STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
W000000	This visit was for a fundamental recertification and state licensure survey. Dates of Survey: 10/22, 10/23, 10/24, 10/25 and 11/8/13. Facility Number: 000735 Provider Number: 15G207 AIMS Number: 100243180 Surveyor: Paula Chika, QIDP-TC These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review completed November 18, 2013 by Dotty Walton, QIDP.	W000000		

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:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G207	A. BUILDING 00 B. WING	11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, interview and record review for 2 of 4 sampled clients (#1 and #4) and for 2 additional clients (#6 and #7), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the group home's living room furniture was in good repair and of height to accommodate clients with physical limitations. Findings include: During the 10/22/13 observation periods between 4:10 PM and 6:45 PM and the 10/23/13 observation period between 4:45 AM and 7:10 AM, at the group home, there were 2 love seats, one couch and a chair (which matched the couch) in the living room. The love seat, near the patio door, cushions went into a V shape at the center of the love seat as if the couch/love seat's frame was broken. During the above mentioned observation periods, client #5, who was ambulatory sat on the couch and/or love seat in the living room. Clients #1, #4, #6 and #7 who used walkers, wheelchairs and/or gait belts with staff assistance, sat in chairs at the dining room table for activities, training	W000104	W104 - The governing body must exercise general policy, budget and operating direction over the facility. - The facility will ensure that the group home's living room furniture is in good repair and height to accommodate client's with physical limitations. -The facility will ensure that new living room furniture will be purchased and that furniture fits the needs of the clients - Staff will be retrained on notifying Residential Manager if any furniture is not in proper order and if it does not fit the needs of the clients. - Staff will be retrained on submitting a work order to the maintenance department if any piece of furniture in the home is in need of repair or replacement. - Residential Manager will be trained on Residential Manager Audit form which includes environmental checks on a weekly basis -Program Manager will be retrained on reporting any environmental issues during home audits on a monthly basis -Property Manager will be retrained on reporting to the Executive Director any environmental issues during home audits Persons Responsible: Staff, Residential Manager, Program Manager, Property Manager, & Executive	12/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	and for dinner. Client #4 sat in the living room chair during the 10/22/13 observation period for a brief period. Clients #1, #6 and #7 did not sit on the living room couch and/or love seats. During the 10/23/13 observation period, client #4 sat down on the living room love seat. Client #4 had a cane with her. When client #4 attempted to stand from the love seat which sat low to the floor, client #4 leaned over to try and stand up from the love seat. Client #4 was slow to stand and stated "Oh my legs." Interview with client #4 on 10/23/13 at 6:56 AM indicated she had trouble getting up from the couch/love seats. Client #4 stated she had "Arthritis in my legs." Client #4 stated the couch was "too low to the floor." Confidential interview A indicated the love seat's wood (love seat with V shape) was broken. When asked why clients sat at the dining room table versus the living room, confidential interview A stated the couches were "low. Clients cannot get up off couch." Staff #1 indicated some clients had to sit in a chair with arms. Staff #1 stated the group home had been "promised new furniture, but the facility has not gone through with it." Client #4's record was reviewed on		Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	10/23/13 at 2:37 PM. Client #4's 8/6/13 Individual Support Plan (ISP) indicated client #4's diagnoses included, but were not limited to, Osteoporosis and Osteoarthritis of the knee. Client #4's 8/6/13 ISP indicated client #4 was at risk for falls. Client #4's 10/15/13 Nursing Notes indicated the client received injections in her knees due to her arthritis. Client #1's record was reviewed on 10/24/13 at 10:40 AM. Client #1's 3/12/13 ISP indicted client #1 used a roller walker and gait belt when ambulating. Client #1's ISP also indicated client #1 was a fall risk. Client #7's record was reviewed on 10/24/13 at 2:05 PM. Client #7's 8/6/13 ISP indicated client #7's diagnoses included, but were not limited to, "Spasticity and hyper-reflexia (over active reflexes)" of both legs. Client #7's ISP indicated client #7 utilized a wheelchair, leg braces and a gait belt for transfers. Client #6's record was reviewed on 10/24/13 at 2:08 PM. Client #6's 8/1/13 ISP indicated client #6's diagnoses included, but were not limited to, Legally Blind, Scoliosis-severe, Mild Kyphosis (curvature of the back), and Neuropathy			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	(nerve damage). Client #6's ISP indicated client #6 required the use of a walker, gait belt and wheelchair as needed. Interview with the Director of Maintenance on 10/23/13 at 10:42 AM indicated client #1, #4, #6 and #7's group home was on his list to receive new living room furniture. The Maintenance Director stated the furniture was "not ordered. On bottom of list. The furniture is to be replaced as it comes up." The Maintenance Director indicated he was not aware clients did not sit on the couch/love seats because they were low to the floor. Interview with administrative staff #1 on 10/23/13 at 2:10 PM indicated he did not know the love seat was broken. Administrative staff #1 indicated he was not aware clients did not use the furniture because the couch and love seat were low to the floor. 9-3-1(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
W000149	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 observation, interview and record review for 1 of 4 sampled clients (#1), the facility failed to implement its policy and procedures to prevent neglect of a client in regard to falls which resulted in injuries. Findings include: During the 10/22/13 observation period between 4:10 PM and 6:45 PM and the 10/23/13 observation period between 4:45 AM and 7:10 AM, at the group home, client #1 had a Walker Cast Boot on her left foot. Client #1 utilized a roller walker when ambulating and had a gait belt on as well. Facility staff walked/ambulated with the client holding onto the gait belt as client #1 walked with the walker. The facility's reportable incident reports, internal incident reports, and/or investigations were reviewed on 10/22/13 at 12:14 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following (not all inclusive): -5/20/13 "[Client #1] fell this morning	W000149	W149 - The facility must ensure to follow all policies and procedures to prevent neglect of a client in regards to falls -QIDP will be retrained on conducting thorough investigations in regards to environment in which the incident occurred and staff actions at the time of the incident. -QIPD will review all investigations with Executive Director to determine appropriate recommendations. -Residential Manager will be retrained on ensuring that all adaptive equipment is included on the clients' ISP and that the ISP specifies when adaptive equipment is to be used. - Residential Manager will be retrained on conducting an IDT meeting after each fall to review the high risk plan for appropriateness and training all staff on any updates made to the clients plans. Residential Manager will monitor through daily visits to the home. -Program Manager will be retrained on ensuring that all adaptive equipment is included on the clients' ISP and that the ISP specifies when adaptive equipment is to be used. - Program Manager will be retrained on conducting an IDT meeting after each fall to review	12/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	going into [name of workshop] result in a very faint abrasion of top layer of skin on right shoulder (sic)." The reportable incident report indicated client #1 "...has a full ROM (range of motion) of extremity. There are no other apparent injuries noted. [Client #1] has a fall prevention plan that remain (sic) appropriate. Staff will continue to monitor as precautionary measure." The facility's 5/20/13 internal Incident Report indicated client #1 fell down on her left side on a curb." -7/11/13 Client #1 fell and bumped the right side of her head. No injuries indicated. -8/17/13 Client #1 fell when she opened up the food pantry cabinet causing the client to fall on her side. No injury indicated. -9/3/13 "[Client #1] fell using the restroom. [Client #1] was sent to [name of medical facility] to be evaluated. A (sic) x-ray shows a small fracture on fourth and fifth toes of her left foot. She was released and is to wear a boot. She was also referred to [name of Orthopedic group]. [Client #1] has a fall prevention plan in place it was being followed and remains appropriate. Per policy an		the high risk plan for appropriateness and training all staff on any updates made to the clients plans. Program Manager will monitor trough weekly visits to the home. -Nurse will be retrained on High Risk Plans in regards to specifying what assistance is needed to client's who require a walker, wheelchair and/or gait belt. Persons Responsible: Staff, Residential Manger, Program Manger, QIDP, Nurse, Nursing Manager & Executive Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	investigation has been initiated." The facility's 9/6/13 Internal Incident Investigation Review indicated "...CONCLUSION AND FINDINGS: After review of all statements and documentation of the investigation it is concluded that [client #1] fractured her 4th and 5th toes on her left foot during a fall on 9/3/13 in the bathroom stall while using the bathroom at Res-Care office." The 9/6/13 investigation indicated at the time of the fall, client #1 did not appear to have any injuries from the fall. The investigation indicated later on 9/3/13, staff noticed "discoloration" to client #1's left foot. Staff #3's witness statement indicated while client #1 was at the Res-Care office to get weighed, "...