what happened with [client A]?"</p> <p>-"[Staff #4]: She was gagging (dry heaving per interview with staff #4 on 12/22/21) and making sounds all night. I couldn't get her to eat. The RM (Resident Manager) was supposed to come in and take her to the ER."</p> <p>-"IO (FAD #1): Did you give her night meds to her?"</p> <p>-"[Staff #4]: No, I was under the impression that the RM was coming to take her to the ER and I couldn't even get her to eat."</p> <p>-"IO (FAD #1): Who came in for you when you left?"</p> <p>-"[Staff #4]: [Staff #6] and I showed him how to take care of her. I was afraid that she would have a seizure so I made sure that he knew how to handle her if she did. He (staff #6) called [HM #1] and she was going to be there at 1 (am), so I went ahead and left."</p> <p>-"[Staff #6] via phone 11/29/21:"</p> <p>-"IO (FAD #1): What happened with [client A]?"</p>			

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  12/30/2021
--	---	--	---

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

(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>-"[Staff #6]: The lady before me said that she had been throwing up and gagging all night..."</p> <p>-"...IO (FAD #1): Did you notify anyone that she was throwing up and gagging?"</p> <p>-"[Staff #6]: Yes, we called the manager, [HM #1] and she said that she was going to be there at 1 am, but she never showed up until after I left the next morning."</p> <p>-"IO (FAD #1): Did you think to call someone else?"</p> <p>-"[Staff #6]: No, I thought she was going to come."</p> <p>-"IO (FAD #1): So you are aware, you should have then called the next step of leadership. That would have been [FPC #1], do you have her number?"</p> <p>-"[Staff #6]: Yes."</p> <p>-"IO (FAD #1): If you feel like it is an emergency you should call 911 and then call your PC/PD (Program Director)/AD (Area Director)."</p> <p>-"[HM #1] via phone 11/29/21:"</p> <p>-"IO (FAD #1): What happened with [client A]?"</p> <p>-"[HM #1]: She had been sick and she was supposed to go to the hospital."</p> <p>-"IO (FAD #1): Did you take her to the hospital?"</p> <p>-"[HM #1]: Yes the next morning, I had been</p>			

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  12/30/2021
--	---	--	---

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

(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>trying to get a hold of you ([FAD #1]) or [FPC #1]."</p> <p>-"IO (FAD #1): I know for me you text me and that doesn't wake me up in the night, did you call or text [FPC #1]?"</p> <p>-"[HM #1]: I did both. I didn't have a sitter so I couldn't come in."</p> <p>-"IO (FAD #1): Did you call [LPN (Licensed Practical Nurse) #1] to let her know?"</p> <p>-"[HM #1]: No, but I called [FPC #1]."</p> <p>-"[FPC #1]."</p> <p>-"IO (FAD #1): What happened (sic) [client A]?"</p> <p>-"[FPC #1]: [Client A] was throwing up and [HM #1] never called me. [RD #1] asked to see my call log and she never called me since 8:45 (pm) (sic)."</p> <p>-"IO (FAD #1): Did you hear from her after?"</p> <p>-"[FPC #1]: No, she never called me again."</p> <p>-"Findings:"</p> <p>-"1. [Client A] was sick and needed to go to the hospital."</p> <p>-"2. The house manager was supposed to take the consumer to the hospital."</p> <p>-"3. House manager did not show up."</p> <p>-"4. House manager said she tried to call but no one could help her."</p>			

