PRINTED: 09/19/2022

	PARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES							
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255				JILDING	onstruction <u>00</u>	X3) DATE SURVEY COMPLETED 08/25/2022		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD			
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN	VERSAILLES, IN 47042					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
W 0000								
Bldg. 00	recertification and s	pre-determined full state licensure survey. 22, 8/23/22, 8/24/22 and	W	0000				
	accordance with 46	15G255 0248960 also reflect state findings in 0 IAC 9. this report completed by #15068						
W 0227	483.440(c)(4)							
Bldg. 00	specific objectives client's needs, as comprehensive as paragraph (c)(3) of Based on record rev	gram plan states the some necessary to meet the identified by the seessment required by this section.	W)227	W227: Program Implementati	ion	09/18/2022	
), the facility failed to develop fter client #1 was hospitalized						
	on 8/4/22 and diagr infection.	nosed with a urinary tract			Corrective Action: Nurse created a High Ri Plan for Urinary Tract Infection			
	Bureau of Develope (BDDS) incident re	PM, a review of the facility's mental Disabilities Services sports was conducted. The e following incident report			client (1). (Attachment A) All staff trained on client High Risk Plan for Urinary Tra Infection. (Attachment B) Nurse completes weekly audit to ensure all medical pla	act		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

BDDS incident report dated 8/4/22 indicated, "On

which affected client #1:

TITLE

audit to ensure all medical plans

are in place. (Attachment C)

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 4GO711 Facility ID: 000775 If continuation sheet Page 1 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 08/25/2022			
		PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		154 CH	DDRESS, CITY, STATE, ZIP COD AD DR ILLES, IN 47042			
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	ind	8/4/22 at 6:35 AM, his room and into the was having trouble head, and face were right. Staff called 9 transported to [nam	[client #1] a [age], came out of ne kitchen. Staff noticed he standing and that his body, e leaning and dropping to the 11 and [client #1] was e] Hospital where he was liagnosis) of UTI (urinary tract		1710	Monitoring of Corrective Action: Nurse will update all plan annually and as needed. Nurse weekly audit is se the IDT weekly for review.		BAIL	
		On 8/23/22 at 11:08	3 AM, client #1's record was			Completion Date: 9/18/22			
		for Appointment: S weakness with facia Examination: UTI (Pneumonia sugg x-rays (electronic in Orders/Recommend	ated 8/4/22 indicated, "Reason troke Symptoms/Right side al droop. Results/Findings of (Urinary Tract Infection) / ested by labs (laboratory) and maging) Physician/Consult dations: Admit for management uids and antibiotics".						
		indicated, "Date of Discharge: 8/5/22 suspicious for infec (milligrams) IV dai	summary dated 8/5/22 Admission: 8/4/22 Date of Plan: Urinanlysis (sic) is tion Rocephin 1000 mg ly and monitor output Urinary acute cystitis (inflammation of						
			dated 8/22/22 indicated, 8/5 (2022) for UTI/Pneumonia 1".						
		-No Health Risk Pla for review.	an to prevent UTI was available						
		Disabilities Profess The QIDP was aske	O AM, the Qualified Intellectual ional (QIDP) was interviewed. ed about client #1's recent if a health risk plan for UTI						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	ľ í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED		
		15G255	B. W	/ING		08/25/	2022	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		154 CH	DDRESS, CITY, STATE, ZIP COD AD DR ILLES, IN 47042			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.IE	DATE	
	was available for re	view. The QIDP stated, "He						
	has had a hospitaliz	ation for UTI, we should have						
	a UTI plan for him". The QIDP indicated client #1							
	did not have a healt	h risk plan for UTI available						
	for review.							
	On 8/23/22 at 1:02 PM, the Qualified Intellectual							
		onal Designee (QIDPD) was						
	-	IDPD was asked about client						
		ization and if a health risk plan						
	-	ble for review. The QIDPD						
		t been informed about a						
		The QIDPD indicated client #1						
	did not have a healt	h risk plan for UTI available						
	for review.							
	0 9/25/22 + 10 50	AM (1 N						
		AM, the Nurse was						
		urse was asked about client, diagnosis of UTI and need for						
	-	e Nurse stated, "He developed						
	-	ehabilitation) at the nursing						
	- '	was asked if client #1 had a						
		The Nurse stated, "Yes". The						
		client #1 had a health risk plan						
		reviewed client #1 record and						
	stated at 10:56 AM,	, "No, I don't see that". The						
	Nurse was asked if	client #1 needed a health risk						
	plan for UTI. The N	Nurse stated, "Yes".						
	On 8/25/22 at 12:50	PM, the Program Manager was						
		ogram Manager was asked						
		ed for a UTI health risk plan.						
		ger stated, "Yes, there should						
		omething should have been put						
	into place".							
	9-3-4(a)							
W 0252	483.440(e)(1)	IN ACRICATION I						
	PROGRAM DOCI	JMENTATION						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4GO711 Facility ID: 000775

