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 10/14/2011
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN46016	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0000	This visit was for an extended recertification and state licensure survey. Dates of survey: October 3, 4, 5, 6, 7, 12, 13, and 14, 2011 Surveyor: Kathy Craig, Medical Surveyor III Facility Number: 000918 Provider Number: 15G404 AIMS Number: 100235430 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/20/11 by Chris Greeney, Medical Surveyor Supervisor and Ruth Shackelford, Medical Surveyor III.	W0000		
W0122	The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement their	W0122	Please refer to the plan of correction for W149 and W157 for information as to how the agency will implement Prevention of Abuse and Neglect policy and	11/13/2011

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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	neglect policy by failing to protect 1 of 4 sampled clients (client #2) by not taking sufficient corrective action to prevent client #2 from completing harmful suicidal gestures after a pattern of suicidal gestures had been identified. Findings include: 1. The facility neglected to implement their policy for 1 of 2 sampled clients (client #2) by failing to supervise and protect client #2 from suicidal gestures. Please see W149. 2. The facility neglected to take sufficient corrective action for 1 of 2 sampled clients (client #2) to prevent her from attempting harmful suicidal gestures after a pattern had been established. Please see W157. 9-3-2(a)		will protect and take sufficient corrective action to prevent harmful suicidal gestures after a pattern of such has been identified.	

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W0149	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, the facility failed for 1 of 4 sampled clients (client #2) by not implementing their abuse/neglect policy by failing to provide sufficient corrective action to prevent her from harmful suicidal gestures after a pattern had been established. Findings include: Review on 10/3/11 at 2:50 PM of the facility's records included the following BDDS (Bureau of Developmental Disabilities Services) incident reports and an Index Event Prevention Review regarding client #2: 1. On 11/17/10, "staff noticed a reddened scraped area on [client #2]'s arm just above her wrist. When staff asked how that happened, she stated that she found a paring knife in the dishwasher and scraped her arm with it, unbeknownst to staff. No one saw [client #2] scraping her arm with the knife; it is just what she reported when staff asked why her arm was reddened. The nurse reported that [client #2] could have caused the injury with her fingernail. [Client #2] caused only a superficial nickel sized scrape. No blood drawn. . .All sharps have been	W0149	The facility policy 6.22 Consumers with Unusually High Service Needs has been revised to specify that harmful suicidal gestures occuring even once are cause for prompt IST review and response. The team will assure assessment, ISP revisions, and staff training to assist in keeping the consumer safe. "Index events" shall be identified that will initiate prompt review of the ISP for proposed revisions to prevent future recurrence. Staff will receive training regarding the revised policy and the responsibilities lying therein. Additionally, staff shall receive very specific training regarding facility policy 7.07 Preventing Abuse and Neglect.	11/13/2011

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	secured. [Client #2] will not be permitted access to sharps until the IST (interdisciplinary team) determines otherwise. [Client #2] now has 'eyes on' staffing at all times. Staff will also assure that [client]'s fingernails remain trimmed and smooth. [Client]'s brother is currently pursuing guardianship that should be finalized any day. The IST plans to pursue a more restrictive behavior plan that targets self injurious behavior. [Client #2] currently has an appointment with her counselor." 2. On 1/13/11, client #2 "was seen for routine counseling appointment at which time she stated to the counselor that she felt like she wanted to hurt herself. Counselor consulted with on-call psychiatrist who agreed to admit her to the [name of psychiatric center] for evaluation." The BDDS follow-up report dated 1/19/11 indicated client #2 was released from the center on 1/19/11. It indicated client #2 had medication changes to discontinue the 10 milligrams of Abilify and increased the Effexor from 75 mg (milligrams) to 150 mg. daily. It indicated staff "will continue to monitor [client #2]'s mental health upon her return to the group home. [Client #2] will resume her regular schedule upon returning to the group home which includes completing her training programs			

