STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G554	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	1435 W CONGRESS ST MIDDLETOWN, IN 47356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00178949. This visit was done in conjunction with the PCR (Post Certification Revisit) to the pre-determined full recertification and state licensure survey completed on 3/13/15. This visit included the PCR to the investigation of complaint IN00156546 completed on 3/13/15. Complaint #IN00178949: Substantiated, a federal and state deficiency related to the allegations is cited at W149. Dates of Survey: 8/5/15, 8/6/15 and 8/10/15 Facility Number: 001068 Provider Number: 15G554 AIMS Number: 100239880 This deficiency also reflects a state finding in accordance with 460 IAC 9.	W 0000		
W 0149 Bldg. 00	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	W 0149	Agency administrators followed agency policy upon receipt ofthe	09/09/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G554	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	1435 W CONGRESS ST MIDDLETOWN, IN 47356

(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
	1 of 3 sampled clients (A), the facility failed to implement its policy and procedures to prevent staff to client abuse regarding client A. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 8/5/15 at 1:30 PM. The review indicated the following: -BDDS report dated 7/23/15 indicated, "During the course of another allegation being investigated an allegation was made that [staff #1] interacted inappropriately with [client A] in an effort to get him to take his evening medication on 7/18/15. An investigation was immediately initiated to determine the facts of this allegation. Information has also been obtained that another staff, [staff #2], is also alleged to have used physical force at this same time to get [client A] to take his medication. [Staff #1] and [staff #2], and the staff who witnessed this incident and failed to report immediately have all been suspended pending completion of this investigation." The facility's video camera footage dated 7/28/15 from 1:55 PM through 1:58 PM		allegation of abuse in ensuring immediate suspension of the staff involvedand the completion of an investigation. Given that the allegations of abusewere substantiated the three employees involved were all terminated fromemployment with the agency. The evidence was also provided to the local police departmentand a request was made of the Middletown police department to pursue legalcharges. The associated incident wasreported to start with client A's refusal to take his prescribed medications. Theinvestigation revealed that he does have regular refusals to take hismedications. The behavior development program for client A was updated toaddress medication refusals. This plan has been implemented with the approvalof his guardian and the HRC. The updated program includes use of positivereinforcement for compliance with taking medications. The IST also determinedthat another resident of the home does regularly refuse to take hermedications. Her behavior development program was also updated to address thisand has been approved and implemented. Since this incident a professional staff has been present inthe home no less 3-4 times per week when clients and staff are present, this isan increase to the frequency at which there was presence prior to this incident.This has included QIDPs	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G554	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/10/2015
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC		STREET ADDRESS, CITY, STATE, ZIP CODE 1435 W CONGRESS ST MIDDLETOWN, IN 47356	

(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
	was reviewed on 8/5/15 at 1:45 PM. The video showed staff #1 physically holding/restraining and sitting on top of client A on the home's living room couch to force administer medication while staff #3 observed the incident. The video showed staff #2 attempting to force the medication into client A's mouth and then pushing client A when his attempts to administer client A's medications failed. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 8/5/15 at 1:30 PM. The review indicated the following: The Investigation Summary Form (ISF) dated 7/24/15 indicated the following: -"It is substantiated that both [staff #1] and [staff #2] abused [client A] by using excessive force to get him to take him medications. [Staff #3] witnessed the incident during which [staff #1] was abusive towards [client A]." -"[Staff #3] failed to report what she witnessed. When interviewed she denied being able to see what [staff #1] actually did." -"[Staff #3] lied to the IO (Investigating Officer) about what she witnessed, thus		and administrators. This frequency of presence continuesuntil otherwise directed by the agency Program Services Director. The agency will maintain routine professionalpresence and monitoring of staff to client interactions on-going. While presentin the home each professional staff is observing staff to client interactions, implementationof client A's and one additional client's updated behavior programs, and isalso reviewing camera footage in the home to monitor staff to clientinteractions when professional staff are not in the home. The camera reviewdoes include review of footage of staff with the staff in the footage toprovide feedback. These reviews are documented. There have been no further allegations orobservations of abuse towards any residents in the home. All staff who work in the home will receive a retraining onagency policies and procedures regarding Prevention of Abuse and Neglect. Thistraining will be provided by an agency administrator. Responsible Party: Area Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G554	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	1435 W CONGRESS ST MIDDLETOWN, IN 47356

(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
	impeding the investigation." Program Quality Coordinator (PQC) #1 was interviewed on 8/5/15 at 2:00 PM. PQC #1 indicated the allegation of staff to client abuse regarding client A and staff #1, staff #2 and staff #3 was substantiated. PQC #1 indicated staff #1 and staff #2 used unapproved physical force to administer client A's medications. PQC #1 indicated staff #3 observed staff #1's interactions and did not intervene to stop the abuse, did not report the abuse and lied during the investigation to impede (sic) the investigation. PQC #1 indicated the facility should prevent staff to client abuse. PQC #1 indicated the facility's abuse and neglect policy should be implemented. The facility's policy's and procedures were reviewed on 8/10/15 at 12:00 PM. The facility's Preventing Abuse and Neglect policy dated 10/2013 indicated the following: -"DSA (Developmental Service Alternatives), Incorporated prohibits abuse, neglect, exploitation, mistreatment or violation of the rights of the consumers it serves." -"Abuse means the following:...; (2.)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G554	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	1435 W CONGRESS ST MIDDLETOWN, IN 47356

(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
	Unnecessary use of physical or chemical restraints or isolation; (3.) Inappropriate use of physical or chemical restraints...." -"Neglect means failure to provide supervision, training, appropriate care, food, medical care or medical supervision to an individual." This federal tag relates to complaint #IN00178949. 9-3-2(a)			