If continuation sheet Page 3 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00	COMPL	
		15G255	B. W	ING		08/25/	2022
	ROVIDER OR SUPPLIER	LTERNATIVES SE IN	-	STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00	Data relative to ac	complishment of the					
	·	n client individual program					
	plan objectives must be documented in measurable terms.						
	Based on observation, record review and		W ()252	W252: Program Implementation	on	09/18/2022
	interview for 1 of 3 sampled clients (#1), the						
	-	sure staff documented on client					
		ministration Record (MAR)			Corrective Action:		
		did not receive his nebulizer			· All staff trained on		
		according to his physician's			medication administration poli	cy.	
	orders.				(Attachment B)		
	E' 1' ' 1 1				· Area Supervisor trained	on	
	Findings include:				weekly medication audits.		
	01 .:				(Attachment D)		
		conducted at the group home			Staff received disciplinary		
		66 PM to 6:15 PM and on			actions for failing to administe	ra	
		AM to 9:08 AM. During these #1 was supported by staff #3			prescribed medication.		
		medication administration on			(Attachment E) All staff trained on correct	.4	
		f #1 during his morning					
	-	stration on 8/23/22. On 8/22/22			way to document if a medication is not available in the home.	OH	
		asked client #1 if he was ready			(Attachment B)		
		tions and to come to the			· Area Supervisor will		
	_	tration room as she began to			complete medication audits or	ne	
		nedications. At 4:12 PM staff			time weekly on all medications		
		don't have Ipratropium 3 ml			the home. (Attachment D)		
		#3 indicated she could not			· Nurse completes weekly		
		's breathing treatment through			check in the home. (Attachme		
		a lack of medication supplies.			(C)	-	
		ceive his breathing treatment			<u> </u>		
	by use of a nebulize	_					
	On 8/23/22 at 8:15	AM, staff #1 stated, "I had an			Monitoring of Corrective		
		izer. It's on here (medication			Action:		
	administration recor	rd), but I don't have it".			· Area Supervisor will send	t	
					weekly medication audit to the		
		AM, the Team Leader (TL) was			Program Manager for review a	and to	
		L was asked about client #1's			ensure completion.		
	breathing treatment	_			Nurse weekly check is see	ent	
	medication supplies	to administer his breathing			to the IDT for review.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/25/2022	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	154 CI	ADDRESS, CITY, STATE, ZIP COD HAD DR AILLES, IN 47042	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
	them know I still no the doctor and phar	stated, "I called [name] to let seeded the nebulizer. It's both macy issue. As far as I know, a supposed to send it over to		Completion Date: 9/18/22	
		3 AM, client #1's record was rd indicated the following:			
	"Ipratropium / Sol (dated 7/12/22 indicated, (solution) Albuter (asthma) s) (one vial) via nebulizer three			
	7/1/22 through 7/3 l Sol (solution) Albu nebulizer three time PM". Client #1's M staff initials for a la 7/13/22 through 7/3	distration Record (MAR) dated /22 indicated, "Ipratropium / ter Use 3 ml (one vial) via es daily7 AM, 4 PM and 8 AR indicated circles around eck of administration from July 1/22 after client #1 had ng facility placement. In review			
	of the backside of c document the reaso completed on the fo during the month of	lient #1's MAR, staff failed to n client #1's breathing was not ollowing dates and times f July 2022:			
	"7/13 at 4 PM and 8 7/15 at 7 AM, 7/16 at 7AM and 4 7/17 at 4 PM and 8 7/18 at 4 PM and 8	PM, PM,			
	7/19 at 4 PM and 8 7/20 at 4 PM and 8 7/21 at 7 AM, 4 PM 7/22 at 7 AM, 4 PM 7/23 at 7 AM, 4 PM	PM, I and 8 PM, I and 8 PM, I and 8 PM,			
	7/24 at 4 PM and 8 7/25 at 4 PM and 8 7/26 at 4 PM and 8 7/27 at 4 PM and 8	PM, PM,			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4GO711 Facility ID: 000775