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	and following her Behavior Development Plan." 3. On 6/19/11, client #2 "gained access to the keys that secure the medication administration area and unbeknownst to staff, proceeded to take Ibuprofen in excess of what the physician had ordered for her. . .[Client #2] was evaluated by a physician and found to have suffered no ill effect as a result of taking the Ibuprofen. A procedure has been put into place requiring staff to carry keys to the medication administration area on their person at all person at all times, signing responsibility for the keys over shift to shift." The BDDS follow-up incident report dated 6/27/11 indicated client #2 "took the keys to the medication administration area from a table where the staff member had just been sitting reviewing documentation from the medication pass she'd just completed. The staff member stepped into the adjoining room to address a different situation, and [client #2] took the keys, unbeknownst to staff. Seven 200mg Ibuprofen were missing from [client]'s medication card. [Client #2] has a history of attention seeking behavior. Her intentions of taking the Ibuprofen are not known. She does have a Behavior Development Program that addresses suicide threats/attempts." It indicated			

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	"Staff at the home have received training regarding keeping the keys to the medication administration area on their (sic) person at all times they are not personally passing medications. Staff will physically wear the keys on a lanyard, clip, or bracelet. [Client #2] has suffered no ill effect as a result of this incident. She sees a psychiatrist regularly." The Plan to Resolve on these BDDS reports does not indicate if client #2 was to continue to be "eyes on" as previously indicated. 4. An Index Event Prevention Review dated 6/24/11 indicated the workshop rehab coordinator had called the RD (Residential Director) informing her client #2 "told a peer at workshop that she was attempting to cut her wrist with the cardboard they are working on. No injuries noted." The RD had the workshop coordinator to place client #2 on suicide watch and complete a report on the incident. It indicated "Note that earlier less than two hours earlier, [client #2] cut her hair with scissors because she didn't like the way her hair stuck out of her baseball cap she was wearing. [Client #2] was removed from the cardboard job for the rest of the day." It was noted on this report client #2 did not harm herself. 5. On 6/27/11, client #2 had an argument			

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	with her boyfriend. Client #2 attempted to cut herself with a safety razor. She ended up succeeding in causing a small pencil eraser sized cut. Special observation procedures were put into place for client #2 in which she was under constant supervision to assure her safety until the RD determined the intensified supervision could be lifted. It indicated "The home was searched for any other items she could harm herself with and all sharps were secured." The Plan to Resolve indicated client #2's "counseling appointment was moved up to 6/29/11. The IST met on 6/28/11 to review the incident. DSA staff will continue to monitor [client #2]'s health and safety." The follow-up report dated 7/5/11 indicated after this incident, intensified supervision remained in place for client #2 for 48 hours following this incident. Review on 10/3/11 at 2:40 PM of the facility's abuse/neglect policy dated 6/09 indicated "DSA, Inc., prohibits abuse, neglect, exploitation, mistreatment or violation of the rights of the consumers it serves. . ."Neglect" means failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual." Review on 10/4/11 at 11:00 AM of client #2's BDP (Behavior Development			

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	Program) Update dated 12/3/10, indicated client #2's "behavior has become increasingly erratic and her IST is gravely concerned that she will harm herself or place herself in danger. [Client #2] frequently voices suicidal ideations and makes suicidal gestures. Although there is a distinct manipulative quality to the suicidal behavior, [client #2] clearly knows how to kill herself and could do so either intentionally or by accident. Component 4 of the Behavior Development Program for [client #2] includes reactive procedures for protecting [client #2] when she makes suicide threats/attempts." Interview on 10/13/11 at 2:15 PM with the RD and the ARC (Area Residential Coordinator) was conducted. The RD indicated client #2's behavior plan had not been updated since December 2010. The ARC and the RD indicated after the June 19, 2011 incident, client #2 was determined to be a client with unusually high service needs and an index event prevention review will be created if client #2 has any suicide ideations. The RD and ARC indicated a protocol was put in place for client #2 when she threatens or attempts suicide and all staff were trained on it in July, 2011. They indicated client #2 has not threatened or attempted suicide since the June 27, 2011 incident.			

