

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
W 0000 Bldg. 00	<p>This visit was for the investigation of complaint #IN00187794.</p> <p>Complaint #IN00187794: SUBSTANTIATED, Federal and State deficiencies related to the allegations were cited at W120, W148, W159, and W210.</p> <p>Dates of Survey: 1/5, 1/6, 1/7, 1/8, 1/12, 1/13, 1/14, and 1/15/2016.</p> <p>Facility number: 000715 Provider number: 15G182 AIM number: 100234640</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review of this report completed on 1/21/16 by #09182.</p>	W 0000		
W 0120 Bldg. 00	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on record review and interview, for 1 of 3 sampled clients (client C) who attended the outside day service site, the facility failed to ensure the outside day</p>	W 0120	The administrator for the facility met with administrators from Shares Inc. on 1/27/16. This issue was discussed and reviewed that staff the day program did not follow the	02/14/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
	<p>services met and followed client C's documented BSP (Behavior Support Plan).</p> <p>Findings include:</p> <p>On 1/5/16 at 11:50am, a review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 7/1/2015 through 1/5/16 was conducted and included the following for client C:</p> <p>-A 11/4/15 BDDS report for an incident on 11/4/15 at 10:00am indicated the contracted workshop administered client C's PRN (as needed) behavior control medication without contacting the agency. The BDDS report indicated this resulted in client C's continued "escalated" behavior and a call to "9-1-1" emergency assistance was made from the workshop.</p> <p>-A 11/3/15 BDDS report for an incident on 11/3/15 at 11:45am indicated client C was "verbally aggressive" toward a "co-worker" at the contracted workshop and the workshop administered client C's "PRN (as needed)" medication for behaviors without contacting the facility agency first.</p> <p>-An 10/26/15 BDDS report for an</p>		<p>behavior program for client C specific to administration of a PRN medication. The notes of this meeting are attached for review. The QIDP and Behavior consultant will ensure that Shares staff clearly understand how to implement behavior development programs for all clients in the facility that have a program. This will include the use of a competency assessment that will verify understanding of the plan. Additionally the QIDP and behavior consultant will complete observations at the day program no less than monthly to ensure the programs are being followed and to interview staff to ensure their understanding and determine if there are any questions or concerns that need to be addressed. These observations will be documented and forwarded to the administrator for review.</p> <p>Responsible Party: Area Director</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
	<p>incident on 10/26/15 at 10:15am indicated client C was physically aggressive toward workshop staff and a PRN medication was administered.</p> <p>-An 10/2/15 BDDS report for an incident on 10/2/15 at 12:15pm indicated client C was administered PRN behavioral medications at the workshop following "attempted aggression."</p> <p>Client C's record was reviewed on 1/6/16 at 2:00pm. Client C's record indicated he was admitted to the facility on 9/12/2015 and discharged from the facility on 11/20/2015. Client C's record indicated a 9/2015 BSP (Behavior Support Plan). Client C's BSP included the targeted behaviors of Anxiety, Physical Assault, Property Destruction, and Non Severe Anger Control defined as "Acts angry or annoyed in an overly reactive manner to an extent that interferes with [Client C's] social functioning, displays of anger that may include accelerated motor and verbal behavior...hostile language used to threaten, intimidate, or belittle..." Client C's BSP indicated "...Use of PRN medication. Component Developed 9/2015. [Client C] is prescribed PRN medication by his physician, if his behaviors meet the criteria below, call the (Agency's) Area Director on call as well as the (Agency's) nurse on call to gain</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