If continuation sheet

Page 5 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G255	B. W	ING		08/25	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	S.		154 CH			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			ILLES, IN 47042		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	7/28 at 7 AM, 4 PM	I and 8 PM,					
	7/29 at 7 AM, 4 PM						
	7/30 at 7 AM, 4 PM and 8 PM, and						
	7/31 at 4 PM and 8 PM".						
	-Medication Administration Record (MAR) dated						
		/22 indicated, "Ipratropium /					
	Sol (solution) Albut	ter Use 3 ml (one vial) via					
		es daily 7 AM, 4 PM and 8					
		AR indicated circles around					
		ck of administration from 8/1/22					
	_	review of the backside of					
		aff failed to document the					
		reathing was not completed on					
	_	and times during the month of					
	August 2022:	10 70 6					
	8/1 at 7 AM, 4 PM						
	8/2 at 7 AM, 4 PM						
	8/3 at 7 AM, 4 PM						
	8/4 at 7 AM, 4 PM a 8/5 at 7 AM, 4 PM a						
	8/6 at 7 AM, 4 PM						
	8/7 at 7 AM, 4 PM						
	8/8 at 7 AM, 4 PM	· ·					
	8/9 at 7 AM, 4 PM						
	8/10 at 7 AM, 4 PM	· · · · · · · · · · · · · · · · · · ·					
	8/11 at 7 AM, 4 PM						
	8/12 at 7 AM, 4 PM						
	8/13 at 7 AM, 4 PM						
	8/14 at 7 AM, 4 PM						
	8/15 at 7 AM, 4 PM						
	8/16 at 7 AM, 4 PM						
	8/17 at 7 AM, 4 PM						
	8/18 at 7 AM, 4 PM						
	8/19 at 7 AM, 4 PM	<i>'</i>					
	8/20 at 7 AM, 4 PM						
	8/21 at 7 AM, 4 PM						
	8/22 at 7 AM, 4 PM						
	8/23 at 7 AM".	<i>y</i> = -:-, -:					
			1				I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4GO711 Facility ID: 000775

If continuation sheet Page 6 of 21

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 08/25/2022	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	154 CH	ADDRESS, CITY, STATE, ZIP COD HAD DR AILLES, IN 47042		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		
	On 8/23/22 at 1:23 Disabilities Profess interviewed. The Q documentation of c on the backside of I don't have the meds we've not documen meds not given". The was a documentation MAR. The QIDPD On 8/23/22 at 1:37 Disabilities Profess The QIDP was asked documentation on c did not receive his I stated, "Yes" and in document on the bareason his breathing. On 8/25/22 at 10:50 interviewed. The N #1's documentation not administered du August of 2022. The consistently document and time breathing treatment. On 8/25/22 at 12:50 interviewed. The Program should document the sould be one". The Program should document the sould be one". The Program should document the sould be one when the sould be one th	PM, the Qualified Intellectual ional Designee (QIDPD) was IDPD was asked about staff lient #1's breathing treatment MAR. The QIDPD stated, "We is (medication supplies) and ted why we're circling the me QIDPD was asked if this on error by staff on client #1's				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4GO711 Facility ID: 000775

If continuation sheet

Page 7 of 21

PRINTED: 09/19/2022 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 08/25/2022	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	154 CH	ADDRESS, CITY, STATE, ZIP COD HAD DR AILLES, IN 47042		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LEGG IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
W 0368 Bldg. 00	all dates and times of The Program Mana 9-3-4(a) 483.460(k)(1) DRUG ADMINIST The system for dru assure that all dru compliance with the Based on record revisampled clients (#3 and #6), the facility #4 and #6's medicate physician's orders. Findings include: On 8/22/22 at 2:14 Bureau of Developm (BDDS) incident review indicated the affected clients #3, 1) BDDS incident review indicated the affected clients #3, 1) BDDS incident review indicated the affected clients #3, 1) BDDS incident review indicated the affected clients #3, 1) BDDS incident review indicated the affected clients #3, 1) BDDS incident review indicated the affected clients #3, 1) BDDS incident review indicated the affected clients #3, 1) BDDS incident review indicated the affected clients #3,	ELSC IDENTIFYING INFORMATION client #1 missed his treatment. ger stated, "Yeah". RATION ug administration must gs are administered in ne physician's orders. view and interview for 1 of 3), and 2 additional clients (#4 failed to administer clients #3, viions according to their PM, a review of the facility's mental Disabilities Services ports was conducted. The te following incidents which	W 0368	W368: The facility for drug administration must assure that drugs, including those that are self-administered are administe without error. Corrective Action: Staff received a medication error as a result of not administering client (3) medications (Attachment F) Staff received a medication error as a result of not administering client (4) medications (Attachment G) Staff received a medication error as a result of not administering client (4) medications (Attachment G) Staff received a medication error as a result of not administering client (6)	DATE 09/18/2022 et all ered on	
	pass". 2) BDDS incident r "[Client #6] is order bowel syndrome) 0 Hyoscyamine was s the home in the more 6/25/22. The month	eport dated 6/27/22 indicated, red Hyoscyamine (irritable .125 mg 3 times daily. The scheduled to be delivered at nthly cycle refill delivery on aly cycle refill was not delivered 6/22, [Client #6] did not have		medications (Attachment H) All staff trained on Medication Administration. (Attachment B) Area Supervisor will cond medication administration observations weekly for no less than 60 days. (Attachment D) Nurse Manager or Design will complete 1 medication	s	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4GO711

