

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G492	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/24/2012
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 1480 W 47TH ST JASPER, IN 47546		
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W0000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: August 20, 22, 23, and 24, 2012.</p> <p>Surveyor: Dotty Walton, Medical Surveyor III</p> <p>Facility Number: 001006 AIM Number: 100235270 Provider Number: 15G492</p> <p>The following federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/31/12 by Ruth Shackelford, 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.

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W0203	<p>483.440(b)(5)(i) ADMISSIONS, TRANSFERS, DISCHARGE At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status.</p> <p>Based on observation, record review and interview for 1 additional client (client #5), the facility failed to ensure a discharge summary of the client's programming and medical needs was developed at the time of her discharge from the facility.</p> <p>Findings include:</p> <p>During observations at the facility on 8/20/12 from 4:15 PM until 5:45 PM and on 8/22/12 from 6:00 AM until 8:30 AM, client #5's belongings were still at the facility although she was not. The room which client #5 shared with client #3 still contained her flat screen television, clothes and personal mementos.</p> <p>Interview with LPN #1 on 8/20/12 at 4:15 PM indicated client #5 had been discharged to a nursing home closer to her family.</p> <p>Qualified Intellectual Disabilities Professional/QIDP #2 was asked (4:30 PM 8/20/12) to get a copy of client #5's discharge summary so her status at the time of her discharge could be reviewed.</p>	W0203	<p>W 203: At the time of the discharge the facility must develop a final summary of the client's developmental, behavioral, social, health and nutritional status. Corrective Action (Specific): The QMRP and Home Manager will be retrained that at the time of the discharge a final summary of the client's developmental, behavioral, social, health and nutritional status must be developed. The Operations Manager and the QMRP will be retrained that all personal belongings and finances of the discharged client will be moved to the client's new address. How Others Will Be Identified (Systemic): The Operations Manager will ensure that each client who is discharged will have on file a final discharge summary.</p> <p>Measures to be put in Place: The QMRP and the home manager will be retrained that at the time of the discharge a final summary of the client's developmental, behavioral, social, health and nutritional status must be developed. The Operations Manager and the QMRP will be retrained that all personal belongings of the discharged client will be moved to the client's</p>	09/23/2012			

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	<p>Staff #4 indicated (8/22/12 10:15 AM) client #5's pocket money (\$7.00) was still at the facility and had not been sent to her.</p> <p>QIDP #2 produced a copy, of what was termed a discharge summary, on 8/22/12 at 10:30 AM and it was reviewed. The single page document indicated client #5's name, the address of the facility, her new address and the effective date of discharge as 7/31/12. The document indicated this document was sent on 8/09/12 by the facility to a state agency. The document contained no programming information, no medical status, no nutritional needs, and no information concerning her funds or her personal effects. QIDP #2 had no further information.</p> <p>9-3-4(a)</p>		<p>new address. Monitoring of Corrective Action: The Operations Manager will maintain a file of discharge summaries for clients discharged from the facility. Completion Date: September 15, 2012</p>				

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W0249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (client #4), the facility failed to implement client #4's mealtime dining plan during times of opportunity.</p> <p>Findings include:</p> <p>During observations at the facility on 8/20/12 from 4:15 PM until 5:45 PM clients returned from day services and went about their evening routine of medications, leisure pursuits and mealtime. Client #3 was cooking the evening meal while supervised by staff #4. The table was set and the meal consisting of spaghetti with meat sauce, garlic bread, salad and jello was served. Client #4 prepared her food by using a food processor to alter it to a mechanically chopped consistency. Staff #4 sat beside client #4 who ate her blended food with a small spoon. The client leaned over her food and did not place her utensil down between bites. Client #4 did not take sips of fluids after</p>	W0249	<p>249: As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Corrective Action (Specific): Staff will be trained on client #4's dining plan. How Others Will Be Identified (Systemic): Staff will be trained on dining plans of clients #1, #2,#3, #5, #6 and #7. Measures to be put in Place: Staff will be trained on client #4's dining plan.</p> <p>Monitoring of Corrective Action: The QMRP and the nurse will conduct random meal observations at the home to ensure that meal time goals are implemented as written. Completion Date: September 15, 2012</p>	09/23/2012	

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	<p>bites of food. Client #4 coughed during the meal. Staff #4 verbally prompted client #4 to slow her eating pace. Staff #4 and #5, who were sitting with clients during the meal, did not prompt client #4 to set her eating utensil down between bites. Staff did not prompt the client to swallow before more food was taken. The staff did not ask client #4 to swallow an additional time (dry swallow) after bites of food. Staff did not have client #4 take fluids to help "wash" food bites down.</p> <p>Review of client #4's record on 8/22/12 at 11:00 AM and on 8/23/12 at 2:30 PM indicated client #4's diagnosis included, but was not limited to, dysphagia; according to a swallow study dated 8/17/10. The record review indicated client #4 had an Individual Support Plan/ISP dated 6/22/12 with an accompanying dining plan. The ISP had a mealtime objective for client #4 to chew, swallow food and drink with verbal prompting. The dining plan indicated client #4 should take small bites of food and small sips of fluids. The plan indicated the client should "dry swallow" (swallow additionally) before more food/fluids were ingested. The dining plan indicated the client should sit at the dining table with her hips at a 90 degree angle and not lean over her food. The dining plan indicated client #4 should lay</p>			

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	<p>her eating utensil down, chew/swallow, and then pick up the utensil.</p> <p>Interview with Qualified Intellectual Disabilities Professional/QIDP #2 on 8/22/12 at 12:45 PM indicated all clients should be engaged in training objectives. The interview also indicated client #4 had been identified as being at risk for choking and her objectives should be reinforced by staff for her safety.</p> <p>9-3-4(a)</p>			

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W0440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), and 3 additional clients (#6, #7 and #8), the facility failed to ensure evening shift and night shift evacuation drills were conducted at least quarterly.</p> <p>Findings include:</p> <p>Fire evacuation drills from 7/18/11 to 8/8/12 with clients #1, #2, #3, #4, #6, #7 and #8, as participants were reviewed on 8/22/12 at 10:00 AM. The review indicated no night shift fire drill (12:00 AM until 8:00 AM) for the third quarter of 2011 (July, August, September), the first quarter of 2012 (January, February, March), and the second quarter of 2012 (April, May and June). The review indicated no evening shift fire drill (4:00 PM until 12:00 AM) for the third quarter of 2011 (July, August, September), and the second quarter of 2012 (April, May and June).</p> <p>Interview with Program Coordinator #2 and House Manager #3 on 8/22/12 at 10:15 AM indicated no additional drill records for the facility.</p> <p>9-3-7(a)</p>	W0440	<p>440: The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Corrective Action: (Specific): The home manager will be trained that evacuation drills must be completed at least quarterly for each shift of personnel.</p> <p>How others will be identified: (Systemic) The Program Coordinator will review each drill to ensure that they were completed as indicated by regulation.</p> <p>Measures to be put in place: The home manager will be trained that evacuation drills must be completed at least quarterly for each shift of personnel</p> <p>Monitoring of Corrective Action: The Operations Manager for Supervised Group Living will review fire drills to ensure that they were completed as indicated by regulation</p> <p>Completion date: 09/15/2012</p>	09/23/2012			

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