

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G106	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 4122 TRIPLE CROWN NEWBURGH, IN 47630
--	--

(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
W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: January 27, 29, 30, 31, and February 3, 2014</p> <p>Provider Number: 15G106 Aims Number: 100234140 Facility Number: 000643</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/13/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000193	<p>483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients.</p> <p>Based on observation, record review and interview, the facility staff failed for 1 non-sampled client (#7), to demonstrate staff training (knowledge/skills) to implement client #7's individual support plan (ISP) intervention (locked sharps).</p>	W000193	W193: - Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of a client. -All staff including staff at Day Program will be retrained on client #7's ISPs,	03/05/2014

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:  15G106	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 4122 TRIPLE CROWN NEWBURGH, IN 47630		
(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>Finding include:</p> <p>An observation was done on 1/30/14 from 9:52a.m. to 10:58a.m. at the facility owned group home where client #7 attended a day program. At 10:46a.m., staff #5 (day program lead staff) opened an unlocked kitchen drawer, that contained sharp knives. Staff #5 was interviewed at 10:46a.m. Staff #5 indicated the sharps/ knives were not kept locked at this group home, where client #7 attended day services. Staff #5 indicated she was not aware any of the clients had a sharps/knives restriction. Staff #5 indicated there was a copy of client #7's ISP at the facility group home day program.</p> <p>The record of client #7 was reviewed on 2/3/14 at 2:08p.m. Client #7's 12/19/13 ISP indicated the facility sharps/knives were to be kept locked due to client #7 "having aggressive behavior related to anything sharp. Client will be restricted of access of knives/forks."</p> <p>Interview of staff #1 (program manager) on 2/3/14 at 2:08p.m. indicated the facility day program staff had failed to run client #7's ISP by not ensuring the sharps/knives were locked. Staff #1 indicated a copy of client #7's ISP was kept in the day program group home.</p>		<p>BSPs and HRP's including their sharp restrictions due to behavioral issues. - An IDT meeting will be held with all individuals at the Triple Crown Group home to assess whether or not there continues to be a need for the sharps to be restricted. -Specifically for client #7, the IDT will meet to review client #7's ISP, BSP &amp; HRP to ensure that all plans remain appropriate. - Staff responsible for implementing each clients program plan will be re-trained regarding proper oversight and review of each clients plan to ensure that observations and on-site training are included as part of the overall process for ensuring that each client receives necessary services. - The facility has a policy regarding client rights which remains appropriate, as well as, a policy regarding grievance procedures which remains appropriate; these policies will be reviewed with all clients in the home. -Residential Manger will observe in the home daily to ensure that all clients' program plans are being implemented appropriately and necessary trainings are provided. -Program Manger will observe in the home weekly to ensure that all clients' program plans are being implemented appropriately and necessary trainings are provided. - DPRM will observe at Day Program daily to ensure client #7's program</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G106		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 4122 TRIPLE CROWN NEWBURGH, IN 47630			
(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
W000227	<p>Staff #1 indicated all staff would need to be trained on client #7's ISP.</p> <p>9-3-3(a)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on observation, record review and interview, the facility failed for 1 of 4 sampled clients (#2) to ensure the client's individual support program (ISP) had a training program in place to address client #2's identified hygiene need (wiping saliva off his bottom lip).</p> <p>Findings include:</p> <p>An observation was done at the group home on 1/30/14 from 5:51a.m. to 7:12a.m. At 5:57a.m. client #2 was talking to the surveyor and client #2 had saliva drop from his bottom lip to the surveyor's pants leg. At 6:08 staff #2 (nurse) indicated client #2 has some</p>			W000227	<p>plans are being implemented appropriately and necessary trainings are provided. - Day Program Manager will observe at Day Program daily to ensure client #7's program plans are being implemented appropriately and necessary trainings are provided.</p> <p>Persons Responsible: Staff, Residential Manger, Program Manager, DPRM, Day Program Manager &amp; Executive Director.</p> <p>W227 -The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c) (3) of this section. - Residential Manger will be retrained on job responsibilities, including the monitoring and updating of ISP/BSP. - An IDT meeting will be held with all clients residing at the Triple Crown Group home to review all clients ISP's and ensure that the remain appropriate. -Specifically for client #2, the Residential Manger will meet with the IDT and review client #2's ISP and ensure that all necessary changes are made to client # 2's hygiene goal. -</p>		03/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G106		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 4122 TRIPLE CROWN NEWBURGH, IN 47630			
(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>drooling issues related to his medications. At 6:11 a.m. client #2 was in the kitchen and had saliva hanging from his bottom lip. Client #2 had his saliva fall from his bottom lip to the kitchen floor. At 6:16 a.m., client #2 had more saliva drop from his bottom lip to the kitchen floor. Staff did not prompt client #2 to wipe his mouth.</p> <p>Record review of client #2 was done on 2/3/14 at 1:18 p.m. Client #2's 1/3/14 ISP did not have any training programs in place to address his identified hygiene (wiping saliva from lip) training need.</p> <p>Staff #1 was interviewed on 2/3/14 at 1:58 p.m. Staff #1 indicated client #2 had hygiene training needs in regards to wiping his bottom lip of saliva. Staff #1 indicated client #2 did not have a training program in place to address this identified need.</p> <p>9-3-4(a)</p>		<p>Specifically for client #2, staff responsible for monitoring the ISP/BSP will be retrained on any changes. -Residential Manger shall monitor through daily observations in the home to assure that Client #2's, as well as all clients in the home, program plans are being implemented as written. - Program Manager shall monitor through weekly observations in the home to assure that Client #2's, as well as all clients in the home, program plans are being implemented as written. Persons Responsible: Staff, Residential Manger, Program Manager &amp; Executive Director.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G106		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 4122 TRIPLE CROWN NEWBURGH, IN 47630			
(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			
W000249	<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, the facility failed for 1 non-sampled client (#7) to ensure client #7's individual support plan (ISP) intervention for locked sharps, was implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation was done on 1/30/14 from 9:52a.m. to 10:58a.m. at the facility owned group home where client #7 attended a day program. At 10:46a.m., staff #5 (day program lead staff) opened an unlocked kitchen drawer, that contained sharp knives. Staff #5 was interviewed at 10:46a.m. Staff #5 indicated the sharps/ knives were not kept locked at this group home, where client #7 attended day services. Staff #5 indicated she was not aware any of the clients had a sharps/knives restriction. Staff #5 indicated there was a copy of client #7's ISP at the facility group home day program.</p>	W000249	<p>W249 - To resolve and ensure that each client's treatment program consists of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the program plan the following actions will occur: - Staff responsible for implementing each clients program plan will be re-trained regarding proper oversight and review of each clients plan to ensure that observations and on-site training are included as part of the overall process for ensuring that each client receives necessary services. -All staff both day program and home will be re-trained regarding client #7's ISPs, BSPs &amp; HCP including their sharps restrictions due to behavioral issues with emphasis on consistently implementing the program plan for each client to assure continuous active treatment at all times. - An IDT meeting will be held with all individuals at the Triple Crown home to assess whether or not there continues to be a need for</p>	03/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G106	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/03/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 4122 TRIPLE CROWN NEWBURGH, IN 47630		
(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>The record of client #7 was reviewed on 2/3/14 at 2:08p.m. Client #7's 12/19/13 ISP indicated the facility sharps/knives were to be kept locked due to client #7 "having aggressive behavior related to anything sharp. Client will be restricted of access of knives/forks."</p> <p>Interview of staff #1 (program manager) on 2/3/14 at 2:08p.m. indicated client #7 had a sharps restriction due to past threats to harm self and others. Staff #1 indicated client #7 attended a day program held in a facility owned group home. Staff #1 indicated client #7's ISP intervention for locked sharps should have been implemented at the day program group home.</p> <p>9-3-4(a)</p>		<p>the sharps to be restricted. -Specifically for client #7, the IDT will meet to review client #7's ISP, BSP &amp; HRP to ensure that all plans remain appropriate. - The facility has a policy regarding client rights which remains appropriate, as well as, a policy regarding grievance procedures which remains appropriate; these policies will be reviewed with all clients in the home. -Residential Manger will observe in the home daily to ensure that all clients' program plans are being implemented appropriately and necessary trainings are provided. -Program Manger will observe in the home weekly to ensure that all clients' program plans are being implemented appropriately and necessary trainings are provided. - DPRM will observe at Day Program daily to ensure client #7's program plans are being implemented appropriately and necessary trainings are provided. - Day Program Manager will observe at Day Program daily to ensure client #7's program plans are being implemented appropriately and necessary trainings are provided.</p> <p>Persons Responsible: Staff, Residential Manger, Program Manager, DPRM, Day Program Manager &amp; Executive Director.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G106	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 4122 TRIPLE CROWN NEWBURGH, IN 47630
--	--

