STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/15/2011
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL		STREET ADDRESS, CITY, STATE, ZIP CODE 725 CARR ST MILAN, IN47031	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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	This visit was for the annual fundamental recertification and state licensure survey. Dates of Survey: October 31, November 2, 3, 4 and 15, 2011 Facility Number: 000623 Provider Number: 15G080 AIM Number: 100233870 Surveyor: Jo Anna Scott, Medical Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9.	W0000		
W0104	The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 1 of 3 sampled clients (client #1) and 1 additional client (client #4), the governing body failed to exercise operating direction over the facility to ensure the client's personal funds were not	W0104	**W104:** The governing body must exercise general policy, budget, and operating direction over facility.	12/09/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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: 15G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/15/2011
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL		STREET ADDRESS, CITY, STATE, ZIP CODE 725 CARR ST MILAN, IN47031	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	used to provide a dental treatment. Findings include: The review of client #1's finances was conducted on 11/3/11 at 8:20 AM. The Resident Fund Management Service (RFMS) account for client #1 indicated on 10/6/11 $66.50 was deducted from his account for a non-covered Medicaid expense (for dental treatment). The review of client #4's finances was conducted on 11/3/11 at 8:25 AM. The RFMS account for client #4 indicated on 10/7/11 two deductions for non-covered Medicaid expenses were deducted. One deduction was for $38.00 and the other was $66.50, making a total of $104.50 deducted for non-Medicaid expenses (for dental treatments). Interview with staff #3, Home Manager, on 11/3/11 at 9:00 AM indicated the charges were for dental appointments not covered by Medicaid. Interview with staff #10, Accounts Payable, on 11/4/11 at 4:00 PM indicated the money was used from the clients' personal accounts to pay the charges that Medicaid would not cover. Staff #10, Accounts Payable, indicated after they paid the charges, they would enter a		**Corrective action:** · Social Services Director, Accounts Payable staff have been inserviced that in lieu of clients paying and lowering liabilities for non covered Medicaid services, within per diems, ResCare will remit payment (Attachment A). **How we will identify others:** Social Services Director will review client non covered Medicaid services, within per diems, to ensure that non covered Medicaid services, within per diem, have not been paid out of RFMS accounts. **Measures to be put in place:** Social Services Director will review client non covered Medicaid services, within per diems, to ensure that they are being paid by ResCare. **Monitoring of Corrective Action:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/15/2011
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL		STREET ADDRESS, CITY, STATE, ZIP CODE 725 CARR ST MILAN, IN47031	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	liability reduction request. Staff #10 indicated if and when they got the reduction, they would reimburse the clients. 9-3-1(a)		Executive Director will review client non covered Medicaid services, within per diem, to ensure that services are paid for correctly **Completion Date: 12-9-2011**	
W0242	The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. Based on record review and interview for 3 of 3 sampled clients (clients #1, #2 and #3), the facility failed to include training in personal hygiene and bathing. Findings include: The record review for client #1 was conducted on 11/3/11 at 12:30 PM. The Individual Support Plan (IPP) dated 7/12/11 indicated client #1 had the following training goals: 1. "[Client #1] will take small bites.". 2. "[Client #1] will open his mouth to brush teeth." 3. "[Client #1] will identify his	W0242	**W242:** The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring	12/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/15/2011
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL		STREET ADDRESS, CITY, STATE, ZIP CODE 725 CARR ST MILAN, IN47031	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Depakote." 4. "[Client #1] will sign the [letter] on the back of his check." The IPP indicated client #1 required assistance with personal hygiene (face washing and shaving) and bathing. The record review for client #2 was conducted on 11/3/11 at 2:12 PM. The IPP dated 6/14/11 indicated client #2 had the following training goals: 1. "[Client #2] will not talk with food in his mouth." 2. "[Client #2] will lay out clean clothes for the morning." 3. "[Client #2] will look both ways while crossing road to get mail." 4. "[Client #2] will sign his withdrawal slip at the bank." 5. "[Client #2] will point to the Zocor (cholesterol reduction)." The IPP indicated client #2 required assistance with personal hygiene and bathing. The record review for client #3 was conducted on 11/3/11 at 11:45 AM. The IPP dated 7/12/11 indicated client #3 had the following training goals: 1. "[Client #3] will put on his ted hose each morning." 2. "[Client #3] will chew his food." 3. "[Client #3] will brush teeth for two minutes."		them. **Corrective Action:** · Personal hygiene goals have been implemented for Client #'s 1, 2, 3 (Attachment B). **How we will identify others:** Program Coordinators will review client goals to ensure that identified needs, including personal hygiene, have goals to address. **Measures to be put in place:** Human Rights Committee will review and approve implementation of goals, including personal hygiene if it is an identified need. **Monitoring of Corrective Action:** Director of Supervised Group Living, Quality Assurance will perform periodic service reviews to ensure that identified needs, including personal	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/15/2011
