

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 04/04/2025
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NAME OF PROVIDER OR SUPPLIER DEVELOPMENTAL SERVICE ALTERNATIVES	STREET ADDRESS, CITY, STATE, ZIP CODE 2326 BERWICK DR SHELBYVILLE, IN 46176
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W 0000 Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey.</p> <p>Dates of Survey: March 31, April 1, 2 and 4, 2025.</p> <p>Facility Number: 000715 Provider Number: 15G182 AIMS Number: 100234640</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/24/25.</p>	W 0000		
W 0159 Bldg. 00	<p>483.430(a) QIDP</p> <p>Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), plus 1 additional client (#4), the facility's QIDP (Qualified Intellectual Disabilities Professional) failed to complete quarterly reviews of clients #1, #2 and #3's goals/objectives, ensure staff completed documentation of clients #1, #2 and #3's goals/objectives being implemented, and ensure clients #1, #3 and #4's ISPs (Individual Support Plans) were reviewed/revised annually.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 4/1/25 at 11:03 AM. Client #1's record did not indicate documentation of completed quarterly reviews pertaining to client #1's goals/objectives for the months of October 2024, November 2024, December 2024, January 2025 and February 2025.</p>	W 0159	<p>W-159 QIDP [483.430(a)] <i>The facility's QIDP failed to complete quarterly reviews of clients #1, #2 and #3's goals/objectives, ensure staff completed documentation of clients #1, #2 and #3's goals/objectives being implemented, and ensure clients #1, #3 and #4's ISP were reviewed/revised annually.</i></p> <p>The lapse occurred due to an acute deficiency of QIDP. Currently there is only 1 QIDP overseeing the group homes in the Indianapolis / Greenfield / Shelbyville area. The facility is actively engaged in the recruitment of suitable candidates for QIDP positions to improve the</p>	05/30/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Shamepane Martin

Quality Assurance Manager

05/01/2025

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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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W 0252 Bldg. 00	<p>Client #2's record was reviewed on 4/1/25 at 12:35 PM. Client #2's record did not indicate documentation of completed quarterly reviews pertaining to client #2's goals/objectives for the months of October 2024, November 2024, December 2024, January 2025 and February 2025.</p> <p>Client #3's record was reviewed on 4/2/25 at 9:17 AM. Client #3's record did not indicate documentation of completed quarterly reviews pertaining to client #3's goals/objectives for the months of October 2024, November 2024, December 2024, January 2025 and February 2025.</p> <p>QIDP #1 was interviewed on 4/2/25 at 2:55 PM. QIDP #1 indicated the facility did not have documentation of completed quarterly reviews for clients #1, #2 and #3.</p> <p>2. The facility's QIDP failed to ensure staff completed documentation of clients #1, #2 and #3's goals being implemented. Please see W252.</p> <p>3. The facility's QIDP failed to ensure clients #1, #3 and #4's ISPs were revised/reviewed annually. Please see W260.</p> <p>9-3-3(a)</p> <p>483.440(e)(1) PROGRAM DOCUMENTATION</p>		<p>response time for correction of the deficiencies noted.</p> <p>Furthermore, the company has set forth a correction plan with a holistic approach to ensure such errors are addressed in a timely manner. A database of all clients has been created for the due dates of all CFAs / ISPs of the resident clients which is maintained by the QA office. This would ensure that the monitoring is done in a timely fashion. In addition, the goals of the residents are being updated to make them (SMART) so they can be effectively measured and concomitantly the DSP(s) are being trained on how to monitor and enter the new goals for the individual clients. This a paradigm shift in the process of monitoring and measuring individual goals. The preparation of measurable goals and updating of the ISP would be dependent on availability of all IST members to approve the said ISP(s). The process of update is at hand and guardians are being contacted for each client as the draft ISP(s) are prepared by the QIDP for team approval. It is hoped that the IST meetings would be completed with approval of the ISPs by May 30 2025.</p>	