[Client #1] had to use the bathroom. [Staff #3] stated that she went into the bathroom with her and [client #1] fell inside the stall. [Staff #3] stated that she checked [client #1] and there were no visible injuries and she did not complain of pain...." The facility's investigation indicated facility staff were interviewed in regard to the incident. The facility's investigation failed to indicate how client #1 fell in the bathroom if a staff person was with the client. The investigation did not indicate if client #1 had any assistive adaptive equipment at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	the time of the fall and/or if the floor was wet in the bathroom stall. The 9/6/13 investigation did not include anything about the environmental factors. The 9/6/13 investigation also did not indicate any recommendations in regard to client #1's pattern of falls. Client #1's record was reviewed on 10/24/13 at 10:40 AM. Client #1's 9/3/13 Medical Consult Report indicated client #1 fractured her left 4th and 5th toes. The consult report indicated a "walking boot" was ordered and the client was to follow up with an Orthopedist on 9/4/13. Client #1's Nursing Notes indicated the following (not all inclusive): -9/3/13 "Staff called to report [client #1] had fallen in Bathroom Staff @ (at) office. Checked for injuries none seen per staff. Staff called to report bluish brown discoloration present on (L) (left) foot and last 2 toes left foot. Sent to [name of medical facility] for eval (evaluation)." -9/4/13 "X-ray revealed FX (fracture) of 5th Metatarsal and of the 4th phalange. Boot applied to F/U (with) [name of Orthopedist] tomorrow." -9/4/13 "Seen by [name of Orthopedist]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	confirmed fracture x (times) 2 4th and 5th toe (sic) (L) foot - Cont (continue) Boot, orders for gait belt, W/C (wheelchair) PRN (as needed) (with) Leg extension - Commode extender (with) handles. OK to go to Day Program. Try to keep foot (up) some thru (through) out day...Boot on during activity off for Bed/Shower." Client #1's 7/17/13 physician's order indicated "May use walker as needed." Client #1's 7/3/13 High Risk Plan (plan in place prior to fall with fracture) indicated "...3. Staff will provide a safe environment and prevent falls i.e. floor free from clutter,...5. Staff will assist individual with application of AFO (leg splint) to left foot daily (on am and remove pm)...11. Staff will encourage use of walker to provide stability during ambulation." Client #1's Physical Therapy (PT) assessments indicated the following (not all inclusive): -8/29/13 "Pt (patient) states she 'fell yesterday in the big bathroom because the floor was wet.' States that she 'did not have shoes on.' She was 'getting ready for work.' States that (R) (right) knee hurts. States that it hurts with movement." The PT assessment indicated client #1 "...Requires verbal instructions for safe			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	transfer technique...." The assessment indicated client #1 would continue PT once a week for gait and transfer training. The 8/29/13 assessment further indicated "...*Staff to assist in pt. in donning (L) AFO (with) proper strap placement & (and) shoes to be laced properly to assist in decreasing falls...." Client #1's 9/6/13 Physical Therapy Treatment Form indicated "Pt fell in bathroom due to water per pt. Fx 4th and 5th toe (L) foot. Wearing boot (L) foot...." The PT form indicated client #1 was ambulating with a walker and with a gait belt. The PT form indicated "...Cont (continue) with P.O.C (Plan of Care). PT recommend gait belt to be used for gait/transfers." Client #1's 9/13/13 PT form indicated "Continue to ambulate (with) rw (roller walker) (with) assist of 1 for safety...D/C (discontinue) pt. from PT. Reached max (maximum) potential (with) (L) LE (lower extremity) Boot....." Client #1's 9/4/13 High Risk plan Addendum for "Left Foot deformity/Potential for falls indicated "...3. Staff will provide a safe environment and prevent falls i.e. floor free from clutter,...13. Staff will assist individual with application of AFO (leg			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	splint) to left foot daily (on am and remove pm)...18. Staff will monitor during shower. 19. Staff will assist with the use of walker and gait belt to provide stability during ambulation. 20. Staff will assist with use of w/c PRN, and shower bench to promote safety." Client #1's Interdisciplinary Team (IDT) meeting notes indicated the following (not all inclusive): -7/18/13 "Team met to discuss [name of doctor's] recommendation that [client #1] use a walker as needed. All agree this should be implemented." -9/4/13 "Team met to discuss [client #1] using a gait belt, PRN wheelchair. Also [client #1] will return to [name of day program]." -10/7/13 :Team met to discuss [client #1's] High Risk Plan (HRP) for falls. [Client #1's] HRP remains appropriate @ this time. Team agrees." Client #1's 3/12/13 Individual Support Plan (ISP) indicated client #1 did not have any adaptive equipment/devices. Client #1's ISP, High Risk plan, and/or above mentioned IDT notes indicated the facility failed to meet after each fall prior to client #1's fall/fracture on 9/3/13 to determine if client #1's fall risk plan was appropriate,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	and/or to determine the nature of the fall. Client #1's 3/12/13 ISP and/or 9/4/13 risk plan also failed to specifically indicate when the PRN wheelchair was to be utilized with the client to prevent falls, and/or specifically indicate how facility staff were to assist with the use of the walker/gait belt when ambulating with client #1. Interview with the Director of Quality Assurance (DQA) on 10/27/13 at 9:21 AM indicated client #1 fell in the bathroom at the Res-Care office. The DQA indicated there were 2 staff with the client at the time of the incident. The DQA indicated one staff was in the bathroom with client #1 and the second staff was with the other clients as they had been brought to the office to get weighed. When asked how client #1 fell in the bathroom with staff present, the DQA stated "Went to use bathroom, went in stall and fell." The DQA indicated the 9/6/13 investigation did not specifically indicate where/what staff was doing and/or indicate if the environment had been checked. When asked if client #1 was using any adaptive equipment at the time of the fall, the DQA indicated he did not know. When asked if the 9/6/13 investigation had any recommendations, the DQA indicated he recommended the client's fall prevention plan be reviewed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	and a PT evaluation be conducted. The DQA indicated the client's IDT met on 9/4/13. Interview with LPN #1 and the Program Manager (PM) on 10/24/13 at 2:11 PM indicated client #1 had a history of falls. LPN #1 indicated PT was started prior to client #1's 9/3/13 fall which resulted in a fracture. LPN #1 indicated PT had since stopped due to client #1's fractured left foot. LPN #1 indicated client #1's fall risk plan was last updated on 9/4/13 after the fracture. LPN #1 indicated facility staff was to hold onto client #1's gait belt when the client ambulated. LPN #1 indicated facility staff were trained to be with the client when she ambulated. LPN #1 indicated client #1's wheel chair should be used for long distances. LPN #1 and the PM indicated client #1's ISP did not specifically indicate how facility staff were to assist the client to ambulate with a gait belt and/or walker as the ISP did not specifically indicate client #1 was to have one on one staffing (one staff to one client) when ambulating. LPN #1 and the PM indicated client #1's ISP did not specifically indicate when the client was to use her wheelchair. The PM and LPN #1 indicated client #1's IDT did not meet after each fall incident. The PM indicated on 7/11/13 client #1 did not have a walker. The PM indicated client			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	#1 should have had her walker when she fell on 8/17/13. The PM and/or LPN #1 did not know if the client had the walker as no IDT reviewed the fall. The PM and/or LPN #1 did not know if client #1 used any adaptive device/equipment when she fell on 9/3/13. The PM indicated client #1's 3/12/13 ISP needed to be updated as the ISP did not include any adaptive equipment (roller walker, gait belt, extended toilet seat and wheelchair with extenders). The facility's policy and procedures were reviewed on 10/22/13 at 12:00 PM. The facility's 3/1/09 policy and procedure entitled Procedures: Abuse/Neglect/Exploitation, Death, Incident Reporting & Investigation indicated "...Any act of abuse/neglect/exploitation is strictly prohibited and will not be tolerated...." The facility's policy indicated the "...QAC (Quality Assurance Coordinator) is to complete a thorough investigation within 5 business days and per regulations, local, state, federal and ResCare guidelines. Obtain full statements from the complainant, witnesses, or persons who may provide collateral information. Obtain photographs of evidence and/or physical environment, where applicable, obtain diagrams or other supporting documents, review consumer records,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	where applicable...." 9-3-2(a)			