	<p>approval to administer the PRN medications. Please administer 1mg (milligram) of Ativan generic Lorazepam to [client C] under the following conditions: [Client C] appears to be on edge as evidenced by aggressive speech, loud demanding, rude to his supervisors/staff and/or his peers, cursing; His behavior is restless with psychomotor agitation including threatening posturing; He displays physical assault and/or property destruction. [Client C] acknowledges that he needs medication to calm his agitation either by initiating a request of medication or affirming the need for medication when asked by staff. However, if the aforementioned behaviors are presenting and escalating, even if [client C] is verbally resistant to medication example: if you ask him if he needs medicine and he says no or that he does not want it, provide the medicine for him to take anyways (sic), it should be administered to de-escalate his agitation. If the behaviors continue after an hour of the PRN administered, call the AD (Area Director) on call and Nurse on call to get approval for an additional 0.5mg tablet of Haldol." Client C's BSP did not indicate if all of the behavioral criteria had to be met or if some of the behavioral criteria had to be met in order for client C's PRN Ativan and Haldol behavior medications</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
	<p>to be authorized for use. Client C's record did not indicate the use of PRN Ativan and Haldol medications at the group home.</p> <p>On 1/5/16 at 5:10pm, client C's workshop record was reviewed. Client C's "PRN Sheet" for as needed behavior controlling medication was reviewed. Client C's PRN Sheet indicated PRN "Lorazepam 1mg" was administered on 10/6/15, 11/3/15, and 11/4/15.</p> <p>CI (Confidential Interview) #1 indicated client C's guardian was not notified of incidents and PRN behavior medication use. CI #1 indicated client C should have received his PRN behavioral medication when client C requested the medication to prevent client C's behaviors from escalating.</p> <p>On 1/5/16 at 5:00pm, an interview with the contracted workshop Social Worker (SW) and the Director of Support Services (DSS) was conducted. The SW and the DSS both indicated client C received his PRN Lorazepam 1mg four (4) times from 10/2/15 through 11/19/15. The SW indicated client C received PRN medication 10/6/15, 11/3/15, and 11/4/15. The SW indicated she believed the fourth date was 10/2/15 for which no documentation was available for review.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
	<p>The SW indicated client C had attended the contracted workshop before being admitted to the agency group home and the workshop had administered client C's Lorazepam 1mg for behaviors before. The SW and DSS both indicated the workshop did not document and did not contact the group home and/or the agency staff before client C was administered his PRN behavior medication at the workshop. The DSS stated client C could have his PRN behavior medication offered and used if client C demonstrated "any of the criteria" documented in the protocol.</p> <p>On 1/15/16 at 1:58pm, an interview with the Program Quality Coordinator (PQC) was conducted. The PQC indicated client C was administered his PRN Lorazepam four (4) times at the contracted workshop. The PQC indicated client C received his PRN on 10/2/15, 10/6/15, 11/3/15, and 11/4/15 at the contracted workshop. The PQC indicated client C had no PRN use at the group home.</p> <p>This federal tag relates to complaint IN00187794.</p> <p>9-3-1(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
W 0148 Bldg. 00	<p>483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS &</p> <p>The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence.</p> <p>Based on record review and interview, for 1 of 3 sampled clients (client C), the facility failed to ensure client C's guardian was notified of client C's incidents of aggression at the workshop which included the use of PRN (as needed) behavior controlling medication.</p> <p>Findings include:</p> <p>On 1/5/16 at 11:50am, a review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 7/1/2015 through 1/5/16 was conducted and included the following incidents of physical aggression and use of PRN (as needed) behavior medication for client C without documented evidence client C's guardian was notified:</p> <p>-A 11/4/15 BDDS report for an incident on 11/4/15 at 10:00am indicated the contracted workshop administered client C's PRN (as needed) behavior control medication without contacting the agency. The BDDS report indicated this</p>	W 0148	<p>The administrator for the facility met with administrators from Shares Inc. on 1/27/16. During this meeting Shares administrators agreed to update their internal incident report to include specifics on whom is notified, when, and by whom regarding all incidents including BQIS incident reports. This form has been updated and a copy provided to DSA Inc. See the attached. When Shares completes these reports, a copy will be submitted to the DSA administrator and QIDP. The Administrator and QIDP will ensure this is received with all incident report notifications. DSA has a documentation system which is used by professional staff to document guardian notifications of incidents. This practice will continue. This documentation is reviewed monthly by the IST and at other times by the administrator to ensure compliance. The QIDP records all communications with guardians in this system.</p> <p>Responsible Party: Area Director</p>	02/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
