

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  11/15/2013
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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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of survey: October 29, 30, 31, November 1, 8 and 15, 2013.</p> <p>Surveyor: Jo Anna Scott, QIDP</p> <p>Facility Number: 001006 Provider Number: 15G492 AIMS Number: 100235270</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed November 25, 2013 by Dotty Walton, QIDP.</p>	W000000			

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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W000104	<p><b>483.410(a)(1) GOVERNING BODY</b> The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 3 additional clients (clients #5, #6 and #7), the governing body failed to ensure clients were able to attend day program a full day.</p> <p>Findings include:</p> <p>During the observation period on 10/30/13 from 11:30 AM to 6:45 PM, clients #3, #4, #5, #6 and #7 returned to the home from their day program at 3:41 PM. Client #1 did not attend the day program on 10/30/13 because of an injury and client #2 did not attend because of a doctor's appointment. During the observation period on 10/31/13 from 5:50 AM to 9:14 AM, clients #3, #4, #5, #6 and #7 left for their day program at 9:14 AM. Clients #1 and #2 did not go to day program because of appointments.</p> <p>Interview with Administrative staff #2 on 10/31/13 at 3:00 PM indicated the clients went to two day programs in another city and they were in a different time zone (one hour behind the facility's time). Administrative staff #2 indicated there were two vans from the facility that went</p>	W000104	W104: The governing body must exercise general policy, budget, and operating direction over the facility. Corrective Action: (Specific) The Program Manager has met with the staff at the day program and has scheduled an earlier start time and later end time so all individuals will attend a full day workshop. How others will be identified: (Systemic) The Program Manager will complete weekly observations at the home to ensure that all clients are attending a full day at the workshops and that clients are not staying home due to house mates medical appointments. Measures to be put in place: The Program Manager has met with the staff at the day program and has scheduled an earlier start time and later end time so all individuals will attend a full day workshop. Monitoring of Corrective Action: the Residential Manager will complete observations at the home at least five times weekly to ensure that staff is running all clients program plans as written. A member of the management team will complete observations at the home at least five times weekly to ensure that staff is running all client program plans as written. The Program	12/15/2013			

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	<p>to the workshops every day and the staff driving the vans stayed in the workshops and worked with the clients at the day programs. Administrative staff #2 indicated the van drivers picked up clients from the other agency facilities and it sometimes took an hour to get "on the road" to the workshops. Administrative staff indicated the vans didn't leave the facility until 9:00 AM or later. Administrative staff #2 indicated the drive took at least 1-1/2 hours one way. Administrative staff #2 indicated the clients were not able to attend the day program very long because the van drivers' work hours were 8:00 AM to 4:00 PM.</p> <p>Interview with Administrative staff #1 on 11/1/13 at 10:30 AM indicated clients #1, #2, #3, #4, #5, #6 and #7 attended day programs in towns 1-1/2 hours drive one way from the facility. Administrative staff #1 indicated the clients had to go in two separate vans because of behaviors of some of the other clients riding with them. Administrative staff #1 indicated the van driver stayed at the day program and their work hours were 8:00 AM to 4:00 PM. Administrative staff #1 indicated they were aware the clients were on the vans at least 3 hours or longer every day and that they were not at the day program more than 3 or 4 hours.</p>		<p>Manager will review investigations at least weekly to ensure that the investigations are thorough and corrective measures have been implemented. Completion date: 12/15/13</p>				

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	<p>Interview with work shop supervisor on 10/31/13 at 10:30 AM indicated the clients arrived at facility just before lunch and left between 1:00 and 1:30 PM. Work shop supervisor indicated they were "seldom" at the workshop facility more than 3 hours.</p> <p>9-3-1(a)</p>			

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W000154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview on 1 of 5 incidents reported to BDDS (Bureau of Developmental Disabilities Services), the facility failed to investigate client #1's accident resulting in a fracture at the superior and inferior pubic rami (pelvis area).</p> <p>Findings include:</p> <p>The record review of incident reports was conducted on 10/29/13 at 3:22 PM. The BDDS report with incident date of 10/22/13 and reported date of 10/23/13 indicated the following: "As [Client #1] was coming off the van to report to work, she went to the passenger door to help house mate out of the van. Someone coming out of the back of the van pushed open the door and it hit [client #1] knocking her to the ground. She landed on her right side which caused a knot to form by her right hip and she complained of pain in her inner thigh. Ice pack was applied to hip by nurse (name of nurse)."</p> <p>The record review for client #1 was conducted on 10/30/13 at 2:39 PM. The record contained a Radiology report dated 10/22/13 with the following findings:</p>	W000154	<p>W154: The facility must have evidence that all alleged violations are thoroughly investigated. Corrective Action: (Specific) QA will be in-serviced on abuse/neglect/exploitation policy as well as the completion of investigations for client accidents that result in fractures or serious injury. How others will be identified: (Systemic) The Program Manager will review incident reports at least weekly to ensure that investigations are completed in regard to client accidents that result in fractures or serious injury. Measures to be put in place: QA will be in-serviced on abuse/neglect/exploitation policy as well as the completion of investigations for client accidents that result in fractures or serious injury. Monitoring of Corrective Action: The Program Manager will review incident reports at least weekly to ensure that investigations are completed in regard to client accidents that result in fractures or serious injury.. Completion date: 12/15/13</p>	12/15/2013	