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
	15G207		11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
W000154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on interview and record review for 1 of 2 allegations of abuse/neglect and/or injuries of unknown source reviewed, the facility failed to ensure an allegation of possible neglect regarding a fall was thoroughly investigated for client #1. Findings include: The facility's reportable incident reports, internal incident reports, and/or investigations were reviewed on 10/22/13 at 12:14 PM. The facility's 9/3/13 reportable incident report indicated, "[Client #1] fell using the restroom. [Client #1] was sent to [name of medical facility] to be evaluated. A (sic) x-ray shows a small fracture on fourth and fifth toes of her left foot. She was released and is to wear a boot. She was also referred to [name of Orthopedic group]. [Client #1] has a fall prevention plan in place it was being followed and remains appropriate. Per policy an investigation has been initiated." The facility's 9/6/13 Internal Incident Investigation Review indicated "...CONCLUSION AND FINDINGS: After review of all statements and	W000154	W154 - The facility must ensure that evidence that all alleged violations are thoroughly investigated - QIDP will be retrained on conducting a thorough investigation in regards to environmental issues and use of adaptive equipment when incidents occur - Persons Responsible: QIDP and Executive Director ADDENDUM:W154- The facility has a policy for conducting investigations which remains appropriate -The Executive Director will be notified of all reportable incidents within 24 hours after the incident occurs -QIDP will be retrained on the abuse and neglect policy -Residential Manager will be retrained on the abuse and neglect policy -Program Manager will be retrained on the abuse and neglect policy -The Executive Director will approve all investigations and approve all recommendations	12/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	documentation of the investigation it is concluded that [client #1] fractured her 4th and 5th toes on her left foot during a fall on 9/3/13 in the bathroom stall while using the bathroom at Res-Care office." The 9/6/13 investigation indicated at the time of the fall, client #1 did not appear to have any injuries from the fall. The investigation indicated later on 9/3/13, staff noticed "discoloration" to client #1's left foot. Staff #3's witness statement indicated while client #1 was at the Res-Care office to get weighed, "...[Client #1] had to use the bathroom. [Staff #3] stated that she went into the bathroom with her and [client #1] fell inside the stall. [Staff #3] stated that she checked [client #1] and there were no visible injuries and she did not complain of pain...." The facility's investigation indicated facility staff were interviewed in regard to the incident. The facility's investigation failed to indicate how client #1 fell in the bathroom if a staff person was with the client. The investigation did not indicate if client #1 had any assistive adaptive equipment at the time of the fall and/or if the floor was wet in the bathroom stall. The 9/6/13 investigation did not include anything about the environmental factors. Interview with the Director of Quality			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	Assurance (DQA) on 10/27/13 at 9:21 AM indicated client #1 fell in the bathroom at the Res-Care office. The DQA indicated there were 2 staff with the client at the time of the incident. The DQA indicated one staff was in the bathroom with client #1 and the second staff was with the other clients as they had been brought to the office to get weighed. When asked how client #1 fell in the bathroom with staff present, the DQA stated "Went to use bathroom, went in stall and fell." The DQA indicated the 9/6/13 investigation did not specifically indicate where/what staff was doing and/or indicate if the environment had been checked. When asked if client #1 was using any adaptive equipment at the time of the fall, the DQA indicated he did not know. When asked if the 9/6/13 investigation had any recommendations, the DQA indicated he recommended the client's fall prevention be reviewed and a PT evaluation be conducted. The DQA indicated the client's IDT (interdisciplinary team) met on 9/4/13. 9-3-2(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
W000186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, interview and record review for 4 of 4 sampled clients (#1, #2, #3 and #4) and for 4 additional clients (#5, #6, #7 and #8), the facility failed to ensure sufficient staff were provided to supervise/monitor clients who required assistance to ambulate and to meet the active treatment needs of clients. Findings include: During the 10/22/13 observation period between 4:10 PM and 6:45 PM and the 10/23/13 observation period between 4:45 AM and 7:10 AM, at the group home, client #1 had a Walker Cast Boot on her left foot. Client #1 utilized a roller walker when ambulating and had a gait belt on as well. Facility staff walked/ambulated with the client holding onto the gait belt as client #1 walked with the walker. Specifically during the 10/22/13 observation period, at 5:07 PM, client #1 came out of her bedroom without her walker and/or staff being with	W000186	W186 - The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans - The facility will develop a schedule which will include increased staffing to meet the clients' needs in the home - The Residential Manager will be retrained on monitoring schedules daily to ensure sufficient staffs are present to meet clients' needs. - The Program Manager will be retrained on monitoring schedules weekly to ensure sufficient staffs are present to meet clients' needs. - All staff will be trained on the new schedule once it is developed Persons Responsible: Staff, Residential Manager, Program Manager, Executive Director	12/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	her. Staff #2 stated to client #1 "You should have called staff." Staff #2 physically assisted client #1 to walk back to her room as one staff was in the medication room and one staff was in the kitchen with the dinner meal. Client #7 wore a gait belt and required staff assistant to transfer to a seat and/or to stand. Client #7 also required staff to push her wheelchair. Client #6 also required staff physical assistance to ambulate with a walker as client #6 was legally blind and wore a gait belt. Client #8, who was a new admittant to the group home, utilized a cane while ambulating. During the 10/22/13 observation period between 4:10 PM and 6:45 PM, at the group home, client #3 sat without an activity at the dining room table, and/or stood near/in the kitchen area while the dinner meal was being prepared. The PM (Program Manager) , the Qualified Intellectual Disabilities Professional (QIDP), staff #2, staff #4 and #5 did not provide client #3 an alternate activity and/or training to participate in except to prompt the client to sit down when eating her snack. During the 10/22/13 observation period between 4:10 PM and 6:45 PM and the 10/23/13 observation period between 4:45 AM to 7:10 AM, at the group home,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	client #2 walked around the group home without an activity, sat without an activity, sat with her fingers in her mouth and/or followed the surveyor around the group home without being redirected to an alternate activity and/or training except to watch TV during the 10/23/13 observation period. Client #4 sat and watched TV and was not involved in a meaningful activity or meal preparation. During the 10/22/13 observation period between 4:10 PM and 6:45 PM, at the group home, client #5 demonstrated hyperactivity as the client kept getting into the refrigerator. Client #5 retrieved a slice of cheese and ate the whole slice in one bite. Client #5 returned to the refrigerator to get a second slice of cheese. Staff #2 prompted client #5 to sit down if she wanted to eat a snack. Client #5 was given graham crackers to eat. Client #5 ate the graham crackers and went to the refrigerator to get milk. Client #5 carried the milk to the table and poured herself a glass of milk with hand over hand assistance. Once client #5 finished her milk, client #5 quickly returned to the refrigerator. The QIDP prompted client #5 to leave the kitchen but no alternate activity/training was offered the client.