STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G664	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 12/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	1566 BONNIEVIEW DR EVANSVILLE, IN 47715

(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	This visit was for a recertification and state licensure survey. Survey Dates: December 11, 13, 14, 2012 Provider Number: 15G664 Aims Number: 100234080 Facility Number: 001223 Surveyor: Mark Ficklin, Medical Surveyor III This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review completed 12/19/12 by Ruth Shackelford, Medical Surveyor III.	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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W0322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview, the facility failed for 1 of 4 sampled clients (#1) to ensure client #1 received identified medical services in regards to his identified Mellaril therapy monitoring needs which included an electrocardiogram (EKG). Findings include: Record review for client #1 was done on 12/13/12 at 10:11a.m. Client #1's 1/15/12 physician's orders indicated client #1 was to receive an EKG every 6 months due to Mellaril therapy. The physician's orders indicated client #1 received Mellaril for Intermittent Explosive Disorder. Client #1 had a documented EKG on 1/13/12. There were no EKG's completed from 1/13/12 through time of survey on 12/13/12. Staff #3 (nurse) was interviewed on 12/13/12 at 11:28a.m. Staff #3 stated client #1 was to have an EKG every 6 months. Staff #3 indicated the last EKG for client #1 was done on 1/13/12. 9-6-3(a)	W0322	The Nurse will be retrained on the ResCare Nursing Manual.An EKG will be completed for Client #1.Program Coordinator will be retrained on ensuring that all appoinments for Client #1 are completed as required.The Nurse will be retrained on ensuring that all appointments for Client #1 are completed as required.The Nurse will conduct quarterly reviews of all charts in the home to ensure that all required appointments are scheduled.The Program Coordinator will conduct home visits to ensure that doctor appointments and procedures are scheduled & completed as required.Responsible Person: Nurse & Program Coordinator	01/13/2013

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 1566 BONNIEVIEW DR EVANSVILLE, IN 47715	

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