STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G462	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	2228 VAN BUSKIRK RD ANDERSON, IN 46011

(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 investigation of complaint #IN00109343. Complaint #IN00109343: Unsubstantiated. Additional Deficiencies Cited. Dates of Survey: June 21 and 22, 2012 Facility Number: 000976 Provider Number: 15G462 AIMS Number: 100235450 Surveyor: Kathy Craig, Medical Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Reveiw completed on 6/29/12 by Tim Shebel, Medical Surveyor III.	W0000		

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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W0122	483.420 CLIENT PROTECTIONS 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 neglect policy by failing to prevent 1 of 2 sampled clients (client A), from vacating the group home and the workshop; and for not taking appropriate corrective action to prevent client A from vacating after learning of a prior incident where client A vacated from his prior home. Findings include: 1. The facility failed to implement their abuse/neglect policy for 1 of 2 sampled clients (client A) by failing to prevent client A from vacating the group home and the workshop. Please see W149. 2. The facility neglected to take appropriate corrective action for 1 of 2 sampled clients (client A) to prevent client A from vacating the group home and the workshop on the same day. Please see W157. 9-3-2(a)	W0122	W122 Client A's Behavior Development Program (BDP) has been revised (See Appendix A) to prevent him from vacating. The BDP has been approved by the IST and HRC. Staff have been trained and the plan has been implemented. The agency policy on Behavior Management (See Appendix B) includes directives to professional and direct care staff for increasingly dangerous behavior exhibited by consumers. Staff will receive additional training regarding the policy. Person Responsible: Residential Director	07/22/2012

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W0149	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, the facility failed to implement their abuse/neglect policy in 2 of 7 reviewed BDDS (Bureau of Developmental Disabilities Services) incident reports reviewed by failing to ensure 1 of 2 sampled clients (client A) had a sufficient plan in place to prevent him from going AWOL (Absent With Out Leave). Findings include: Review on 6/21/12 at 1:45 PM of the facility's BDDS incident reports included the following: 1. An incident dated 6/6/12 indicated on 6/6/12 at 6:05 AM, "[client A] placed 4 phone calls to 911 using his cell phone. Police determined there was no emergency after speaking with staff and did not respond to the home. Reportedly, [client A] was cursing at the dispatcher when he made the calls. Once [client A] realized that the police were not coming, he told staff he was leaving the group home. Staff immediately followed [client A] once he left the property. Upon returning to the group home, [client A] pulled a jar of hot fudge topping out of his	W0149	W149 Client A's Behavior Development Program (BDP) has been revised (See Appendix A) to prevent him from vacating. The BDP has been approved by the IST and HRC. Staff have been trained and the plan has been implemented. The agency policy on Behavior Management (See Appendix B) includes directives to professional and direct care staff for increasingly dangerous behavior exhibited by consumers. Staff will receive additional training regarding the policy.	07/22/2012

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	pocket. When questioned about it, [client A] replied that he stole it from the [name of store] during his elopement. Staff did not witness the theft as [client A] had run ahead of staff and in and out of the establishment very quickly as staff approached to enter. The Residential Director assisted [client A] in returning the topping to the [store]. A police report was filed following the incident as per the Social Security Act (reporting reasonable suspicion of a crime). Officer [name] completed the police report numbered 2012-20543. [Client A] appeared to be calm and was taken to workshop to resume normal activity. Not long after he arrived at [name of workshop], other issues occurred-see incident 455793." 2. An incident dated 6/6/12 indicated on 6/6/12 at 9:30 AM, "This morning, [name], workshop Rehab Coordinator, received a call from [name], DSA QMRP [Qualified Mental Retardation Professional] to let workshop staff know [client A] had eloped from the group home this morning and tried to take something from the local convenience store. [QMRP's name] instructed [name of worskhop rehabilitation coordinator] to closely monitor [client A] but do planned ignoring. While at workshop like (sic) [client A] started to sing a song with expletives about the police. Workshop			