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	During the above mentioned 10/22/13 observation period, 3 staff (staff #2, #4 and #5), the Qualified Intellectual Disabilities Professional (QIDP), the Program Manager and LPN #1 were at the group home. During the 10/23/13 observation period, 3 facility staff (staff #1, #3 and #6), the PM, the QIDP and LPN #1 were at the group home with clients #1, #2, #3, #4, #5, #6, #7 and #8. Confidential interview A stated "Normally two staff work in the evening and two staff in the mornings." When asked if 2 staff were able to meet the needs of the clients confidential interview A stated "No." Confidential interview A indicated client #1 required one on one staffing assistance to ambulate as the client had fractured her foot from a fall. Confidential interview A indicated clients #6 and #7 required one on one staff assistance to use walkers and/or wheelchairs. Client #1's record was reviewed on 10/24/13 at 10:40 AM. Client #1's 9/3/13 Medical Consult Report indicated client #1 fractured her left 4th and 5th toes. The consult report indicated a "walking boot" was ordered and the client was to follow up with an Orthopedist on 9/4/13. Client #1's 9/13/13 PT (physical therapy)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	form indicated "Continue to ambulate (with) rw (roller walker) (with) assist of 1 for safety...." Client #1's 9/4/13 High Risk plan Addendum for "Left Foot deformity/Potential for falls indicated "...3. Staff will provide a safe environment and prevent falls i.e. floor free from clutter,...13. Staff will assist individual with application of AFO (leg splint) to left foot daily (on am and remove pm)...18. Staff will monitor during shower. 19. Staff will assist with the use of walker and gait belt to provide stability during ambulation. 20. Staff will assist with use of w/c PRN, and shower bench to promote safety." Client #3's record was reviewed on 10/23/13 at 12:35 PM. Client #3's 8/6/13 ISP (Individual Support Plan) indicated client #3 had the following objectives (not all inclusive): -To identify a quarter. -To identify street signs. -To choose and participate in group leisure activity. -To complete a daily chore. -To correctly respond to questions independently. -To clean her eyeglasses.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	Client #2's record was reviewed on 10/23/13 at 2:20 PM. Client #2's 8/6/13 ISP indicated client #2 had the following objectives (not all inclusive): -To use her voice when talking. -To identify a quarter by pointing. -To identify a picture from communication book by pointing to the item staff asks for. -To participate in an activity of choice for 5 minutes. -To wipe her mouth thoroughly with a napkin. Client #2's 8/1/13 BSP indicated client #2 had a targeted behavior of putting her fingers in and out of her mouth. Client #2's BSP indicated when client #2 placed her fingers in her mouth, "Staff will prompt [client #2] to stop sticking her fingers in her mouth. Staff will explain to [client #2] that it is unsanitary to put fingers in her mouth...Staff will redirect [client #2] to an activity. Staff will praise [client #2] for stopping." Client #4's record was reviewed on 10/23/13 at 2:37 PM. Client #4's 8/6/13 ISP indicated client #4 was at risk for falls. Client #4's ISP indicated client #4 had objectives to answer how and why questions, add various coins to a dollar, participate in a group activity for 10			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	minutes, and an objective to clean her eyeglasses. Client #5's record was reviewed on 10/24/13 at 2:00 PM. Client #5's 8/1/13 BSP indicated client #5 demonstrated "Hyperactivity (being excessively active)." Client #5's BSP indicated facility staff were to prompt/encourage client #5 to participate in an activity with the group. The BSP indicated if client #5 did not want to participate in activity with the group, staff were to offer the client an alternate activity. Client #7's record was reviewed on 10/24/13 at 2:05 PM. Client #7's 8/6/13 ISP indicated client #7's diagnoses included, but were not limited to, "Spasticity and hyper-reflexia (over active reflexes)" of both legs. Client #7's ISP indicated client #7 utilized a wheelchair, leg braces and a gait belt for transfers. Client #6's record was reviewed on 10/24/13 at 2:08 PM. Client #6's 8/1/13 ISP indicated client #6's diagnoses included, but were not limited to, Legally Blind, Scoliosis-severe, Mild Kyphosis (curvature of the back), and Neuropathy (nerve damage). Client #6's ISP indicated client #6 required the use of a walker, gait belt and wheelchair as needed.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	The facility's time cards were reviewed on 10/27/13 at 4:34 PM. The facility's Time Cards for 10/14/13 to 10/18/13 indicated 2 staff worked the morning shifts of 10/14/13, 10/15/13, 10/17/13 and 10/18/13 and the evening shifts of 10/16/13, 10/17/13 and 10/18/13. Interview with the PM on 10/24/13 at 2:11 PM indicated 2 facility staff worked in the group home during the morning shift when the clients got up in the morning and 2 staff worked in the PM. When asked if 2 staff could monitor/supervise clients #1, #6, #7 and #8 who utilized adaptive equipment when ambulating and implement active treatment programs, the PM stated "It would be hard for 2 staff to do everything." The PM indicated clients #1, #6 and #7 required staff assistance to ambulate/walk. Interview with administrative staff #1 on 10/27/13 at 8:58 AM stated 2 staff worked the day, evening, and the morning shifts at the group home as the home was a "6.0 Intensive Training home." Administrative staff #1 indicated he should have looked at the staffing of the group home after there had been "a second gait belt." 9-3-3(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
W000210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, interview and record review for 1 of 4 sampled clients (#3), the client's interdisciplinary team (IDT) failed to re-assess the client's diabetes to ensure the client's diet did not affect/increase the client's blood sugar level and/or obtain an assessment by a specialist in regard to the client's diabetes. Findings include: During the 10/22/13 observation period between 4:10 PM and 6:45 PM, at the group home, client #3 was given graham crackers for a snack. For the dinner meal, client #3 was served 2 slices of pizza, 1 cup of salad, salad dressing and a chocolate pudding cup. Client #3 required several prompts to eat as the client would sit and look around. During the 10/23/13 observation period between 4:45 AM and 7:10 AM, at the group home, client #3 received Metformin (diabetes) 1 tablet before breakfast at 5:00 AM. Client #3 returned to the medication room at 5:38 AM for a blood sugar level reading/check. Client	W000210	W210 - Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission - IDT will be held in regards to obtaining a referral/assessment by a specialist in regards to client #3's diabetic management. - IDT will be held in regards to client #3's high blood sugar reading and/or diets. IDT will review nutritional assessment and ISP. - The nurse will notify the dietician for re-evaluation of client # 3's nutritional assessment. - The nurse will consult with dietician regarding menus and food logs. - All staff will be retrained on any changes made to any clients ISP, BSP, High Risk plans and/or diets. - All staff will be retrained on all clients' diets. - The nurse will be retrained on notifying client #3's PCP of any abnormal blood sugar reading. - The nurse will monitor through weekly home audits to ensure that the PCP is notified of blood sugar reading weekly or as needed. -Residential Manager will observe in the home daily to ensure that Client #3's blood	12/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	#3's blood sugar level was 131. The Program Manager administered 12 units of Humalog and 50 units of Lantus insulin injections for the client's diabetes. Client #3 went to the dining room to eat her breakfast which consisted of orange juice, raisin toast, cereal, milk and margarine. The facility's reportable incidents and/or investigations were reviewed on 10/22/13 at 12:14 PM. The facility's 7/16/13 reportable incident report indicated client #3's blood sugar level "was high (actual level not mentioned)." The reportable incident report indicated client #3's doctor was contacted and he sent the client to the hospital. Client #3 was admitted to the hospital for further tests. The facility's 7/22/13 follow-up report indicated client #3 was discharged on 7/22/13 with medication changes to the client's insulin and the Metformin was discontinued. The facility's menus were reviewed on 10/24/13 at 2:00 PM. The facility's week 4 Regular Living Lite No Added Salt menu indicated this was the menu/diet client #3 followed at the group home. The Week 4 Tuesday dinner menu indicated the following:		sugar reading and nutritional logs are being completed per her protocol. -Residential Manager will observe in the home daily to ensure that all clients ISP's, BSP's, High Risk Plans & diets are being implemented appropriately. - The Residential Manager will be retrained on IDT policy in regards to discussing issues involving health and safety of the client -Program Manager will observe in the home weekly to ensure that Client #3's blood sugar reading and nutritional logs are being completed per her protocol. - Program Manager will observe in the home weekly to ensure that all clients ISP's, BSP's, High Risk Plans & diets are being implemented appropriately. - Program Manager will be retrained on IDT policy in regards to discussing issues involving health and safety of the client Persons Responsible: Residential Manager, Program Manager, Nurse, Nursing Manager, and Executive Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	"PIZZA 1 SERV (serving) LETTUCE SALAD 1 C (cup) LF (LOW FAT) SALAD DRESSING 2 Tbs (tablespoons) LF PUDDING 1/2 C SKIM MILK 1 C" The Week 4 Wednesday breakfast menu indicated the following: "ORANGE JUICE 1/2 C HOT CEREAL 3/4 C OR COLD CEREAL 3/4 C RAISIN TOAST 1 sl (slice) SKIM MILK 1 C COFFEE 1 C MARGARINE 1 Tsp (teaspoon)" The week 4 menu indicated client #3 was to receive tuna salad, wheat bread, creamy coleslaw, banana, beverage and a multigrain snack bar for lunch/snack on Wednesday. The week 4 Wednesday dinner meal indicated client #3 would receive baked ham, cream style corn, green beans, tossed salad, LF dressing, cornbread, margarine, pudding parfait and skim milk. Review of the week 4 menu indicated the client received bread, dinner roll and/or a bun at each meal. The week 4 menu indicated client #3 received fresh fruit/fruit cup, pudding, low fat ice cream, pear halves, pineapple, and/or angel food cake with fruit topping for dessert at the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	lunch and/or dinner meals. The dinner menus also included items like mixed vegetables, tater tots, potato salad, baked sweet potato, pasta salad, scalloped potatoes and breaded fish. Client #3's record was reviewed on 10/23/13 at 12:36 PM. Client #3's 7/16/13 History and Physical (H&P) indicated client #3 was brought to the emergency room as client #3 "...has been having high blood sugar basically today...." The H&P indicated client #3 had a blood sugar (BS) level reading of "...400 before lunch and was given 10 extra units of insulin. 