Facility ID: 000775

If continuation sheet

Page 8 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G255	B. W	ING		08/25/	/2022
		<u>I</u>	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹		154 CH			
RES CAR	RE COMMINITY A	LTERNATIVES SE IN			ILLES, IN 47042		
INLO CAI	L COMMONTT A	LILIMATIVES SE IIV		VLNSA			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		.125 mg in the home for			administration observation we	ekly	
		y 6/27/22 at the 7 AM. He did			for no less than 60 days.		
		amine 0.125 mg (2 tablets) at 7			(Attachment I)		
		22. [Client #6] has not					
	experienced any negative effects from this med error".				l		
	error".				Monitoring of Corrective		
	3) BDDS incident report dated 6/26/22 indicated,				Action:	d 4	
		red Hyoscyamine 0.125 mg 3			· Area Supervisor will cond		
		voscyamine was scheduled to			med pass observations 2 time week for no less than 60 days		
		home in the monthly cycle refill			submit the observation to the	anu	
		He did not receive			Program Manager for review a	and to	
	_	5 mg (2 tablets) at 4 PM and 8			ensure completion.	and to	
		ient #6] did not experience any			Area Supervisor will repo	ort	
	negative effects from				any issues with medication		
	8				administration to the Program		
	4) BDDS incident r	report dated 3/25/22 indicated,			Manager and Nurse immediat		
		red Divalproex (anticonvulsant)			Nurse retrained all staff of	-	
	500 mg DR (delaye	ed release) (3 tablets) at 8 PM.			medication administration.		
	Last night (3/24/22)) while completing the 8 PM			· Nurse completes weekly		
	med pass staff foun	d a med error. The med error			medication pass observations		
		PM [client #3] received			· Nurse sends completed		
		ER (extended release) (1 tablet)			medication observations to Nเ	ırse	
		lets that are ordered. [Client			Manager.		
		nced any negative effects from					
	this med error".						
	5) PDDC : ::	. 1 . 12/20/22 : " 1			Completion Date: 9/18/22		
	l '	report dated 2/20/22 indicated,					
		red Lovastatin (cholesterol) 20					
		the staff was passing meds					
		rror. The med error is: On was given Lovastatin 20 mg at 6					
		the Lovastatin 20 mg again at					
	_	0 mg dose for the day. [Client					
		nced any negative effects from					
	this med error".	need any negative cricets from					
	ans med entri .						
	On 8/23/22 at 10:14	4 AM, client #3's record was					
		rd indicated the following:					
	13.10						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	00	COMPL	ETED
		15G255	B. W	ING		08/25/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8		154 CH			
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN			ILLES, IN 47042		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
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TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
		ated 6/6/22 indicated,					
	"Divalproex Tab (ta	ablet) 500 mg DR Sub					
	(substitute) for Depakote (anticonvulsant): Give						
	two (2) tablets (100	00 mg) by mouth every morning					
	DX (diagnosis): Seizures						
	Division on Tab 50	00 m a DD airea thmaa (2)					
	-	00 mg DR give three (3) by mouth every evening. DX:					
	Seizures".	y mount every evening. DA.					
	Scizures						
	On 8/24/22 at 2:15	PM, a focused review of client					
		iducted. The review indicated					
	the following:						
	I	ated 6/6/22 indicated,					
		mg Give one tablet by					
	_	or cholesterol give with meal					
	".						
	On 8/24/22 at 2:19	PM, a focused review of client					
		iducted. The review indicated					
	the following:	radicted. The feview indicated					
		ated 6/6/22 indicated,					
	"Sertraline Tab 100	_					
		ive one tablet by mouth every					
	morning. Give with	50 mg to equal 150 mg.					
	Sartralina Tab 100	mg Give **one half** tablet					
		every morning. Give with 100					
	mg to equal 150 mg						
	ing to equal 150 life	5···					
	- Hyoscyamine 0.12	25 mg Give two (2) tablets by					
		laily before meals. DX:					
	Diarrhea".						
		PM, the Qualified Intellectual					
		ional Designee (QIDPD) was					
	`	IDPD was asked about the					
	incident history of i	medication errors for clients #3,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4GO711 Facility ID: 000775