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	<p>"Two views were submitted at 1646 hours. There is no evidence of an acute hip fracture or dislocation. However, there are nondisplaced fractures suspected at the superior and inferior pubic rami."</p> <p>Interview with Administrative staff #5 on 10/29/13 indicated the incident on 10/22/13 happened at the workshop and there had not been an investigation into the incident since they knew how it happened. There was no information on why the van driver was not assisting the clients out of the van.</p> <p>9-3-2(a)</p>				

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W000159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 2 of 4 sampled clients (clients #3 and #4), the QIDP (Qualified Intellectual Disabilities Professional) failed to review the ISP (Individual Support Plan) training objectives.</p> <p>Findings include:</p> <p>The record review for client #3 was conducted on 10/31/13 at 4:08 PM. The ISP dated 6/10/13 indicated client #3 had the following training objectives:</p> <ol style="list-style-type: none"> <li>1. Pick up his medicine cup containing Miralax and drink.</li> <li>2. Apply hand sanitizer to his hands before medication pass.</li> <li>3. Will participate in dancing to music with staff.</li> <li>4. Will put his dirty clothes into the hamper.</li> <li>5. Will wipe his place at the table after a meal.</li> <li>6. Will put his clean laundry away.</li> <li>7. Will budget his money.</li> <li>8. Will brush his teeth.</li> <li>9. Will take a shower.</li> <li>10. Will shave with staff assistance.</li> <li>11. Will recognize the number 72.</li> </ol>	W000159	<p>W159: Each Clients active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Corrective Action: (Specific) The Program Manager has reviewed all clients programming and has been in-serviced on reviewing all client programming at least monthly to ensure that it remains appropriate and that changes are made at least quarterly and more often if needed. How others will be identified: (Systemic) The Program Manager will complete observations at the home at least weekly and review client programming to ensure that it remains accurate and is signed off on at least quarterly. Measures to be put in place: The Program Manager has reviewed all clients programming and has been in-serviced on reviewing all client programming at least monthly to ensure that it remains appropriate and that changes are made at least quarterly and more often if needed. Monitoring of Corrective Action: The Program Manager will complete observations at the home at least weekly and review client programming to ensure that it</p>	12/15/2013			

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	<p>There was no indication in the record the training objectives had been reviewed by the QIDP since 6/2013.</p> <p>The record review for client #4 was conducted on 10/30/13 at 1:24 PM. The ISP dated 6/24/13 indicated client #4 had the following training objectives:</p> <ol style="list-style-type: none"> <li>1. Identify her Namenda and Depakote, the mg (milligram), the times she takes them and the reason for taking.</li> <li>2. Will walk to the garbage can daily.</li> <li>3. Will chew and swallow all food and drink before talking.</li> <li>4. Will budget her money.</li> <li>5. Will read an article in the newspaper and then summarize.</li> <li>6. Will wash her hands when appropriate.</li> <li>7. Will audibly state to staff her address and phone number as well as date and year of her birth.</li> <li>8. Will spend up to 15 minutes each evening talking with staff.</li> </ol> <p>There was no indication in the record the training objectives had been reviewed by the QIDP since 6/2013.</p> <p>Interview with Administrative staff #4 on 11/1/13 at 1:00 PM indicated the QIDP review on training objectives for client #3 and #4 had not been conducted since implementation of the ISPs in June, 2013.</p>		remains accurate and is signed off on at least quarterly. Completion date: 12/15/13				

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W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>Based on observation, record review and interview for 1 of 1 sampled clients who used a walker (client #4), the facility failed to ensure the client received training on how to properly use the walker.</p> <p>Findings include:</p> <p>During the observation period on 10/30/13 from 11:30 AM to 6:45 PM client #4 returned from the day program at 3:41 PM. Client #4 was observed walking to the kitchen using a rolling walker at 5:00 PM. Client #4 was leaning forward pushing the walker out in front of her body. During the observation period on 10/31/13 from 5:50 AM to 9:30 AM, client #4 came from her bedroom at 6:25 AM again pushing the walker out in front of her body, leaning forward. Client #4 was not prompted to walk between the handles of the walker.</p> <p>The internal incident reports were reviewed on 10/29/13 at 3:00 PM. Client #4 had an internal incident report dated</p>	W000436	<p>W436: The facility must furnish, maintain in good repair, and teach clients to use and 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.</p> <p>Corrective Action: (Specific): A referral to OT/PT will be obtained from the PCP and an appointment will be scheduled for OT/PT evaluation for client #4. The falls risk plan has been updated to reflect staff prompting of client #4 to walk between the handles of walker How others will be identified: (Systemic): The Residential Manager will complete observations at the home at least three times weekly to ensure that staff are prompting client #4 to walk between the handles of her walker. The Program Manager will make weekly visits to the home to complete observations and ensure that staff are prompting client #4 to walk between the handles of her walker. Measures to be put in place: A referral to OT/PT will be obtained from the</p>	12/15/2013			