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	staff directed him to stop as the curse words were upsetting other consumers. [Client A] refused. [Client A] was then asked to move to a work station by himself so that other would not have to listen to his song. He complied. At approximately 9:30 a.m., [client A] took his lunchbox, exited the workshop doors closest to him and started running North towards [name of street]. Staff saw him running and followed him. [Client A] ignored directions to stop. [Professional workshop staff] arrived at the scene in a vehicle and asked [client A] to get in the car. [Client A] refused and ran faster. Work Center Manager and [name of staff], Training supervisor followed [client A] in the vehicle but staying a distance away. It appeared that every time we go closer, he would run faster. [Client A] entered a neighborhood east of the workshop where he continued to run/walk. At one point, he threw his coat and lunch box away. He continued to ignore staff calling for him to stop and talk." Under Plan to Resolve the report indicated "The police were called per DSA staff. Officers arrived at the scene shortly. The Police officer approached [client A] in the police vehicles and asked him to get in the car. He complied and got in the back seat. [Client A] told [Professional workshop staff] that he was walking home to [name of another town].			

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	[Client A] appeared calm and proceeded to tell staff and the police officer the incident this morning including his stay at the detention center in [name of the town detention center is in]. [Client A] stated he wanted to go back to the detention center." Review on 6/21/12 at 1:40 PM of the facility's "Preventing Abuse and Neglect" dated 12/15/11 indicated "DSA, Inc. prohibits abuse, neglect, exploitation, mistreatment or violation of the rights of the consumers it serves." It defined neglect as "failure to provide supervision, training, appropriate care, food, medical care, or medical supervision to an individual." Review on 6/21/12 at 3:20 PM of client A's records was conducted. The report included the following: 1. Client A's "Personal History" dated 5/18/12 indicated client A was an 18 year-old man who first received services from DSA, Inc. on 4/19/12. The report indicated prior to placement at DSA, client A lived with his adopted father. It indicated client A was vulnerable to abuse and required 24-hour supervision to protect him from strangers who may cause harm to him. . . ."			

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	2. Client A's "Behavior Development Program" (BDP) dated 5/14/12, indicated client A had a vacating behavior which was being addressed. The BDP indicated vacating was defined as if client A leaves the group home property without following agency sign-out procedures; or, while on community outings or at work, distances self from group or attempts to leave group. It indicated if client A vacated, the following instructions were to be followed: "1. Instead of directing [client A] to cease the behavior or to come back, walk with him but minimize talking with him. 2. Remain with [client A] until he has returned to a safe location and keep him under observation until you are sure he will not vacate again. 3. If [client A] has vacated unobserved, search the premises for three minutes. If you locate him, implement steps 1-2 above. If you do not locate him, immediately initiate a 911 page to the RD [Residential Director] or the on-call RD. 4. Try to avoid calling the police. Their involvement may reinforce the behavior. It is preferable to have staff search for [client A] than to have the police involved. Only involve the police if it is necessary to do so when staff cannot locate or keep [client A] safe." 3. Client A's Individualized Support Plan" dated 5/18/12 indicated client A			

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	"has previously been hit by a car as the result of improperly crossing a busy road. . . ." and that he "previously vacated. . . ." Interview on 6/21/12 at 2:35 PM with the Residential Director (RD) was conducted. The RD indicated there was nothing in client A's history prior to him moving in regarding him vacating. The RD indicated before client A moved in, they learned of one incident of client A vacating when he lived at home with his adoptive father. The RD indicated at client A's May ISP (Individual Support Plan) meeting they learned from client A's father that client A had another incident of vacating which resulted in client A getting hit by a car. Client A sustained a chipped tooth in that incident. The RD indicated client A's behavior plan was revised on 6/6/12 after the above-mentioned incidents. The RD indicated client A was being watched at the workshop. The RD indicated the workshop supervisor saw client A exit the door and followed him immediately. 9-3-2(a)			