If continuation sheet Page 10 of 21

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY PLETED P5/2022
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	154 CH	ADDRESS, CITY, STATE, ZIP IAD DR NLLES, IN 47042	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	DRRECTION SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	#4 and #6. The QID medication errors he indicated medication according to physic On 8/23/22 at 1:37. Disabilities Profess: The QIDP was asked medication error for QIDP indicated a proccurred. The QIDI medications and being doses of medication clients #3, #4 and # stated, "Yes". The Comedication errors he "Yes. It's errors account QIDP indicated medication errors he "Yes. It's errors account without error. On 8/25/22 at 10:50 interviewed. The New of medication errors Nurse indicated she incident of medication has called into the Nurse was asked ab medications not given Nurse indicated she some of the pattern before she began we #6. The Nurse was administered according without error. The Nore Nore Nore Nore Nore Nore Nore Nor	PPD indicated a pattern of ad occurred. The QIDPD in should be administered ian orders without error. PM, the Qualified Intellectual ional (QIDP) was interviewed. Id about the incident history of a clients #3, #4 and #6. The attern of medication errors had a was asked if missed ing given extra 20 milligram is were not according to 6's physician orders. The QIDP QIDP was asked if a pattern of ad occurred. The QIDP stated, ording to our policy". The dications should be ling to the physician orders PAM, the Nurse was arse was asked about a pattern is for clients #3, #4 and #6. The could recall client #6's ion not being delivered. The I think he missed a dose. It back up pharmacy". The out clients #3, #4 and #6's en and/or an extra dose. The started in June of 2022 and of medication errors was orking with clients #3. #4 and asked if medications should be ling to their physician's order Nurse stated, "Yeah".				
	about the pattern of	medication error history	1			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4G0711 Faci

Facility ID: 000775

If continuation sheet

Page 11 of 21

i ´		r í	(X2) MULTIPLE CONSTRUCTION (X3) DATE				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		15G255	B. WI	NG		08/25/	/2022
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		154 CH	ADDRESS, CITY, STATE, ZIP COD IAD DR IILLES, IN 47042		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	recall client #6's me delivered in time an to staff failing to ad physician orders. The asked if clients #3, if be administered acc	n Manager indicated she could edications had not been did the other errors were related minister according to their ne Program Manager was #4 and #6's medications should ording to the physicians to The Program Manager nould".					
W 0369	483.460(k)(2) DRUG ADMINIST	RATION					
Bldg. 00	The system for dru assure that all dru self-administered, error. Based on observation interview for 1 of 3 facility failed to ens	gs, including those that are are administration must gs, including those that are are administered without on, record review and sampled clients (#1), the sure client #1 received his treatment according to his	w o	369	W369: The facility for drug administration must assure the drugs, including those that are self-administered are administ without error.	:	09/18/2022
	Findings include: Observations were conducted at the group home on 8/22/22 from 3:56 PM to 6:15 PM and on 8/23/22 from 6:15 AM to 9:08 AM. During these observations, client #1 was supported by staff #3 during his evening medication administration on 8/22/22, and by staff #1 during his morning medications administration on 8/23/22. On 8/22/22 at 4:06 PM, staff #3 asked client #1 if he was ready for evening medications and to come to the medication administration room as she began to prepare client #1's medications. At 4:12 PM staff #3 stated, "We still don't have Ipratropium 3 ml (milliliters)". Staff #3 indicated she could not administer client #1's breathing treatment through				Corrective Action: All staff trained on medication administration polic (Attachment B) Area Supervisor trained of weekly medication audits. (Attachment D) Staff received disciplinary actions for failing to administe prescribed medication. (Attachment E) All staff trained on correct way to document if a medication is not available in the home. (Attachment B)	on y ra	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4GO711 Facility ID: 000775

