

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G254	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2013
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 740 OAK BLVD GREENFIELD, IN 46140
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W000000	<p>This visit was for the fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 2/25/13, 2/26/13, 2/27/13 and 3/1/13.</p> <p>Facility Number: 000774 Provider Number: 15G254 AIM Number: 100243450</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed March 7, 2013 by Ruth Shackelford, Medical Surveyor III.</p>	W000000		

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.

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W000149	<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.</p> <p>Based on record review and interview for 1 of 27 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to implement its policy and procedure to ensure the facility conducted a thorough investigation regarding client #7 being unsupervised in the group home van.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/26/13 at 8:38 AM. The review indicated the following:</p> <p>-BDDS report dated 10/6/12 indicated client #7 was left unsupervised on the group home van on 10/5/12.</p> <p>-Investigation dated 10/11/12 regarding the 10/6/12 BDDS report for client #7 indicated, "It was reported on 10/5/12 that [client #7] was on the van unattended for a period of time while it was parked at his group home. An investigation is required to determine how this occurred." The 10/11/12 investigation findings indicated, "After completion of the</p>	W000149	<p>The Residential Directors who are assigned to complete investigations regarding incidents that occur at this home have received re-training on completion of investigations. There was specific conversation about how to ensure completion of a thorough investigation, including establishing timelines as applicable. For any future investigations concerning consumers being without supervision a timeline for time unsupervised will be determined and included in the investigation. The documentation of this completed training is attached. When the administrator reviews investigations she will ensure they are completed thoroughly and include timelines as applicable.</p> <p>Responsible Party: Area Director</p> <p>Completed on: 3/18/13</p>	03/18/2013			

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	<p>investigation it was found that [client #7] did remain in the van unattended. This was accidental and staff did not intentionally leave [client #7] in the van. [Staff #1] and [staff #2] went on transport to [day service provider] and [staff #3] stayed at the home with another consumer. Once staff arrived home a consumer who is to be in eye sight (supervision) got out of the van and went into the home, [staff #1] followed. [Staff #2] was outside at the van helping the remaining consumers inside. [Client #7] stated he did not want to get out of the van because it was raining. [Staff #1] told him okay and left the van door open thinking [client #7] would exit the van shortly. [Client #7] was located in the second bench seat. [Staff #1] went into the home and set her purse down. [Other facility group home] came by to pick up [other facility group home client] and [staff #1] helped her to the van. [Staff #1] then went to get in the van to look for her phone. [Staff #1] stated when she went to the van all doors were shut and she did not see [client #7]. [Staff #1] assumed [client #7] was in the house. [Staff #3] (sic) short time later came out to the van and did a walk around of the van and did not notice [client #7]. [Staff #3] then went to the office and was returning home when she pulled in the driveway (sic) [client #7] popped up from the back seat." The 10/11/12 Investigation did not indicate</p>			

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	<p>client #7's assessed level of supervision and how long he was unsupervised while in the group home van.</p> <p>Interview with AS (Administrative Staff) #1 on 2/27/13 at 11:42 AM indicated client #7's assessed level of supervision was 24 hour monitoring. AS #1 indicated client #7 initially arrived at the group home at 4:30 PM. AS #1 indicated staff #3 traveled from the group home to the facility office at 4:50 PM. AS #1 indicated staff #3 returned to the group home at 5:10 PM. AS #1 indicated client #7 was unsupervised for 40 minutes. AS #1 indicated the 10/11/12 investigation did not address how long client #7 was unsupervised. AS #1 indicated the 10/11/12 investigation should have indicated client #7's assessed level of supervision and determined how long client #7 was unsupervised. AS #1 indicated the facility's abuse and neglect policy should be implemented.</p> <p>The facility's policy and procedures were reviewed on 3/1/13 at 8:40 AM. The 12/15/11 policy entitled, "Preventing Abuse and Neglect" indicated, "Section III, (d)(2) Document the investigation procedures and results; (5) Immediately upon receiving notification of the incident from the RD (Residential Director) the Area Director will</p>			

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	initiate an investigation of the allegation(s) to provide a factual basis for management actions." 9-3-2(a)			

