STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G167	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	749 SOUTH BEARS BEND ROAD FRENCH LICK, IN 47432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 fundamental recertification and state licensure survey. Survey Dates: May 22, 23, 24, 25 and June 4, 2012 Facility Number: 000701 Provider Number: 15G167 AIM Number: 100248800 Surveyor: Jo Anna Scott, Medical Surveyor III These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed on June 8, 2012 by Dotty Walton, 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G167	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 06/04/2012
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP CODE 749 SOUTH BEARS BEND ROAD FRENCH LICK, IN 47432	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation and interview for 1 of 4 sampled clients (client #1) and 1 additional client (client #7), the facility failed to ensure their hearing aids were stored where they were available to clients at all times. Findings include: During the morning observation on 5/23/12, client #7, went to the medication/office room at 6:30 AM to receive his medication. Client #7 asked staff #5 if it was okay for him to get his hearing aid. Staff #5 prompted client #7 to get them out of the box that was on top of the desk. Client #1 followed client #7 in getting his medications. When he came into the room, staff #5 prompted client #1 to get his hearing aids from the box on the desk. Client #1 got his hearing aids and put them in his ears with staff assistance. Interview with staff #5 on 5/23/12 at 8:00 AM indicated clients #1 and #7 would take out their hearing aids when they got their evening medications and would put them in the box that was kept on the desk	W0137	**W 137:** The facility will ensure the rights of clients, therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing by specifically: **Corrective Action:** The Program Director will retrain the staff on the clients' right to retain and use appropriate personal possessions and clothing to ensure the clients' hearing aids are stored where they are available to clients at all times and the designated storage location on the table outside the office door in the living area. **How others will be identified:** The QMRP will monitor to ensure that clients continue to retain and use appropriate personal possessions and clothing. **Measures to be put in place:** The Program Director will retrain the staff on the clients' right to retain and use appropriate personal possessions and clothing to ensure the clients' hearing aids are stored where they are available to clients at all times and the designated storage location on the table outside the office door in the living area, **Monitoring of Corrective Action:** Management staff, including the QMRP, will observe	07/04/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G167	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	749 SOUTH BEARS BEND ROAD FRENCH LICK, IN 47432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	in the medication room. Staff #5 indicated the room was locked when they were not passing medications. Interview with staff #2, Home Manager (HM), on 5/24/12 at 3:00 PM indicated the clients had put their hearing aids in the medication room to ensure they were kept safe. Staff #2, HM, indicated the room would be unlocked by staff if the client requested his hearing aids. 9-3-2(a)		active treatment for compliance of all related issues. **Completion Date: 7/4/2012**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G167	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	749 SOUTH BEARS BEND ROAD FRENCH LICK, IN 47432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
W0153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 8 incident reports reported to the Bureau of Developmental Disabilities Services (BDDS) reviewed, the facility failed to ensure the incident included the information client #2 had left the home without staff knowledge. Findings include: The facility BDDS incident reports were reviewed on 5/22/12 at 1:49 PM. The BDDS incident report for an incident dated 4/9/12 at 5:50 AM indicated "[Client #2] began having behaviors and attempting to hit staff. Staff redirected him to his bedroom. A few minutes later, staff heard yelling in the bathroom and found [client #2] had left his bedroom and was in the bathroom and had hit [client #3 and client #5] in their shoulders. [Client #2] was again redirected to his bedroom to calm down. Staff assessed the consumers, no injuries noted. Staff counseled the consumers on appropriate interaction between one another."	W0153	**W 153:** The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures by specifically: **Corrective Action:** The Director of Supervised Group Living will inserviceQA on reporting all incidents to the Bureau of Developmental Disabilities Services per reporting guidelines. **How others will be identified:** The Director of Supervised Group Living will monitor reporting of all incidents to ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. **Measures to be put in place:** The Director of Supervised Group Living will inservice QA on reporting all incidents to the Bureau of Development Disabilities Services per reporting guidelines. **Monitoring of**	07/04/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	15G167		06/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	749 SOUTH BEARS BEND ROAD FRENCH LICK, IN 47432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	The facility internal report dated 4/9/12 at 5:50 AM written by staff #5 indicated "I had arrived early...something caught my attention out of the corner of my eye. When I turned to look it was [client #2] heading toward the church next door. It was still dark and chilly. I immediately got out of my car and walked towards the church to get his attention to see why he was there. [Client #2] was at the doors pulling on them like he was trying to get in. I asked what he was doing - he said it was none of my business, he was getting away from that 'crazy place' and to leave him alone." The internal incident report indicated [client #2] did return to the home where he proceeded to yell and threaten to hit others. The report indicated client #2 did hit two clients and staff did witness [client #2] running out of the house to the building next door. There was no indication the administrator had been notified of client #2 getting out of the home before daylight and trying to get in the church next door without staff knowledge. Interview with staff #5 on 5/23/12 at 1:30 PM indicated when she came into the house on 4/9/12, client #2 followed her after a while, but was still upset. Staff #5 indicated the staff that was in the home did not realize client #2 had gone out the back door.		**Corrective Action:** The Director of Supervised Group Living will monitor reporting of all incidents. **Completion Date: 7/4/2012**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G167	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/04/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	749 SOUTH BEARS BEND ROAD FRENCH LICK, IN 47432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	Interview with staff #7, Quality Review (QR), on 5/24/12 at 11:00 AM indicated she had done the BDDS report and did not realize the client had gone out the door without staff knowledge. Staff #7 indicated the client going out of the home at 5:50 AM on 4/9/12 without staff knowledge should have been reported for BDDS. 9-3-1(b)(5) 9-3-2(a)			