If continuation sheet Page 12 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 08/25/2022			
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	(X5) COMPLETION DATE			
140	his nebulizer due to Client #1 did not re by use of a nebulize On 8/23/22 at 8:15 issue with his nebul	a lack of medication supplies. ceive his breathing treatment	TAG	Area Supervisor will complete medication audits of time weekly on all medication the home. (Attachment D) Nurse completes weekly check in the home. (Attachment C) Area Supervisor will	one as in		
	On 8/23/22 at 8:24 AM, the Team Leader (TL) was interviewed. The TL was asked about client #1's breathing treatment and not having the medication supplies to administer his breathing treatment. The TL stated, "I called [name] to let them know I still needed the nebulizer. It's both the doctor and pharmacy issue. As far as I know, [pharmacy name] is supposed to send it over to [medical store]".			complete the new Medication Storage Checklist All staff retrained on medication administration. (Attachment · Area Supervisor will con 2 medication administration observations weekly for no le than 60 days. (Attachment D · Nurse Manager or Designation	J) nduct ss		
	reviewed. The recon- -Physician's orders "Ipratropium / Sol (AM, client #1's record was and indicated the following: dated 7/12/22 indicated, solution) Albuter (asthma) s) (one vial) via nebulizer three		administration observation we for no less than 60 days. (Attachment I)	eekly		
	7/1/22 through 7/31 Sol (solution) Albut nebulizer three time PM". Client #1's M staff initials for a la breathing treatment 7/31/22 after client facility placement. -Medication Admin	istration Record (MAR) dated /22 indicated, "Ipratropium / er Use 3 ml (one vial) via s daily 7 AM, 4 PM and 8 AR indicated circles around ck of administering his s from July 7/13/22 through #1 had returned from nursing istration Record (MAR) dated /22 indicated, "Ipratropium /		Monitoring of Corrective Action: Area Supervisor will corweekly med administration observation and submit to the Program Manager for review ensure completion. Site Supervisor will report any issues with medication administration to the Program Manager and Nurse immediator Area Supervisor retrained	and to ort tely.		
	Sol (solution) Albut	ser Use 3 ml (one vial) via staily 7 AM, 4 PM and 8		staff on medication administr Nurse sends completed	ation.		

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRU			(X3) DATE SURVEY		
		IDENTIFICATION NUMBER		JILDING	00	COMPLETED		
15G255			B. W.	ING		08/25/	2022	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	-	STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		AR indicated circles around			medication observations to Nu	ırse		
		ck of administering his			Manager.			
	breathing treatment	s from 8/1/22 through 8/23/22.						
	Disabilities Professinterviewed. The Qiof medication supplementing treatment orders and if it was administration error don't have the meds. The QIDPD was asserror. The QIDPD sindicated medication according to the physical profession. The QIDP was asked to the physical profession.	PM, the Qualified Intellectual ional Designee (QIDPD) was IDPD was asked about the lack lies to complete client #1's according to his physician considered a medication of the Policy of			Completion Date: 9/18/22			
		to his physician orders and if						
		medication administration licated client #1 not receiving						
		ing treatment according to						
		as a medication error. The						
	QIDP indicated med	dication should be						
		ling to client #1's physician						
		r and stated, "Yes. It's errors						
	according to our po	iicy".						
		AM, the Nurse was						
		urse was asked about client						
		ng treatments. The Nurse						
		home, I think it was Tuesday I if they did not have the						
		nachine. I was reassured he did						
		n. I brought the machine here						
		ted". The Nurse reviewed the						
		tration room and at 11:04 AM						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4GO711 Facility ID: 000775

If continuation sheet Page 14 of 21

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER 15G255	A. BU B. WII		00	08/25		
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD			
RES CAF	RE COMMUNITY AI	LTERNATIVES SE IN			ILLES, IN 47042			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG		c) 3 boxes of it (medication)	+	TAG	BEI CELICIT		DATE	
		ere, and I brought the machine						
		ew machine here". The Nurse						
		chine was just delivered. The						
		not the medication, but the						
	machine, yes". The	Nurse indicated all medical						
	supplies were curren	ntly available to complete						
	client #1's breathing	treatments.						
	On 8/25/22 at 12:59	PM, the Program Manager was						
	interviewed. The Program Manager was asked about client #1's missed breathing treatment and if those treatments should have been administered							
		cians orders without error.						
	The Program Manager stated, "Yes, they should".							
	9-3-6(a)							
W 0455	483.470(I)(1)							
DI . 00	INFECTION CON							
Bldg. 00		active program for the						
	•	I, and investigation of municable diseases.						
		on, record review and	W 0	155	W455: The facility must prov	ide a	09/18/2022	
		sampled clients (#2), and 1	** 0	433	sanitary environment to avoid		09/16/2022	
), the facility failed to ensure			sources and transmission of			
		actices were implemented			infections.			
	-	#7 were not provided plates						
	to place their toast of	on during their morning meal.			Corrective Action:			
	Findings include:				All staff trained on mealti plans and procedures, ensuring			
	An observation was	conducted on 8/23/22 from			the surfaces are cleaned prior	_		
		M. At 6:27 AM, clients #2 and			meals, all food is served on pl			
		s at the dining room table for			or in bowls. (Attachment B)			
		which consisted of oatmeal,			· Area Supervisor will			
	yogurt, toast with co	offee and juice to drink.			complete mealtime observation	ns 2		
		ad 2 bowls for their oatmeal			times weekly for no less than	30		
		AM, both clients #2 and #7			days to ensure infection contr	ol		
	were seated at oppo	site ends of the table and			practices are implemented.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4GO711

