

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G594	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 1412 CLOVER ST MOUNT VERNON, IN 47620
--	---

(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
W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: November 13, 14, 15 and 19, 2012</p> <p>Provider Number: 15G594 Aims Number: 100245590 Facility Number: 001108</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 3, 2012 by Dotty Walton, Medical Surveyor III.</p>	W0000		

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: 15G594	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/19/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 1412 CLOVER ST MOUNT VERNON, IN 47620		
(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	
W0317	<p>483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #1) who took behavior control drugs, to ensure the behavior control medications were monitored with the input of the interdisciplinary team (IDT) and the prescribing physician.</p> <p>Findings include:</p> <p>Review of the record of client #1 was done on 11/15/12 at 11:05a.m. Client #1's 8/1/12 individual support plan (ISP) indicated client #1's diagnoses included, but were not limited to, Mood Disorder. Primary Care Physician's orders on 11/6/12 indicated client #1 received the behavior control medication Abilify 5 milligrams one per day for Mood disorder. Client #1's behavior medication (Abilify) had been prescribed and monitored by her psychiatrist. The psychiatrist on 2/12/12, had ordered Abilify 10 milligrams two times a day for Mood Disorder. On 8/24/12 the psychiatrist had indicated "no changes." Client #1 had a documented visit to her</p>	W0317	<p>W317: Drug Usage</p> <ul style="list-style-type: none"> - The nurse has been inserviced to contact the doctor in regards to any medication changes. - The PC has been inserviced to hold an IDT meeting so that the team can discuss medication changes. - Specifically for Client #1 the team will complete an IDT and discuss the medication recommendation for Abilify. The psychiatrist has been notified. - The PC will conduct weekly home visits to ensure that all recommendations related to behavior medications have been approved by the IDT team and implemented. <p>Staff Responsible: PC & Nurse</p>	12/19/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G594		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/19/2012	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 1412 CLOVER ST MOUNT VERNON, IN 47620			
(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>Primary Care Physician on 9/20/12. The Primary Care Physician on 9/20/12 had changed the behavior medication (Abilify) to 5 milligrams per day. There was no documentation the prescribing psychiatrist or the facility's IDT had been consulted in regards to the behavior medication change.</p> <p>Interview of staff #1 (area director) on 11/15/12 at 1:28p.m. indicated client #1 currently received Abilify 5 milligrams daily. Staff #1 indicated the Abilify had been prescribed by the psychiatrist. Staff #1 indicated on 9/20/12 client #1's Primary Care Physician had changed the daily dosage of the behavior medication, Abilify. Staff #1 indicated the facility's IDT had not been involved with the medication reduction and was not aware of the reason the Primary Care Physician had changed the Abilify order. Staff #1 indicated there was no documentation the prescribing psychiatrist had been consulted in regards to the medication change. Staff #1 was interviewed on 11/19/12 at 10:21a.m. Staff #1 indicated they had contacted client #1's psychiatrist and the psychiatrist indicated he was not aware of any medication changes regarding the behavior medication (Abilify).</p> <p>9-3-5(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G594	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/19/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 1412 CLOVER ST MOUNT VERNON, IN 47620
--	---

(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