

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G127	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 11/02/2011
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 1031 WEST ST NEW ALBANY, IN47150		
(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 post certification revisit (PCR) to the recertification and state licensure survey completed on 8/31/11.</p> <p>Survey Dates: October 24, 25, 27 and November 2, 2011</p> <p>Facility Number: 000664 Provider Number: 15G127 Aim Number: 100234310</p> <p>Surveyor: Jo Anna Scott, Medical Surveyor III</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 11/28/11 by Ruth Shackelford, Medical Surveyor III.</p>	W0000			
W0125	<p>The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on record review and interview for 1 of 4 sampled clients (client #4), the facility failed to ensure a legally sanctioned health care representative was provided.</p>	W0125	<p>The team has identified an individual who has agreed to become Client #4's Health Care Representative and Tim Naville, Attorney at Law, in New Albany, IN has been contacted about the completion and filing of the paperwork with the court to be</p>	12/06/2011	

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>Findings include:</p> <p>The record review for client #4 was conducted on 10/25/11 at 3:00 PM. The informed consent assessment, undated, indicated client #4 should have a health care representative to assist in making medical decisions. The client's record indicated a staff from the workshop was currently identified as his health care representative. The staff from the workshop was not related to client #4 and was not a member of the clergy.</p> <p>Interview with staff #1, Program Coordinator (PC), on 10/25/11 at 3:45 PM indicated they were in the process of trying to find a family member that would be willing to serve as health care representative. Staff #1, PC, indicated the person listed as the health care representative agreed to serve as his health care representative before she was aware of the regulation of a health care representative being a family member or a clergy. Staff #1 indicated the facility had not been successful in finding an appropriate representative.</p> <p>This deficiency was cited on 8/31/11. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-2(a)</p>		reviewed and signed by a judge.		

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

PRINTED: 12/15/2011

FORM APPROVED

OMB NO. 0938-0391

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