

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G253		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/12/2013	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1757 S 600 W NEW PALESTINE, IN 46163			
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W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: 3/6/13, 3/7/13, 3/8/13, 3/11/13 and 3/12/13.</p> <p>Facility Number: 000773 Provider Number: 15G253 AIMS Number: 100243410</p> <p>Surveyor: Keith Briner, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/20/13 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. Based on record review and interview for 1 of 21 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 reported the results of an investigation of an incident of client to client aggression regarding clients #1 and #2 to the facility administrator within 5 business days.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 3/6/13 at 12:22 PM. The review indicated the following:</p> <p>-BDDS report dated 10/19/12 indicated, "[Client #1] reached over and grabbed [client #2] then punched [client #1] in the mouth, causing quite a bit of bleeding."</p> <p>-Investigation dated 10/18/12 regarding the 10/19/12 BDDS report indicated, "Assigned on 10/18/12 due on 10/25/12" was signed by the administrator on 10/30/12.</p> <p>AS (Administrative Staff) #1 was interviewed on 3/7/13 at 1:30 PM. AS #1 indicated the results of investigations should be reported to the administrator within 5 business days. AS #1 indicated the facility's</p>	W000149	In the event that an incident occurs in which the health and safety of the individual is jeopardized or there is an allegation of abuse, mistreatment or neglect suspected, the Area Director will initiate an investigation into the incident which will provide a factual basis for management decisions. Investigations will be completed within 5 business days and will include administrator review. Person Responsible: Area Director and Residential Director	04/11/2013			

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	<p>abuse and neglect policy should be implemented.</p> <p>The facility's policy and procedures were reviewed on 3/12/13 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 initiate an investigation of the allegation(s) to provide a factual basis for management actions."</p> <p>9-3-2(a)</p>			

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W000156	<p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 21 allegations of abuse, neglect, mistreatment, exploitation and injuries of unknown origin reviewed, the facility failed to report the results of an investigation within 5 working days for an incident of client to client aggression regarding clients #1 and #2.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 3/6/13 at 12:22 PM. The review indicated the following:</p> <p>-BDDS report dated 10/19/12 indicated, "[Client #1] reached over and grabbed [client #2] then punched [client #1] in the mouth, causing quite a bit of bleeding."</p> <p>-Investigation dated 10/18/12 regarding the 10/19/12 BDDS report indicated, "Assigned on 10/18/12 due on 10/25/12" was signed by the administrator on 10/30/12.</p>	W000156	<p>In the event that an incident occurs in which the health and safety of the individual is jeopardized or there is an allegation of abuse, mistreatment or neglect suspected, the Area Director will initiate an investigation into the incident which will provide a factual basis for management decisions. Investigations will be completed within 5 business days and will include administrator review. Person Responsible: Area Director and Residential Director</p>	04/11/2013			

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	AS (Administrative Staff) #1 was interviewed on 3/7/13 at 1:30 PM. AS #1 indicated the results of investigations should be reported to the administrator within 5 business days. 9-3-2(a)				

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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 (16. A medication error or medical treatment error as follows: (a) wrong medication given; (b) wrong medications dosage given; (c) missed medication-not given; (d) medication given wrong route; or (e) medication error that jeopardized an individual's health and welfare and requires medical attention. 18. Use of any PRN (as needed) medication related to an individual's behavior. 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 of 16 incidents of physical/manual restraints, use of PRN behavioral medication and missed dosages of medication reviewed, the facility failed to immediately notify the BDDS (Bureau of Developmental Disabilities Services) regarding two incidents of medication omission for client #2 and an</p>	W009999	<p>Professional staff will be retrained on the 24 hour deadline provided by BDDS to report these incidents. A summary sheet will be available to the RD to refer to should they question whether an event is reportable. Developmental Service Alternatives has a policy No. 8.01.01, which addresses BDDS reportable incidents and the timeline in which they must be filed.</p> <p>Persons Responsible: Residential Director and Area Director</p>	04/11/2013			

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	<p>incident of physical/manual restraint for client #3.</p> <p>Findings include:</p> <p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 3/6/13 at 12:22 PM. The review indicated the following BDDS reports:</p> <p>-BDDS report dated 10/23/12 indicated, "It was discovered on 10/22/12 when SGL (Support Group Living) staff viewed the medication card for [client #2] that staff members at [day services] failed to administer the 12:00 PM dose of [client #2's] Abilify (bi-polar) on 10/4/12 and 10/5/12."</p> <p>-BDDS report dated 2/11/13 indicated, "On 2/9/13 [client #3] began hitting himself in the face. Staff attempted re-direction without results. Staff then held [client #3's] (sic) down in his lap to prevent him from injuring his face. [Client #3's] hands were restrained for approximately five minutes with a five minute calm period and then an additional five minutes. Staff were unable to determine what initially upset [client #3] resulting in him hitting himself."</p> <p>AS (Administrative Staff) #1 was interviewed on 3/7/13 at 1:30 PM. AS #1 indicated staff did not report the 2/9/13 incident to the on call supervisor as a restraint. AS #1 indicated the staff reported the 2/9/13 incident as physical prompting/gesture redirection. AS #1 indicated incidents of missed medications should be reported to BDDS within 24 hours of knowledge of the incident. AS #1 indicated the day services should have reported the medication errors for client #2.</p> <p>9-3-1(b)</p>						

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