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	<p>10/11/13 with the following description: "[Client #4] fell over her walker onto floor." Another internal incident report dated 10/26/13 had the following description: "Was putting laundry in the washer and fell on her hands and knees and walker was underneath her."</p> <p>The record review for client #4 was conducted on 10/30/13 at 1:24 PM. The record included IDT (Interdisciplinary Team) meeting notes from 10/11/13 indicating the following: "IDT met to discuss [client #4's] fall on 10/11/13. Team agreed that due to getting use (sic) to the new walker this was an isolated incident. Nurse was called. The Plan of Action Taken: Staff is to encourage [client #4] to use walker at all times, and to slow down when walking. Staff to report any changes in gait and/or complaint of pain with ambulation. Staff will assist with ambulation as needed to ensure safety." The IDT meeting notes from 10/27/13 indicated the following: "IDT met to discuss [client #4's] fall on 10/26/13. Called for an appointment with PCP (primary care physician) due to follow-up. Nurse called and care plan updated. Plan of Action taken: Follow up with PCP. Staff will help [client #4] with laundry to make sure she doesn't fall." The Fall Risk Plan dated 10/27/13 indicated "Staff is to encourage [client</p>		<p>PCP and an appointment will be scheduled for OT/PT evaluation for client #4. The falls risk plan has been updated to reflect staff prompting of client #4 to walk between the handles of walker. Monitoring of Corrective Action: The Residential Manager will complete observations at the home at least three times weekly to ensure that staff are prompting client #4 to walk between the handles of her walker. The Program Manager will make weekly visits to the home to complete observations and ensure that staff are prompting client #4 to walk between the handles of her walker. Completion date: 12/15/13</p>				

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	<p>#4] to use rolling walker at all times, and to slow down when walking. Staff to report any changes in gait and/or complaint of pain with ambulation." The Fall Risk Plan did not indicate staff was to prompt client #4 to walk between the handles of the walker.</p> <p>Interview with Staff #3, LPN (Licensed Practical Nurse), on 10/31/13 at 4:00 PM indicated the client had requested a walker in September and the PCP had agreed to request. Staff #3, LPN, indicated client #4 did not have any training on the proper use of the walker.</p> <p>9-3-7(a)</p>			

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W000488	<p>483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (client #2), the facility failed to ensure client #2 ate at the dining table.</p> <p>Findings include:</p> <p>During the observation period on 10/30/13 from 11:30 AM to 6:45 PM, client #2 returned from an appointment at 12:30 PM. Client #2 prepared a sandwich at 12:45 PM and stood beside the table eating the sandwich rapidly, chewing the food with her mouth open and did not use a napkin. Client #2 ate her pudding left from dinner at 6:25 PM. Client #2 stood at the table while eating the pudding. Staff did not prompt client #2 to sit down at the table.</p> <p>Record review for client #2 was conducted on 10/31/13 at 3:50 PM. The record indicated client #2 did have a training objective for table manners as follows: "[Client #2] will display acceptable table manners with verbal assistance. The methodology of the training objective was as follows: "Staff will remind [client #2] to not touch her face or hair when she is</p>	W000488	<p>W488: The facility must assure that each client eats in a manner consistent with his or her developmental level. Corrective Action: (Specific): All staff will be in-serviced on client #2's dining plan and ensuring that all client's eat at the dining table for all meals and snacks. All staff will be in-serviced on client #2's training goal for meal time. How others will be identified: (Systemic) The Residential Manger will complete observations in the home at least three times weekly to ensure that all client dining plans and training goals related to mealtime are being followed. The Program Manager will complete weekly observations at the home to ensure that all client dining plans and training goals related to mealtime are being followed. Measures to be put in place: All staff will be in-serviced on client #2's dining plan and ensuring that all client's eat at the dining table for all meals and snacks. All staff will be in-serviced on client #2's training goal for meal time. Monitoring of Corrective Action: The Residential Manger will complete observations in the home at least three times weekly to ensure that all client dining plans and training goals related to mealtime are</p>	12/15/2013			

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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 1480 W 47TH ST JASPER, IN 47546		
(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>around food. Staff will instruct [client #2] to place a napkin in her lap to use to wipe her fingers and mouth when dirty. Staff will instruct [client #2] to cut up her food into bite-sized portions. Staff will instruct [client #2] to take only bite-sized amounts of food when eating, avoiding overstuffing her mouth. Staff will instruct [client #2] to wipe her mouth routinely to remove food. Staff will instruct [client #2] to eat with her mouth closed. Staff will instruct [client #2] to drink fluids only after she has swallowed her food, emptying her food prior to drinking. A trial will be documented as accomplished when above steps are completed correctly. Verbal praise and recognition will be given (sic)all attempts."</p> <p>Interview with Administrative staff #2 on 10/31/13 at 4:00 PM indicated client #2 should have been prompted to sit down while eating.</p> <p>9-3-8(a)</p>		<p>being followed. The Program Manager will complete weekly observations at the home to ensure that all client dining plans and training goals related to mealtime are being followed. Completion date: 12/15/13</p>		