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	9-3-2(a)			
W0157	If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #2) by not taking sufficient corrective action to prevent her from harmful suicidal gestures after a pattern had been established. Findings include: Review on 10/3/11 at 2:50 PM of the facility's records included the following BDDS (Bureau of Developmental Disabilities Services) incident reports and an Index Event Prevention Review regarding client #2: 1. On 11/17/10, "staff noticed a reddened scraped area on [client #2]'s arm just above her wrist. When staff asked how that happened, she stated that she found a paring knife in the dishwasher and scraped her arm with it, unbeknownst to staff. No one saw [client #2] scraping her	W0157	The facility policy 6.22 Consumers with Unusually High Service Needs has been revised to specify that harmful suicidal gestures occuring even once are cause for prompt IST review and response. The team will assure assessment, ISP revisions, and staff training to assist in keeping the consumer safe. "Index events" shall be identified that will initiate prompt review of the ISP for proposed revisions to prevent future recurrence. Staff will receive training regarding the revised policy and the responsibilities lying therein. Additionally, staff shall receive very specific training regarding facility policy 7.07 Preventing Abuse and Neglect. In regards to client #2, all sharps in the home are secured. Any sharps, to include disposable safety razors, are to be disposed of in a sharps container. Staff members are to keep keys to the medication cabinets on thier person at all times that the keys are not being	11/13/2011

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	arm with the knife; it is just what she reported when staff asked why her arm was reddened. The nurse reported that [client #2] could have caused the injury with her fingernail. [Client #2] caused only a superficial nickel sized scrape. No blood drawn. . .All sharps have been secured. [Client #2] will not be permitted access to sharps until the IST (interdisciplinary team) determines otherwise. [Client #2] now has "eyes on" staffing at all times. Staff will also assure that [client]'s fingernails remain trimmed and smooth. [Client]'s brother is currently pursuing guardianship that should be finalized any day. The IST plans to pursue a more restrictive behavior plan that targets self injurious behavior. [Client #2] currently has an appointment with her counselor." 2. On 1/13/11, client #2 "was seen for routine counseling appointment at which time she stated to the counselor that she felt like she wanted to hurt herself. Counselor consulted with on-call psychiatrist who agreed to admit her to the [name of psychiatric center] for evaluation." The BDDS follow-up report dated 1/19/11 indicated client #2 was released from the center on 1/19/11. It indicated client #2 had medication changes to discontinue the 10 milligrams of Abilify and increased the Effexor from		used to unlock the cabinet to prevent any consumer from having unauthorized access to medications. All staff members will receive additional training regarding these requirements. Client #2 has not threatened or attempted suicide since June 27, 2011.	

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	75 mg (milligrams) to 150 mg. daily. It indicated staff "will continue to monitor [client #2]'s mental health upon her return to the group home. [Client #2] will resume her regular schedule upon returning to the group home which includes completing her training programs and following her Behavior Development Plan." 3. On 6/19/11, client #2 "gained access to the keys that secure the medication administration area and unbeknownst to staff, proceeded to take Ibuprofen in excess of what the physician had ordered for her. . .[Client #2] was evaluated by a physician and found to have suffered no ill effect as a result of taking the Ibuprofen. A procedure has been put into place requiring staff to carry keys to the medication administration area on their person at all person at all times, signing responsibility for the keys over shift to shift." The BDDS follow-up incident report dated 6/27/11 indicated client #2 "took the keys to the medication administration area from a table where the staff member had just been sitting reviewing documentation from the medication pass she'd just completed. The staff member stepped into the adjoining room to address a different situation, and [client #2] took the keys, unbeknownst to staff. Seven 200mg			

