

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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
W000000	<p>This visit was for a recertification and state licensure survey. This visit included the investigation of complaint #IN00131620.</p> <p>Complaint #IN00131620- Unsubstantiated, due to lack of evidence.</p> <p>Survey Dates: August 12, 13, 15, 19, 20, 22, 2013</p> <p>Facility Number: 000945 Aim Number: 100235210 Facility Number: 15G431</p> <p>Survey Team: Mark Ficklin, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/11/13 by Ruth Shackelford, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, interview and record review for 5 of 7 clients (clients A, C, D, E F) residing in the facility and who attended the facility operated day program, the governing body failed to exercise operating direction over the facility and day program to provide sufficient numbers of staff working at the day program, and to ensure written policies and procedures were implemented to prevent neglect of client C at the day program. The governing body failed to implement written policies and procedures to prevent client to client aggression and to ensure client to client aggression incidents were investigated (C, D, E, F).</p> <p>Findings include:</p> <p>Please see W149. The governing body failed to exercise operating direction over the facility to provide sufficient numbers of staff at the facility operated day program to implement client programming (A, C, D, E, F) and prevent the neglect of client C at the day program. The governing body failed to prevent client to client aggression incidents and to ensure client to client aggression incidents</p>	W000104	<p>W104: The governing body must exercise general policy, budget, and operating direction over the facility. Corrective Action: (Specific): The Residential Manager will be in-serviced on the abuse neglect policy and procedure as well as the completion of client to client investigation per policy and procedure. How others will be identified: (Systemic) The Program Manager will review incident reports and ensure that the Residential Manager is completing client to client investigations to ensure client safety and changes to plans are being made as necessary.</p> <p>Measures to be put in place: The Residential Manager will be in-serviced on the abuse neglect policy and procedure as well as the completion of client to client investigation per policy and procedure. Monitoring of Corrective Action: The Program Manager will review incident reports and ensure that the Residential Manager is completing client to client investigations to ensure client safety and changes to plans are being made as necessary. Completion date: 09/23/13</p>	09/23/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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>were investigated (C, D, E, F).</p> <p>Please see W154. The governing body failed to exercise operating direction over the facility to ensure client to client aggression incidents were investigated (C, D, E, F).</p> <p>Please see W186. The governing body failed to exercise operating direction over the facility to provide sufficient numbers of staff at the the day program (A, C, D, E, F).</p> <p>9-3-1(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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	
W000122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on interview and record review, the facility failed for 5 of 7 clients (A, C, D, E, F) residing in the facility who attended the facility operated day program, to meet the Condition of Participation: Client Protections by failing to implement written policy and procedure to ensure a sufficient number of direct care staff worked at the facility operated day service program to supervise and monitor client behavior to prevent neglect of client C and to prevent reoccurrence.</p> <p>Findings include:</p> <p>Please see W149. The facility failed to implement written policy and procedures to prevent neglect of clients A, C, D, E and F in regards to ensuring sufficient staffing at the facility operated day program to provide monitoring and supervision of client behavior.</p> <p>9-3-2(a)</p>	W000122	<p>W122: The facility must ensure that specific client protection requirements are met. Corrective Action: (Specific): The alternative active treatment day program staffing ratios will be reviewed based on the number of clients attending the program to see if changes to staffing ratios need to be made. How others will be identified: (Systemic) The Program Manager will make weekly random visits to the alternative active treatment day program to ensure that staffing ratios are adequate based on the number of clients attending. Measures to be put in place: The alternative active treatment day program staffing ratios will be reviewed based on the number of clients attending the program to see if changes to staffing ratios need to be made. Monitoring of Corrective Action: The Program Manager will make weekly random visits to the alternative active treatment day program to ensure that staffing ratios are adequate based on the number of clients attending. Completion date: 9/23/13</p>	09/23/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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			