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  12/30/2021
--	---	--	---

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

(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>-"5. No one says that the house manager called for help."</p> <p>-"6. [Client A] did not go to the ER until the next morning...".</p> <p>-"...Also written statement form [HM #1] attached...".</p> <p>-"...(written statement from HM #1) On Monday 11/29 (2021) around 9:30p [staff #4] reported [client A] was still not feeling well vomiting as well as not keeping meds down. I (HM #1) contacted nurse [LPN #1], she said to take her back (to the ER). I let [FPC #1] know I had no one to stay with kids I couldn't take her so (sic) no reply from [FPC #1]. I contacted [FAD #1] to let her know situation. The next morning...I took [client A] to the ER. Stayed with her until around 10 pm when they admitted her."</p> <p>-"(signature of HM #1) 12/2/21...".</p> <p>-"...[HM #1]: 12-9-21."</p> <p>-"IO (QIDP #1): In reviewing the notes it says that you texted [FAD #1] and [FPC #1]?"</p> <p>-"[HM #1]: Yes, I texted [FAD #1], [FPC #1], and [LPN #1]."</p> <p>-"IO (QIDP #1): Did anyone answer you?"</p> <p>-"[HM #1]: Nothing from [FPC #1]. I texted [FAD #1] at 10:30pm and she texted me back at 6:04am. [FAD #1] told me that she does not hear text messages. [LPN #1] had texted me at 9:34pm and we texted back and forth until 9:40-10pm. [LPN #1] said to make sure they</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>don't release her if she can't eat and keep food down."</p> <p>-"IO (QIDP #1): Did you attempt to call anyone?"</p> <p>-"[HM #1]: No, my phone was off I could only text."</p> <p>-"IO (QIDP #1): Did you try to text anyone else?"</p> <p>-"[HM #1]: [FPC #1]."</p> <p>-"IO (QIDP #1): Did you try to text [RD #1] or [QIDP #1]?"</p> <p>-"[HM #1]: No."</p> <p>-"IO (QIDP #1): Did [LPN #1] text you back."</p> <p>-"[HM #1]: No, we had talked earlier through text. I had texted [FCP #1] 5 times, but she never texted me back...".</p> <p>-"...[Staff #4]: 12-9-21...".</p> <p>-"...IO (QIDP #1): When you left, she was in her wheelchair?"</p> <p>-"[Staff #4]: Yes."</p> <p>-"IO (QIDP #1): Did you get any calls from anyone to get [client A] to (sic) hospital?"</p> <p>-"[Staff #4]: No, but [HM #1] said she was coming at 1am as she was looking for a babysitter. Once I left, I didn't hear anything from anyone. I left between 10:45p-11ish."</p> <p>-"[FPC #1]: 12-9-21."</p>			