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 27 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to conduct a thorough investigation regarding client #7 being unsupervised in the group home van.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 2/26/13 at 8:38 AM. The review indicated the following:</p> <p>-BDDS report dated 10/6/12 indicated client #7 was left unsupervised on the group home van on 10/5/12.</p> <p>-Investigation dated 10/11/12 regarding the 10/6/12 BDDS report for client #7 indicated, "It was reported on 10/5/12 that [client #7] was on the van unattended for a period of time while it was parked at his group home. An investigation is required to determine how this occurred." The 10/11/12 investigation findings indicated, "After completion of the investigation it was found that [client #7] did</p>	W000154	<p>The Residential Directors who are assigned to complete investigations regarding incidents that occur at this home have received re-training on completion of investigations. There was specific conversation about how to ensure completion of a thorough investigation, including establishing timelines as applicable. For any future investigations concerning consumers being without supervision a timeline for time unsupervised will be determined and included in the investigation. The documentation of this completed training is attached. When the administrator reviews investigations she will ensure they are completed thoroughly and include timelines as applicable.</p> <p>Responsible Party: Area Director</p> <p>Completed on: 3/18/13</p>	03/18/2013			

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	<p>remain in the van unattended. This was accidental and staff did not intentionally leave [client #7] in the van. [Staff #1] and [staff #2] went on transport to [day service provider] and [staff #3] stayed at the home with another consumer. Once staff arrived home a consumer who is to be in eye sight (supervision) got out of the van and went into the home, [staff #1] followed. [Staff #2] was outside at the van helping the remaining consumers inside. [Client #7] stated he did not want to get out of the van because it was raining. [Staff #1] told him okay and left the van door open thinking [client #7] would exit the van shortly. [Client #7] was located in the second bench seat. [Staff #1] went into the home and set her purse down. [Other facility group home] came by to pick up [other facility group home client] and [staff #1] helped her to the van. [Staff #1] then went to get in the van to look for her phone. [Staff #1] stated when she went to the van all doors were shut and she did not see [client #7]. [Staff #1] assumed [client #7] was in the house. [Staff #3] (sic) short time later came out to the van and did a walk around of the van and did not notice [client #7]. [Staff #3] then went to the office and was returning home when she pulled in the driveway (sic) [client #7] popped up from the back seat." The 10/11/12 Investigation did not indicate client #7's assessed level of supervision and</p>			
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	<p>how long he was unsupervised while in the group home van.</p> <p>Interview with AS (Administrative Staff) #1 on 2/27/13 at 11:42 AM indicated client #7's assessed level of supervision was 24 hour monitoring. AS #1 indicated client #7 initially arrived at the group home at 4:30 PM. AS #1 indicated staff #3 traveled from the group home to the facility office at 4:50 PM. AS #1 indicated staff #3 returned to the group home at 5:10 PM. AS #1 indicated client #7 was unsupervised for 40 minutes. AS #1 indicated the 10/11/12 investigation did not address how long client #7 was unsupervised. AS #1 indicated the 10/11/12 investigation should have indicated client #7's assessed level of supervision and determined how long client #7 was unsupervised.</p> <p>9-3-2(a)</p>						

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W009999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-1 Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by division (19. Use of any physical or manual restraint regardless of: (a) planning; (b) human rights committee approval; (c) informed consent.)</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 3 incidents of physical restraints reviewed, the facility failed to immediately notify BDDS (Bureau of Developmental Disabilities Services) regarding three separate incidents of using a physical restraint for client #4.</p> <p>Findings include:</p> <p>The facility's BDDS reports and investigations were reviewed on 2/26/13 at 8:38 AM. The review indicated the following:</p> <p>-BDDS report dated 10/22/12 indicated client #4 was placed in a basket hold containment</p>	W009999	<p>The Residential Directors who are responsible for filing incident reports and for notifying BDDS when reportable incidents, including application of physical containment, have been re-trained on timelines for reporting to ensure reports are filed within 24 hours as required. The documentation of this training is attached. The direct care staff in the home will also be re-trained on reporting all reportable incidents immediately per agency policy. Additionally the agency now uses an electronic documentation system that includes a requirement for staff to identify the occurrence of any reportable incidents that may occur for each individual in the home at each shift. This information is accessible to administrators immediately and helps ensure reports are filed timely.</p> <p>Responsible Party: Area Director</p> <p>Completed by 3/31/13</p>	03/31/2013			

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	<p>during an incident of physical aggression on 10/20/12.</p> <p>-BDDS report dated 10/24/12 indicated client #4 was placed in a basket hold containment during an incident of physical aggression on 10/22/12.</p> <p>-BDDS report dated 11/14/12 indicated client #4 was placed in an elbow pin containment during an incident of physical aggression on 11/9/12.</p> <p>Interview with AS (Administrative Staff) #1 on 2/27/13 at 11:42 AM indicated the use of physical restraints should be reported to BDDS within 24 hours of knowledge of the incident.</p> <p>9-3-1(b)</p>				