W000149	<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 record review and interview, the facility failed to implement its policy and procedures to monitor client behavior at the facility day service (clients A, C, D, E, F) and thoroughly investigate 3 of 4 incidents reviewed for allegations of abuse (client to client physical aggression) for clients C, D, E and F.</p> <p>Findings include:</p> <p>A. The facility's reportable incidents were reviewed on 8/13/13 at 9:12a.m. The following client to client physical aggression incidents were reviewed: 1) 3/2/13, client D was physically aggressive to client E. 2) 6/5/13, client E and client F had a physically aggressive argument and client F received a scratch on her cheek. 3) 6/16/13, client C had a physical altercation with client E and threw a curtain rod and hit client E on the arm. There was no documentation these allegations of (physical aggression) client to client abuse had been investigated.</p> <p>B. Review of the incident reports on 8/15/13 at 2:08p.m. indicated there was an incident report for 8/13/13 of a</p>	W000149	W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Corrective Action: (Specific) The Residential Manager will be in-serviced on the abuse neglect policy and procedure as well as the completion of client to client investigation per policy and procedure. In addition, the alternative active treatment day program staffing ratios will be reviewed based on the number of clients attending the program to see if changes to staffing ratios need to be made. How others will be identified: (Systemic) The Program Manager will review incident reports and ensure that the Residential Manager is completing client to client investigations to ensure client safety and changes to plans are being made as necessary. In addition, the Program Manager will make weekly random visits to the alternative active treatment day program to ensure that staffing ratios are adequate based on the number of clients attending. Measures to be put in place: The Residential Manager will be in-serviced on the abuse neglect policy and procedure as well as the completion of client to	09/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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>consensual sexual encounter (client C and a peer from another group home) at the facility day service, in the activity room bathroom. The incident report indicated there were 2 staff at the day service at the time of the incident. The incident report indicated at the time of the incident, one staff had gone outside at the day service with a client from another group home and the other staff (supervising inside the day service) was doing client charting in the office/activity room. The incident report indicated the staff person supervising the inside activity room was not aware of the incident with client C and a peer, at the time it had occurred in the activity room bathroom.</p> <p>The facility's policy and procedures were reviewed on 8/20/13 at 1:28p.m. The facility's "ABUSE/NEGLECT/EXPLOITATION POLICY AND PROCEDURE," dated 7/2/12 "Policy" section indicated: "Community Alternatives South East staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and/or exploitation shall be reported and thoroughly investigated. Community Alternatives South East strictly prohibits abuse, neglect and/or exploitation." The "Procedures" section indicated: "the QA Director will assign an investigative team and a thorough investigation will be completed within 5 business days of the report of the incident. Once the investigation has been completed, the investigation will be given to the Executive Director or designee for review." The "Definitions and Examples" section indicated: "Abuse and neglect may be</p>		<p>client investigation per policy and procedure. In addition, the alternative active treatment day program staffing ratios will be reviewed based on the number of clients attending the program to see if changes to staffing ratios need to be made. Monitoring of Corrective Action: The Program Manager will review incident reports and ensure that the Residential Manager is completing client to client investigations to ensure client safety and changes to plans are being made as necessary. In addition, the Program Manager will make weekly random visits to the alternative active treatment day program to ensure that staffing ratios are adequate based on the number of clients attending. Completion date: 9/23/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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>defined as, but not limited to, the following: A. "Non-accidental injury inflicted by another person or persons." E. "Failure to provide goods and/or services necessary for the individual to avoid physical harm."</p> <p>Professional staff #1 was interviewed on 8/15/13 at 2:08p.m. Staff #1 indicated she was not able to produce documentation of completed investigations for the 3/2/13, 6/5/13 and 6/16/13 identified client to client physical aggression. Staff #1 indicated a client to client physical aggression investigation should have been completed for each client to client physical aggression.</p> <p>Professional staff #1 was interviewed on 8/20/13 at 1:48p.m. In regards to the facility day service program, staff #1 indicated there was normally one staff on the transport van to day services for 4 to 8 clients (varied on days of the week). Staff #1 indicated clients A, C, D, E and F had attended the facility day program. The day service program was located in another town approximately 40 minutes away. Staff #1 indicated there were usually 2 staff for 4 to 8 clients at the day service. Staff #1 indicated there was one regular staff at the day service and the 2nd staff was the staff that had driven the van to day service. Staff #1 indicated the staff that drove the van also had to do client program charting before leaving for the day from the day program with the clients. Staff #1 indicated the staff, if positioned right in the activity/office</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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>room, should be able to see the clients in the activity/bathroom area while doing the charting. Staff #1 indicated the staff that was charting on the clients was responsible to watch the activity area, at the facility operated day program, when the incident on 8/13/13 occurred. On 8/13/13, staff #1 indicated a client had gone outside and the 2nd staff at the day service had gone outside with him. This left one staff and 5 clients in the activity area. Staff #1 indicated the staff person that was charting/supervising the activity room was not aware that client C and a peer had entered the bathroom together and had engaged in sexual interaction. Staff #1 indicated they sometimes had 3 staff at the day service program.