

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G537	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/16/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMMUNITY LIVING INC	STREET ADDRESS, CITY, STATE, ZIP CODE 433 N SUPERIOR ANGOLA, IN 46703
--	---

(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: August 15, 16, 2012.</p> <p>Facility number: 001051 Provider number: 15G537 AIM number: 100235300</p> <p>Surveyor: Susan Reichert, Medical Surveyor III, Team Leader</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 8/24/12 by Tim Shebel, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G537		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/16/2012	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY LIVING INC				STREET ADDRESS, CITY, STATE, ZIP CODE 433 N SUPERIOR ANGOLA, IN 46703			
(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			
W0104	<p><b>483.410(a)(1) GOVERNING BODY</b> The governing body must exercise general policy, budget, and operating direction over the facility. Based upon interview and record review, the facility's governing body failed to exercise operation direction over the facility by charging 1 of 2 sampled clients (client #2) for tips associated with facility provided personal care haircuts.</p> <p>Findings include:</p> <p>During interview with client #2 on 8/15/12 at 5:25 PM, he indicated he paid \$1 for a tip when he got his hair cut.</p> <p>Client #2's financial record was reviewed on 8/15/12 at 5:05 PM. Client #2's record indicated personal spending money was available for client #2 to use as discretionary funds.</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 8/16/12 at 12:45 PM and indicated all the clients living in the group home used their personal funds to provide tips for haircuts, and the facility provided the money to purchase haircuts for clients. He indicated tipping was optional for haircuts, and if the clients did not tip the stylist, no tip was provided by the agency.</p>	W0104	<p>W 104 Governing Body</p> <p>The governing body exercises general policy, budget, and operating direction over the facility.</p> <p>The management team reviewed this citation and moved to immediately halt the practice of clients providing a voluntary tip for haircuts. The Agency will have hair stylists add a suitable tip onto the bill given to the agency. Even though there were questions raised as to whether the rate setters, Myers and Stauffer, would approve tips for haircuts as an allowable expense on the Medicaid cost report, the insignificance of the item seemed to make it a non-issue to pursue</p>	08/21/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G537	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/16/2012
NAME OF PROVIDER OR SUPPLIER  COMMUNITY LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 433 N SUPERIOR ANGOLA, IN 46703		
(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	
	9-3-1(a)		<p>further. The agency has provided haircuts as part of the daily rate since the interpretation of the rule in recent years, and the paying of tips for haircuts seems to make equal sense.</p> <p>1. QMRP's are trained to instruct staff to not allow consumers to pay a tip for their haircuts.</p> <p>Completed: 08/21/2012</p> <p>Responsible: CEO, QMRP</p> <p>2. Stylists are contacted and asked to include the tip for haircuts onto the bill given to the agency. In addition, stylists are asked to not accept tips from consumers, if offered.</p> <p>Completed: 08/21/2012</p> <p>QMRP</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G537		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/16/2012	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY LIVING INC				STREET ADDRESS, CITY, STATE, ZIP CODE 433 N SUPERIOR ANGOLA, IN 46703			
(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			
W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview, the facility neglected to develop written policy and procedures to protect 4 of 4 clients living in the group home (clients #1, #2, #3, and #4) by failing to include in their procedures the need to report the reasonable suspicion of a crime to law enforcement authorities, failed to conspicuously post the requirement, and failed to train staff on the requirement to report reasonable suspicion of a crime to law enforcement authorities.</p> <p>Findings include:</p> <p>During observation periods at the group home on 8/15/12 from 4:25 PM to 5:35 PM and on 8/16/12 from 7:00 AM to 8:07 AM, there was no evidence posted of the need to report a reasonable suspicion of a crime to law enforcement in the home where clients #1, #2, #3 and #4 resided. There was no evidence of the requirement to report the suspicion of a crime to law enforcement posted at the facility offices during the dates of the survey from 8/15/12 to 8/16/12.</p> <p>The facility's Abuse Reporting</p>	W0149	<p><b>W149 The governing body exercises general policy, budget, and operating direction over the facility.</b></p> <p><b>System To Prevent Recurrence:</b> Please note that policies and procedures developed to correct this finding were subsequently reviewed by the same surveyor when one of our other facilities was surveyed. The surveyor found our policies and procedures to be in compliance. Copies of these are not appended to this document, but are available for upload and review if needed.</p> <p><b>A. Description: Facility Determination of Applicability.</b> The facility has determined that the facility received at least \$10,000 in Federal funds under the Act during the preceding fiscal year. A facility that received at least \$10,000 must comply with provisions of the Act. Completion Date: 08/20/2012 Responsible: CEO 1. Action Item: The CEO of the Agency makes this determination annually and sends notification to the Board of Directors.. Completion Date: 08/20/2012</p>	08/24/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G537	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/16/2012
