STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G182	A. BUILDING 00 B. WING	09/03/2021

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

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W 0000 Bldg. 00	This visit was for the pre-determined full recertification and state licensure survey. This visit included a COVID-19 focused infection control survey. Dates of Survey: August 31, September 1, 2, and 3, 2021. Facility Number: 000715 Provider Number: 15G182 AIMS Number: 100234640 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/23/21.	W 0000		
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- Based on record review and interview for 2 of 2 sampled clients (clients #1 and #2), the facility's QIDP (Qualified Intellectual Disabilities Professional) failed to ensure client #1 and #2's ISPs (Individual Support Plans) were reviewed and updated annually, and to ensure client #1 and #2's goals were being reviewed monthly for progress. Findings include: Client #1's record was reviewed on 9/1/21 at 10:00 AM.	W 0159	The new QIDP will receive training on her responsibility to integrate, coordinate and monitor each client's active treatment program. The training will include how to complete a monthly review of goals and associated changes, auditing to assure that all ISP's are current, and a perpetuating schedule is developed. The training will also include annual review and update of the CFA's for all individuals. The Area Director, or designee, will review these work	10/08/2021

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 determin other safegaurds 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 disclo 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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	Client #1's record indicated documentation of an ISP dated 1/22/20. Client #1's record did not indicate documentation of a current ISP. Client #1's record did not indicate documentation of monthly summaries completed by the QIDP, reviewing client #1's goals and progress. Client #2's record was reviewed on 9/1/21 at 10:37 AM. Client #2's record indicated documentation of an ISP dated 1/27/20. Client #2's record did not indicate documentation of a current ISP. Client #2's record did not indicate documentation of monthly summaries completed by the QIDP, reviewing client #2's goals and progress. CM (Case Manager) #1 was interviewed on 9/2/21 at 12:04 PM. CM #1 indicated the facility did not have current ISPs on record for clients #1 and #2. CM #1 indicated client #1's ISP was being finalized at the time of the survey and client #2 had a team meeting scheduled for 9/7/21 to update his ISP. CM #1 was asked about clients #1 and #2's monthly summaries reviewing goals and progress. CM #1 indicated the facility did not have documentation of monthly summaries completed by the QIDP. 9-3-3(a)		products weekly in meetings with the QIDP to monitor for completion.	
W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 2 of 2	W 0259	The new QIDP will receive training	10/08/2021

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	sampled clients (clients #1 and #2), the facility failed to ensure client #1 and #2's CFAs (Comprehensive Functional Assessments) were reviewed and updated annually. Findings include: Client #1's record was reviewed on 9/1/21 at 10:00 AM. Client #1's record indicated documentation of a CFA dated 6/29/20. Client #1's record did not indicate documentation of a current CFA. Client #2's record was reviewed on 9/1/21 at 10:37 AM. Client #2's record indicated documentation of a CFA dated 9/12/2019. Client #2's record did not indicate documentation of a current CFA. CM (Case Manager) #1 was interviewed on 9/2/21 at 12:04 PM. CM #1 indicated clients #1 and #2 did not have a current CFA. CM #1 indicated they would be updated. 9-3-4(a)		on her responsibility to annually review and update the CFA's for all individuals. The CFA's will be reviewed and updated for all individuals and stored in each individual's record. The Area Director, or designee, will review these work products weekly in meetings with the QIDP to monitor for completion.	
W 0260 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the individual program plan must be revised, as appropriate, repeating the process set forth in paragraph (c) of this section. Based on record review and interview for 2 of 2 sampled clients (clients #1 and #2), the facility failed to ensure client #1 and #2's ISPs (Individualized Support Plans) were reviewed and updated annually. Findings include: Client #1's record was reviewed on 9/1/21 at 10:00 AM. Client #1's record indicated documentation	W 0260	The new QIDP will receive training on her responsibility to review and revise the individual program plan. The QIDP will audit to assure that all ISP's are current, and a perpetuating schedule is developed. As determined necessary, ISP meetings will be held with the applicable IST's, the information updated, shared, and	10/08/2021