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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			
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, the facility failed to thoroughly investigate 3 of 4 incident reports reviewed for allegations of (physical aggression) client to client abuse (clients C, D, E, F).</p> <p>Findings include:</p> <p>The facility's reportable incidents were reviewed on 8/13/13 at 9:12a.m. The following client to client physical aggression incidents were reviewed:</p> <p>1) 3/2/13, client D was physically aggressive to client E.</p> <p>2) 6/5/13, client E and client F had a physically aggressive argument with client F and client F received a scratch on her cheek.</p> <p>3) 6/16/13, client C had a physical altercation with client E and threw a curtain rod and hit client E on the arm. There was no documentation these allegations of (physical aggression) client to client abuse had been investigated.</p> <p>Professional staff #1 was interviewed on 8/15/13 at 2:08p.m. Staff #1 indicated she was not able to produce documentation of completed investigations for the 3/2/13, 6/5/13 and 6/16/13 identified client to</p>	W000154	<p>W154: The facility must have evidence that all alleged violations are thoroughly investigated. Corrective Action: (Specific): The Residential Manager will be in-serviced on the abuse neglect policy and procedure as well as the completion of client to client investigation per policy and procedure. How others will be identified: (Systemic) The Program Manager will review incident reports and ensure that the Residential Manager is completing client to client investigations to ensure client safety and changes to plans are being made as necessary.</p> <p>Measures to be put in place: The Residential Manager will be in-serviced on the abuse neglect policy and procedure as well as the completion of client to client investigation per policy and procedure. Monitoring of Corrective Action: The Program Manager will review incident reports and ensure that the Residential Manager is completing client to client investigations to ensure client safety and changes to plans are being made as necessary. Completion date: 09/23/13</p>	09/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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>client physical aggression. Staff #1 indicated a client to client physical aggression investigation should have been completed for each client to client physical aggression.</p> <p>9-3-2(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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			
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 2 of 4 sampled clients (A, B) and one non-sample client (E) to ensure the qualified intellectual disabilities professional (QIDP) monitored client A's mailed program for guardian approval and ensure client B had quarterly program reviews completed during the past year. The QIDP also failed to ensure client E's recommended sex education training need had been addressed.</p> <p>Findings include:</p> <p>1. Record review for client A was done on 8/15/13 at 12:35p.m. Client A's 2/23/13 individual support plan (ISP) indicated client A had a guardian. There was no written guardian consent for the ISP which included a behavior support plan (BSP) with behavior medication. The QIDP had documentation the ISP was mailed to the guardian on 2/27/13 but no reply had been received. There was no documentation the QIDP had attempted follow up contact with the guardian to get written consent for the 2/23/13 ISP.</p>	W000159	<p>W159: Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Corrective Action: (Specific) The Residential Manager will be in-serviced on obtaining guardian approval for client plans when written and for the completion of quarterly reviews for all clients. In addition, client E will be scheduled to attend sex education training. How others will be identified: (Systemic) The Program Manager (QIDP) will review plans for all clients to ensure that guardian approvals are being obtained timely and that quarterly reviews for all clients are being completed. Measures to be put in place: The Residential Manager will be in-serviced on obtaining guardian approval for client plans when written and for the completion of quarterly reviews for all clients. In addition, client E will be scheduled to attend sex education training. Monitoring of Corrective Action: The Program Manager (QIDP) will review plans for all clients to ensure that guardian approvals are being obtained timely and that quarterly reviews for all clients are</p>	09/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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>Professional staff #1 was interviewed on 8/15/13 at 2:08p.m. Staff #1 indicated client A had a guardian. Staff #1 indicated there was no documentation of follow up attempts since the 2/27/13 mailing of the ISP.