

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G241	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/23/2015
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 651 SOUTH 100 EAST WASHINGTON, IN 47501
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W000000	<p>This visit was for a fundamental recertification and state licensure survey.</p> <p>Survey Dates: January 21, 22, 23, 2015</p> <p>Facility Number: 000764 Aims Number: 100234870 Provider Number: 15G241</p> <p>Surveyor: Mark Ficklin, QIDP</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 1/29/15 by Ruth Shackelford, QIDP.</p>	W000000		
W000242	<p>483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.</p> <p>Based on record review and interview, the facility failed for 1 of 4 sampled clients (client #1) to include training in client #1's annual Individual Support Plan (ISP) for her identified self feeding</p>	W000242	<p>PROVIDER IDENTIFICATION #: 15G241</p> <p>NAME OF PROVIDER: RESCARE COMMUNITY ALT.,</p>	02/10/2015

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>needs.</p> <p>The findings include:</p> <p>An observation was done on 1/22/15 from 2:48p.m. to 5:30p.m. at the group home. At 5:10p.m. client #1 ate her supper. Client #1 did not have a drink within arms reach while she ate supper. When client #1 had finished eating, staff #4 moved client #1's 8 to 10 ounce glass of juice to her (arms reach). Client #1 independently drank the glass of juice in one drink and did not put the glass down.</p> <p>Record review of client #1 was done on 1/23/15 at 8:18a.m. Client #1's 12/30/14 dietician review indicated client #1 "feeds self." Client #1's 5/13/14 ISP did not have a training program to address client #1 not having her drink at meal time until she had finished eating. The ISP did not address client #1 consuming all of her meal time drink in one drink without putting her cup down.</p> <p>Interview of staff #2 on 1/23/15 at 10:46a.m. indicated during supper on 1/22/15 client #1 was not given her meal time drink until she had completed her meal. Staff #2 indicated this was not part of client #1's training program. Staff #2 indicated client #1 drinks her entire drink, in one drink, without putting her</p>		<p>SOUTH CENTRAL</p> <p>ADDRESS: 651 South 100 East Washington, IN 47501</p> <p>SURVEY EVENT ID #: OVQF11</p> <p>DATE SURVEY COMPLETED: 01/23/2015</p> <p>PROVIDER'S PLAN OF CORRECTION</p> <p><u>W 242: INDIVIDUAL PROGRAM PLAN:</u></p> <p>The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and</p> <p>Independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing,</p> <p>grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of</p> <p>acquiring them</p>				

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	<p>cup down. Staff #2 indicated client #1 was not given her drink with her meal because she will consume her drink prior to eating and then will not finish her meal. Staff #2 indicated client #1 was in need of a training program to address her drinking rate at meal time and to ensure client #1 had her drink available during meals.</p> <p>9-3-4(a)</p>		<p>Corrective action:</p> <ul style="list-style-type: none"> ·IDT convened to determine best course of action to address identified issue of a drink with meals. (ATTACHMENT A) ·Order requested and received from PCP for an assistive device to slow fluid intake to measured amounts per drink. (ATTACHMENT B) ·Dining plan updated to include Provail cup. (ATTACHMENT C) ·Staff Training (ATTACHMENT D) <p>How we will identify others:</p> <ul style="list-style-type: none"> ·All individuals will have an assessment completed upon admission. (ATTACHMENT E) ·All individuals will have an assessment done annually. (ATTACHMENT E) ·IDT will meet quarterly and discuss any needed changes to individuals' plans. (ATTACHMENT F) <p>Measures to be put in place:</p> <ul style="list-style-type: none"> ·Residential Manager will complete two (2) Active Treatment Observations weekly to ensure compliance with all treatment plans. (ATTACHMENT 	

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			<p>G)</p> <ul style="list-style-type: none"> ·Residential Manager will offer immediate feedback/ correction as needed to direct care staff during observation. (ATTACHMENT G) ·Residential Manager will offer to direct care staff to share opinions/suggestions concerning treatment plans during observation. (ATTACHMENT G) ·Residential Manager will conduct a monthly meeting giving staff opportunity to contribute opinions/suggestions on success or opportunity with current treatment plans. (ATTACHMENT H) ·Nurse will do a Quarterly Meal Time Assessment. (ATTACHMENT I) <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·Clinical Supervisor will review Active Treatment Observations, Monthly meeting notes, Nurses quarterly mealtime assessment, and participate in IDT's to discuss plans and needed modifications. ·Clinical Supervisor, Program Manager, Executive Director, QIDP, Human Resources Specialist, Nursing Manager or Business Manager will perform Best in Class Audits to ensure that all plans are being followed, and regulations are being adhered to in accordance with 	

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			<p>state law.</p> <p>·Per ResCare policy Best in Class standards dictate that a review of 10% of ICF homes, up to 5, be reviewed quarterly.</p> <p>Completion Date: February 22, 2015</p>		