

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G352	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2012
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 240 1ST ST NE LINTON, IN 47441
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(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
W0000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Dates of Survey: March 14 and 15, 2012</p> <p>Provider Number: 15G352 Aims Number: 100249190 Facility Number: 000868</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on 3/22/2012 by Dotty Walton, 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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W0227	<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.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (#3) to ensure client #3's individual support plan (ISP) had a training program in place to address the identified training need with client #3's invading personal space/stealing from housemates.</p> <p>Findings include:</p> <p>Client #2 was interviewed on 3/14/12 at 4:28 p.m. Client #2 indicated he kept his bedroom locked because client #3 goes into his bedroom sometimes.</p> <p>Record review for client #3 was done on 3/15/12 at 10:30 a.m. Client #3 had a 2/12 program review that indicated client #3 had started to steal from housemates. Client #3's 12/7/11 ISP did not address any training with client #3's identified behavior of going into peers' bedrooms and stealing.</p> <p>Staff #1 was interviewed on 3/15/12 at 10:42 a.m. Staff #1 indicated they were not aware of client #3 going into peers' bedrooms and stealing. Staff #1 indicated</p>	W0227	<p>PROVIDER IDENTIFICATION #: 15G352</p> <p>NAME OF PROVIDER: RESCARE COMMUNITY ALT., SOUTH CENTRAL</p> <p>ADDRESS: 240 1 st Street NE, Linton, IN 47441</p> <p>SURVEY EVENT ID #: EGBK11</p> <p>DATE SURVEY COMPLETED: 3-15-2012</p> <p>PROVIDER'S PLAN OF CORRECTION</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..</p>	04/02/2012	

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	<p>this could have been an isolated event. Staff #1 indicated client #3 did not have a training program in place to address his behavior of going into peers' rooms and stealing.</p> <p>9-3-4(a)</p>		<p>Corrective action:</p> <ul style="list-style-type: none"> · IDT meeting has been held on Client #3 and a tracking sheet for stealing has been implemented (Attachment A). · Program Coordinator and Home Manager have been inserviced on following up on client behaviors noted in monthly review (Attachment B). <p>How we will identify others:</p> <p>Program Coordinators review monthly team notes to ensure that any new behaviors documented by staff have been addressed accordingly.</p> <p>Measures to be put in place:</p> <p>Program Coordinators will review and document the review on all monthly team reviews to ensure that any behaviors are being addressed appropriately and promptly..</p> <p>Monitoring of Corrective Action:</p>		

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			<p>Director of Supervised Group Living, Quality Assurance Director/Coordinator and supervisory staff will perform periodic service reviews to ensure that behaviors are being addressed appropriately and timely.</p> <p>Completion Date: 4-2-2012</p>		