</p> <p>2. Record review for client B was done on 8/15/13 at 1:04p.m. Client B had annual ISP on 9/27/12. There was no documentation of quarterly program reviews by the QIDP since the 9/12 annual review.</p> <p>Professional staff #1 was interviewed on 8/15/13 at 2:08p.m. Staff #1 indicated they could not find any documentation of program reviews for client B since the 9/27/12 annual.</p> <p>3. Record review of the facility incident reports was done on 8/13/13 at 9:12a.m. Client E had a 6/16/13 incident report that indicated she had been alone with her boyfriend and had kissed him. The incident report indicated "sex education and counseling are being scheduled." There was no documentation client E had attended sex education training.</p> <p>Professional staff #1 was interviewed on 8/15/13 at 2:08p.m. Staff #1 indicated there was no documentation client E's recommendation for sex education had</p>		being completed. Completion date: 9/23/13		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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	
	been addressed by the facility QIDP. 9-3-3(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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			
W000186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview, the facility failed for 3 of 4 sampled clients (A, C, D) and two non-sample clients (E, F) to ensure a sufficient number of direct care staff were at the facility operated day service, to supervise and manage the clients to meet their needs.</p> <p>Findings include:</p> <p>Review of the incident reports on 8/15/13 at 2:08p.m. indicated there was an incident report for 8/13/13 of a consensual sexual encounter while at the day service between client C and a client from another group home. The incident report indicated there were 2 staff at the day service at the time of the incident.</p> <p>The incident report indicated at the time of the incident, one staff had gone outside at the day service with a client from another group home and the other staff (supervising inside the day service) was doing client charting in the office/activity room. Client C and a peer were in the the</p>	W000186	W186: The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Corrective Action: (Specific) The Residential Manager will be in-serviced on the abuse neglect policy and procedure. In addition, the alternative active treatment day program staffing ratios will be reviewed based on the number of clients attending the program to see if changes to staffing ratios need to be made. How others will be identified: (Systemic) The Program Manager will make weekly random visits to the alternative active treatment day program to ensure that staffing ratios are adequate based on the number of clients attending. Measures to be put in place: The Residential Manager will be in-serviced on the abuse neglect policy and procedure. In addition, the alternative active treatment day program staffing ratios will be reviewed based on the number of clients attending the program to see if changes to	09/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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>day service bathroom together while the staff in the activity area was charting and unaware.</p> <p>Staff #5 was interviewed on 8/19/13 at 1:52p.m. Staff #5 indicated the day service program usually had 2 staff for 5 to 8 clients, it varied each day. Staff #5 indicated there was a client from another group home that attended the day service and often took one staff's time as he would go out of the activity area and a staff would have to follow him. This would leave one staff in the activity rooms.</p> <p>Professional staff #1 was interviewed on 8/20/13 at 1:48p.m. In regards to the facility day service program, staff #1 indicated there was normally one staff on the transport van to day services for 4 to 8 clients (varied on days of the week). Staff #1 indicated clients A, C, D, E and F attended the day service program on various days during the week. The day service program was located in another town approximately 40 minutes away. Staff #1 indicated there were usually 2 staff for 4 to 8 clients at the day service. Staff #1 indicated there was one regular staff at the day service and the 2nd staff was the staff that had driven the van to day service. Staff #1 indicated the staff that drove the van also had to do client</p>		<p>staffing ratios need to be made Monitoring of Corrective Action: The Program Manager will make weekly random visits to the alternative active treatment day program to ensure that staffing ratios are adequate based on the number of clients attending. Completion date: 9/23/13</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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>program charting before leaving for the day from the day program with the clients. Staff #1 indicated the staff, if positioned right in the activity/office room, should be able to see the clients in the activity/bathroom area while doing the charting. Staff #1 indicated the staff that was charting on the clients was responsible to watch the activity area when the incident on 8/13/13 occurred. Staff #1 indicated a client had gone outside and the 2nd staff at the day service had gone outside with him. This left one staff and 5 clients in the activity area. Staff #1 indicated they sometimes had 3 staff at the day service program.</p> <p>9-3-3(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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	
