

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 04/04/2014
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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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(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
W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: April 2, 3 and 4, 2014.</p> <p>Facility Number: 000773 Provider Number: 15G253 Aims Number: 100243410</p> <p>Surveyor: Jo Anna Scott, QIDP.</p> <p>This deficiency also reflects a state finding in accordance with 460 IAC 9.</p> <p>Quality review completed April 11, 2014 by Dotty Walton, QIDP.</p>	W000000		
W000240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client #4), the Individual Support Plan failed to address client #4's refusing to cooperate for dental appointments making it necessary for client #4's dental treatments to be done under general anesthesia.</p> <p>Findings include:</p> <p>The record review for client #4 was conducted on 4/3/14 at 12:18 PM. The Individual Support Plan (ISP) was dated 1/7/14 and did not include a training objective (interventions/methodologies) to aid client #4</p>	W000240	<p>The program nurse for the service site will receive retraining on the need for and the completion of dental examinations on an annual basis. The residential director will receive retraining on the necessity to develop and implement training objectives which decrease the sensitivity to medical appointments when a need is identified through medical exam, evaluation or Individual Support Team meeting. A goal has been written and implemented which will work to desensitize client # 4 to completion of dental</p>	05/04/2014

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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	<p>to get dental treatments without a general anesthetic. The Dental Consultant Visit form dated 12/28/12 was the most recent dental visit and indicated the following: "Comprehensive dental rehab. (rehabilitation) in the OR (Operating Room) under GA (General Anesthesia)." The record indicated client #4 did not receive an annual dental examination.</p> <p>The interview with staff #2, RN (Registered Nurse), was conducted on 4/3/14 at 1:00 PM. Staff #2, RN, stated "Because client #4 had to be sedated before they could work on his teeth, the dentist said he could return in 1-1/2 to 2 years." Staff #2, RN, indicated the client didn't have any problem with staff assisting with the brushing of his teeth. Staff #2, RN, indicated there was no training goal (interventions/methodologies) in place for client #4 to go to the dentist without a general anesthetic.</p> <p>9-3-4(a)</p>		<p>appointments. Person responsible: Facility Nurse, Residential Director and AreaDirector completion date 5/4/14</p>	