

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  08/27/2014
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NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR JASPER, IN 47546
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W000000	<p>This visit was for the recertification and state licensure survey.</p> <p>Dates of survey: August 25, 26 and 27, 2014.</p> <p>Facility Number: 000945 Provider Number: 15G431 AIM Number: 100235210</p> <p>Surveyor: Dotty Walton, QIDP.</p> <p>The following federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/12/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 1 of 3 sampled clients (#3), the facility's governing body failed to exercise general policy and operating direction over the facility in a manner to maintain a system</p>	W000104	<p><b>W104: The governing body must exercise general policy, budget, and operating direction over the facility. Corrective Action: (specific): Client 3 has been reimbursed in the amount</b></p>	09/26/2014

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.

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W000120	<p>which ensured client #3 did not pay for a counseling session out of the client's personal funds.</p> <p>Findings include:</p> <p>On August 26, 2014, at 10:00 AM, client #3's Resident Fund Management Service/RFMS account statement was reviewed. The review indicated client #3 had paid \$21.00 for a "Medical bill" on 4/01/14.</p> <p>The staff in charge of accessing the RFMS account information, staff #15, was contacted via electronic mail and indicated on 8/26/14 at 10:36 AM, client #3 paid for "counseling" and would be reimbursed by the agency.</p> <p>9-3-1(a)</p> <p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. Based on record review, and interview for 1 of 3 sampled clients (#2), the facility failed to ensure the day services provider adequately supervised client #2 to prevent sexual misconduct.</p>	W000120	<p><b>of 21.00 for the medical bill. The residential manager will be in-serviced on reviewing monthly RFMS statements and alert the Business Office Manager if there are questionable items on the account. How others will be identified: (Systemic): The residential manager will review the monthly RFMS statements for each client in the home. Measures to be put in place: Client 3 has been reimbursed in the amount of 21.00 for the medical bill. The residential manager will be in-serviced on reviewing monthly RFMS statements and alert the Business Office Manager if there are questionable items on the account. Monitoring of Corrective Action: The residential manager will review the monthly RFMS statements for each client in the home. Completion date: 9/26/14</b></p> <p><b>ADDENDUM 9/29/14</b></p> <p><b>W120:</b> The facility must assure that outside services meet the needs of</p>	09/29/2014			

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	<p>Findings include:</p> <p>Review of facility investigations on 8/27/14 at 12:15 PM indicated an investigation wherein client #2 had made an allegation of sexual misconduct against a peer at the workshop. Client #2 reported on 1/9/14 a male coworker at the workshop tried to inappropriately touch her under the table. The allegation was unsubstantiated due to a lack of corroborating evidence.</p> <p>A second investigation regarding sexual misconduct at the workshop dated 5/14/14 indicated the following:</p> <p>"On 5/12/14 at 12:15 PM [client #2] brought to staff's [workshop staff #10 and #11] attention that she had done something bad. [Client #2] explained to staff that she had sex with a boy in the men's bathroom. Staff asked [client #2] what she meant by having sex with a boy and she replied with 'I went down on him' pointing to the genital area. Staff asked [client #2] how it was started and she replied with 'He asked me to.' Staff asked male peer if something happened in the rest room. Male peer replied 'Yes.' Staff asked what happened. Male peer replied with 'I didn't touch her but she did it to me.' Staff asked male peer who asked to perform the act. Male peer replied with 'I</p>		<p>each client.</p> <p>What kind of consistent observation/monitoring is the QIDP providing at the day service/workshop?</p> <p><b>Corrective Action: (specific):</b> The day service will provide daily progress reports to the QIDP. Also, the QIDP will visit the day service at least one time monthly to observe the client. The IDT will meet regarding any concerns and/or updates needed to the programming plans.</p> <p><b>How others will be identified: (Systemic):</b> The QIDP will be in-serviced on reviewing day service documentation and immediately addressing any concerns as well as visiting the day service at least one time monthly.</p> <p><b>Measures to be put in place:</b> The day service will provide daily progress reports to the QIDP. Also, the QIDP will visit the day service at least one time monthly to observe the client. The IDT will meet regarding any concerns and/or updates needed to the programming plans.</p>				

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	<p>asked her, she did.' This was reported by [name of workshop] that [client #2] attends throughout the week...."</p> <p>Client #2 was interviewed on 5/14/14 and stated the male peer asked her to have sex. "We went to lunch and waited for everyone to leave and we went in the men's bathroom."</p> <p>Workshop staff #10 was interviewed on 5/13/14 and stated "We have about 80 group home individuals that are in [client #2's] area. We are not set up for 1:1 (one staff monitoring one client) supervision which includes going to the rest room with them. The rest rooms are also located next to [client #2's] area...."</p> <p>The investigation's conclusion was as follows: "[Client #2] and her male coworker planned the incident that took place on 5/12/14 without informing staff. It appears that there was adequate supervision at the time of the incident and [client #2] and her coworker planned the event so staff would not know what was taking place."</p> <p>An interdisciplinary team (IDT) meeting with agency staff and workshop staff was conducted on 5/20/14 (reviewed 8/27/14 at 2:00 PM). The client was suspended for 2 months but must wait 6 months before she could return to the same workshop.</p>		<p><b>Monitoring of Corrective Action:</b> The QIDP will be in-serviced on reviewing day service documentation and immediately addressing any concerns as well as visiting the day service at least one time monthly.</p> <p><b>Completion date: 9/29/14</b> <b>W120:</b> The facility must assure that outside services meet the needs of each client. <b>Corrective Action: (specific):</b> As of 9/22, client 2, is attending a new day service. <b>How others will be identified: (Systemic):</b> The day service was given client 2's programming plans prior to receiving services. <b>Measures to be put in place:</b> As of 9/22, client 2, is attending a new day service. <b>Monitoring of Corrective Action:</b> The day service was given client 2's programming plans prior to receiving services. <b>Completion date: 9/26/14</b></p>				