W000212	<p>483.440(c)(3)(i) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. Based on record review and interview, the facility failed for 1 of 4 sampled clients (B) to identify client B's diagnosis and purpose for the use of the behavior medication Risperdal.</p> <p>Findings include:</p> <p>Review of the record of client B was done on 8/15/13 at 1:04p.m. Client B's physician's orders dated 5/22/13 indicated client B was to start Risperdal .5 milligram (mg) for behavior. Client B's 7/24/13 physician's order indicated client B was receiving Risperdal .5 mg. The Physician Orders did not indicate client B's diagnosis for the use of the medication.</p> <p>Interview of professional staff #1 on 8/15/13 at 2:08p.m. indicated they did not know the diagnosis/purpose for the medication. Staff #1 indicated there was no documentation of the diagnosis. Staff #1 indicated client B's primary care physician had started the medication on 5/22/13. Staff #1 indicated client B and the use of Risperdal needed to be evaluated by her psychiatrist.</p>	W000212	<p>W212: The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. Corrective Action: (Specific) The Residential Manager will be in-serviced on obtaining psychiatric diagnosis for any psychotropic medications prescribed and that psychotropic medications will be monitored by a psychiatrist. How others will be identified: (Systemic) The Program Manager will review plans to ensure that appropriate psychiatric diagnosis is documented by the psychiatrist and that psychotropic medications are monitored by a psychiatrist. Measures to be put in place: The Residential Manager will be in-serviced on obtaining psychiatric diagnosis for any psychotropic medications prescribed and that psychotropic medications will be followed by a psychiatrist. Monitoring of Corrective Action: The Program Manager will review plans to ensure that appropriate psychiatric diagnosis is documented by the psychiatrist and that psychotropic medications are monitored by a psychiatrist. Completion date: 9/23/13</p>	09/23/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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
	9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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			
W000249	<p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, record review, and interview, the facility failed for 2 of 4 sampled clients (A, B) to ensure client A (dining) and client B's (hand washing) training programs were implemented when opportunities were present.</p> <p>Findings include:</p> <p>An observation was done at the group home on 8/13/13 from 7:05a.m. to 8:48a.m. At 7:53a.m. client B came from the living room to the kitchen/dining room to eat breakfast. Client B did not wash her hands before eating. Staff #4 was in the dining room and did not prompt client B to wash her hands before eating breakfast. At 8:27a.m. staff #4 cut up an apple for client A. At 8:32a.m. client A was left alone at the dining room table while she was still eating her apple.</p> <p>The record of client A was reviewed on 8/15/13 at 12:35p.m. Client A's 2/23/13 individual support plan (ISP) indicated she had a training program to take</p>	W000249	<p>W249: As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of objectives identified in the individual program plan The comprehensive functional assessment must identify the presenting problems and disabilities and where possible, their causes. Corrective Action: (Specific) The staff will be in-serviced on client A, B and all other client training programs. How others will be identified: (Systemic) The Residential Manager will complete observations at the home at least weekly to ensure that all client program plans are being implemented as written. Measures to be put in place: The staff will be in-serviced on client A, B and all other client training programs. Monitoring of Corrective Action: The Residential Manager will</p>	09/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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>appropriate sized bites. Client A's program also included that staff should sit at the dining room table and verbally remind her of bite size bites. Client A's program also indicated staff were to closely monitor client A in/or near the kitchen due to her sneaking food and over fills her mouth.</p> <p>The record of client B was reviewed on 8/15/13 at 1:04p.m. Client B's 9/27/12 ISP indicated she had a training program to tell staff why she needed to wash her hands before dining.</p> <p>Professional staff #1 was interviewed on 8/15/13 at 2:08p.m. Staff #1 indicated client A's training program to be monitored during food intake should have been implemented at all opportunities. Staff #1 indicated client B's hand washing training program should have been implemented at all opportunities.</p> <p>9-3-4(a)</p>		<p>complete observations at the home at least weekly to ensure that all client program plans are being implemented as written. Completion date: 9/23/13</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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			