	<p>resulted in client C's continued "escalated" behavior and a call to "9-1-1" emergency assistance was made from the workshop.</p> <p>-A 11/3/15 BDDS report for an incident on 11/3/15 at 11:45am indicated client C was "verbally aggressive" toward a "co-worker" at the contracted workshop and the workshop administered client C's "PRN (as needed)" medication for behaviors without contacting the facility agency first.</p> <p>-An 10/26/15 BDDS report for an incident on 10/26/15 at 10:15am indicated client C was physically aggressive toward workshop staff and a PRN medication was administered.</p> <p>-An 10/2/15 BDDS report for an incident on 10/2/15 at 12:15pm indicated client C was administered PRN behavioral medications at the workshop following "attempted aggression."</p> <p>Client C's record was reviewed on 1/6/16 at 2:00pm. Client C's record indicated he was admitted to the facility on 9/12/2015 and discharged from the facility on 11/20/2015. Client C's record indicated he had a legal guardian. Client C's record indicated a 9/2015 BSP (Behavior Support Plan). Client C's BSP included</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
	<p>the targeted behaviors of Anxiety, Physical Assault, Property Destruction, and Non Severe Anger Control defined as "Acts angry or annoyed in an overly reactive manner to an extent that interferes with [Client C's] social functioning, displays of anger that may include accelerated motor and verbal behavior...hostile language used to threaten, intimidate, or belittle..." Client C's BSP indicated "...Use of PRN medication. Component Developed 9/2015. [Client C] is prescribed PRN medication by his physician, if his behaviors meet the criteria below, call the (Agency's) Area Director on call as well as the (Agency's) nurse on call to gain approval to administer the PRN medications. Please administer 1mg (milligram) of Ativan generic Lorazepam to [client C] under the following conditions: [Client C] appears to be on edge as evidenced by aggressive speech, loud demanding, rude to his supervisors/staff and/or his peers, cursing; His behavior is restless with psychomotor agitation including threatening posturing; He displays physical assault and/or property destruction. [Client C] acknowledges that he needs medication to calm his agitation either by initiating a request of medication or affirming the need for medication when asked by staff.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
	<p>However, if the aforementioned behaviors are presenting and escalating, even if [client C] is verbally resistant to medication example: if you ask him if he needs medicine and he says no or that he does not want it, provide the medicine for him to take anyways (sic), it should be administered to de-escalate his agitation. If the behaviors continue after an hour of the PRN administered, call the AD (Area Director) on call and Nurse on call to get approval for an additional 0.5mg tablet of Haldol." Client C's BSP did not indicate if all of the behavioral criteria had to be met or if some of the behavioral criteria had to be met in order for client C's PRN Ativan and Haldol behavior medications to be authorized for use. Client C's record did not indicate the use of PRN Ativan and Haldol medications at the group home. Client C's record did not include documentation by the agency staff and/or group home staff of notification of client C's guardian for the incidents.</p> <p>On 1/5/16 at 5:10pm, client C's workshop record was reviewed. Client C's "PRN Sheet" for as needed behavior controlling medication was reviewed. Client C's PRN Sheet indicated PRN "Lorazepam 1mg" was administered on 10/6/15, 11/3/15, and 11/4/15. Client C's workshop record did not include</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
	<p>documented evidence of notification of client C's guardian for the incidents and PRN behavior medication use.</p> <p>On 1/5/16 at 5:00pm, an interview with the contracted workshop Social Worker (SW) and the Director of Support Services (DSS) was conducted. The SW and the DSS both indicated client C received his PRN Lorazepam 1mg four (4) times from 10/2/15 through 11/19/15. The SW indicated client C received PRN medication 10/6/15, 11/3/15, and 11/4/15. The SW indicated she believed the fourth date was 10/2/15 for which no documentation was available for review. The SW indicated no documented evidence was available for review that client C's guardian was notified of incidents and the use of PRN behavior medications.</p> <p>On 1/15/16 at 1:58pm, an interview with the Program Quality Coordinator (PQC) was conducted. The PQC indicated client C was administered his PRN Lorazepam four (4) times at the contracted workshop. The PQC indicated client C received his PRN on 10/2/15, 10/6/15, 11/3/15, and 11/4/15 at the contracted workshop. The PQC indicated no documented evidence was available for review of notification of client C's guardian.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
