

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G080		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  02/06/2013	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL				STREET ADDRESS, CITY, STATE, ZIP CODE 725 CARR ST MILAN, IN 47031			
(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 an annual fundamental recertification and state licensure survey.</p> <p>Dates of survey: January 29, 30, 31 and February 6, 2013.</p> <p>Facility Number: 000623 Provider Number: 15080 AIM Number: 100233870</p> <p>Surveyor: Dotty Walton, Medical Surveyor III</p> <p>This deficiency reflects state findings in accordance with 460 IAC 9. Quality Review completed 2/15/13 by Ruth Shackelford, 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.

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W0104	<p><b>483.410(a)(1) GOVERNING BODY</b> The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 2 of 4 sampled clients (#3 and #4), the Governing Body failed to exercise general operating direction over the facility by failing to maintain a system which ensured clients did not pay for medical equipment.</p> <p>Findings include:</p> <p>Client #3's financial record was reviewed on January 30, 2013 at 10:35 AM and indicated client #3 had been charged \$40.00 for a pair of "gradient comp. (compression) stockings" on 1/15/13.</p> <p>Client #4's financial record was reviewed on January 30, 2013 at 10:50 AM and indicated he had been billed \$23.90 for "gradient compression stockings" on 1/15/13.</p> <p>Interview with staff #3 on 1/30/13 at 4:15 PM indicated charging clients #3 and #4 for the medically necessary hosiery was a mistake. The interview indicated it was not the policy of the agency to charge clients for medically necessary items.</p> <p>9-3-1(a)</p>	W0104	<p><b>Corrective action:</b></p> <ul style="list-style-type: none"> <li>Request for reimbursement for Clients #3, #4 has been submitted (Attachment A).</li> <li>Nurse Manager, staff have been inserviced on Adaptive Equipment Protocol (Attachment B).</li> </ul> <p><b>How we will identify others:</b></p> <p>Nursing Manager will review client non covered Medicaid services, within per diems, to ensure that non covered Medicaid services, within per diem, have not been paid out of RFMS accounts.</p> <p><b>Measures to be put in place:</b></p> <p>Nursing Manager will review client non covered Medicaid services, within per diems, to ensure that they are being paid by ResCare.</p>	02/28/2013			

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			<p><b>Monitoring of Corrective Action:</b></p> <p>Executive Director will review client non covered Medicaid services, within per diem, to ensure that services are paid for correctly</p> <p><b>Completion Date:</b> <b>2-28-2013</b></p>		