STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G404	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 03/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	314 W 13TH ST ANDERSON, IN 46016

(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
W000000	This visit was for a fundamental recertification and state licensure survey. Dates of survey: March 3, 4, 5 and 6, 2014. Facility Number: 000918 Provider Number: 15G404 AIM Number: 100235430 Surveyor: Susan Reichert, QIDP These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed March 25, 2014 by Dotty Walton, QIDP.	W000000		

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

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

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W000149	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 4 sampled clients (clients #1, #3), and for 2 additional clients (clients #5 and #7), the facility neglected to implement policy and procedure to protect the clients from neglect of staff supervision (sleeping staff), and failed to protect and report for 1 of 4 sampled clients (client #2) an incident of improper restraint. Findings include: The facility's reports to the Bureau of Developmental Disabilities Services (BDDS) and investigations of abuse and neglect were reviewed on 3/3/14 at 4:44 PM and included the following: 1. An investigation completed 8/15/13 indicated on 8/11/13 clients #1 and #7 reported staff #11 had fallen asleep "one morning" (date not specified) while clients #1, #3, #5 and #7 were at the group home and were waiting for transportation to go to day services. Staff #11 was interviewed on 8/12/13 and indicated, in her statement, she "did nod off last week" and indicated she was asleep for "no more than 5 minutes."	W000149	W149-All staff will receive training on prohibition of abuse, neglect, and other forms of mistreatment. Additional training will include the requirement to report all suspected/alleged abuse/neglect/mistreatment immediately. Staff will demonstrate competency by passing a quiz. The Residential Director will complete weekly interviews with consumers to monitor that they are free from all forms of abuse and neglect and fade to monthly interviews.	04/05/2014

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	Client #1 was interviewed on 8/15/13 and indicated staff #11 had fallen asleep from 8:05 AM until 8:50 AM, and client #7 "had to yell at [staff #11] 2-3 times to wake her up...." Client #1 "states that no other staff was present," and "when asked why she waited until Sunday to say anything, states that she told someone, thinks it may have been [staff #12] on Thursday (date not specified) after it happened." Client #7 was interviewed on 8/15/13 and indicated, in her statement, staff #11 had fallen asleep from 8:05 AM until the van arrived to take clients #1, #3, #5 and herself to day services. Client #7 "states that she had to yell at [staff #11] about 5 times before [staff #11] woke up for her to leave when her van arrived." Staff #12 was interviewed on 8/15/13 and indicated she was unaware of the incident. Client #1 was interviewed again on 8/15/13 and indicated she had reported the incident to staff #12. The findings of the investigation indicated "1. [Staff #11] admitted to closing her eyes for approximately 45 minutes in length. 2. Consumers present at the time of the incident include [clients #1, #3, #5 and #7]. 3. It is unclear if [client #1] actually reported to a staff or just thought she had reported." The recommendation indicated staff #11 "should receive disciplinary action for			

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	neglect." 2. An investigation dated 10/24/13 indicated client #2 "alleged that [staff #13] had threatened to restrain take her down (restrain her) while she was on suicide watch." An interview dated 10/23/14 indicated client #2 "states that one of her staff threatened to take her down if she didn't sit up and she wanted to know if they were allowed to do this... [Client #2] states that she was just sitting on the couch and [staff #13] told her this." An interview dated 10/23/13 with staff #13 indicated client #2 was lying on the couch and she (staff #13) told client #2 "she was going to get permission from the RD (Residential Director) to take her down because she wasn't listening to her...." Staff #13 indicated client #2 was lying on the couch and "she was told that consumers aren't allowed to lie down and they had to be sitting up when on suicide watch...When asked who told her that consumers couldn't lay down while they were on suicide watch, [staff #13] indicated [staff #7] did." Staff #7 was interviewed on 10/24/13 and indicated she had not instructed staff #13 to "take down or contain a consumer lying on the couch." Staff #7 indicated client #2 had asked her if staff were able to "take her down for sitting on the couch," but did not provide names. There was no			