W 0159 Bldg. 00	<p>CI (Confidential Interview) #1 indicated client C's guardian was not notified of incidents and PRN behavior medication use.</p> <p>On 1/11/16 at 7:09pm, client C's guardian indicated she did not recall being notified of client C's workshop incidents and PRN behavior medication use.</p> <p>This federal tag relates to complaint IN00187794.</p> <p>9-3-2(a)</p> <p>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 (client C), the QIDP (Qualified Intellectual Disabilities Professional) failed to develop and clarify specific criteria for the use of PRN (as needed) behavior controlling medication and to develop, integrate, coordinate, and monitor client C's assessments and guardian notification of incidents.</p> <p>Findings include:</p>	W 0159	The QIDP will be trained to ensure that she understands her responsibility to ensure that the day program staff understand and are properly implementing behavior development programs as well as other meeting other programming needs. The QIDP will complete observations at the day program no less than monthly to ensure the programs are being followed and to interview staff to ensure their understanding and determine if	02/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/15/2016	
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC				STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176			
(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			
	<p>On 1/5/16 at 11:50am, a review of the facility's BDDS (Bureau of Developmental Disabilities Services) reports from 7/1/2015 through 1/5/16 was conducted and included the following for client C:</p> <p>-A 11/4/15 BDDS report for an incident on 11/4/15 at 10:00am indicated the contracted workshop administered client C's PRN (as needed) behavior control medication without contacting the agency. The BDDS report indicated this resulted in client C's continued "escalated" behavior and a call to "9-1-1" emergency assistance was made from the workshop.</p> <p>-A 11/3/15 BDDS report for an incident on 11/3/15 at 11:45am indicated client C was "verbally aggressive" toward a "co-worker" at the contracted workshop and the workshop administered client C's "PRN (as needed)" medication for behaviors without contacting the facility agency first.</p> <p>-A 10/26/15 BDDS report for an incident on 10/26/15 at 10:15am indicated client C was physically aggressive toward workshop staff and a PRN medication was administered.</p>		<p>there are any questions or concerns that need to be addressed. These observations will be documented and forwarded to the administrator for review.</p> <p>The administrator for the facility met with administrators from Shares Inc. on 1/27/16. During this meeting Shares administrators agreed to update their internal incident report to include specifics on whom is notified, when, and by whom regarding all incidents including BQIS incident reports. This form has been updated and a copy provided to DSA Inc. See the attached. When Shares completes these reports, a copy will be submitted to the DSA administrator and QIDP. The Administrator and QIDP will ensure this is received with all incident report notifications. DSA has a documentation system which is used by professional staff to document guardian notifications of incidents. This practice will continue. This documentation is reviewed monthly by the IST and at other times by the administrator to ensure compliance. The QIDP records all communications with guardians in this system.</p> <p>The QIDP will also be trained to ensure she knows the requirements to have a comprehensive functional assessment, Individual Support Program, and goals/objectives completed and available within 30 days of admission for new clients and</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
	<p>-A 10/2/15 BDDS report for an incident on 10/2/15 at 12:15pm indicated client C was administered PRN behavioral medications at the workshop following "attempted aggression."