(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
--------------------	--	---------------	---	----------------------

W000288	<p>483.450(b)(3) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program.</p> <p>Based on record review and interview, the facility failed for 1 non-sampled client (#7) with a restrictive behavior management intervention, to ensure that all interventions (locked sharps: knives/forks) to manage client #7's behavior were included in a training program.</p> <p>Findings include:</p> <p>Record review of the facility incident reports was done on 1/27/14 at 11:24a.m. Client #7 had an incident report on 3/14/13. The report indicated client #7 had threatened to harm himself with sharp objects. The facility had an interdisciplinary team (IDT) meeting on 3/14/13. The IDT report indicated the sharps (knives/forks) in the home were to be kept locked due to client #7's behavior.</p> <p>Record review for client #7 was done on 2/3/14 at 2:08p.m. Client #7's most current ISP, dated 12/19/13, indicated the group home sharps were to be kept locked due to client #7's behavior of threats of self harm. The 12/19/13 ISP</p>	W000288	<p>W288 - Techniques to manage inappropriate client behavior must never be used as a substitute for an active treatment program. - Client # 7's will have a formal ISP/BSP written to address their sharps restrictions, due to them exhibiting the behavior of threats of self harm. Human Right's committee approval along with guardian approval will be obtained prior to implementation of plans. - Staff will be retrained on any updates made to client # 7's plans. - An IDT shall meet to review the ISP, BSP, restrictions and behavior control medication. Written informed consent shall be obtained from the client and family/guardian to assure compliance prior to Human Rights Committee approval. -Residential Manager shall monitor through weekly review and as needed to ensure that all ISP/BSPs are reviewed prior to implementation and all necessary approvals are obtained. -Program Manager shall monitor through monthly review and as needed to ensure that all ISP/BSPs are reviewed prior to implementation and all necessary approvals are obtained. Persons Responsible: Residential Manger, Program</p>	03/05/2014
---------	---	---------	---	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G106	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/03/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 4122 TRIPLE CROWN NEWBURGH, IN 47630
--	--

(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>did not address (in a documented training program) the behavior of self harm and the facility intervention of locking the group home sharps.</p> <p>Interview of staff #1 on 2/3/14 at 2:08p.m., indicated the group home sharps (knives/forks) were kept locked. Staff #1 indicated client #7's inappropriate behavior was the reason for the facility sharps to be kept locked. Staff #1 indicated client #7 did not have a documented training program to address client #7's misuse of sharps. Staff #1 indicated they thought the restriction had been incorporated into the ISP before it (the ISP) was revised on 12/19/13.</p> <p>9-3-5(a)</p>		Manager & Executive Director	