1 hour after lunch the BS was 410. Because of the persistently high BS, her PCP's (Primary Care Physician's) office asked her to be sent to the ER (emergency room)...." Client #3's blood sugar level was 413 in the ER. The H&P indicated "...According to the caregivers it is not unusual for her BS to run high...." Client #3's 7/23/13 Discharge Summary indicated client #3 was admitted to the hospital on 7/16/13 with the following admission diagnoses: "1. Hyperglycemia (high blood sugar) 2. Hypercalcemia (high calcium levels) 3. Hyperkalemia (high potassium) 4. Hypertension (high blood pressure)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	5. Past DVT (Deep Vein Thrombosis) (blood clot) on Coumadin anticoagulation." The discharge summary indicated client #3 presented with a blood sugar of 409 (high) which "...blood sugar persisted as elevated." The discharge summary indicated "...The patient was felt to be in acute renal failure with hyperglycemia, hyperkalemia and hypocalcemia (sic) as well as elevated INR (test to monitor clotting of blood) and some leg edema...." Client #3's discharge diagnoses included the following (not all inclusive): "Acute kidney failure, unspecified Type II or unspecified type diabetes mellitus with unspecified complication, uncontrolled...." Client #3's Blood Glucose Monitoring Forms indicated the following BS levels/ranges (not all inclusive): -June 2013 Client #3's BS ranged from 71 to 484 (12 days with a blood sugar over 300 and 14 days BS levels between 200 and 300). -July 2013 Client #3's BS ranged from 70 to 452 -August 2013 Client #3's BS ranged from 40 to 499 (6 days with a blood sugar over			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	300 all pre-dinner and 20 days BS levels between 200 and 300). -September 2013 Client #3's BS ranged from 47 to 482 (9 days with a blood sugar over 300 and 15 days BS between 200 and 300). -October 2013 Client #3's BS ranged from 70 to 423 (5 days with a blood sugar over 300 all pre-dinner and 12 days BS levels between 200 and 300). Client #3's Nursing Notes indicated the following (not all inclusive): -10/15/13 "Per report of [name of day program] Lunch BS 476. Instructed to give Humalog 10 units in addition to 12 units scheduled. Re (check) in one hour." -10/15/13 "BS (down) sl (slightly) to 456. Re (check) at 2 PM." -10/15/13 "BS 450 Notified [name of doctor's] office. reported above no s/s (signs/symptoms)." -10/15/13 "[Name of doctor] office called. No new orders." -10/15/13 "Eve (evening) PreDinner BS 354. Adjusted Carbs (carbohydrates). No further intervention required."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	-10/3/13 "Reported 10-2-13 Eve BS to [name of doctor's] office." -8/13/13 "New orders received from [name of doctor] to (decrease) Humalog to 12 units for BS 91 and above 3 x (times) daily before meals. (Decrease) bedtime Lantus to 30 units." -8/13/13 "Notified [name of doctor's] office reported [client #3's] BS of 41. Orange Juice given. (Increase) 61 repeat OJ (orange juice), (increase) to 87. No S/S." -8/2/13 "Reported AM BS reading to [name of doctor's] office." -8/1/13 "Reported AM BS reading to [name of doctor's] office." -7/25/13 "Accompanied [client #3] to appt (appointment) (with) [name of doctor] for hospital F/U (follow up)...Orders to restart Metformin, (increase) Humalog to 15 units TID AC (three times a day before meals)...." -7/22/13 "Discharged from [name of hospital] today (with) the following med (medication) changes (Increase) Lantus AM dose to 50 units, (decrease) Humalog before meals to 12 units, D/C'd			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	(discontinued) Metformin, Lisinopril...." Client #3's 8/6/13 physician's orders indicated client #3's BS levels were checked 3 times a day before each meal and at bed time. Client #3's 8/10/12 High Risk Plan for Type II Diabetes Mellitus indicated client #3 was on a regular no concentrated sweets (NCS), low fat and no added salt (NAS) diet. The risk plan indicated "...May have occasional dessert, i.e. holidays and special occasions per physician's orders...." Client #3's 10/10/13 Nutritional Assessment indicated client #3 was within her normal body weight range. The assessment indicated client #3 was on a regular NAS, NCS and low fat diet. The 10/10/13 assessment indicated client #3's labs were within normal limits. The assessment indicated the following recommendations: "1) Cont (continue) current diet/monitor. 2) Monitor wts (weights) monthly. 3) Consult RD (registered dietician) (with) nutr (nutritional) concerns. 4) Enc. (encourage) fluids (with) laxative use. 5) Enc. diet compliance/healthy food/beverage choices that are NAS,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	NCS, (low) fat." Client #3's 9/10/13 Consultant Dietician Report indicated "[Client #3]- Not eating all of mandarin oranges. D/C (discontinue) 2 x's/day at Brkfst (breakfast) & HS (bed time). Change diet to: Regular, NAS, NCS, (low) fat 2% milk TID (three times a day) at Brkfst, Supper, HS. HS snack- 1/2 meat sandwich (with) 2 % milk (may add CIB (carnation instant breakfast) at Bedtime)." Client #3's 8/6/13 Individual Support Plan (ISP) indicated client #3's interdisciplinary team IDT) had not met in regard to client #3's high blood sugar readings and/or diet. Client #3's 10/10/13 nutritional assessment, ISP and/or record did not indicate client #3's IDT assessed/re-assessed client #3's high blood sugar levels in regard to the client's regular NCS, NAS, low fat diet, or sought expert consultation with a medical professional with expertise in diabetes management. Interview with staff #1 on 10/23/13 at 6:25 AM indicated client #3 was not on a regular NCS, NAS and low fat diet. Staff #1 stated client #3's diabetes was "doing much better with the new insulin." Staff #1 stated when client #3's BS was high they would "follow steps to bring (it)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	down." Interview with LPN #1 and the Director of Health Care Services on 10/24/13 at 2:11 PM indicated client #3 was using insulin pen injections for the last couple of months. LPN #1 stated client #3's diabetes "Has her ups and downs. Still has high blood sugars." When asked who was monitoring client #3's diabetes, LPN #1 stated "[Client #3's] PCP." LPN #1 indicated client #3 saw a diabetic specialist a couple of years ago. LPN #1 indicated client #3's regular NCS, NAS and low fat diet was considered to be an 1800 calorie diabetic diet. When asked if client #3's diet/consumption had been assessed in regard to her blood sugar level readings to see if there was any correlation to the client's high blood sugar levels, LPN #1 and DHS stated "No." LPN #1 indicated they did not document what client #3 ate/consumed. LPN #1 and DHS indicated the facility's dietician monitored the client's diet. LPN #1 and the DHS indicated the nursing staff were undergoing additional training in regard to diabetes/diets on 10/25/13 by a diabetic educator/nutritionist. 9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