Facility ID: 000775

If continuation sheet

Page 15 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/25/2022	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	154 (T ADDRESS, CITY, STATE, ZIP COD CHAD DR SAILLES, IN 47042	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ast. Clients #2 and #7 were not	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY) (Attachment D)	N (X5) SEE COMPLETION DATE
	provided small plates and would take a bite and then lay their toast down on the surface of the dining room table. Client #7 picked his toast up and finished eating it. At 6:49 AM, client #7 stood and took his two bowls to the kitchen sink. Client #2 continued to eat his toast and lay it back down on the surface of the dining room table between			Rescare Management complete mealtime observa times weekly for no less that days to ensure infection compractices are implemented. (Attachment K)	tions 2 in 30
	bites. At 6:50 AM, with his left hand a laid his toast back of table. At 6:51 AM, up with his left han laid it back down of Client #2 used his rebowls together from oatmeal and yogurt	client #2 picked his toast up and took a bite. Client #2 then lown on the surface of the client #2 picked his toast back d and took another bite and an the surface of the table. ight hand to put his two empty an where he finished eating his client #2 then picked the toast up from the table surface		Monitoring of Corrective Action: The Area Supervisor a Supervisor will send comple observations to the Program Manager for monitoring and ensure completion. Rescare Management observations will be sent to Program Manager for review ensure completion.	eted n I to the
	interviewed. The Tenough plates for so TL nodded her head cabinet to show the everyone. The TL velients #2 and #7 di their toast down on dining room table. Stated, "That's my f should have set mo lack of infection co and #7 had to lay the surface of the dining her head yes. On 8/23/22 at 12:17 reviewed. The reviewed.	AM, the Team Leader (TL) was L was asked if the home had erving the morning meal. The d yes and opened a kitchen re was enough plates for was asked if she had noticed d not have small plates to lay and used the surface of the The TL shook her head no and fault. I did not notice that. I re". The TL was asked about a nitrol practice when clients #2 their piece of toast down on the g room table. The TL nodded		Completion Date: 9/18/22	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	CON	TE SURVEY MPLETED 25/2022		
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	indicated, "Priority Objectives: Mealtime safety Methodology: Staff will supervise mealtimes".						
	On 8/24/22 at 3:34 PM, a focused review of client #7's record was conducted. The review indicated the following:						
	-Individual Support Plan (ISP) dated 8/6/22 indicated, "Who is [client #7]: Needs verbal assistance to complete all ADLs (adult living skills) Priority Objectives: Mealtime safety Goal #4: Mealtime Safety Methodology: Staff will supervise meals".						
	On 8/23/22 at 1:23 PM, the Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed. The QIDPD was asked about clients #2 and #7 placing their toast on the dining room table and implementation of infection control practices. The QIDPD stated, "Should have been on a napkin or a plate". The QIDPD was asked if clients #2 and #7 act of putting their toast on the surface of the dining room table was a lack of infection control. The QIDPD nodded her head yes.						
	On 8/23/22 at 1:37 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about clients #2 and #7 placing their toast on the dining room table and implementation of infection control practices. The QIDP stated, "Yes, it's an infection control issue". The QIDP indicated clients #2 and #7 should have used a plate to be able to place their toast down between bites.						
	On 8/25/22 at 10:50 AM, the Nurse was interviewed. The Nurse was asked about clients #2 and #7 placing their toast on the dining room table and implementation of infection control						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4GO711 Facility ID: 000775

If continuation sheet

Page 17 of 21

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		(X2) MULTIPLE CO A. BUILDING B. WING	X3) DATE SURVEY COMPLETED 08/25/2022				
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION PREFIX (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
W 9999	practices. The Nurs witnessed anything indicated she usuall supper mealtimes at control issues such toast onto the surfactonsuming it. The National would be a lack of istated, "Absolutely" On 8/25/22 at 12:59 interviewed. The Prabout infection contant #7 did not have toast down on the dark to the Program Mana	e stated, "Exactly, I've not like that". The Nurse y observed either the lunch or and had not witnessed infection as clients #2 and #7 placing the of the table and then Nurse was asked if this practice infection control. The Nurse			DATE		
Bldg. 00							
	Persons with Devel not met: 460 IAC 9-3-1(b) C (b) The residential processes to the following circumstate telephone no later the division: 16. A treatment error as for given; b. Wrong do	provider shall report the ances to the division by han the first business day summaries as requested by medication error or medical bllows: a. Wrong medication sage given; c. Missed	W 9999	W 9999: Governing Body: Corrective action: Quality Assurance Managinserviced that all medications errors are to be reported within hours to BDDS. (Attachment LAM All staff trained to report medication errors immediately a BDDS report is to be complet within 24 hours of the error. (Attachment B) Monitoring of Corrective Action:	24 .) as		
		ven; d. Medication given		·All incident reports are review	wed		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4GO711 Facility ID: 000775