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  12/30/2021
--	---	--	---

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

(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>- "IO: (QIDP #1): Did you receive any texts from [HM #1]?"</p> <p>- "[FPC #1]: Remember that I came in the next day and found out that [client A] hadn't gone. I did not receive any text from [HM #1] except on 11/29 (2021) at 10:16pm stating that she was not going to be able to get there until about 1ish (1:00 AM) and then at 10:21pm that she couldn't take her."</p> <p>- "IO (QIDP #1): Did you respond to those texts?"</p> <p>- "[FPC #1]: I didn't see the texts until the next morning."</p> <p>- "IO (QIDP #1): I checked the phone and did not see any other text messages from [HM #1]..."</p> <p>- "IO (QIDP #1): When [client A] came home the 1st time on Monday who brought her home?"</p> <p>[FPC #1]: [HM #1]. The hospital had called and said she was ready to come home. I called [HM #1]...She brought her home around 4pm."</p> <p>- "IO (QIDP #1): Do you know if the hospital sent any diapers home with her?"</p> <p>- "[FPC #1]: No, I don't."</p> <p>- "IO (QIDP #1): Did you get a report that [client A] was not sitting in her chair appropriately?"</p> <p>- "[FPC #1]: The next morning when [HM #1] came in she reported to [FAD #1] that [client A] was not sitting in her chair correctly."</p> <p>- "IO (QIDP #1): Did anyone report that they were afraid or having trouble changing [client</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>A]?"</p> <p>-"[FPC #1]: No."</p> <p>-"IO (QIDP #1): Did [staff #6] or anyone report that [client A] was in her chair not her bed?"</p> <p>-"[FPC #1]: No."</p> <p>-"[Staff #6]: 12-9-21."</p> <p>-"IO (QIDP #1): Did [HM #1] ever call or text you with any plans on what was going on with [client A]?"</p> <p>-"[Staff #6]: No, she did text at 4am and said that she would be in in the morning and she was."</p> <p>-"IO (QIDP #1): Did you contact anyone?"</p> <p>-"[Staff #6]: No."</p> <p>-"IO (QIDP #1): Should you have contacted someone?"</p> <p>-"[Staff #6]: No."</p> <p>-"IO (QIDP #1): Was [client A] in bed?"</p> <p>-"[Staff #6]: No."</p> <p>-"IO (QIDP #1): She was in her chair all night?"</p> <p>-"[Staff #6]: Yes, I thought she was going to the ER, so I left her in her chair."</p> <p>-"IO (QIDP #1): How did [client B] slide her butt down from the seat of the chair to the footrest?"</p> <p>-"[Staff #6]: I don't know how that happened? She</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>wasn't like that when I was there. I checked on her throughout the night...".</p> <p>- "...IO (QIDP #1): Do you have consumer specific training?"</p> <p>- "[Staff #6]: Yes at [name of different group home]."</p> <p>- "IO (QIDP #1): Anywhere else?"</p> <p>- "[Staff #6]: No, the lady that was there with me changed [client B] before she left."</p> <p>- "IO (QIDP #1): After [HM #1] called at 4 (am), do you think you should have called someone?"</p> <p>- "[Staff #6]: I had texted [HM #1] like 7 times. She never answered."</p> <p>- "IO (QIDP #1): If you don't get an answer you have to go up the chain of command to talk to someone. It is important that we follow instructions given by the nurse. You should have called [FPC #1], then [FAD #1], then [RD #1] -chain of command."</p> <p>- "[Staff #6]: So, I am to follow the chain of command until I get a hold of someone?"</p> <p>- "IO (QIDP #1): Yes, for emergencies."</p> <p>- "IO (QIDP #1): Do you have training on the Hoyer Lift?"</p> <p>- "[Staff #6]: No."</p> <p>- "Training Reviewed: 12-9-21...".</p> <p>- "...[Staff #6]: CST training [different group</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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] 12-1-18 and C111 12/9/18...".</p> <p>-"...IO NOTE: 12-9-21."</p> <p>-"This IO (QIDP #1) received a text message from the nurse [LPN #1] at 9:55pm on 11/29/21 that she (LPN #1) was sending [client A] to the ER, unable to keep anything down. No other calls or texts received from anyone...".</p> <p>-"...[LPN #1]: 12-10-21."</p> <p>-"See attached written statement...".</p> <p>-"...(written statement from LPN #1) Nov (November) 29th 7pm, [staff #4] called me and told me that [client A] was having n/v (nausea/vomiting) and she was having trouble getting [client A] to keep any meds down. I encouraged her to hold the 7p meds and give Zofran then if she kept the Zofran down, then try her meds at 8p. [Staff #4] then called back and said that she (client A) couldn't keep anything down. Instructed [staff #4] to call [HM #1] or [FPC #1] and get [client A] to the hospital since she had already had (sic) been seen earlier for seizure activity. I was concerned that her seizures would continue since we weren't getting adequate fluids in her. It wasn't until the next morning in the office that [HM #1] said that she had never taken [client A] to the hospital because she didn't have staff. I asked her if [FPC #1] knew and she (HM #1) said yes and that [FPC #1] hadn't done anything about it to help her."</p> <p>-"(signature of LPN #1)...".</p> <p>-"[LPN #1]: 12-10-21."</p> <p>-"IO (QIDP #1): Who did you contact regarding</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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 A] to go (sic) to the ER besides [HM #1]?"</p> <p>-"[LPN #1]: I did not contact [HM #1]. I was in contact with [staff #4]. I let [DON (Director of Nursing) #1] know what was going on and I sent you (QIDP #1) a text."</p> <p>-"IO (QIDP #1): Did [client #4] then call [HM #1]?"</p> <p>-"[LPN #1]: She (client #4) made contact with whoever."</p> <p>-"IO (QIDP #1): Who were you supposed to contact for [client A] going to the ER?"</p> <p>-"[LPN #1]: Staff contacted the Manager, the Manager contacts [FPC #1] or whomever and above. I always contact [DON #1]..."</p> <p>-"...Findings:"</p> <p>-"1. [Staff #4] states that she changed [client A], [staff #6] did not see [client #4] change her and [HM #1] said she had the same diaper/depends was on in the morning."</p> <p>-"2. [Staff #6] did not change [client #4] overnight and left her sitting in her wheelchair."</p> <p>-"3. [Staff #6] does not know anything about [client A] not being in her chair correctly, she was when he left per him. [HM #1] says that [client A] was not seated correctly when she arrived."</p> <p>-"4. [HM #1] did not call anyone as phone was not working only texted [FPC #1], [FAD #1], and did not use chain of command any further up the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>chain when she did not get a response."</p> <p>-"5. [HM #1] was not able to take [client A] to the hospital as she could not find a babysitter but did not call anyone as phone was down, she did attempt to text [FPC #1] and [FAD #1] but did not use chain of command and these texts were made before 11pm."</p> <p>-"6. [LPN #1] only contacted [DON #1] (phone), [QIDP #1] (text) and [staff #4] (by phone and text). [LPN #1] did not contact the PC/PD..."