

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G179	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/24/2015
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 8206 BUCKRIDGE TR EVANSVILLE, IN 47715
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W 0000  Bldg. 00	<p>This visit was for an investigation of Complaint #IN00178980.</p> <p>Complaint #IN00178980: Substantiated, Federal/State deficiency related to the allegation was cited at W149.</p> <p>Dates of Survey: 8/20, 8/21 and 8/24, 2015.</p> <p>Facility Number: 000712 AIM Number: 100243090 Provider Number: 15G179</p> <p>This deficiency reflects state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #15068 on 9/3/15.</p>	W 0000		
W 0149  Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on interview and record review for</p>	W 0149		09/23/2015

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>1 of 3 sampled clients (C), the facility failed to implement written policies and procedures to prohibit abuse and mistreatment of the client in regard to two staff making the client walk laps around the perimeter of the group home due to incontinence.</p> <p>Findings include:</p> <p>The facility's reportable incident reports and/or investigations were reviewed on 8/20/15 at 2:04 PM. The facility's 7/24/15 reportable incident report indicated "allegation that staff [staff #1] and [staff #2] made [client C] walk around the [name of group home] yard due to having an accident in her clothes."</p> <p>The Investigative Summary completed on 7/27/15 indicated in its Summary of Interviews:</p> <p>"[staff #1] indicated that she was working on 7/18/15. She indicated that she could not recall whom she was working with. She indicated that yes [client C] did have an accident. She indicated that [client C] often does not make it to the bathroom in time. She indicated that she has never made [client C] walk around the house as a form of punishment for having a bowel movement/incontinence in her underwear, and not making it to the</p>		<p><b>W149-</b></p> <p>-The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>-In order to correct the deficiency with W149:</p> <p>-The facility has a policy regarding abuse and neglect that remains accurate and appropriate.</p> <p>-The Clinical Supervisor will retrain the Residential Manager regarding this policy and procedure.</p> <p>The Residential Manager will retrain the Direct Care Staff regarding this policy and procedure.</p> <p>- The Clinical Supervisor will retrain the Residential Manager on job responsibilities.</p> <p>-The Residential Manager will retrain the Direct Care Staff on job responsibilities.</p> <p>-The Residential Manager will monitor through daily observations in the group home to ensure policy and procedure is being followed appropriately.</p> <p>-The QIDP will monitor through</p>	

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	<p>bathroom. She indicated that when [client C] does have an accident she does not help her clean it up. She indicated that [client C] can do it by herself. She indicated that when [client C] takes a shower she does not assist her, she just verbally tells her to wash herself, and she says she is in and out fast.</p> <p>[Staff #2] indicated that she was working on 7/18/15 at the [name of group home]. She indicated that she was working with [staff #1]. She indicated that she could not remember if [client C] had a bowel movement in her clothes or not. She indicated she could not remember if [staff #1] made [client C] go outside and walk around as a punishment for having an accident. She indicated that when [client C] has an episode of incontinence she does not assist her in cleaning up. She indicated that [client C] can clean herself up. She indicated that she verbally directs her to go clean herself. She indicated that she has never punished [client C] by making her walk around the house because of incontinence of having a bowel movement before making it to the toilet.</p> <p>[Client C] indicated on the 7/18/15 (sic) her staff [staff #1 and staff #2] made her walk laps around the group home when she had an accident in her pants. She</p>		<p>weekly observations in the group home to ensure policy and procedure is being followed appropriately.</p> <p>-The Clinical Supervisor will monitor through monthly observations in the group home to ensure policy and procedure is being followed appropriately.</p> <p>-IDT with individuals in the group home to explain the Bill of Rights, Grievance Policy, offer counseling, and reviewing each individual's ISP and BSP.</p> <p>-Bill of Rights with all individuals.</p> <p>-Grievance Policy with all individuals.</p> <p>Persons Responsible: Residential Manager, QIDP, Clinical Supervisor, and Executive Director.</p>	

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	<p>indicated that it made her really upset and made her cry. She indicated that it was really hot and [staff #2] let her come and get a drink.</p> <p>[Client E] indicated that on 7/18/15 [staff #1] and [staff #2] were working. She indicated that [client C] had had a bowel movement, and did not make it to the bathroom in time. She indicated that [staff #1] made [client C] walk laps around the house when she wets herself. She indicated that on this particular day, she made [client C] walk around the house 7 times. She indicated that it was very hot this day, and she did not think it was right what they did to [client C]. [Client E] stated that she arrived when [client C] was walking into the home and did not see her walking.</p> <p>[Client B] indicated that on 7/18/15 her staff was (sic) [staff #1] and [staff #2]. She indicated that [client C] had a bowel movement and did not make it to the bathroom in time. She indicated that [client C] said that [staff #1] made [client C] clean herself with no assistance, and then made her walk around the house as punishment. She indicated that [client C] walked around the house approximately 5 times. She indicated that she does not like [staff #1].</p>			

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	<p>[Client F] indicated that on 7/18/15 her staff was (sic) [staff #1] and [staff #2]. She indicated that [client C] had wet herself. She indicated that [staff #1] made [client C] walk laps around the house as punishment. She indicated that [staff #2] let [client C] come back in to get a drink of water because it was hot outside. She indicated that she does not like her [staff #1].</p> <p>[Client G] indicated that on 7/18/15 her staff was (sic) [staff #1] and [staff #2]. She indicated that [client C] did have an accident in her clothes. She indicated that [staff #1] is mean but was not specific."</p> <p>The conclusion of the investigation indicated "after review of all statements and documentation, the investigative committee concludes that the allegation that [staff #1] and [staff #2] made [client C] walk laps around the [name of group home] due to having an accident in her clothes is substantiated."</p> <p>Interview with client C was completed on 8/20/15 at 4:40 pm. Client C stated "last month I was told by [staff #1] and [staff #2] I had to walk around the group home yard 5 times because I had an accident in my pants. It was hot outside! I don't like them at all!"</p>			

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	<p>Interview with the QIDP (Qualified Intellectual Disabilities Professional) on 8/20/15 at 5:12 pm indicated staff #1 had already applied for and was granted leave for FMLA (Family Medical Leave Act). She stated "[staff #1] had already begun her leave prior to the investigation being completed. I am not sure whether she will be terminated." The QIDP also indicated that staff #2 had given a two week notice to resign her employment prior to the completion of the investigation and was allowed to work out her two weeks. The QIDP stated "it was obvious from the investigation the situation did indeed take place as too many people witnessed it especially some of the other clients." She indicated the current direct support staff working at the group home have transferred from another home that is not being utilized at the present time. She indicated the present staff were not working at the group home at the time of the allegation.</p> <p>The facility's undated "Procedures: Abuse/Neglect/Exploitation, Death Incident Reporting and Investigation" was reviewed on 8/20/15 at 3:22 pm. It indicated "any act of abuse/neglect/exploitation is strictly prohibited and will not be tolerated. All employees receive training upon hire regarding definitions of different types of</p>			

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	<p>abuse/neglect, how to identify abuse/neglect/exploitation, how to report it and what to expect from an investigation. All employees receive this training upon hire and annually, thereafter. Failure to report death, allegations of abuse/neglect/exploitation and/or information related to abuse/neglect/exploitation in a timely manner and in accordance with requirements may result in employee disciplinary action up to and including termination of employment."</p> <p>This federal tag relates to relates to Complaint #IN00178980.</p> <p>9-3-2(a)</p>			

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