W000240	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 1 of 4 sampled clients (#1), the client's Individual Support Plan failed to specifically indicate how facility staff were to assist a client to ambulate and/or specifically indicate when a wheelchair was to be used. Findings include: During the 10/22/13 observation period between 4;10 PM and 6:45 PM and the 10/23/13 observation period between 4:45 AM and 7:10 AM, at the group home, client #1 had a Walker Cast Boot on her left foot. Client #1 utilized a roller walker when ambulating and had a gait belt on as well. Facility staff walked/ambulated with the client holding onto the gait belt as client #1 ambulated. Client #1 required staff assistance to ambulate with a gait belt. The facility's reportable incident report, internal incident reports, and/or investigations were reviewed on 10/22/13 at 12:14 PM. The facility's reportable incident reports, internal incident reports and/or investigations indicated the following (not all inclusive):	W000240	W240 - The Individual program plan must describe relevant interventions to support the individual toward independence - The IDT will meet to review Client #1's Individual Support Plan and High Risk Plan in regards to assisting the client on ambulation and when a wheelchair should be used - The nurse will be retrained on High Risk Plans in regards to specifying how to assist clients with a gait belt or walker and when to use a wheelchair when orders are PRN. - The Residential Manager and Program Manager will be retrained IDT policy in regards to any changes in a client's Individual Support - Program Manager will be retrained IDT policy in regards to any changes in a client's Individual Support. - Staff will be retrained on updated High Risk Plan for Client #1 -Residential Manager will be retrained on ensuring that all adaptive equipment is included on the clients' ISP and specifies when adaptive equipment is to be used. - Residential Manager will be retrained on conducting an IDT meeting after each fall to review the high risk plan for appropriateness and training all staff on any updates made to the clients plans. Residential	12/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	-5/20/13 "[Client #1] fell this morning going into [name of workshop] result in a very faint abrasion (sic) of top layer of skin on right shoulder (sic). The reportable incident report indicated client #1 "...has a full ROM (range of motion) of extremity. There are no other apparent injuries noted. [Client #1] has a fall prevention plan that remain (sic) appropriate. Staff will continue to monitor as precautionary measure." The facility's 5/20/13 internal Incident Report indicated client #1 fell down on her left side on a curb." -7/11/13 Client #1 fell and bumped the right side of her head. No injuries indicated. -8/17/13 Client #1 fell when she opened up the food pantry cabinet causing the client to fall on her side. No injury indicated. -9/3/13 "[Client #1] fell using the restroom. [Client #1] was sent to [name of medical facility] to be evaluated. A (sic) x-ray shows a small fracture on fourth and fifth toes of her left foot. She was released and is to wear a boot. She was also referred to [name of Orthopedic group]. [Client #1] has a fall prevention		Manager will monitor through daily visits to the home. -Program Manager will be retrained on ensuring that all adaptive equipment is included on the clients' ISP and specifies when adaptive equipment is to be used. - Program Manager will be retrained on conducting an IDT meeting after each fall to review the high risk plan for appropriateness and training all staff on any updates made to the clients plans. Program Manager will monitor trough weekly visits to the home. -Nurse will be retrained on High Risk Plans in regards to specifying what assistance is needed to client's who require a walker, wheelchair and/or gait belt. Persons Responsible: Staff, Residential Manger, Program Manger, QIDP, Nurse, Nursing Manager & Executive Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	plan in place it was being followed and remains appropriate...." Client #1's record was reviewed on 10/24/13 at 10:40 AM. Client #1's 9/3/13 Medical Consult Report indicated client #1 fractured her left 4th and 5th toes. The consult report indicated a "walking boot" was ordered. Client #1's Nursing Notes indicated the following (not all inclusive): -9/3/13 "Staff called to report [client #1] had fallen in Bathroom Staff @ (at) office. Checked for injuries none seen per staff. Staff called to report bluish brown discoloration present on (L) (left) foot and last 2 toes left foot. Sent to [name of medical facility] for eval (evaluation)." -9/4/13 "X-ray revealed FX (fracture) of 5th Metatarsal and of the 4th phalange. Boot applied to F/U (with) [name of Orthopedist] tomorrow." -9/4/13 "Seen by [name of Orthopedist] confirmed fracture x (times) 2 4th and 5th toe (sic) (L) foot - Cont (continue) Boot, orders for gait belt, W/C (wheelchair) PRN (as needed) (with) Leg extension - Commode extender (with) handles. OK to go to Day Program. Try to keep foot			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	(up) some thru (through) out day...Boot on during activity off for Bed/Shower." Client #1's 7/17/13 physician's order indicated "May use walker as needed." Client #1's 7/3/13 High Risk Plan (plan in place prior to fall with fracture) indicated "...3. Staff will provide a safe environment and prevent falls i.e. floor free from clutter,...5. Staff will assist individual with application of AFO (leg splint) to left foot daily (on am and remove pm)...11. Staff will encourage use of walker to provide stability during ambulation." Client #1's Physical Therapy (PT) assessments indicated the following (not all inclusive): -8/29/13 "Pt (patient) states she 'fell yesterday in the big bathroom because the floor was wet.' States that she 'did not have shoes on.' She was 'getting ready for work.' States that (R) (right) knee hurts. States that it hurts with movement." The PT assessment indicated client #1 "...Requires verbal instructions for safe transfer technique...." The assessment indicated client #1 would continue PT once a week for gait and transfer training. The 8/29/13 assessment further indicated "...*Staff to assist in pt. in donning (L) AFO (with) proper strap placement &			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	(and) shoes to be laced properly to assist in decreasing falls...." Client #1's 9/6/13 Physical Therapy Treatment Form indicated "Pt fell in bathroom due to water per pt. Fx 4th and 5th toe (L) foot. Wearing boot (L) foot...." The PT form indicated client #1 was ambulating with a walker and with a gait belt. The PT form indicated "...Cont (continue) with P.O.C (Plan of Care). PT recommend gait belt to be used for gait/transfers." Client #1's 9/13/13 PT form indicated "Continue to ambulate (with) rw (roller walker) (with) assist of 1 for safety...." Client #1's 9/4/13 High Risk plan Addendum for "Left Foot deformity/Potential for falls indicated "...3. Staff will provide a safe environment and prevent falls i.e. floor free from clutter,...13. Staff will assist individual with application of AFO (leg splint) to left foot daily (on am and remove pm)...18. Staff will monitor during shower. 19. Staff will assist with the use of walker and gait belt to provide stability during ambulation. 20. Staff will assist with use of w/c PRN...." Client #1's Interdisciplinary Team (IDT) meeting notes indicated the following (not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	all inclusive): -7/18/13 "Team met to discuss [name of doctor's] recommendation that [client #1] use a walker as needed. All agree this should be implemented." -9/4/13 "Team met to discuss [client #1] using a gait belt, PRN wheelchair. Also [client #1] will return to [name of day program]." -10/7/13 "Team met to discuss [client #1's] High Risk Plan (HRP) for falls. [Client #1's] HRP remains appropriate @ this time. Team agrees." Client #1's 3/12/13 Individual Support Plan (ISP) High Risk plan, and/or above mentioned IDT notes did not specifically indicate when the PRN wheelchair was to be utilized with the client to prevent falls, and/or specifically indicate how facility staff were to assist with the use of the walker/gait belt when ambulating with client #1. Interview with LPN #1, the Director of Health Services (DHS) and the Program Manager (PM) on 10/24/13 at 2:11 PM indicated client #1 had a history of falls. LPN #1 indicated client #1's fall risk plan was last updated on 9/4/13 after the fracture. LPN #1 indicated facility staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	was to hold onto client #1's gait belt when the client ambulated. LPN #1 indicated facility staff were trained to be with the client when she ambulated. LPN #1 indicated client #1's wheel chair should be used for long distances. LPN #1 and the PM indicated client #1's ISP did not specifically indicate how facility staff were to assist the client to ambulate with a gait belt and/or walker as the ISP did not specifically indicate client #1 was to have one on one staffing (one staff to one client) when ambulating. LPN #1 and the PM indicated client #1's ISP did not specifically indicate when the client was to use her wheelchair. 9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
W000249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record review for 2 of 4 sampled clients (#2 and #3) and for 1 additional clients (#5), the facility failed to implement the clients' Individual Support Plan (ISP) objectives and/or Behavior Support Plan (BSP) strategies as written when formal and/or informal training opportunities existed. Findings include: 1. During the 10/22/13 observation period between 4:10 PM and 6:45 PM and the 10/23/13 observation period between 4:45 AM to 7:10 AM, at the group home client #2 walked around the group home without an activity, sat without an activity, sat with her fingers in her mouth and/or followed the surveyor around the group home without being redirected to an alternate activity and/or training except to watch TV during the 10/23/13 observation period. During the 10/22/13 observation period, staff #4 custodially wiped client #2's mouth with a	W000249	W249 - To resolve and ensure that each client's treatment program consists of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the program plan the following actions will occur: - Staff responsible for implementing each clients program plan will be re-trained regarding proper oversight and review of each clients plan to ensure that observations and on-site training are included as part of the overall process for ensuring that each client receives necessary services. -IDT will meet to discuss all objectives/ goals for all clients to ensure that all objectives/goals remain appropriate. Any required updates will be made as needed per IDT recommendations. -All staff will be re-trained