</p> <p>A review of the ISF dated 12/10/21 indicated only one staff was working during the overnight shift on 11/29/21. The review indicated staff #6 had not completed CST or site specific training prior to working at the group home. The review indicated staff did not immediately implement instructions given by LPN #1 to have client A taken to the hospital. The review did indicated LPN #1 did not follow up with staff to ensure instructions given to taken client A to the hospital were implemented in a timely manner.</p> <p>Client A's Patient Summary Report dated 12/4/21, was reviewed on 12/22/21 at 10:11 AM. The review indicated client A was admitted to [name of hospital on 11/30/21 at 2:19 PM. The review indicated client A was diagnosed with acute kidney injury and vomiting. The review indicated the acute kidney injury was likely related to her (client A's) recent vomiting and medication usage.</p> <p>Staff #4 was interviewed on 12/22/21 at 12:03 PM. Staff #4 was asked about the evening events at the the group home on 11/29/21. Staff #4 indicated when she arrived to work on 11/29/21 client A was not home. Staff #4 indicated she</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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 at the hospital due to being sick in the morning. Staff #4 indicated client A returned to the group home sometime between 3-4 PM. Staff #4 indicated she called HM #1 and told her she (staff #4) was having issues with client A taking her 4 PM medications. Staff #4 stated, "[HM #1] was going to call the nurse and I pushed (held) the medications until 4:30 PM and tried to give her (client A) the meds again and she (client A) got them down. I called [HM #1] again she said to call [LPN #1]. [LPN #1] instructed me to give her soft foods and fluids. [LPN #1] told me to hold her 6 PM meds and crush her 8 PM meds." Staff #4 stated, "Every time I tried to give her (client A) her 8 PM meds, she would refuse. I tried to give her dinner and she refused. I called [LPN #1] back and [LPN #1] said best bet would be to take her to the hospital if she (client A) couldn't keep her meds down and was not eating." Staff #4 was asked what communication occurred after the instructions were given for client A to go to the hospital. Staff #4 indicated she had communicated with HM #1 and HM #1 had indicated she (HM #1) was going to be coming in to take client A to the hospital. Staff #4 indicated she told HM #1 she would stay with client A until her relief arrived. Staff #4 was asked if client A had experienced any more vomiting or nausea throughout the evening. Staff #4 indicated she (client A) had only vomited one time between when she (client A) came back to the hospital and when staff #4 left around 11:00 PM. Staff #4 indicated client A was experiencing dry heaving throughout the night and was refusing to allow anything around her mouth. Staff #4 was asked if any other communication was made with LPN #1 after the initial instructions were given for client A to go to the hospital. Staff #4 stated, "No." Staff #4 indicated staff #6 arrived around 10 PM and he (staff #6) called FPC #1 and told</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>FPC #1 client A was sick and FPC #1 indicated HM #1 was coming in at 1 AM to take her (client A) to the hospital. Staff #4 was asked if any communication was made with LPN #1 to discuss the plan for transportation of client A to the hospital or if other arrangements needed to be made. Staff #4 indicated no. Staff #4 was asked if any discussion of calling an ambulance to transport client A to the hospital was presented due to HM #1 not being able to come in until at least 1 AM. Staff #4 indicated there was no discussion regarding calling an ambulance.</p> <p>Staff #6 was interviewed on 12/22/21 at 12:58 PM. Staff #6 was asked about the events that occurred on the evening of 11/29/21. Staff #6 indicated when he arrived to work he was told that HM #1 was going to be coming in to take client A to the hospital because she was sick. Staff #6 was asked if he contacted anyone when HM #1 did not arrive at 1 AM to take client A to the hospital. Staff #6 indicated he did not. Staff #6 stated, "I did not have anyone else's number from the home. I just kept trying to call [HM #1]." Staff #6 was asked if he had completed CST for the clients or site specific training for the group home. Staff #6 indicated he had not. Staff #6 stated, "I was informed the same day and same evening about the shift to cover it. [FPC #1] contacted me about working. When I spoke to [FPC #1] I did tell her that was a house I was not trained in. I don't think she said anything back in response to me telling her that I was not trained." Staff #6 was asked how often he checked on client A throughout the night. Staff #6 indicated he checked on her about every 15-20 minutes throughout the night. Staff #6 indicated she was kept in her wheelchair throughout the night as he was told she was going to be going to the hospital</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>so they didn't lay her down. Staff #6 was asked if client A had gotten sick during his overnight shift. Staff #6 indicated she had not experienced any vomiting or dry heaving incidents overnight.</p> <p>HM #1 was interviewed on 12/21/21 at 11:12 AM. HM #1 was asked about the events that occurred on the evening of 11/29/21. HM #1 indicated she was contacted by staff #4 who reported client A wouldn't take her medications and couldn't keep them down. HM #1 indicated staff #4 reported client A was gagging when staff #4 would attempt to put the medications up to her mouth. HM #1 stated, "I contacted [FPC #1], [FAD #1], and [LPN #1]. At the time my phone was off so I was using a text app (application)." HM #1 was asked if instructions were given for client A to be taken to the hospital. HM #1 indicated yes. HM #1 indicated she had planned to go in and take client A to the hospital, but had issues with getting some personal arrangements taken care of and was unable to come in. HM #1 indicated she attempted to contact FPC #1, FAD #1, and LPN #1 during the night via text message to let them know she (HM #1) was not going to be able to come in to take client A and she did not receive any responses. HM #1 indicated she went to the group home on the morning of 11/30/21 and took client A to the hospital at around 9:30 AM. HM #1 indicated client A did not vomit at any point in the morning or at the ER.</p> <p>LPN #1 was interviewed on 12/22/21 at 2:15 PM. LPN #1 was asked about the events that occurred on the evening of 11/29/21. LPN #1 indicated she spoke with staff #4 on at least 3 occasions regarding trying different things to help client A keep her meds down. LPN #1 stated, "After the 8 PM meds when she (client A)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G409	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  12/30/2021
--	---	---	---