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL		STREET ADDRESS, CITY, STATE, ZIP CODE 725 CARR ST MILAN, IN47031	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	4. "[Client #3] will sign banking receipt inside box." The IPP indicated client #3 required assistance with personal hygiene and bathing. Interview with staff #3, Home Manager (HM) on 11/3/11 at 3:30 PM indicated clients #1, #2 and #3 all required assistance with personal hygiene (face washing and shaving) and bathing. 9-3-4(a)		hygiene goals, are being implemented. **Completion Date: 12-9-2011**	
W0369	The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 2 of 6 clients receiving medication (clients #5 and #6), the facility failed to ensure the instructions ordered by the physician were followed. Findings includes: During the morning observation on 11/3/11 from 5:50 AM to 7:55 AM, the medication administration was started at 6:00 AM. Client #5 came to the medication room at 6:20 AM and among his medications was Mouthkute Solution for dry mouth. Client #6 received his medication at 7:00 AM. Client #6	W0369	**W369:** The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. **Corrective Action:** · Staff have been inserviced on following medication orders (Attachment C). **How we will identify others:** Program Coordinators will review medication	12/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/15/2011
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL		STREET ADDRESS, CITY, STATE, ZIP CODE 725 CARR ST MILAN, IN47031	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	received Naproxen 220 mg (milligrams) for arthritis as one of his medications. The Medication Administration Record (MAR) dated 11/1/11 to 11/30/11 was reviewed on 11/3/11 at 9:30 AM. The MAR indicated the Mouthkute Solution for client #5 was artificial saliva and was to be "administered before breakfast and supper." The MAR indicated the Naproxen for client #6 was to be "taken with food." Interview with staff #4 on 11/3/11 at 7:45 PM indicated the clients got up early and had their breakfast at 5:00 AM. Staff #4 indicated the artificial saliva was always given with the other meds and the administration instructions were not followed. Staff #4 indicated she was not aware the Naproxen was supposed to be given with food. Interview with staff #3, Home Manager (HM), on 11/3/11 at 9:45 AM indicated the instructions on the MAR are to be followed and the artificial saliva for client #5 should have been done before breakfast and the Naproxen should have been given with food. 9-3-6(a)		administration policies, including following medication orders as written, to ensure that staff have been trained per policy and procedure. **Measures to be put in place:** Program Coordinators, Nursing Coordinators will perform weekly Active Treatment observations to ensure that privacy is being provided during medication administration (Attachment D). **Monitoring of Corrective Action:** Director of Supervised Group Living, Director of Health Services will review Active Treatment observations to ensure that medication administration is being performed per policy and procedure. **Completion Date: 12-9-2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/15/2011
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL		STREET ADDRESS, CITY, STATE, ZIP CODE 725 CARR ST MILAN, IN47031	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0436	The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview for 1 of 3 sampled clients (client #2), the facility failed to provide handrails outdoors as recommended by physical therapy. Findings include: During the observation periods on 11/2/11 from 4:10 PM to 6:55 PM, the sidewalk going up the sidewalk to the front door of the home did not have a handrail. The record review for client #2 was conducted on 11/3/11 at 2:12 PM. The record included a High Risk Plan for client #2 dated 6/14/11 indicating "At risk for falls." The record contained a physical therapy progress note dated 5/23/11. The progress note indicated "Patent seen for group home safety evaluation. PT (Physical Therapy) recommends group home install HR (handrail) in hallway and outdoors for inclement weather for safety of residents to maintain balance in bad weather and to reduce fall risks." Interview with staff #3, Home Manager	W0436	**W436:** The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communication aids, braces, and other devices identified by the interdisciplinary team as needed by the client. **Corrective Action:** · Handrails have been placed in hallway and outside the home (Attachment E). **How we will identify others:** Nursing Coordinators will review PT/OT recommendations to ensure that all orders have been implemented. **Measures to be put in place:** Nursing Coordinators have been in serviced in reviewing and ensuring that OT/PT recommendations are implemented as ordered, and will review weekly on checklist (Attachment F) **Monitoring of Corrective Action:** Director of Health Services, Director of Supervised Group Living, Quality Assurance will perform periodic service reviews to ensure that OT/PT recommendations have been implemented. **Completion Date: 12-9-2011**	12/09/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/15/2011
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL		STREET ADDRESS, CITY, STATE, ZIP CODE 725 CARR ST MILAN, IN47031	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	(HM), on 11/3/11 at 2:30 PM indicated the clients used the front door for access to the home. Staff #3, HM, indicated the clients had always used the front door to leave and enter the home. Interview with staff #6, Administrator, on 11/4/11 at 4:00 PM indicated a handrail for outside was on order. 9-3-7(a)			