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	<p>Review of client #2's record on 8/26/14 at 10:23 AM indicated a history of sexual misconduct at an agency run day program in 8/13. Client #2 had sexual intercourse with a former boyfriend. The review indicated an ISP/Individual Support Plan dated 5/22/14. This ISP contained an objective to state an appropriate place for a relationship with client #2's boyfriend with 3 or less verbal prompts.</p> <p>Client #2 was interviewed on 8/25/14 at 5:15 PM and indicated she did not attend a workshop at the present time. She indicated she had been suspended for doing something wrong at her former workshop but was looking into a new workshop.</p> <p>Interview with the Qualified Intellectual Disabilities Professional/QIDP #1 on 8/27/14 at 2:30 PM indicated client #2 had a history of sexual misconduct and she had been suspended from her workshop. The interview indicated the workshop had not prevented an incident in the restroom between client #2 and a male peer. The client was currently being evaluated by another day services provider for placement.</p> <p>9-3-1(a)</p>			

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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 for 3 of 3 sampled clients (clients #1, #2 and #3), and 3 additional clients (clients #4, #5 and #6), the facility failed to ensure their policies which prohibited client to client aggression/abuse and client neglect were implemented.</p> <p>Findings include:</p> <p>The facility's BDDS reports (Bureau of Developmental Disabilities Services) and internal incident reports and investigations were reviewed on 8/25/14 at 1:30 PM and on 8/27/14 12:15 PM and indicated the following incidents of client to client aggression:</p> <p>6/7/14, Client #2 pulled client #3's hair, punched the right side of her face, and kneed her in the stomach. Client #3 called the police. Client #2 left the facility but returned shortly thereafter. The report indicated the police came and stated they would "arrest" client #2 if they had to come to the house again due to her history of aggressive acts.</p> <p>6/8/14, Client #3 was calling client #2</p>	W000149	<p><b>W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</b> <b>Corrective Action: (specific):</b> <b>The direct care staff and residential manager will be in-serviced on the abuse, neglect and exploitation policy.</b> <b>How others will be identified: (Systemic):</b> <b>The residential manager will be in the home five times weekly to ensure that direct care staff are following the abuse, neglect and exploitation policy. The clinical supervisor will visit the home once weekly to ensure the same. Measures to be put in place: The direct care staff and residential manager will be in-serviced on the abuse, neglect and exploitation policy. Monitoring of</b> <b>Corrective Action: The residential manager will be in the home five times weekly to ensure that direct care staff are following the abuse, neglect and exploitation policy. The clinical supervisor will visit the home once weekly to ensure the same. Completion</b></p>	09/26/2014			

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	<p>names and client #2 became physically aggressive.</p> <p>6/10/14, Client #2 caused scrapes to both of client #3's arms.</p> <p>6/16/14, Client #2 was aggressive toward client #6. Client #2 had 1/2 inch by 1/2 inch scrape to her left hand knuckle area.</p> <p>6/21/14, Clients #2 and #4 had an incident and client #2 sustained a 1/2 inch long scratch on her lower back.</p> <p>7/1/14, Clients #2 and #3 threw items at each other. Client #2 "attacked" client #3 "physically."</p> <p>7/6/14, Client #2 punched client #3 in the face.</p> <p>8/15/14, Client #1 hit client #6 in the chest.</p> <p>8/16/14, Client #3 shut the medication room door in client #1's face. They began "screaming" at each other. Client #1 pushed client #3's ankle and client #3 kicked client #1's arm.</p> <p>8/17/14, Client #6 was trying to fix her seatbelt and client #2 became impatient. Client #2 pushed client #6 and they called each other names.</p> <p>A BDDS reported dated 6/6/14 indicated an incident wherein client #5 eloped twice from the facility. Client #5 left the facility with staff in pursuit. She lay down in the road. Staff prompted her and she got up and returned to the facility. After dinner on the same evening, client</p>		date: 9/26/14		