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	of an ISP dated 1/22/20. Client #1's record did not indicate documentation of a current ISP. Client #2's record was reviewed on 9/1/21 at 10:37 AM. Client #2's record indicated documentation of an ISP dated 1/27/20. Client #2's record did not indicate documentation of a current ISP. CM (Case Manager) #1 was interviewed on 9/2/21 at 12:04 PM. CM #1 indicated the facility did not have current ISPs on record for clients #1 and #2. CM #1 indicated client #1's ISP was being finalized at the time of the survey and client #2 had a team meeting scheduled for 9/7/21 to update his ISP. 9-3-4(a)		stored in the consumer's record. The Area Director, or designee, will review these work products weekly in meetings with the QIDP to monitor for completion.	
W 9999 Bldg. 00	State Findings 460 IAC 9-3-1(b) Governing Body (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division: 15. A fall resulting in injury, regardless of the severity of the injury. 16. A medication error or medical treatment error as follows: c. Missed medication - not given. This state rule was not met as evidenced by: Based on record review and interview for 2 of 2 sampled clients (clients #1 and #2), plus 2 additional clients (client #3 and FC (Former Client) #1) , the facility failed to report a fall involving	W 9999	The new QIDP will receive training on her responsibility to report falls resulting in injury, regardless of severity, within 24 hours of knowledge to BDDS. The Area Director will monitor for email evidence of the filing to assure that the task was completed in accordance with requirement.	10/08/2021

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	client #1, and an incident of missed medications involving clients #2, #3 and FC #1, to BDDS (Bureau of Developmental Disabilities Services) within 24 hours of knowledge. Findings include: The facility's BDDS reports and investigations were reviewed on 8/31/21 at 12:00 PM. 1. A BDDS report dated 4/20/21 indicated the following: -"...Submitted Date: 4/20/2021...". -"...During the investigation of missed medications at the [name of group home] on 4/17/21 it was discovered that there were more missed medications than previously reported. [Client #2] did not receive Abilify (mental/mood disorder) 5mg (milligrams), Donepezil (used to treat confusion) 10mg, fluticasone (allergy) SPR (Spray) 50mcg (micrograms), Claritin (allergies) 10mg, simvastatin (lower bad cholesterol) 40mg, tamsulosin (prostate) 0.4mg; [FC #1] did not receive ear drops 0.65%, fluticasone SPR 50mcg; and [client #3] did not receive atorvastatin (lower bad cholesterol) 80mg, fluticasone SPR 50mcg, or Prazosin (high blood pressure) HCL (hydrochloride) 1mg...". A review of the BDDS report dated 4/20/21 indicated during an investigation on 4/17/21 it was discovered clients #2, #3, and FC #1 had missed more medications than previously reported. The review indicated the incident was reported to BDDS on 4/20/21. The review indicated the incident was not reported to BDDS within 24 hours of date of knowledge.			

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	2. A BDDS report dated 8/6/21 indicated the following: -"...Submitted Date: 8/6/2021...". -"...Date of Knowledge: 8/3/2021...". -"...Staff stated that [client #1] and her (sic) were walking towards the stairs to go up so the consumer could shower. She was walking behind him and when he went to turn his walker so he could go up the stairs he accidentally tripped himself and fell and scuffed his left knee. The mark was the size of a quarter. He leaned himself up on the door by the stairs and was able to lift himself up off the ground...". A review of the BDDS report dated 8/6/21 indicated client #1 had an incident involving a fall. The review indicated the date of knowledge of the incident was 8/3/21. The review indicated the incident was reported to BDDS on 8/6/21. The review indicated the incident was not reported to BDDS within 24 hours of the incident occurring. AD (Area Director) #1 was interviewed on 8/31/21 at 11:38 AM. AD #1 indicated all reportable incidents should be reported to BDDS within 24 hours of the date of knowledge. 9-3-1(b)			