regarding all clients program plan with emphasis on consistently implementing the program plan for each client to assure continuous active treatment at all times. -Specifically for client #2's,	12/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	napkin once she finished eating. During the above mentioned observation periods, client #2 was non-verbal in communication in that the client did not speak. Facility staff did not implement any communication training and/or utilize any communication device with the client. Client #2's record was reviewed on 10/23/13 at 2:20 PM. Client #2's 8/6/13 ISP indicated client #2 had the following objectives (not all inclusive): -To use her voice when talking. -To identify a quarter by pointing. -To identify a picture from communication book by pointing to the item staff asks for. -To participate in an activity of choice for 5 minutes. -To wipe her mouth thoroughly with a napkin. Client #2's 8/1/13 BSP indicated client #2 had a targeted behavior of putting her fingers in and out of her mouth. Client #2's BSP indicated when client #2 placed her fingers in her mouth, "Staff will prompt [client #2] to stop sticking her fingers in her mouth. Staff will explain to [client #2] that it is unsanitary to put fingers in her mouth...Staff will redirect [client #2] to an activity. Staff will praise		staff will be retrained on client # 2's program plan with emphasis on consistently implementing the program plan for each client to assure continuous active treatment at all times. -Specifically for client #3's, staff will be retrained on client # 3's program plan with emphasis on consistently implementing the program plan for each client to assure continuous active treatment at all times. -Specifically for client #5's, staff will be retrained on client # 5's program plan with emphasis on consistently implementing the program plan for each client to assure continuous active treatment at all times. -Specifically for clients # 2's, 3's & 5's, staff will be retrained with regards to prompting clients 2's, 3's & 5's to choose a leisure activity and offering appropriate activities. -Residential Manager will observe in the home daily to ensure that Client #2's, 3's, & 5's program plan is being implemented appropriately and necessary supports are provided. -Program Manager will observe in the home weekly to ensure that Client # 2's, 3's, & 5's program plan are being implemented appropriately and necessary supports are provided. Program Manager will provide training as needed. Persons	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	[client #2] for stopping." Facility staff did not implement client #2's above mentioned objectives and/or behavior plan when formal and/or informal opportunities for training existed. Interview with the Program Manager (PM) on 10/24/13 at 2:11 PM indicated facility staff did not utilize client #2's communication book during the 10/22 and 10/23/13 observation periods. The PM indicated training should have occurred with client #2's training objectives. The PM also indicated facility staff should have redirected client #2 to another activity when the client placed her fingers into her mouth. 2. During the 10/22/13 observation period between 4:10 PM and 6:45 PM, at the group home, client #3 sat without an activity at the dining room table, and/or stood near/in the kitchen area while the dinner meal was being prepared. The PM, the Qualified Intellectual Disabilities Professional (QIDP), staff #2, staff #4 and #5 did not provide client #3 an alternate activity and/or training except to prompt the client to sit down when eating her snack. Client #3's record was reviewed on 10/23/13 at 12:35 PM. Client #3's 8/6/13 ISP indicated client #3 had the following		Responsible: Staff, Residential Manager, Program Manager, Executive Director.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	objectives (not all inclusive): -To identify a quarter. -To identify street signs. -To choose and participate in group leisure activity. -To complete a daily chore. -To correctly respond to questions independently. -To clean her eyeglasses. Facility staff did not implement client #3's above mentioned objectives when formal and/or informal opportunities for training existed. Interview with the PM on 10/24/13 at 2:11 PM indicated training should have occurred with client #3 during the 10/22/13 observation period. 3. During the 10/22/13 observation period between 4:10 PM and 6:45 PM, at the group home, client #5 demonstrated hyperactivity as the client kept getting into the refrigerator. Client #5 retrieved a slice of cheese and ate the whole slice in one bite. Client #5 returned to the refrigerator to get a second slice of cheese. Staff #2 prompted client #5 to sit down if she wanted to eat a snack. Client #5 was given graham crackers to eat. Client #5 ate the graham crackers and went to the refrigerator to get milk. Client #5 carried the milk to the table and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	poured herself a glass of milk with hand over hand assistance. Once client #5 finished her milk, client #5 quickly returned to the refrigerator. The QIDP prompted client #5 to leave the kitchen but no alternate activity/training was offered the client. Client #5's record was reviewed on 10/24/13 at 2:00 PM. Client #5's 8/1/13 BSP indicated client #5 demonstrated "Hyperactivity (being excessively active)." Client #5's BSP indicated facility staff were to prompt/encourage client #5 to participate in an activity with the group. The BSP indicated if client #5 did not want to participate in an activity with the group, staff were to offer the client an alternate activity. Interview with the PM on 10/24/13 at 2:11 PM indicated facility staff did not implement client #5's BSP when the client kept getting into the refrigerator to get cheese. The PM indicated the client should have been redirected to another activity. 9-3-4(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
W000322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on observation, interview and record review for 1 of 4 sampled clients (#3), the facility failed to ensure client #3's diabetes was re-assessed to ensure the client's diet did not affect/increase the client's blood sugar level, and/or to obtain a referral/assessment by a specialist in regard to the client's diabetes management. Findings include: During the 10/22/13 observation period between 4:10 PM and 6:45 PM, at the group home, client #3 was given graham crackers for a snack. For the dinner meal client #3 was served 2 slices of pizza, 1 cup of salad, salad dressing and a chocolate pudding cup for her dinner meal. Client #3 required several prompts to eat as the client would sit and look around. During the 10/23/13 observation period between 4:45 AM and 7:10 AM, at the group home, client #3 received Metformin (diabetes) 1 tablet before breakfast at 5:00 AM. Client #3 then returned to the medication room at 5:38 AM for a blood sugar level reading/check. Client #3's blood sugar level was 131.	W000322	W322 - The facility must provide or obtain prevention and general medical care. - IDT will be held in regards to obtaining a referral/assessment by a specialist in regards to client #3's diabetic management. - IDT will be held in regards to client #3's high blood sugar reading and/or diets. IDT will review nutritional assessment and ISP. - The nurse will notify the dietician for re-evaluation of client # 3's nutritional assessment. - The nurse will consult with dietician regarding menus and food logs. - All staff will be retrained on any changes made to any clients ISP, BSP, High Risk plans and/or diets. - All staff will be retrained on all clients' diets. - The nurse will be retrained on notifying client #3's PCP of any abnormal blood sugar reading. - The nurse will monitor through weekly home audits to ensure that the PCP is notified of blood sugar reading weekly or as needed. -Residential Manager will observe in the home daily to ensure that Client #3's blood sugar reading and nutritional logs are being completed per her protocol. -Residential Manager will observe in the home daily to ensure that all clients ISP's, BSP's, High Risk Plans & diets are being implemented	12/02/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G207	A. BUILDING 00 B. WING	11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	The Program Manager administered 12 units of Humalog and 50 units of Lantus insulin injections for the client's diabetes. Client #3 then went to the dining room to eat her breakfast which consisted of orange juice, raisin toast, cereal, milk and margarine. The facility's reportable incidents and/or investigations were reviewed on 10/22/13 at 12:14 PM. The facility's 7/16/13 reportable incident report indicated client #3's blood sugar level "was high (actual level not mentioned)." The reportable incident report indicated client #3's doctor was contacted and he sent the client to the hospital. Client #3 was admitted to the hospital for further tests. The facility's 7/22/13 follow-up report indicated client #3 was discharged on 7/22/13 with medication changes to the client's insulin and the Metformin was discontinued. The facility's menus were reviewed on 10/24/13 at 2:00 PM. The facility's week 4 Regular Living Lite No Added Salt menu indicated this was the menu/diet client #3 followed at the group home. The Week 4 Tuesday dinner menu indicated the following:		appropriately. - The Residential Manager will be retrained on IDT policy in regards to discussing issues involving health and safety of the client -Program Manager will observe