</p> <p>Client C's record was reviewed on 1/6/16 at 2:00pm. Client C's record indicated he was admitted to the facility on 9/12/2015 and discharged from the facility on 11/20/2015. Client C's record did not include goals/objectives, an ISP (Individual Support Plan), and CFA (Comprehensive Functional Assessment) available for review. Client C's record indicated a 9/2015 BSP (Behavior Support Plan). Client C's BSP included the targeted behaviors of Anxiety, Physical Assault, Property Destruction, and Non Severe Anger Control defined as "Acts angry or annoyed in an overly reactive manner to an extent that interferes with [Client C's] social functioning, displays of anger that may include accelerated motor and verbal behavior...hostile language used to threaten, intimidate, or belittle..." Client C's BSP indicated "...Use of PRN medication. Component Developed 9/2015. [Client C] is prescribed PRN medication by his physician, if his behaviors meet the criteria below, call the (Agency's) Area Director on call as well as the (Agency's) nurse on call to gain</p>		<p>on-going for all clients in the program. These records for all other clients are recurrent and active at this time. She will ensure ongoing that required items are in place. The administrator will review records to ensure required items are completed and in place within 30 days of admission for new residents for verification purposes. There will also be routine reviews by the administrator to ensure that required items remain current for all clients.</p> <p>Responsible Party: QIDP</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
	<p>approval to administer the PRN medications. Please administer 1mg (milligram) of Ativan generic Lorazepam to [client C] under the following conditions: [Client C] appears to be on edge as evidenced by aggressive speech, loud demanding, rude to his supervisors/staff and/or his peers, cursing; His behavior is restless with psychomotor agitation including threatening posturing; He displays physical assault and/or property destruction. [Client C] acknowledges that he needs medication to calm his agitation either by initiating a request of medication or affirming the need for medication when asked by staff. However, if the aforementioned behaviors are presenting and escalating, even if [client C] is verbally resistant to medication example: if you ask him if he needs medicine and he says no or that he does not want it, provide the medicine for him to take anyways (sic), it should be administered to de-escalate his agitation. If the behaviors continue after an hour of the PRN administered, call the AD (Area Director) on call and Nurse on call to get approval for an additional 0.5mg tablet of Haldol." Client C's BSP did not indicate if all of the behavioral criteria had to be met or if some of the behavioral criteria had to be met in order for client C's PRN Ativan and Haldol behavior medications</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
--------------------	--	---------------	---	----------------------

	<p>to be authorized for use. Client C's record did not indicate the use of PRN Ativan and Haldol medications at the group home.</p> <p>On 1/5/16 at 5:10pm, client C's workshop record was reviewed. Client C's "PRN Sheet" for as needed behavior controlling medication was reviewed. Client C's PRN Sheet indicated PRN "Lorazepam 1mg" was administered on 10/6/15, 11/3/15, and 11/4/15. Client C's workshop record had the same 9/15 BSP and no ISP (Individual Support Plan) was available for review.</p> <p>On 1/5/16 at 2:00pm, on 1/6/16 at 11:00am, on 1/6/16 at 2:30pm, and on 1/15/16 at 1:58pm, client C's CFA, ISP, and goals/objectives were requested for review and none were provided.</p> <p>CI (Confidential Interview) #1 indicated client C's guardian was not notified of incidents and PRN behavior medication use. CI #1 indicated client C should have received his PRN behavioral medication when client C requested the medication to prevent client C's behaviors from escalating.</p> <p>On 1/5/16 at 5:00pm, an interview with the contracted workshop Social Worker (SW) and the Director of Support</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
	<p>Services (DSS) was conducted. The SW and the DSS both indicated client C received his PRN Lorazepam 1mg four (4) times from 10/2/15 through 11/19/15. The SW indicated client C received PRN medication 10/6/15, 11/3/15, and 11/4/15. The SW indicated she believed the fourth date was 10/2/15 for which no documentation was available for review. The SW indicated client C had attended the contracted workshop before being admitted to the agency group home and the workshop had administered client C's Lorazepam 1mg for behaviors before. The SW and DSS both indicated the workshop did not document and did not contact the group home and/or the agency staff before client C was administered his PRN behavior medication at the workshop. The DSS stated client C could have his PRN behavior medication offered and used if client C demonstrated "any of the criteria" documented in the protocol.</p> <p>On 1/15/16 at 1:58pm, an interview with the Program Quality Coordinator (PQC) was conducted. The PQC indicated client C was administered his PRN Lorazepam four (4) times at the contracted workshop. The PQC indicated client C received his PRN without the contracted workshop notifying the agency before administration on 10/2/15,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