NAME OF PROVIDER OR SUPPLIER  COMMUNITY LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 433 N SUPERIOR ANGOLA, IN 46703		
(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>Policy/Purpose Statement was reviewed on 8/15/12 at 3:35 PM and failed to include the requirement to report the suspicion of a crime to law enforcement authorities.</p> <p>The director of group homes was interviewed on 8/16/12 at 4:00 PM. She indicated the agency's team leaders had been trained on the requirement to report suspicion of a crime to law enforcement authorities, but no other staff had been trained. She indicated there were no posted notices in the agency of the requirement.</p> <p>The Qualified Mental Retardation Professional (QMRP) was interviewed on 8/16/12 at 12:40 PM and indicated the requirement was not included in the agency's written policy and procedures to protect clients from abuse, neglect and exploitation, He indicated agency staff would report any concerns about suspicion of a crime to APS (Adult Protective Services).</p> <p>A Memorandum dated June 17, 2011 from Centers for Medicaid Services was reviewed on 8/16/12 at 10:00 AM indicated in part, "Section 1150 B of the Social Security Act (the Act), as established by section 6703(b)(3) of the Patient Protection and Affordable Care</p>		<p>Responsible: CEO <b>B. Description: Coordinate Law Enforcement.</b> The facility coordinates with the facility's local law enforcement entities to determine reporting process and what actions are considered crimes in their political subdivision. . Completion Date: 08/17/2012 Responsible: CEO Action Items: The facility contacted the local law enforcement entities to discuss the reporting process. The County Sheriff and local police entity (City Police Department) are the two primary local law enforcement entities in order to:</p> <ol style="list-style-type: none"> <li>1. Determine contact information and process for reporting suspicions of crimes. Completion Date: 08/17/2012 Responsible: CEO</li> <li>2. Discuss actions that are crimes. Completion Date: 08/17/2012 Responsible: CEO</li> <li>3. Discuss training opportunities to increase crime awareness among facility covered individuals. Completion Date: 08/17/2012 Responsible: CEO</li> </ol> <p><b>C. Description: Post Conspicuous Notice.</b> The facility conspicuously posts, in an appropriate location, a notice for its employees specifying the employees' rights, including the right to file a complaint under this statute. The notice includes a statement that an employee may file a complaint with the ISOH against a long term care facility that retaliates against an</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G537		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/16/2012	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY LIVING INC				STREET ADDRESS, CITY, STATE, ZIP CODE 433 N SUPERIOR ANGOLA, IN 46703			
(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>Act of 2010 (Affordable Care Act), requires specific individuals in applicable long term care facilities to report any reasonable suspicion of crimes committed against a resident of that facility...LTC (Long Term Care) facilities should have policies and procedures to comply with this law...LTC Facility Responsibilities</p> <p>1. Required Functions: A Medicare-or Medicaid-participating LTC facility must:</p> <p>a) <i>Determine Applicability:</i>" Determine annually whether the facility received at least \$10, 000 in Federal funds under the Act during the preceding fiscal year;</p> <p>b) <i>Notify Covered Individuals:</i> Annually notify each covered individual of that individual's reporting obligations described in section 1150B(b) of the Act, if the facility determines that it received at least \$10,000 in Federal Funds under the Act during the preceding fiscal year.</p> <p>c) <i>Post Conspicuous Notice:</i> Conspicuously post, in an appropriate location, a notice for its employees specifying the employees' rights, including the right to file a complaint under this statute. The notice must include a statement that an employee may file a complaint with the SA (State Agency) against a LTC facility that retaliates against an employee as specified</p>		<p>employee as well as include information with respect to the manner of filing such a complaint. Completion Date: 08/20/2012 Responsible: QMRP 1. Action Items: The facility uses the ISDH template for the notice that meets Federal requirements. The facility posts the notice in a "conspicuous" and "appropriate location". Completion Date: 08/20/2012 Responsible: QMRP</p> <p><b>D. Description: Notify Covered Individuals.</b> The facility annually notifies each covered individual of that individual's reporting obligations described in Section 1150(8). Completion Date: 08/17/2012 Responsible: CEO Action Items: The facility does the following: 1. Provide annual notice to each covered individual of that individual's reporting obligations which is mailed out annually at time of CEO compliance review.. Completion Date: 08/20/2012 Responsible: CEO 2. Develop policies and procedures for annual notice of covered individuals to include reporting requirements and process, what constitutes a crime, and prohibitions against retaliation for reporting. Completion Date: 08/20/2012 Responsible: CEO 3. Develop procedures for training of additional covered individuals who begin providing care or services at the facility during the year. Element is added to</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G537	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/16/2012