If continuation sheet Page 18 of 21

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	r /		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G255	A. BUIL B. WING		00	COMPLETED 08/25/2022	
		100200	<u> </u>			00/25/	12022
NAME OF P	PROVIDER OR SUPPLIEI	R		STREET A	ADDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			AD DR ILLES, IN 47042		
							075)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	рі	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110		Medication error that			at quarterly safety meeting to		BITE
		vidual's health and welfare and			monitor for trends and pattern	S.	
	requires medical at	tention.			·Program Manager & Execu	tive	
					Director will receive a copy of		
	This state rule was	not met as evidenced by:			BDDS reports for thoroughnes	SS,	
	D 1 1				timeliness, and complete		
		on, record review and			adherence to state requiremen	nts.	
		sampled clients (#1), the sure incidents involving					
	-	vere reported to the Bureau of			Completion Date: 9/18/22		
		abilities Services (BDDS)			2011piotion 24to: 0/10/22		
	within 24 hours.						
	Findings include:						
	On 8/22/22 at 2:14	PM, a review of the facility's					
		mental Disabilities Services					
	_	eports was conducted. No					
	BDDS incident rep	orts of client #1 missing					
	breathing treatment	ts due to a lack of Ipratropium 3					
	ml (asthma) medica	ation were provided for review.					
	Observations were	conducted at the group home					
		56 PM to 6:15 PM and on					
		AM to 9:08 AM. During these					
		t #1 was supported by staff #3					
		medication administration on					
	8/22/22, and by sta	ff #1 during his morning					
		istration on 8/23/22. On 8/22/22					
		3 asked client #1 if he was ready					
	•	tions and to come to the					
		stration room as she began to					
	prepare client #1's medications. At 4:12 PM staff #3 stated, "We still don't have Ipratropium 3 ml (milliliters)". Staff #3 indicated she could not						
		I's breathing treatment through					
		a lack of medication supplies.					
		eceive his breathing treatment					
	by use of a nebulize						
			1				I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4GO711

Facility ID: 000775

If continuation sheet

Page 19 of 21

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 00 COMPLE B. WING 08/25/2			ETED			
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	issue with his nebu	AM, staff #1 stated, "I had an lizer. It's on here (medication rd), but I don't have it".						
	On 8/23/22 at 11:08 AM, client #1's record was reviewed. The record indicated the following:							
	"Ipratropium / Sol (dated 7/12/22 indicated, (solution) (asthma) Use 3 ml al) via nebulizer three times daily						
	7/1/22 through 7/31 Sol (solution) Use three times daily7 #1's MAR indicated a lack of administer from July 7/13/22 t	nistration Record (MAR) dated 1/22 indicated, "Ipratropium / e 3 ml (one vial) via nebulizer 7 AM, 4 PM and 8 PM". Client d circles around staff initials for ring his breathing treatments hrough 7/31/22, once client #1 nis nursing facility placement.						
	8/1/22 through 8/31 Sol (solution) Use three times daily #1's MAR indicated	histration Record (MAR) dated 1/22 indicated, "Ipratropium / e 3 ml (one vial) via nebulizer 7 AM, 4 PM and 8 PM". Client dicircles around staff initials for ring his breathing treatments h 8/23/22.						
	Disabilities Profess interviewed. The Q reporting the lack of complete client #1's to his physician ordination administrated, "We don't have supplies)". The Q medication error. T	PM, the Qualified Intellectual ional Designee (QIDPD) was IDPD was asked about if medication supplies to separathing treatment according lers and if it was considered a stration error. The QIDPD have the meds (medication IDPD was asked if this was a separather in the QIDPD stated, "Yes". The medication errors should be						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4GO711 Facility ID: 000775

If continuation sheet

Page 20 of 21

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

PRINTED: 09/19/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPL	COMPLETED	
15G255			B. WING 08/25/2022				
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	reported to BDDS v	vithin 24 hours.					
	On 8/23/22 at 1:37 ld Disabilities Profession The QIDP was asked medication supplies breathing treatment orders and if it was administration error medication should be client #1's physician stated, "Yes. It's error The QIDP indicated reported to BDDS was administration of BDDS and August 2022 brown administered as indicated initials on his MAR so". The Nurse was administration error to BDDS within 24 is the policy, yes". On 8/25/22 at 12:59 interviewed. The Program 2022 missed breathing should have been reshours. The Program	PM, the Qualified Intellectual ional (QIDP) was interviewed. Id about reporting the lack of to complete client #1's according to his physician considered a medication. The QIDP indicated be administered according to a orders without error and ors according to our policy".					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 4GO711 Facility ID: 000775 If continuation sheet Page 21 of 21