in the home weekly to ensure that Client #3's blood sugar reading and nutritional logs are being completed per her protocol. - Program Manager will observe in the home weekly to ensure that all clients ISP's, BSP's, High Risk Plans & diets are being implemented appropriately. - Program Manager will be retrained on IDT policy in regards to discussing issues involving health and safety of the client Persons Responsible: Residential Manager, Program Manager, Nurse, Nursing Manager, and Executive Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	"PIZZA 1 SERV (serving) LETTUCE SALAD 1 C (cup) LF (LOW FAT) SALAD DRESSING 2 Tbs (tablespoons) LF PUDDING 1/2 C SKIM MILK 1 C" The Week 4 Wednesday breakfast menu indicated the following: "ORANGE JUICE 1/2 C HOT CEREAL 3/4 C OR COLD CEREAL 3/4 C RAISIN TOAST 1 sl (slice) SKIM MILK 1 C COFFEE 1 C MARGARINE 1 Tsp (teaspoon)" The week 4 menu indicated client #3 was to receive tuna salad, wheat bread, creamy coleslaw, banana, beverage and a multigrain snack bar for lunch/snack on Wednesday. The week 4 Wednesday dinner meal indicated client #3 would receive baked ham, cream style corn, green beans, tossed salad, LF dressing, cornbread, margarine, pudding parfait and skim milk. Review of the week 4 menu indicated the client received bread, dinner roll and/or a bun at each meal. The week 4 menu indicated client #3 received fresh fruit/fruit cup, pudding, low fat ice cream, pear halves, pineapple, and/or angel food cake with fruit topping for dessert at the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	lunch and/or dinner meals. The dinner menus also included items like mixed vegetables, tater tots, potato salad, baked sweet potato, pasta salad, scalloped potatoes and breaded fish. Client #3's record was reviewed on 10/23/13 at 12:36 PM. Client #3's 7/16/13 History and Physical (H&P) indicated client #3 was brought to the emergency room as client #3 "...has been having high blood sugar basically today...." The H&P indicated client #3 had a blood sugar (BS) level reading of "...400 before lunch and was given 10 extra units of insulin. 1 hour after lunch the BS was 410. Because of the persistently high BS, her PCP's (Primary care Physician's) office asked her to be sent to the ER (emergency room)...." Client #3's blood sugar level was 413 in the ER. The H&P indicated "...According to the caregivers it is not unusual for her BS to run high...." Client #3's 7/23/13 Discharge Summary indicated client #3 was admitted to the hospital on 7/16/13 with the following admission diagnoses: "1. Hyperglycemia (high blood sugar) 2. Hypercalcemia (high calcium levels) 3. Hyperkalemia (high potassium) 4. Hypertension (high blood pressure)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	5. Past DVT (Deep Vein Thrombosis) (blood clot) on Coumadin anticoagulation." The discharge summary indicated client #3 presented with a blood sugar of 409 (high) which "...blood sugar persisted as elevated." The discharge summary indicated "...The patient was felt to be in acute renal failure with hyperglycemia, hyperkalemia and hypocalcemia (sic) as well as elevated INR (test to monitor clotting of blood) and some leg edema...." Client #3's discharge diagnoses included the following (not all inclusive): "Acute kidney failure, unspecified Type II or unspecified type diabetes mellitus with unspecified complication, uncontrolled...." Client #3's Blood Glucose Monitoring Forms indicated the following BS levels/ranges (not all inclusive): -June 2013 Client #3's BS ranged from 71 to 484 (12 days with a blood sugar over 300 and 14 days BS levels between 200 and 300). -July 2013 Client #3's BS ranged from 70 to 452 -August 2013 Client #3's BS ranged from 40 to 499 (6 days with a blood sugar over			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	300 all pre-dinner and 20 days BS levels between 200 and 300). -September 2013 Client #3's BS ranged from 47 to 482 (9 days with a blood sugar over 300 and 15 days BS between 200 and 300). -October 2013 Client #3's BS ranged from 70 to 423 (5 days with a blood sugar over 300 all pre-dinner and 12 days BS levels between 200 and 300). Client #3's Nursing Notes indicated the following (not all inclusive): -10/15/13 "Per report of [name of day program] Lunch BS 476. Instructed to give Humalog 10 units in addition to 12 units scheduled. Re (check) in one hour." -10/15/13 "BS (down) sl (slightly) to 456. Re (check) at 2 PM." -10/15/13 "BS 450 Notified [name of doctor's] office. reported above no s/s (signs/symptoms)." -10/15/13 "[Name of doctor] office called. No new orders." -10/15/13 "Eve (evening) PreDinner BS 354. Adjusted Carbs (carbohydrates. No further intervention required."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	-10/3/13 "Reported 10-2-13 Eve BS to [name of doctor's] office." -8/13/13 "New orders received from [name of doctor] to (decrease) Humalog (insulin) to 12 units for BS 91 and above 3 x (times) daily before meals. (Decrease) bedtime Lantus (insulin) to 30 units." -8/13/13 "Notified [name of doctor's] office reported [client #3's] BS of 41. Orange Juice given. (Increase) 61 repeat OJ (orange juice), (increase) to 87. No S/S." -8/2/13 "Reported AM BS reading to [name of doctor's] office." -8/1/13 "Reported AM BS reading to [name of doctor's] office." -7/25/13 "Accompanied [client #3] to appt (appointment) (with) [name of doctor] for hospital F/U (follow up)...Orders to restart Metformin, (increase) Humalog to 15 units TID AC (three times a day before meals)...." -7/22/13 "Discharged from [name of hospital] today (with) the following med (medication) changes (Increase) Lantus AM dose to 50 units, (decrease) Humalog			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	before meals to 12 units, D/C'd (discontinued) Metformin, Lisinopril...." Client #3's 8/6/13 physician's orders indicated client #3's BS levels were checked 3 times a day before each meal and at bed time. Client #3's 8/10/12 High Risk Plan for Type II Diabetes Mellitus indicated client #3 was on a regular no concentrated sweets (NCS), low fat and no added salt (NAS) diet. The risk plan indicated "...May have occasional dessert, i.e. holidays and special occasions per physician's orders...." Client #3's 10/10/13 Nutritional Assessment indicated client #3 was within her normal body weight range. The assessment indicated client #3 was on a regular NAS, NCS and low fat diet. The 10/10/13 assessment indicated client #3's labs were within normal limits. The assessment indicated the following recommendations: "1) Cont (continue) current diet/monitor. 2) Monitor wts (weights) monthly. 3) Consult RD (registered dietician) (with) nutr (nutritional) concerns. 4) Enc. (encourage) fluids (with) laxative use. 5) Enc. diet compliance/healthy			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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
	food/beverage choices that are NAS, NCS, (low) fat." Client #3's 9/10/13 Consultant Dietician Report indicated "[Client #3]- Not eating all of mandarin oranges. D/C (discontinue) 2 x's/day at Brkfst (breakfast) & HS (bed time). Change diet to: Regular, NAS, NCS, (low) fat 2% milk TID (three times a day) at Brkfst, Supper, HS. HS snack- 1/2 meat sandwich (with) 2 % milk (may add CIB (carnation instant breakfast) at Bedtime)." Client #3's 8/6/13 Individual Support Plan (ISP) indicated client #3's interdisciplinary team IDT) had not met in regard to client #3's high blood sugar readings and/or diet. Client #3's 10/10/13 nutritional assessment, ISP and/or record did not indicate the facility obtained an assessment/re-assessment of client #3's high blood sugar levels in regard to the client's regular NCS, NAS, low fat diet. Interview with staff #1 on 10/23/13 at 6:25 AM indicated client #3 was not on a regular NCS, NAS and low fat diet. Staff #1 stated client #3's diabetes was "doing much better with the new insulin." Staff #1 stated when client #3's BS was high they would "follow steps to bring (it) down."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES SW IN	915 JOHANNES CT EVANSVILLE, IN 47725

(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
	Interview with LPN #1 and the Director of Health Care Services on 10/24/13 at 2:11 PM indicated client #3 was using insulin pen injections for the last couple of months. LPN #1 stated client #3's diabetes "Has her ups and downs. Still has high blood sugars." When asked who was monitoring client #3's diabetes, LPN #1 stated "[Client #3's] PCP." LPN #1 indicated client #3 seen a diabetic specialist a couple of years ago. LPN #1 indicated client #3's regular NCS, NAS and low fat diet was considered to be an 1800 calorie diabetic diet. When asked if client #3's diet/consumption had been assessed in regard to her blood sugar level readings to see if there were any correlation to the client's high blood sugar levels, LPN #1 and DHS stated "No." LPN #1 indicated they did not document what client #3 ate/consumed. LPN #1 and DHS indicated the facility's dietician monitored the client's diet. LPN #1 and the DHS indicated the nursing staff were undergoing additional training in regard to diabetes/diets on 10/25/13 by a diabetic educator/nutritionist. LPN #1 and DHS indicated another evaluation with a medical professional in diabetes management had not been sought. 9-3-6(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G207	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/08/2013
NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN		STREET ADDRESS, CITY, STATE, ZIP CODE 915 JOHANNES CT EVANSVILLE, IN 47725	

(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