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	<p>#5 eloped once again. There was only one staff at the facility at the time so the police were called. (One staff was taking a client on her outing). Staff from another agency facility came to look for client #5 and found her before the police could.</p> <p>A BDDS report dated 4/28/14 indicated client #3 had ingested (and self reported) an ink pen cap on 4/27/14 after evening medications. She was taken via ambulance to a local emergency room for evaluation.</p> <p>Review of client #3's record on 8/26/14 at 1:57 PM indicated an ISP/Individual Support Plan dated 5/09/14. The review indicated client #3 had a history of ingesting non-edible items or PICA. The record review indicated a visit to the client's primary care physician: "Foreign body ingested removed from rectum" on 5/7/14.</p> <p>The "Abuse/Neglect/Exploitation Policy and Procedure" component of the agency's 8/01/07 Operational Policy and Procedure Manual (revised 07/02/2012) was reviewed on August 27, 2014 at 10:00 AM. The review indicated the agency prohibited neglect of clients. The definitions of abuse and neglect were as follows: "A. Abuse - Physical Definition:</p>			

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W000484	<p>1. The act or failure to act, that results or could result in physical injury to an individual.</p> <p>2. Non-accidental injury inflicted by another person or persons....</p> <p>F. Neglect--Program Implementation/Intervention</p> <p>Definition:</p> <p>1. Failure to provide goods and/or services necessary for the individual to avoid physical harm.</p> <p>2. Intentional failure to implement a support plan, inappropriate intervention, etc. which may result in jeopardy without qualified person notification/review."</p> <p>Interview with staff #2 on 8/26/14 at 2:15 PM stated client #2 "targeted" client #3 in regards to physical aggression.</p> <p>Interview with the Qualified Intellectual Disabilities Professional/QIDP #1 on 8/27/14 at 2:30 PM indicated the agency prohibited client to client aggression and client neglect.</p> <p>9-3-2(a)</p>				

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	<p><b>DINING AREAS AND SERVICE</b> The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3) and for 2 additional clients (#4 and #5), the facility failed to ensure clients were given knives to assist with cutting up their ham.</p> <p>Findings include:</p> <p>During the 8/25/14 observation period between 5:15 PM and 6:45 PM, at the group home, client #6 was asked to set the table. Client #6 did not add steak knives or table knives to the dining service.</p> <p>The meal consisting of baked ham, sweet potatoes, green beans, cornbread muffins, and sliced cucumbers was placed on the table at 5:45 PM. Clients sat down and passed the foods family style fashion at 6:00 PM. Client #4 obtained a table knife and began cutting up her ham slice. The ham was not easy to cut with a table knife and client #4 worked at slicing the meat. Client #3 had a junior size fork and tried to cut the ham with her small fork. Client #3 stopped trying to cut the ham with her fork and tore it apart with her hands. Client #1 tore her ham slice with her hands and ate it with her fingers.</p>	W000484	<p><b>W484: The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Corrective Action: (specific):</b> The Residential Manager and direct care staff will be in-serviced on each client's dining plan and any restrictions regarding knives at the meal table. <b>How others will be identified: (Systemic):</b> The Residential Manager will observe three meals per week to ensure plans and restrictions are being followed as written. <b>Measures to be put in place:</b> The Residential Manager and direct care staff will be in-serviced on each client's dining plan and any restrictions regarding knives at the meal table. <b>Monitoring of Corrective Action:</b> The Residential Manager will observe three meals per week to ensure plans and restrictions are being followed as written. <b>Completion date: 9/26/14</b></p>	09/26/2014	

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	<p>Staff #7 and #8 supervised the meal. Staff did not obtain sharp knives or other table service (adaptive knives, table knives) to assist clients #1, #2, #3, #4, and #5 with cutting the slices of ham.</p> <p>Review of client #1's record on 8/26/14 at 9:39 AM indicated an Individual Support Plan/ISP dated 9/27/13. The review indicated a rights restriction for sharps (knives to be locked) for which client #1 and her surrogates had consented. The restriction language indicated client #1 could use a sharp knife with staff supervision.</p> <p>Review of client #2's record on 8/26/14 at 10:23 AM indicated an ISP dated 5/22/14. The review indicated a rights restriction for sharps (knives to be locked) for which client #2 and her surrogates had consented. The restriction language indicated client #2 could use a sharp knife with staff supervision.</p> <p>Review of client #3's record on 8/26/14 at 1:57 PM indicated an ISP dated 5/09/14. The review indicated a rights restriction for sharps (knives to be locked) due to client #3's history of "inappropriate physical aggression" and the "potential for harm to her and the others residing in the home...." The restriction language indicated client #3 could not use a sharp</p>						

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	<p>knife without staff supervision. There was no mention of whether client #3 could use a regular table knife. The sharps restriction was consented to on 6/23/14.</p> <p>Interview with staff #1, the Qualified Intellectual Disabilities Professional (QIDP), on 8/26/14 at 1:45 PM indicated clients #1, #2, #4, and #5 should have been given a table knife or sharp knife to cut their meat with staff supervision. Client #3 was not to be given a sharp knife but staff could have assisted her with cutting her meat appropriately.</p> <p>9-3-8(a)</p>			

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(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

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

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 08/27/2014
NAME OF PROVIDER OR SUPPLIER  COMMUNITY ALTERNATIVES SW IN			STREET ADDRESS, CITY, STATE, ZIP CODE 525 S SKYVIEW DR JASPER, IN 47546		
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