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	evidence staff #7 had reported the incident to administrative staff. Investigative findings indicated "1. [Staff #13] admitted to threatening punishment to [client #2] on 10/21/13. 2. Based upon this admission, [staff #13] violated DSA (Developmental Service Alternatives) policy Preventing Abuse/Neglect. 3. [Staff #7] failed to report the allegation told to her by [client #2]." The Residential Director was interviewed on 3/6/14 at 12:35 PM. She indicated the incident involving sleeping staff #11 reported on 8/11/13 involving clients #1, #3, #5, # and #7 and the incident on 10/23/13 involving client #2 being threatened with restraint by staff #13 was in violation of the facility's policy to prevent abuse and neglect. The facility's Preventing Abuse and Neglect policy dated 10/13 was reviewed on 3/3/14 at 3:00 PM and indicated "DSA, Inc. prohibits abuse, neglect, exploitation, mistreatment or violation of the rights of the consumers it serves...'Abuse' means the following:...Emotional/Verbal abuse including but is not limited to communicating with words or actions in a person's presence with intent to: (a) cause the individual to be placed in fear of retaliation;...cause the individual to be			

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	placed in fear of confinement or restraint;...cause the individual to experience emotional distress or humiliation...'Neglect' means failure to provide supervision, training, appropriate care, food, medical care or medical supervision to an individual...Immediately upon learning of an allegation of abuse/neglect, exploitation, sexual abuse and/or sexual exploitation or similar circumstances...staff are to immediately report the incident to the Residential Director on-call...." 9-3-2(a)			

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W000153	483.420(d)(2) 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. Based upon record review and interview, the facility failed for 1 of 4 sampled clients (client #2), to ensure allegations of staff intimidation were immediately reported to the administrative staff for 1 of 5 allegations of abuse and neglect reviewed. Findings include: An investigation dated 10/24/13 indicated client #2 "alleged that [staff #13] had threatened to take her down (restrain her) while she was on suicide watch." An interview dated 10/23/14 indicated client #2 "states that one of her staff threatened to take her down if she didn't sit up and she wanted to know if they were allowed to do this...." An interview dated 10/23/13 with staff #13 indicated client #2 was lying on the couch and she (staff #13) told client #2 "she was going to get permission from the RD (Residential Director) to take her down because she wasn't listening to her...." Staff #13 indicated client #2 was lying on the couch and "she was told that	W000153	W153- All staff will receive training on prohibition of abuse, neglect, and other forms of mistreatment. Additional training will include the requirement to report all suspected/alleged abuse/neglect/mistreatment immediately. Staff will demonstrate competency by passing a quiz. The Residential Director will complete weekly interviews with consumers to monitor that they are free from all forms of abuse and neglect and fade to monthly interviews.	04/05/2014

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	consumers aren't allowed to lie down and they had to be sitting up when on suicide watch...When asked who told her that consumers couldn't lay (sic) down while they were on suicide watch, [staff #13] indicated [staff #7] did". Staff #7 was interviewed on 10/24/13 and indicated she had not instructed staff #13 to "take down or contain a consumer lying on the couch." Staff #7 indicated client #2 had asked her if staff were able to "take her down for sitting on the couch," but did not provide names. There was no evidence staff #7 had reported the incident to administrative staff. Investigative findings indicated "...[Staff #7] failed to report the allegation told to her by [client #2]." The Residential Director was interviewed on 3/6/14 at 12:35 PM. She indicated the incident on 10/23/13 involving client #2 being threatened with restraint by staff #13 was in violation of the facility's policy to report abuse and neglect immediately to the facility's administrator. 9-3-2(a)			

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W000263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on observation, record review and interview, the facility failed to ensure written informed consent was obtained for 4 of 4 sampled clients (clients #1, #2, #3 and #4) for the practice of locking sharp implements and the use of door alarms. Findings include: Observations were completed at the group home on 3/4/14 from 5:00 PM until 6:40 PM. At 6:15 PM, staff #5 took a knife from the kitchen and locked it in the medication room. Staff #5 was interviewed on 3/4/14 at 6:16 PM. She indicated the knife and other sharp implements were locked up at the group home for the safety of clients #2 and #7. She indicated other clients in the home who did not need the restriction would gain access through staff. 1. Client #1's record was reviewed on 3/5/14 at 12:15 PM. An Individual Support Team Meeting Report dated 11/26/13 indicated "Continue to have	W000263	W263-The Residential Director will receive further training regarding the requirement that programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. The Residential Director will then obtain the required written consents and audit programs to assure that the necessary consents are present as necessary for clients 1,2,3 and 4. The Area Director will check records on a biweekly basis fading to intermittently to assure compliance.	04/05/2014