NAME OF PROVIDER OR SUPPLIER  COMMUNITY LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 433 N SUPERIOR ANGOLA, IN 46703		
(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	
	above, as well as include information with respect to the manner of filing such a complaint...."  9-3-2(a)		orientation and annual on-going training. Completion Date: 08/20/2012 Responsible: CEO, Residential Director <b>E.</b> <b>Description: Covered Individuals Reporting.</b> Covered individuals must timely report any reasonable suspicion of a crime against a resident of, or who is receiving care from, a long term care facility. Completion Date: 08/24/2012 Responsible: CEO, QMRP Action Items: Once covered individuals have been provided notice and training on reporting requirements, covered individuals must begin reporting reasonable suspicions of a crime against a resident to a local law enforcement entity and the ISOH. Completion Date: 08/24/2012 Responsible: QMRP <b>F.</b> <b>Description: Review Protocols and Procedures.</b> The facility reviews existing facility protocols and procedures to ensure adherence to existing CMS and State policies and procedures for reporting at the time of the annual review for compliance or more often as needed. Completion Date: 08/20/2012 Responsible: CEO		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G537		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/16/2012	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY LIVING INC				STREET ADDRESS, CITY, STATE, ZIP CODE 433 N SUPERIOR ANGOLA, IN 46703			
(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			
W0362	<p>483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on record review and interview, the facility failed for 2 of 2 sampled clients, (clients #1 and #2) to provide evidence the pharmacist reviewed their medications on a quarterly basis.</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 8/16/12 at 9:30 AM. A print out of client #1's medications which included psychotropic medication included a typed statement at the top, "A drug regimen review for this patient has been performed by the pharmacist with no potential problems found unless noted." There was no further evidence of a signature or date to indicate a pharmacist's review of client #1's medications.</p> <p>Client #2's record was reviewed on 8/16/12 at 12:10 PM. A print out of client #2's medications included, but were not limited to medication to treat hypothyroidism included a typed statement at the top, "A drug regimen review for this patient has been performed by the pharmacist with no potential problems found unless noted." There was no further evidence of a signature or date</p>	W0362	<p><b>W 362 A pharmacist with input from the IDT reviews the drug regimen of each client at least quarterly. System to prevent recurrence:</b> The QA Team reviewed this issue and it was brought to the team's attention that the current procedure had been used since 2010; however, it is agreed that the current system does not provide a clear trail for review. The pharmaceutical company contracted by the Agency has agreed to use the new form provided by the Agency for future drug regimen reviews. Working with the pharmacist, the IDT developed a form which reflects the scope of the review performed by the pharmacy provider. The use of this form will provide a clearer paper trail of reviews. 1. A "Drug Regimen Review" form is created to track reviews in a clear and consistent manner. Completed: 08/30/2012 Responsible: CEO, IDT, Pharmacist 2. The pharmacy provider is contacted and agrees to use the new form on a quarterly basis starting with the quarter which begins 09/01/2012. Completed: 08/31/2012 Responsible: CEO</p>	08/31/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G537	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/16/2012
NAME OF PROVIDER OR SUPPLIER  COMMUNITY LIVING INC			STREET ADDRESS, CITY, STATE, ZIP CODE 433 N SUPERIOR ANGOLA, IN 46703		
(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>to indicate a pharmacist's review of client #2's medications.</p> <p>The QMRP (Qualified Mental Retardation Professional) was interviewed on 8/16/12 at 12:40 PM. He indicated the pharmacy the agency contracted with had indicated the statement at the top was sufficient as evidence of a pharmacist's review of client medications. He indicated there was no other evidence of a review by the pharmacist of client #1, #2, #3, or #4's medications.</p> <p>A contract with the pharmacy for the period of March 2010 to March 18, 2011 used by the facility was reviewed on 8/16/12 at 12:45 PM and indicated drug regimen reviews would be performed monthly, and "A statement attesting to the review with any potential problems will posted (sic) on the Physician's order form which accompanies med orders."</p> <p>9-3-6(a)</p>				