	<p>10/6/15, 11/3/15, and 11/4/15. The PQC indicated client C had no PRN use at the group home. The PQC indicated client C was admitted to the facility 9/12/2015. The PQC indicated client C had no CFA, ISP, and goals/objectives available for review. The PQC indicated the QIDP (Qualified Intellectual Disabilities Professional) was the designated person for the agency who was responsible for developing, ensuring, monitoring, and integrating client C's active treatment plans to include: assessments, CFA, ISP, goals/objectives; and to clarify client C's BSP PRN criteria. The PQC stated the QIDP should have clarified whether client C's BSP was "if any of the behavior" was demonstrated by client C or "if all of the criteria" documented in client C's BSP had to be demonstrated by client C in order for client C to have received his PRN behavior medications. The PQC indicated after client C was discharged from the facility to the psychiatric hospital on 11/19/15 after physical aggression in which the police were contacted and transported client C to the hospital. The PQC stated the agency staff and the guardian discovered after discharge that the guardian was reading client C's BSP regarding PRN behavior medication use as "if any of the listed criteria" was displayed by client C the PRN behavior medications were to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
	<p>have been administered. The PQC stated the agency staff was reading client C's BSP regarding PRN behavior medication use as "when all of the listed criteria" was displayed by client C the PRN behavior medications were to have been administered.</p> <p>Please refer to W120. The QIDP failed for 1 of 3 sampled clients (client C), who attended the outside day service site, to ensure the outside day services met and followed client C's documented BSP (Behavior Support Plan).</p> <p>Please refer to W148. The QIDP failed for 1 of 3 sampled clients (client C), to ensure client C's guardian was notified of client C's incidents of aggression at the workshop which included the use of PRN (as needed) behavior controlling medication.</p> <p>Please refer to W210. The QIDP failed for 1 of 3 sampled clients (client C), to ensure client C's assessments were completed within 30 days of admission.</p> <p>This federal tag relates to complaint #IN00187794.</p> <p>9-3-3(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/15/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
--	---

(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
W 0210 Bldg. 00	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN</p> <p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview, for 1 of 3 sampled clients (client C), the facility failed to ensure client C's assessments were completed within 30 days of admission.</p> <p>Findings include:</p> <p>Client C's record was reviewed on 1/6/16 at 2:00pm. Client C's record indicated he was admitted to the facility on 9/12/2015 and discharged from the facility on 11/20/2015. Client C's record indicated a 9/2015 BSP (Behavior Support Plan). Client C's record did not include goals/objectives, an ISP (Individual Support Plan), and CFA (Comprehensive Functional Assessment) available for review.</p> <p>On 1/5/16 at 2:00pm, on 1/6/16 at 11:00am, on 1/6/16 at 2:30pm, and on 1/15/16 at 1:58pm, client C's CFA, ISP, and goals/objectives were requested for review and none were provided.</p> <p>On 1/15/16 at 1:58pm, an interview with the Program Quality Coordinator (PQC)</p>	W 0210	<p>The QIDP will also be trained to ensure she knows the requirements to have a comprehensive functional assessment, Individual Support Program, and goals/objectives completed and available within 30 days of admission for new clients and on-going for all clients in the program. These records for all other clients are current and active at this time. She will ensure ongoing that required items are in place. The administrator will review records to ensure required items are completed and in place within 30 days of admission for new residents for verification purposes. There will also be routine reviews by the administrator to ensure that required items remain current for all clients.</p> <p>Responsible Party: QIDP</p>	02/14/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G182	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 01/15/2016
NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES INC			STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176		
(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	
	<p>was conducted. The PQC indicated client C was admitted to the facility on 9/12/2015. The PQC indicated client C had no CFA, ISP, and goals/objectives available for review.</p> <p>This federal tag relates to complaint IN00187794.</p> <p>9-3-4(a)</p>				