

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 10/20/2011
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1435 W CONGRESS ST MIDDLETOWN, IN47356
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W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: October 17, 18, 19, and 20, 2011</p> <p>Surveyor: Kathy Craig, Medical Surveyor III</p> <p>Facility Number: 001068 Provider Number: 15G554 AIMS Number: 100239880</p> <p>These deficiencies also reflect state findings under 460 IAC 9.</p> <p>Quality Review completed on 11/7/11 by Tim Shebel, Medical Surveyor III.</p>	W0000		
W0140	<p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #2) by not ensuring her petty cash matched her petty cash ledger.</p>	W0140	<p>The Residential Director shall assure that the petty cash matches the petty cash ledger at all times. The Residential Director shall receive re-training regarding her associated</p>	11/20/2011

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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W0249	<p>Findings include:</p> <p>Review on 10/18/11 at 2:15 PM of client #2's financial records was conducted. Client #2's petty cash ledger as of this date, 10/18/11, indicated there should have been \$116.50 in petty cash. The actual petty cash counted was \$116.62, an overage of 12 cents.</p> <p>Interview on 10/18/11 at 2:15 PM with the QMRP (Qualified Mental Retardation Professional) was conducted. The QMRP indicated she was not sure why there was 12 cents more than client #2 should have had.</p> <p>Interview on 10/19/11 at 8:21 AM with the AD (Area Director) was conducted. The AD indicated client #2's petty cash should match her financial ledger.</p> <p>9-3-2(a)</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client #3) by implementing an unapproved area restriction.</p>	W0249	<p>responsibility. The Area Director or her designee will complete routine on the spot audits to assure the petty cash matches the petty cash ledger.</p> <p>The staff member responsible for completing the unapproved area restriction no longer works in this facility. Other staff shall receive</p>	11/20/2011			

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	<p>Findings include:</p> <p>Review on 10/17/11 at 3:00 PM of the facility's BDDS (Bureau of Developmental Disabilities Services) incident reports was conducted. A BDDS report dated 10/11/11 for an incident that happened on 10/10/11, indicated on "October 10, 2011, an allegation was made that a staff member interacted inappropriately with [initials of clients #4 and #3]. The tone in his [staff #1] voice was inappropriate with [initials of client #4] allegedly. The staff member allegedly interacted inappropriately with [initials of client #3] by placing her in an unapproved area restriction."</p> <p>The investigation dated 10/10/11 to 10/13/11 was reviewed on 10/20/11 at 3:00 PM. An interview conducted in the investigation on 10/13/11 with the staff (staff #1) in question, indicated client #3 was upset and he heard her "screaming and hollering all the way outside." Staff #1 indicated in the investigative interview he took client #3 into her bedroom "by grabbing her wrist and she walked willingly with him." He indicated he placed client #3 in her bedroom from 7-10 minutes. Staff #1 indicated in the interview he put himself in the doorway of client #3's bedroom to keep her from getting out of her room.</p> <p>Review on 10/18/11 at 2:50 PM of client #3's records was conducted and included her behavior plan dated 11/3/10. Her behavior plan did not include area restriction if she had behaviors.</p> <p>Interview on 10/20/11 at 3:55 PM with the AD (Area Director) was conducted. The AD indicated staff #1 made client #3 go in her room and kept her there for 5-7 minutes due to client #3 having behaviors. The AD indicated this was an unapproved area restriction and it is not in her</p>		retraining regarding prohibition of placing consumers into unapproved area restriction. Professional staff will provide routine oversight, completing observation notes to assure that staff members are responding appropriately and correctly to maladaptive behavior issues.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED

OMB NO. 0938-0391

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	behavior plan. 9-3-4(a)				