

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G594	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 1412 CLOVER ST MOUNT VERNON, IN 47620
--	---

(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 8, 9, 14, 15, 2014</p> <p>Provider Number: 15G594 Aims Number: 100245590 Facility Number: 001108</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 1/24/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000124	<p>483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (#3) with a guardian to ensure the guardian was informed of locked knives/sharps at the group home.</p>	W000124	W124 - The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian of the client's medical condition, developmental and behavioral	02/14/2014

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:  15G594		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/15/2014	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 1412 CLOVER ST MOUNT VERNON, IN 47620			
(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>Findings include:</p> <p>The record for client #3 was reviewed on 1/14/14 at 2:02p.m. Client #3's 10/30/13 individual support plan (ISP) indicated client #3 had a guardian. Client #3's record did not have any documentation that client #3's guardian had been informed of the facility's practice to lock up the group home knives/sharps.</p> <p>Professional staff #1 was interviewed on 1/8/14 at 5:26p.m. Professional staff #1 indicated the facility kept the group home knives/sharps locked (only staff had a key) due to clients #3 and #4's behavior. Staff #1 indicated there was no documentation client #3's guardians had been informed of the facility's practice to lock the knives/sharps.</p> <p>9-3-2(a)</p>		<p>status, attendant risks of treatment, and of the right to refuse treatment. -The facility has a policy regarding client rights which remains appropriate. -Staff responsible for assuring all clients' rights is always a foremost consideration will be trained regarding this policy. - Staff will be retrained on all individuals HRP, BSPs &amp; ISPs, including all individuals' rights restrictions. - An IDT will be completed with all individuals living in the home to ensure that their rights are not being infringed upon inappropriately. -The Human Rights Committee will review possible client right's issues as needed and quarterly to assure no client's rights have been taken away without being afforded due process. -RM will be retrained on advocating for all individuals and ensuring that an IDT is completed for any issues that may involve rights restrictions and guardians are contacted as appropriate. - Any changes shall be reviewed by the Human Rights Committee to assure that no rights are being violated for Client #3 and the guardian will be contacted for approval to lock sharps. -Residential Manager will oversee through daily visits in the home to assure that no client rights are being violated. -Program Manger will oversee through weekly visits in the home to assure that no client rights are being violated. Persons</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G594		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/15/2014	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 1412 CLOVER ST MOUNT VERNON, IN 47620			
(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			
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, the facility failed for 3 of 4 sampled clients (#1, #2, #4) to ensure the qualified intellectual disabilities professional (QIDP) monitored clients #1, #2 and #4's annual individual support program (ISP) and behavior support program (BSP) for written guardian approval.</p> <p>Findings include:</p> <p>1. Record review for client #1 was done on 1/14/14 at 12:42p.m. Client #1's 8/1/13 ISP indicated client #1 had a guardian. There was no written guardian consent for the ISP/BSP which included behavior medication. There was no documentation from 8/1/13 through 1/10/14, that the QIDP had attempted follow up contact with the guardian to get written consent for the 8/1/13 ISP.</p> <p>Professional staff #1 (QIDP) was interviewed on 1/15/14 at 1:32p.m. Staff #1 indicated client #1 had a guardian. Staff #1 indicated the facility did not</p>	W000159	<p>Responsible: Residential Manager, Program Manager, QIDP &amp; Executive Director.</p> <p>W159 -Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. -The Residential Manager will be retrained on job responsibilities and duties. -A complete review of each client residing at the group home will be conducted to assure proper monitoring and implementation of each client's program. Any issues found in need of being addressed will be brought to the team and staff responsible for implementing each program shall be re-trained to assure proper implementation. The Residential Manger will be retrained on ensure that all guardians are contact and written consent for annual ISP, BSP and HRP is obtained and an IDT is completed, prior to implementation of the plans. -Specifically for client #1's, the IDT will meet to review client #1's ISP, BSP &amp; HRP ensuring that written guardian consist is obtain prior to implementation of the plans. . The ISP will be reviewed to make any appropriate</p>	02/14/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G594		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/15/2014	
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 1412 CLOVER ST MOUNT VERNON, IN 47620			
(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>have written consent from the guardian for the 8/1/13 ISP/BSP. Staff #1 stated the facility had not attempted to get written consent from 8/1/13 through 1/10/14. Staff #1 indicated a certified letter had been sent on 1/10/14 to the guardian for signatures.</p> <p>2. Record review for client #2 was done on 1/14/14 at 10:02a.m. Client #2's 8/1/13 ISP indicated client #2 had a guardian. There was no written guardian consent for the ISP/BSP which included behavior medication. There was no documentation from 8/1/13 through 1/10/14, that the QIDP had attempted follow up contact with the guardian to get written consent for the 8/1/13 ISP.</p> <p>Professional staff #1 (QIDP) was interviewed on 1/15/14 at 1:32p.m. Staff #1 indicated client #2 had a guardian. Staff #1 indicated the facility did not have written consent from the guardian for the 8/1/13 ISP/BSP. Staff #1 stated the facility had not attempted to get written consent from 8/1/13 through 1/10/14. Staff #1 indicated a certified letter had been sent on 1/10/14 to the guardian for signatures.</p> <p>3. Record review for client #4 was done on 1/14/14 at 11:54a.m. Client #4's 8/1/13 ISP indicated client #4 had a</p>		<p>changes. -Specifically for client #2's, the IDT will meet to review client #2's ISP, BSP &amp; HRP ensuring that written guardian consist is obtain prior to implementation of the plans. . The ISP will be reviewed to make any appropriate changes. -Specifically for client #4's, the IDT will meet to review client #4's ISP, BSP &amp; HRP ensuring that written guardian consist is obtain prior to implementation of the plans. . The ISP will be reviewed to make any appropriate changes. -Staff will be retrained regarding any changes made to client #1, client #2, and client #4's ISP and BSP's. -Residential Manager will monitor program plans weekly and update as needed. -Program Manger will review program plans monthly to ensure appropriateness. -QIDP will review all IDTs and program plans monthly to ensure appropriatenessPerson Responsible: Residential Manager, Program Manager, QIDP &amp; Executive Director</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G594	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 1412 CLOVER ST MOUNT VERNON, IN 47620
--	---