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	sharps locked up and use door alarms on the outside doors of the home." Client #1's record indicated she had a guardian to assist her in making decisions. There was no evidence client #1's guardian had signed consent for the practice of locking up sharps and for the use of door alarms. 2. Client #2's record was reviewed on 3/5/14 at 1:30 PM. An Individual Support Team Meeting Report dated 11/26/13 indicated "Continue to have sharps locked up and use door alarms on the outside doors of the home for health and safety of consumers." Client #2's record indicated she had a guardian to assist her in making decisions. There was no evidence client #2's guardian had signed consent for the practice of locking up sharps and for the use of door alarms. 3. Client #3's record was reviewed on 3/5/14 at 3:20 PM. An Individual Support Team Meeting Report dated 11/26/13 indicated "Continue to have sharps locked up and use door alarms on the outside doors of the home for health and safety of consumers." Client #3's record indicated he did not require a guardian to assist him in making decisions. There was no evidence client #3 signed consent for the practice of locking up sharps and for door alarms.			

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	4. Client #4's record was reviewed on 3/5/14 at 3:50 PM. An Individual Support Team Meeting Report dated 11/26/13 indicated "Continue to have sharps locked up and use door alarms on the outside doors of the home for health and safety of consumers." Client #4's record indicated she had a guardian to assist her in making decisions. There was no evidence client #4's guardian had signed consent for the practice of locking up sharps and for the use of door alarms. The Residential Director was interviewed on 3/6/14 at 4:41 PM and indicated the forms to obtain signatures of consent for the restrictive programs/practices had been mailed out to the clients' guardians, but had not been returned. 9-3-4(a)			

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W000323	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview, for 1 of 4 sampled clients (client #3), the facility failed to ensure his hearing was screened annually. Findings include: Client #3's record was reviewed on 3/5/14 at 3:20 PM. Client #3's annual physical examination dated 9/20/13 did not include a hearing screening. Client #3's last hearing assessment was 9/30/08 and indicated "annual audiogram...moderate conductive HL (hearing loss)...." The Residential Director was interviewed on 3/6/14 at 12:08 PM. She indicated there was no evidence client #3's hearing had been screened since 9/30/08. 9-3-6(a)	W000323	W323-Client 3 will be scheduled to have a hearing assessment. The nurse will audit to assure that all clients have current hearing assessments. Any necessary appointments will be scheduled as necessary. The Health Services Director and nurse will review the records monthly to assure compliance with requirements for an annual hearing screening.	04/05/2014

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W000391	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. Based on observation, record review and interview for 1 additional client (client #8) of 4 clients who received medications, the facility failed to ensure all medication labels were easily read (legible). Findings include: Medication administration conducted by the House Manager (HM) was observed at the group home on 3/5/14 at 6:35 AM. Client #8 was given 1 spray in each nostril of Flonase (allergies) 50 mcg (micrograms). The label on the plastic bag used to store the Flonase was illegible. Client #8's March, 2014 MAR (medication administration record) was reviewed on 3/5/14 at 6:45 AM. The MAR indicated client #8 was to administer 1 spray in each nostril of Flonase. The HM was interviewed on 3/5/14 at 6:40 AM and indicated the label was illegible.	W000391	W391-staff will receive training regarding the requirement that drug containers with worn, illegible, or missing labels must be removed from use. The nurse will complete medication cabinet audits to monitor for such issues biweekly.	04/05/2014

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	The Residential Director was interviewed on 3/5/14 at 4:25 PM and indicated the labels on medications being dispensed should be legible. 9-3-6(a)			