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W0157	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview, the facility failed for 2 of 7 reviewed BDDS (Bureau of Developmental Disabilities Services) incident reports reviewed by failing to ensure 1 of 2 sampled clients (client A) had a sufficient plan in place to prevent him from going AWOL (Absent With Out Leave). Findings include: Review on 6/21/12 at 1:45 PM of the facility's BDDS incident reports included the following: 1. An incident dated 6/6/12 indicated on 6/6/12 at 6:05 AM, "[client A] placed 4 phone calls to 911 using his cell phone. Police determined there was no emergency after speaking with staff and did not respond to the home. Reportedly, [client A] was cursing at the dispatcher when he made the calls. Once [client A] realized that the police were not coming, he told staff he was leaving the group home. Staff immediately followed [client A] once he left the property. Upon returning to the group home, [client A] pulled a jar of hot fudge topping out of his pocket. When questioned about it, [client	W0157	W157 Client A's Behavior Development Program (BDP) has been revised (See Appendix A) to prevent him from vacating. The BDP has been approved by the IST and HRC. Staff have been trained and the plan has been implemented. The agency policy on Behavior Management (See Appendix B) includes directives to professional and direct care staff for increasingly dangerous behavior exhibited by consumers. Staff will receive additional training regarding the policy.	07/22/2012

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	A] replied that he stole it from the [name of store] during his elopement. Staff did not witness the theft as [client A] had run ahead of staff and in and out of the establishment very quickly as staff approached to enter. The Residential Director assisted [client A] in returning the topping to the [store]. A police report was filed following the incident as per the Social Security Act (reporting reasonable suspicion of a crime). Officer [name] completed the police report numbered 2012-20543. [Client A] appeared to be calm and was taken to workshop to resume normal activity. Not long after he arrived at [name of workshop], other issues occurred-see incident 455793." 2. An incident dated 6/6/12 indicated on 6/6/12 at 9:30 AM, "This morning, [name], workshop Rehab Coordinator, received a call from [name], DSA QMRP [Qualified Mental Retardation Professional] to let workshop staff know [client A] had eloped from the group home this morning and tried to take something from the local convenience store. [QMRP's name] instructed [name of worskhop rehabilitation coordinator] to closely monitor [client A] but do planned ignoring. While at workshop like (sic) [client A] started to sing a song with expletives about the police. Workshop staff directed him to stop as the curse			

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	to tell staff and the police officer the incident this morning including his stay at the detention center in [name of the town detention center is in]. [Client A] stated he wanted to go back to the detention center." Review on 6/21/12 at 3:20 PM of client A's records was conducted. The report included the following: 1. Client A's "Personal History" dated 5/18/12 indicated client A was an 18 year-old man who first received services from DSA, Inc. on 4/19/12. It indicated prior to placement at DSA, client A lived with his adopted father. It indicated client A was vulnerable to abuse and required 24-hour supervision to protect him from strangers who may cause harm to him. 2. Client A's "Behavior Development Program" (BDP) dated 5/14/12, indicated vacating was defined as if client A leaves the group home property without following agency sign-out procedures; or, while on community outings or at work, distances self from group or attempts to leave group. The BDP indicated if client A vacated, the following instructions were to be followed: "1. Instead of directing [client A] to cease the behavior or to come back, walk with him but minimize talking with him. 2. Remain			

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	with [client A] until he has returned to a safe location and keep him under observation until you are sure he will not vacate again. 3. If [client A] has vacated unobserved, search the premises for three minutes. If you locate him, implement steps 1-2 above. If you do not locate him, immediately initiate a 911 page to the RD [Residential Director] or the on-call RD. 4. Try to avoid calling the police. Their involvement may reinforce the behavior. It is preferable to have staff search for [client A] than to have the police involved. Only involve the police if it is necessary to do so when staff cannot locate or keep [client A] safe." 3. Client A's Individualized Support Plan" dated 5/18/12 indicated client A "has previously been hit by a car as the result of improperly crossing a busy road. . . ." and that he "previously vacated. . . ." Interview on 6/21/12 at 2:35 PM with the Residential Director (RD) was conducted. The RD indicated there was nothing in client A's history prior to him moving in regarding him vacating. The RD indicated before client A moved in, they learned of one incident of client A vacating when he lived at home with his adoptive father. The RD indicated at client A's May ISP (Individual Support Plan) meeting they learned from client A's			

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	father that client A had another incident of vacating which resulted in client A getting hit by a car. Client A sustained a chipped tooth in that incident. The RD indicated client A's behavior plan was revised on 6/6/12 after the above-mentioned incidents. The RD indicated client A was being watched at the workshop. The RD indicated the workshop supervisor saw client A exit the door and followed him immediately. 9-3-2(a)			