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

(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>couldn't keep them down, around 8-8:30 PM the decision was made to take her to the hospital. I told [staff #4] to call [HM #1] and [FPC #1] and she (client A) need to go to the hospital." LPN #1 was asked what the plan was for client A to be transported to the hospital. LPN #1 indicated after the instructions were given for client A to be taken to the hospital she (LPN #1) was not communicated with again by any staff. LPN #1 indicated she had contacted DON (Director of Nursing) alerting her of the situation and attempted to contact QIDP #1 via text message. LPN #1 indicated she was not made aware of client A not going to the hospital until the morning of 11/30/21. LPN #1 was asked if a delay should have occurred in getting client A to the hospital after she (LPN #1) had given the instructions. LPN #1 stated, "No, the expectation is that if a client is instructed to be taken to the hospital, then it needs to be done immediately." LPN #1 was asked if she attempted to follow-up with any of the staff at the group home during the night to ensure client A was transported to the hospital. LPN #1 indicated she did not assess client A.</p> <p>QIDP #1 and RD #1 were interviewed on 12/27/21 at 11:01 AM. RD #1 was asked if directions were given from the facility nurse for a client to be taken to the hospital for evaluation, when should this directive be carried out. RD #1 stated, "Should be carried out immediately." QIDP #1 was asked if issues arise and staff are unable to complete tasks instructed for them to do in a timely manner, what communication should occur. QIDP #1 indicated staff should utilize the chain of command calling. QIDP #1 stated, "Staff should be calling and notifying the PC (Program Director) and move up the chain from there." RD #1 was asked if a nurse or</p>			

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  12/30/2021	
NAME OF PROVIDER OR SUPPLIER  DEVELOPMENTAL SERVICE ALTERNATIVES				STREET ADDRESS, CITY, STATE, ZIP CODE 912 N PARKWAY DR ANDERSON, IN 46013			
(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>supervisor were to give instructions to staff pertaining to the care and/or health and safety of the clients, what expected follow up should occur and in what timeframe should this occur. RD #1 stated, "The nurse should be closing the loop. She (nurse) should be making follow up calls and making sure instructions were followed through." RD #1 was asked if the proper follow up by the nurse occurred on the evening of 11/29/21. RD #1 stated, "No."</p> <p>This federal tag relates to complaint #IN00368243.</p> <p>9-3-6(a)</p>						