STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G472	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 02/29/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVELOPMENTAL SERVICE ALTERNATIVES INC	3708 LUEWAN DR INDIANAPOLIS, IN 46229

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W0000	This visit was for the annual fundamental recertification and state licensure survey. Dates of Survey: 2/20/12, 2/21/12, 2/22/12 and 2/29/12. Facility Number: 000986 Provider Number: 15G472 AIMS Number: 100244890 Surveyor: Keith Briner, Medical Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 3/8/12 by Ruth Shackelford, 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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W0137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation and interview for 1 additional client (#6), the facility failed to ensure the client had proper fitting clothing. Findings include: Observations were conducted at the group home on 2/20/12 from 5:10 PM through 6:30 PM. Client #6 was observed in the group home throughout the observation period. Client #6 was dressed in a pair of blue jeans, buttoned up dress shirt and a tie. Client #6's right pant leg was cuffed or rolled up due to the length of the pant leg exceeding the length of the client's legs. The cuffed or rolled up portion on his right side was 5 inches in length. Client #6's left pant leg extended beneath the client's left shoe in that he was walking on the pant leg as the pant leg extended the length of the client's legs. The excessive portion of pant leg material was 5 inches in length. Observations were conducted at the group home on 2/21/12 from 5:45 AM through 7:45 AM. Client #6 was observed in the	W0137	Staff will receive training which will focus on the need for all consumers to have properly fitting clothes. Staff will ensure that any clothing that is purchased for the consumers will fit appropriately. Staff will be trained to appropriately use of the Individualized Weekly Status Check. This form will be used to ensure that all clothing that the consumers wear fits appropriately. Staff will be trained to inform the Residential Director any time that consumers have clothing that does not fit appropriately. Alterations will occur to address the excess length on client #6 pants. The Residential Director will routinely review the Individualized Weekly Status Check and address any issues that are identified on the form. Routine observations will be completed to ensure that each consumer is wearing clothing that fits appropriately. Persons Responsible: Residential Director and Area Director	03/30/2012

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	group home throughout the observation period. Client #6 was dressed in a pair of blue jeans, buttoned up dress shirt and a tie. Client #6's right and left pant legs were cuffed or rolled up due to the length of the pant leg exceeding the length of the client's legs. The cuffed or rolled up portion on his pant legs was 5 inches in length. Interview with QMRP #1 (Qualified Mental Retardation Professional) on 2/20/12 at 6:00 PM indicated client #6's pants were too long and did not fit properly. QMRP #1 indicated client #6 prefers to roll up his pant legs but should have properly fitting clothing. Interview with DSA #1 (Direct Support Associate) on 2/21/12 at 6:15 AM indicated client #6 was wearing the same clothing as he had on 2/20/12. DSA #1 indicated client #6's pants did not fit properly. 9-3-2(a)			

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W0140	483.420(b)(1)(i) CLIENT FINANCES 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 for 1 of 3 sampled clients (#2), the facility failed to assure a full and complete accounting of client's expenditures/purchases. Findings include: Client #2's financial record was reviewed on 2/21/12 at 10:11 AM. Client #2's IFR (Individual Financial Record) dated 2/1/12 through 2/20/12 indicated an ending ledger balance of $23.43 us dollars. Client #2's actual cash on hand amount was $42.40 us dollars. Client #2's ledger balance and actual cash on hand amount had not been reconciled to accurately reflect account activity. Interview with AA #1 (Administrative Assistant) on 2/21/12 at 10:15 AM indicated client #2's account ledger and actual cash on hand amounts should be reconciled to account for expenditures and purchases. 9-3-2(a)	W0140	Those staff members responsible for the client finances will receive retraining to ensure that they maintain a full and complete accounting of the client finances. Routine audits will be completed on at least a monthly basis of client finances to ensure that a full and complete accounting of the client's expenditures and purchases. The Area Director and Residential Director will routinely receive a ledger following the audit which reflects the client's finances to ensure that the accounting is accurate. Persons Responsible: Residential Coordinator, Residential Director and Area Director	03/30/2012

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W0159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 1 of 3 sampled clients (#3), the QMRP (Qualified Mental Retardation Professional) failed to assess the client's vision needs. Findings include: Client #3's record was reviewed on 2/21/12 at 10:35 AM. Client #3's VCF (Vision Consultation Form) dated 6/9/09 indicated, "[Client #3] (sic) non-verbal, non-cooperative, [client #3] has refused to wear glasses in the past, see no need to prescribe any now. [Eye Doctor] see again as needed." Client #3's record did not indicate any additional VCF follow up. Client #3's record did not indicate the QMRP/IST (Interdisciplinary Team) had addressed the VCF notes. QMRP #2 and MC #1 (Medical Coordinator) were interviewed on 2/21/12 at 10:40 AM. QMRP #2 indicated client #3 did not have eyeglasses. When asked if client #3 needed eyeglasses or was not prescribed glasses due to behavioral issues related to wearing/use of eyeglasses, QMRP #2 indicated she did	W0159	Client #3 will be seen for a routine vision exam. At this time, it will be determined if the need for glasses remains a current need. The IST will meet to discuss the need for Client # 3 to wear glasses if so ordered, as well as the need for programming to support the use of glasses. Persons Responsible: Residential Director and Area Director	03/30/2012

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	not know. QMRP #2 indicated the IST had not assessed and/or followed up to determine if client #3 was in need of eyeglasses or in need of formal training and supports to use eyeglasses. MC #1 indicated no additional visual assessment had been completed. 9-3-3(a)			

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W0331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and interview for 1 of 3 sampled clients (#3), the facility nurse failed to ensure staff implemented the client's dysphasia prevention protocol. Findings include: Observations were conducted at the group home on 2/21/12 from 5:45 AM through 7:45 AM. At 5:50 AM client #3 was prompted to the medication administration area of the group home. Client #3 was administered his morning medications with a 6 ounce cup of water. Client #3's 6 ounce cup of water was not thickened to honey consistency. Client #3's record was reviewed on 2/21/12 at 10:35 AM. Client #3's ISP (Individual Support Plan) dated 5/10/11 indicated the client drank thickened liquids due to choking risks with staff supervision during all meals in which at least one staff member will sit at his table. Client #3's Emergency Information and Special Consideration sheet (undated) indicated the client drank honey thick liquids due to choking risk. Client #3's Physicians Order form dated 2/1/12	W0331	All staff working in the home will receive retraining on ensuring that all liquids served to the clients are presented to them prepared to the proper consistency as ordered by the physician. Routine observations of meal s and medication passes will occur to ensure that staff are presenting each client with liquids prepared to the proper consistency as ordered by the physician.Persons responsible: Residential Coordinator, Residential Director and Area Director	03/30/2012

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	indicated thicken liquids to prevent choking aspiration. Interview with DSA #2 (Direct Support Associate) on 2/21/12 at 6:20 AM indicated client #3's water was not thickened during medication administration. DSA #2 indicated she was aware of client #3's dysphasia prevention protocol to have liquids thickened to honey consistency but was uncertain if this included the water given with medication administration. Interview with MC #1 (Medical Coordinator) on 2/21/12 at 9:15 AM indicated client #3's medication administration was not included in the dysphasia prevention protocol but would consult with the facility nurse to verify. After consulting with the facility nurse MC #1 indicated client #3's water should have been thickened to honey like consistency during all consumption of liquids. 9-3-6(a)			