

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G139	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 6611 CHESHIRE DR NEWBURGH, IN 47630
--	---

(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: January 15, 18, 24, 25, 2013</p> <p>Provider Number: 15G139 Aims Number: 100234450 Facility Number: 000676</p> <p>Surveyor: Mark Ficklin, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review was completed on 1/31/13 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: 15G139	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/25/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 6611 CHESHIRE DR NEWBURGH, IN 47630
--	---

(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
W0124	<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 2 of 2 sampled clients (#2, #4) with a guardian to ensure the guardians were informed of locked knives/sharps at the group home.</p> <p>Findings Include:</p> <p>The record for client #2 was reviewed on 1/24/13 at 10:58a.m. Client #2's 4/25/12 individual support plan (ISP) indicated client #2 had a guardian. Client #2's record did not have any documentation that client #2's guardian had been informed of the facility's practice to lock up the group home knives/sharps.</p> <p>The record for client #4 was reviewed on 1/24/13 at 10:22a.m. Client #4's 5/21/12 individual support plan (ISP) indicated client #4 had a guardian. Client #4's record did not have any documentation that client #4's guardian had been informed of the facility's practice to lock up the group home knives/sharps.</p> <p>Professional staff #2 was interviewed on 1/18/13 at 6:46a.m. Professional staff #2 indicated the facility kept the group home knives/sharps locked (only staff had a key) due to client #7's behavior. Staff #2 indicated there was no documentation client #2 and #4's guardians had been informed of the facility's practice to lock the knives/sharps. Professional staff #1 was interviewed on 1/24/13 at 2:04p.m. Staff #2 indicated the facility should</p>	W0124	<p>W124: Protection of Clients Rights</p> <ul style="list-style-type: none"> - The IDT will meet with each client including their guardian to ensure that the knives/sharps restriction remains appropriate and are approved. - The Human Rights Committee will review the all restrictions in the home and determine if they remain appropriate - All staff will be retrained on client rights - Program Coordinator and Operations Manager will be retrained on client rights and including all rights restrictions in the ISP on the Modification of Rights page - Program Coordinator will complete weekly home visits to ensure that client rights are not being violated - Operations Manager will complete monthly home visits to ensure that client rights are not being violated. <p>Persons Responsible: Program Coordinator, Operations Manager</p>	02/24/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G139	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/25/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 6611 CHESHIRE DR NEWBURGH, IN 47630		
(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	
	have had documentation all guardians were informed of the facility practice to lock knives/sharps. 9-3-2(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G139	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/25/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 6611 CHESHIRE DR NEWBURGH, IN 47630		
(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	
W0312	<p>483.450(e)(2) DRUG USAGE</p> <p>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 2 of 4 sampled clients (#2, #4) who took behavior control drugs, to ensure the clients' behavior control medication was documented in a plan of reduction.</p> <p>Findings include:</p> <p>Review of the record of client #2 was done on 1/24/13 at 10:55a.m. Client #2's 4/25/11 individual support plan (ISP) indicated client #2's diagnoses included, but were not limited to, Autism with generalized anxiety. Physician orders on 12/18/12 indicated client #2 received the behavior control medication Klonopin. The ISP failed to include the behavior control medication in a plan of reduction.</p> <p>Review of the record of client #4 was done on 1/24/13 at 10:22a.m. Client #4's 5/21/12 ISP indicated client #4's diagnoses included, but were not limited to, attention deficit disorder. Physician orders on 12/18/12 indicated client #4 received the behavior control medication</p>	W0312	<p>W312: Drug Usage</p> <ul style="list-style-type: none"> - IDT will meet with Client #2 and Client #4 to ensure that behavior control medications are appropriate. - Human Rights Committee will review behavior control medications for Client #2 and Client #4 to ensure that they are appropriate - The Program Coordinator and Operations Manager will be retrained on gaining appropriate approvals and updating Behavior Modification of Rights in the ISP when behavior control medications are adjusted. <p>Persons Responsible: Program Coordinator, Operations Manager</p>	02/24/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G139		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/25/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 6611 CHESHIRE DR NEWBURGH, IN 47630			
(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>Adderall. The ISP failed to include the behavior control medication in a plan of reduction.</p> <p>Interview of professional staff #1 on 1/23/13 at 2:04p.m. indicated clients #2 and #4 did not have their current behavior control medication addressed/included in a plan of reduction.</p> <p>9-3-5(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G139		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 01/25/2013	
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 6611 CHESHIRE DR NEWBURGH, IN 47630			
(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			
W0455	<p>483.470(l)(1) INFECTION CONTROL</p> <p>There must be an active program for the prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation and interview, the facility failed for 2 of 4 sampled clients (#1, #2) and 1 non-sampled client (#7) to ensure clients did not use the same electric razor.</p> <p>Findings include:</p> <p>An observation was done at the group home on 1/18/13 from 6:10a.m. to 7:11a.m. At 6:22a.m. staff #4 got an electric razor from client #1's bedroom. Staff #4 had clients #2 and #7 come to the bathroom and shaved both clients with client #1's electric razor. Interview of staff #4 at 6:25a.m. indicated she had shaved clients #2 and #7 with the same electric razor. Staff #4 indicated the electric razor used on clients #2 and #7 was client #1's electric razor.</p> <p>Professional staff #1 was interviewed on 1/23/13 at 2:04p.m. Staff #1 indicated clients should not share electric razors and each client should be shaved with their own razor.</p> <p>9-3-7(a)</p>	W0455	<p>W455: Infection Control</p> <ul style="list-style-type: none"> - All staff will be retrained on infection control in regards to sharing razors - Each client will have their own personal razor. - Program Coordinator and Operations Manager will be retrained on ensuring that all clients do not share personal and hygienic items in the home - Program Coordinator will complete weekly home visits to ensure that infection control is being followed - Operations Manager will complete monthly home visits to ensure that infection control is being followed <p>Persons Responsible: Program Coordinator, Operations Manager</p>	02/24/2013			