W000262	<p>483.440(f)(3)(i) PROGRAM MONITORING & CHANGE The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. Based on record review and interview, the facility's Human Rights Committee (HRC) failed for 1 of 4 sampled clients (B) with behavior control medication, to ensure client B's behavior medication was reviewed/monitored.</p> <p>Findings include:</p> <p>The record of client B was reviewed on 8/15/13 at 1:04p.m. Client B's 7/24/13 physician's orders indicated client B received the behavior medication Risperdal for behavior. The medication was started on 5/22/13. There was no documentation of a diagnosis for the behavior medication. There was no documentation the behavior medication had been reviewed and approved by the HRC.</p> <p>Interview of professional staff #1 on 8/15/13 at 2:08p.m. indicated there was no documentation the facility's HRC had reviewed client B's behavior control medication (Risperdal).</p>	W000262	<p>W262: The committee should review, approve and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. . Corrective Action: (Specific) The residential manager will be in serviced on obtaining HRC approval for all psychotropic medications prior to the start of the medication. Client B's Risperdal has been approved by HRC. How others will be identified: (Systemic) The Program Manager will review plans to ensure that all psychotropic medications are approved by HRC prior to the medication being started. Measures to be put in place: The residential manager will be in serviced on obtaining HRC approval for all psychotropic medications prior to the start of the medication. Client B's Risperdal has been approved by HRC. Monitoring of Corrective Action: The Program Manager will review plans to ensure that all psychotropic medications are approved by HRC prior to the medication being started.</p>	09/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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	
	9-3-4(a)		Completion date: 9/23/13		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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	
W000312	<p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Based on record review and interview, the facility failed for 1 of 4 sampled clients (client B) who took behavior control drugs, to ensure the behavior control medication (Risperdal) was part of client B's individual support plan (ISP) and included in a plan of reduction.</p> <p>Findings include:</p> <p>Review of the record of client B was done on 8/15/13 at 1:04p.m. Client B's 9/27/12 ISP indicated client B did not have a behavioral diagnosis. Physician Orders on 5/22/13 indicated client B received the behavior control medication Risperdal. The ISP failed to include the behavior control medication in a plan which included a withdrawal criteria.</p> <p>Interview of professional staff #1 on 8/15/13 at 2:08p.m. indicated client B did not have her current behavior control medication addressed in a plan of reduction.</p> <p>9-3-5(a)</p>	W000312	<p>W312: Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed. Corrective Action: (Specific): The residential manager will be in serviced on including a plan of reduction for psychotropic mediations. Client B's ISP has been updated to include a plan of reduction for Risperdal. How others will be identified: (Systemic) The Program Manager will review plans to ensure that all psychotropic medications and a plan of reduction is included in client's ISP's. Measures to be put in place: The residential manager will be in serviced on including a plan of reduction for psychotropic mediations. Client B's ISP has been updated to include a plan of reduction for Risperdal. Monitoring of Corrective Action: The Program Manager will review plans to ensure that all psychotropic medications and a plan of reduction are included in client's</p>	09/23/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/22/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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
			ISP's. Completion date: 9/23/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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			
W000440	<p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed for 7 of 7 clients (A, B, C, D, E, F, G) residing at the facility to ensure evacuation drills were completed quarterly, for each of the facility's personnel shifts, from 8/1/12 through 8/15/13.</p> <p>Findings include:</p> <p>Record review of the facility's evacuation drills from 8/1/12 through 8/15/13 for clients A, B, C, D, E, F and G was completed on 8/15/13 at 10:18a.m. The documented "night shift," sleep time, evacuation drills were documented on 11/21/12, 12/30/12 and 6/14/13. There were no documented night shift drills during the 1st quarter (8/12 through 10/12) and for the 3rd quarter (2/13 through 5/13). There was a day shift drill on 4/20/13. This was the only documented day shift drill from 8/1/12 through 8/15/13.</p> <p>Interview of professional staff #1 on 8/13/13 at 10:43a.m. indicated the day shift was from 6a.m. to 2p.m. and the night shift was from 12a.m. to 8a.m. Staff #1 indicated the facility should run an evacuation drill at least once per each</p>	W000440	<p>W440: The facility must hold evacuation drills at least quarterly for each shift for each personnel. Corrective Action: (Specific): The residential manager will be in serviced on including the completion of fire drills quarterly for each shift of personnel. How others will be identified: (Systemic) The Program Manager will review drill during home visits to ensure that drills are being conducted at least quarterly for each shift of personnel. Measures to be put in place: The residential manager will be in serviced on including the completion of fire drills quarterly for each shift of personnel. Monitoring of Corrective Action: The Program Manager will review drill during home visits to ensure that drills are being conducted at least quarterly for each shift of personnel. Completion date: 9/23/13</p>	09/23/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G431	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/22/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR 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	
	shift during quarter. 9-3-7(a)				