(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
W000263	<p>guardian. There was no written guardian consent for the ISP/BSP which included behavior medication. There was no documentation from 8/1/13 through 1/10/14, that the QIDP had attempted follow up contact with the guardian to get written consent for the 8/1/13 ISP.</p> <p>Professional staff #1 (QIDP) was interviewed on 1/15/14 at 1:32p.m. Staff #1 indicated client #4 had a guardian. Staff #1 indicated the facility did not have written consent from the guardian for the 8/1/13 ISP/BSP. Staff #1 stated the facility had not attempted to get written consent from 8/1/13 through 1/10/14. Staff #1 indicated a certified letter had been sent on 1/10/14 to the guardian for signatures.</p> <p>9-3-3(a)</p> <p>483.440(f)(3)(ii) PROGRAM MONITORING &amp; CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. Based on record review and interview, the facility's human rights committee (HRC) failed for 3 of 4 sampled clients (#1, #2, #4) with guardians and with</p>	W000263	W263 – The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. -Residential	02/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G594	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/15/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 1412 CLOVER ST MOUNT VERNON, IN 47620		
(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>restrictive programs, to ensure the facility had received written informed consent from the clients' guardians, for restrictive programs, prior to HRC approval.</p> <p>Findings include:</p> <p>Record review for client #1 was done on 1/14/14 at 12:42p.m. Client #1's 8/1/13 behavior support plan (BSP) indicated client #1 had a guardian. There was no written guardian consent for the BSP which included the behavior medications Abilify and Klonopin for mood disorder. The facility's HRC had approved the BSP on 9/18/13.</p> <p>Record review for client #2 was done on 1/14/14 at 10:02a.m. Client #2's 8/1/13 BSP indicated client #2 had a guardian. There was no written guardian consent for the BSP which included the behavior medications Celexa and Trazodone for anxiety. The facility's HRC had approved the BSP on 9/18/13.</p> <p>Record review for client #4 was done on 1/14/14 at 11:54a.m. Client #4's 8/1/13 BSP indicated client #4 had a guardian. There was no written guardian consent for the BSP which included the behavior medications Prozac and Geodon for explosive disorder. The facility's HRC</p>		<p>Manger will be retrained on ISP process which includes obtaining written approval from the client, parent or legal guardian which remains appropriate. -Residential Manger will be retrained on Job responsibilities with emphasis of obtaining written guardian prior to submitting to the Human Rights Committee for approval. -A complete review of all clients residing in the facility shall be conducted to assure that written informed consent is obtained prior to implementation of clients' plans. . Any issues will be addressed with the Residential Manager for resolution and signature. -Specifically for Clients #1, 2 &amp; 4 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.-Staff responsible for proper implementation shall be trained regarding Clients #1, 2 &amp; 4 plan and any changes as a result of the IDT meeting. -Residential Manager shall monitor through weekly review and as needed to ensure that all ISP's 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's are reviewed prior to implementation and all necessary</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G594	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/15/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 1412 CLOVER ST MOUNT VERNON, IN 47620
--	---

(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
W000289	<p>had approved the BSP on 1/9/14.</p> <p>Professional staff #1 was interviewed on 1/15/14 at 1:32p.m. Staff #1 indicated the facility did not have guardian written informed consent for clients #1, #2 and #4's restrictive BSPs prior to the facility's HRC approval.</p> <p>9-3-4(a)</p> <p>483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR</p> <p>The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview, the facility failed for 1 of 4 sampled clients (#3) with a restrictive behavior management plan, to ensure that all interventions (locked knives) to manage client #3's behavior were included in the client's behavior support plan (BSP).</p> <p>Findings include:</p> <p>Record review of the facility incident reports was done on 1/8/14 at 1:38p.m. Client #3 had an incident report on</p>	W000289	<p>approvals are obtained. Persons Responsible: Residential Manger, Program Manager, QIDP &amp; Executive Director</p> <p>W289 - The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with 483.440 © (4) and (5) of this subpart. - Client # 3 will have a formal 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</p>	02/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G594	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/15/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 1412 CLOVER ST MOUNT VERNON, IN 47620		
(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>11/6/13. The report indicated client #3 had threatened to harm herself. The report indicated the sharps (knives) in the home were to be locked.</p> <p>Record review for client #3 was done on 1/14/14 at 2:02p.m. Client #3's 10/30/13 BSP did not address the facility behavior intervention of locking of the group home knives.</p> <p>Interview of staff #1 on 1/15/14 at 1:32p.m., indicated the group home knives were kept locked. Staff #1 indicated client #3's inappropriate behavior was the reason for the facility knives to be kept locked. Staff #1 indicated the facility intervention practice of locking the knives had not been included in client #3's current BSP.</p> <p>9-3-5(a)</p>		<p>on any updates made to client #3'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 BSP's 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 BSP's are reviewed prior to implementation and all necessary approvals are obtained. Persons Responsible: Residential Manger, Program Manager, QIDP &amp; Executive Director</p>		