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	Ibuprofen were missing from [client]'s medication card. [Client #2] has a history of attention seeking behavior. Her intentions of taking the Ibuprofen are not known. She does have a Behavior Development Program that addresses suicide threats/attempts." It indicated "Staff at the home have received training regarding keeping the keys to the medication administration area on their (sic) person at all times they are not personally passing medications. Staff will physically wear the keys on a lanyard, clip, or bracelet. [Client #2] has suffered no ill effect as a result of this incident. She sees a psychiatrist regularly." The BDDS reports did not indicate if client #2 still had "eyes on" supervision as indicated above. 4. An Index Event Prevention Review dated 6/24/11 indicated the workshop rehab coordinator had called the RD (Residential Director) informing her client #2 "told a peer at workshop that she was attempting to cut her wrist with the cardboard they are working on. No injuries noted." The RD had the workshop coordinator to place client #2 on suicide watch and complete a report on the incident. It indicated "Note that earlier less than two hours earlier, [client #2] cut her hair with scissors because she didn't like the way her hair stuck out of			

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	her baseball cap she was wearing. [Client #2] was removed from the cardboard job for the rest of the day." It was noted on this report client #2 did not harm herself. 5. On 6/27/11, client #2 had an argument with her boyfriend. Client #2 attempted to cut herself with a safety razor. She ended up succeeding in causing a small pencil eraser sized cut. Special observation procedures were put into place for client #2 in which she was under constant supervision to assure her safety until the RD determined the intensified supervision could be lifted. It indicated "The home was searched for any other items she could harm herself with and all sharps were secured." The Plan to Resolve indicated client #2's "counseling appointment was moved up to 6/29/11. The IST met on 6/28/11 to review the incident. DSA staff will continue to monitor [client #2]'s health and safety." The follow-up report dated 7/5/11 indicated after this incident, intensified supervision remained in place for client #2 for 48 hours following this incident. Review on 10/4/11 at 11:00 AM of client #2's BDP (Behavior Development Program) Update dated 12/3/10, indicated client #2's "behavior has become increasingly erratic and her IST is gravely concerned that she will harm herself or			

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	place herself in danger. [Client #2] frequently voices suicidal ideations and makes suicidal gestures. Although there is a distinct manipulative quality to the suicidal behavior, [client #2] clearly knows how to kill herself and could do so either intentionally or by accident. Component 4 of the Behavior Development Program for [client #2] includes reactive procedures for protecting [client #2] when she makes suicide threats/attempts." Interview on 10/13/11 at 2:15 PM with the RD and the ARC (Area Residential Coordinator) was conducted. The RD indicated client #2's behavior plan had not been updated since December 2010. But the ARC and the RD indicated after the June 19, 2011 incident, client #2 was determined to be a client with unusually high service needs and an index event prevention review will be created if client #2 has any suicide ideations. The RD and ARC indicated a protocol was put in place for client #2 when she threatens or attempts suicide and all staff were trained on it in July, 2011. They indicated client #2 has not threatened or attempted suicide since the June 27, 2011 incident. 9-3-2(a)			

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W0286	Techniques to manage inappropriate client behavior must never be used for disciplinary purposes. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #2) by restricting access to her computer due to suicidal gestures. Findings include: Review on 10/4/11 at 11:00 AM of client #2's records was conducted. Client #2's BDP (Behavior Development Program Update (dated December 3, 2010) indicated the following: Client #2 will be permitted to have 60 minutes of her computer access on evenings preceding workdays and no more than 120 minutes of computer access on weekend days and holidays. [Client #2]'s IST (Interdisciplinary Team) in conjunction with her co-guardians can change the daily limits of her computer access for cause at any time. . .If [client #2] resists surrendering access to the computer one day her access for the following day will be withheld. . .During any period when [client #2] is under suicide precautions	W0286	Client #2's Behavior Development Program shall be revised so that it does not restrict access to her computer due to suicidal gestures. The Residential Director shall receive further training that techniques to manage inappropriate client behavior must never be used for disciplinary purposes.	11/13/2011

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 10/14/2011
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 314 W 13TH ST ANDERSON, IN46016	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	(on suicide watch). she will not have access to her computer." Interview on 10/13/11 at 2:15 PM with the RD (Residential Director) was conducted. She indicated client #2 did have a time frame on how long she could be on the computer each day but she could get on any sites she wanted during that time. The RD indicated if client #2 threatens or attempts suicide, she does not get access to the computer and it has been effective in preventing client #2 from the suicide attempts. 9-3-5(a)			