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	<p>Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure staff completed documentation of clients #1, #2 and #3's goals/objectives being implemented.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 4/1/25 at 11:03 AM.</p> <p>Client #1's ISP (Individual Support Plan) dated 2/15/24 indicated client #1 had goals/objectives related to medication administration skills, meal preparation skills, oral hygiene skills, money management skills. Client #1's record did not indicate documentation client #1's goals/objectives being implemented.</p> <p>2. Client #2's record was reviewed on 4/1/25 at 12:35 PM.</p> <p>Client #2's ISP dated 8/4/24 indicated client #2 had goals/objectives related to oral hygiene skills, showering skills, cooking, money skills, housekeeping skills and laundry skills. Client #2's record did not indicate documentation of client #2's goals/objectives being implemented.</p> <p>3. Client #3's record was reviewed on 4/2/25 at 9:17 AM.</p> <p>Client #3's ISP dated 9/8/23 indicated client #3 had goals/objectives related to medication administration skills, meal preparation skills, personal hygiene skills, personal safety skills, housekeeping skills and money management skills. Client #3's record did not indicate documentation of client #3's goals/objectives being implemented.</p>	W 0252	<p>W-252 Program Documentation [483.440(e)(1)] <i>The facility failed to ensure staff completed documentation of Clients #1, #2 and #3's goals/objectives being implemented.</i></p> <p>The previous QIDP had not properly trained the staff on documentation of goals in Sandata. The previous QIDP was separated from employment. Once the new goals are completed by the QIDP by 2/14/2025. Training in tracking the goals on Sandata will commence with the staff. Initially, 3 sessions / week will be dedicated to re-training on goal tracking for the first 2 weeks. Then, depending on the response of the staff in goal tracking and how accurately the tracking is documented, the re-training sessions will be reduced in a gradual manner. The QIDP and the RSD will be responsible to ensure that the staff is effectively re-trained in goal tracking on Sandata. A Paper format will also be prepared by the QIDP for each goal of each consumer to ensure tracking in cases of loss internet connectivity to the central Sandata database. Oversight of goal tracking will be maintained by QA and progress / points of concern will be communicated by the QA to the QIDP / RSD for rectification.</p>	05/30/2025

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W 0260 Bldg. 00	<p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 4/2/25 at 2:55 PM. QIDP #1 indicated the facility did not have documentation of clients #1, #2 and #3's goals/objectives being implemented. QIDP #1 stated, "We need to get better with our staff completing the documentation."</p> <p>9-3-4(a)</p> <p>483.440(f)(2) PROGRAM MONITORING & CHANGE</p> <p>Based on record review and interview for 2 of 3 sampled clients (#1 and #3), plus 1 additional client (#4), the facility failed to ensure clients #1, #3 and #4's ISPs (Individual Support Plans) were review/revised annually.</p> <p>Findings include:</p> <p>1. Client #1's record was reviewed on 4/1/25 at 11:03 AM. Client #1's record indicated an ISP dated 4/26/23 with a revision date of 2/15/24. Client #1's record did not indicate documentation of a current ISP.</p> <p>2. Client #3's record was reviewed on 4/2/25 at 9:17 AM. Client #3's record indicated an ISP dated 9/8/23. Client #3's record did not indicate documentation of a current ISP.</p> <p>2. Client #4's record was reviewed on 4/2/25 at 10:02 AM. Client #4's record indicated an ISP dated 3/22/23. Client #4's record did not indicate documentation of a current ISP.</p> <p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 4/2/25 at 2:55</p>	W 0260	<p>W-260 Program Monitoring & Change [483.440(f)(2)] <i>The facility failed to ensure clients #1, #3 and #4's ISPs were reviewed/revised annually.</i></p> <p>The deficiency is noted and omission regretted. The former QIDP had not ensured to update the consumers ISP's in a timely manner. Review of all clients documentation revealed that ISP's of 5 consumers had not been updated adequately to define individualized goals for their specific needs. The ISPs are being revised by the QIDP the goals of the residents are being updated to make them (SMART) so they can be effectively measured and concomitantly the DSP(s) are being trained on how to monitor and enter the new goals for the individual clients. The process of update is at hand and guardians are being contacted for each client as the draft ISP(s) are</p>	05/30/2025

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W 9999 Bldg. 00	<p>PM. QIDP #1 indicated the facility did not have documentation of current ISPs for clients #1, #3 and #4.</p> <p>9-3-4(a)</p> <p>State Findings:</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.</p> <p>460 IAC 9-3-3 Facility Staffing</p> <p>(e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux tuberculosis skin test or chest x-ray was completed. The results of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 1 of 3 sampled employees, the facility failed to ensure staff #3's Mantoux screening was completed annually.</p> <p>Findings include:</p> <p>The facility's Employee Records were reviewed on 4/2/25 at 11:00 AM.</p> <p>Staff #3's employee record did not indicate documentation of a completed Mantoux screening.</p>	W 9999	<p>prepared by the QIDP for team approval. It is hoped that the IST meetings would be completed with approval of the ISPs by May 30 2025.</p> <p>W-9999 Final Observations The facility failed to ensure staff #3's Mantoux screening was completed annually. All staff documentation is maintained centrally by HR department of the facility. Due to recent staffing changes and separation of previous HR professional from the company, the oversight is regretted. Staff TB screening is under process by the newly rehired nurse. The new HR professional has been sensitized to ensure monthly monitoring and updating of all teams of statutory staff documentation requirements inclusive of Mantoux screening. On receipt of information from the HR department, the RSD will ensure the staff documentation requirements are fulfilled in a timely manner. The RSD will provide the RD a report confirming that the Mantoux test has been done for all staff they manage.</p>	05/30/2025

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

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	<p>QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 4/2/25 at 2:55 PM. QIDP #1 indicated staff were to have Mantoux screenings completed annually. QIDP #1 stated, "We could not locate documentation of a completed Mantoux screening for [staff #3]."</p> <p>9-3-3(e)</p>				