STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G096		(X2) MULTIPLE CC A. BUILDING B. WING	00	COMI	e survey pleted 7/2013		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2745 WINDEMERE DR EVANSVILLE, IN 47725				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL YAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT TAG DEFICIENCY)			(X5) COMPLETION DATE	
W0000	recertification a Dates of Survey 1/17/13 Facility Numbe Provider Numb AIMS Number: Surveyor: Paula Chika, M Leader These federal d state findings in 9. Quality Review	er: 15G096	W0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 02/12/2013

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.

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G096	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/17/2013	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE VINDEMERE DR		
COMMUNITY ALTERNATIVES SW IN				SVILLE, IN 47725		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETION	
TAG V0130	REGULATORY O 483.420(a)(7)	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	PROTECTION (The facility must clients. Therefo privacy during tr personal needs.	DF CLIENTS RIGHTS t ensure the rights of all re, the facility must ensure eatment and care of vation and interview for 2	W0130	W130: Protection of Clients	02/16/2013	
	of 4 sampled clients (#3 and #4), the Rights		Rights			
	when bathing and dressing. client rights; including client	- Staff will be retrained on client rights; including clients righ to privacy related to bathing and	ıt			
	Findings includ	e:		dressing. - Staff will be retrained on		
	•	13 observation period		Client #3 & #4's Individual Support Plan.		
		M and 7:00 AM, at the		- Program Coordinator and		
		aff #2 was assisting client ith the door open. Client		Operations Manager will be retrained clients rights to privacy		
		n the shower with the door		and ensuring that client's rights		
		M. Once client #4 finished		are not being violated in the		
	-	ff #2 and client #4 returned		home. - The Program Coordinator		
		droom to dress. Staff #2		will complete home visits on a		
		⁴ 4 to dress with the door		weekly basis to ensure that		
		8, who was client #4's		client's rights are not being violated specifically related to		
	-	sed with the door open		privacy.		
		vas in the bedroom with		- The Operation Manager		
	both clients. St	aff #2 did not close the		will complete home visits on a monthly basis to ensure that		
	door and/or enc	ourage clients #3 and #4		client's rights are not being		
	to close the doc	or to protect their privacy.		violated specifically related to privacy.		
		administrative staff #3 on		Persons Responsible: Program		
		AM indicated there was		Coordinator, Operations Manage	r	
	-	n the home so the door was $aff #2$ could been what we				
		aff #2 could hear what was				
	going on in the	group nome.				

Facility ID: 000635

If continuation sheet Page 2 of 13

INTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-03	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	IULTIPLE CON	(X3) DA	(X3) DATE SURVEY		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING 00			COMPLETED	
		15G096	A. BU B. WI			01/	17/2013	
			D. WI		DDRESS, CITY, STATE, ZIP	CODE		
NAME OF 1	PROVIDER OR SUPPLIEI	3			NDEMERE DR	CODE		
сомми	NITY ALTERNATIV	ES SW IN			/ILLE, IN 47725			
X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION	ORRECTION	(X5)	
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE	COMPLETIC DATE	
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	<i>Burelux(e1)</i>		DATE	
		dministrative staff #2 on						
		AM stated the facility						
	staff should hav	e "closed or cracked the						
	bathroom door." Administrative staff #2							
	indicated the fac	ility staff should have						
		s' bedroom door to						
	protect the clien							
	r	r,						
	0.2.2(a)							
	9-3-2(a)							

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 15G096 01/17/2013 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2745 WINDEMERE DR COMMUNITY ALTERNATIVES SW IN EVANSVILLE. IN 47725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG W0137 483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation, interview and W0137 02/16/2013 W137: Protection of Clients record review for 1 of 4 sampled clients Rights (#3), the facility failed to allow the client Staff will be retrained on to keep/maintain possession of her client rights including restrictions hearing aid as the facility locked the on personal property. Program Coordinator and client's hearing aid in a medication closet. Operations Manager will be retrained on ensuring that client Findings include: rights are not being violated in the home. An IDT will be completed During the 1/9/13 observation period on Client #3 in regards to locking between 4:55 AM and 7:00 AM, at the her hearing aids when not in use. group home, administrative staff #3 Human Rights Committee retrieved client #3's hearing aid container will review restriction of hearing from a locked medication closet and aids. If the Human Rights handed the hearing aids to the client to Committee approves, the place in both ears. Individual Support Plan will be updated to include restriction and Client #3's record was reviewed on 1/9/13 goal will be put into place to address this area for Client #3. at 3:10 PM. Client #3's 11/2/12 The Program Coordinator Individual Support Plan (ISP) indicated will complete home visits on a client #3 had an objective to wear her weekly basis to ensure that hearing aid and correctly store her hearing client's rights are not being violated specifically related to aid when not in use. Client #3's 11/2/12personal possessions and that ISP and/or objective did not indicate the ISP's are appropriate including client's hearing aids were to be locked. HRC approval related to client Client #3's 11/2/12 ISP indicated client #3 restrictions for all clients in the home. was her own guardian. The ISP did not The Operation Manager indicate client #3 gave written informed will complete home visits on a

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Event ID: YLH311

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Facility ID: 000635

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 15G096 01/17/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2745 WINDEMERE DR COMMUNITY ALTERNATIVES SW IN EVANSVILLE, IN 47725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG monthly basis to ensure that consent to lock her hearing aids. The ISP client's rights are not being also did not indicate the facility's Human violated specifically related to Rights Committee reviewed and/or personal possessions and that approved the restriction of locking the ISP's are appropriate including client's hearing aids. HRC approval related to client restrictions for all clients in the home. Interview with administrative staff #2 on 1/10/13 at 11:20 AM indicated he thought Persons Responsible: Program client #3's hearing aids were being locked Coordinator, Operations Manager in the medication closet as the client would lose her hearing aids. Administrative staff #2 indicated client #3's ISP did not indicate the client's hearing aids should be locked. Administrative staff #3 indicated the facility did not obtain written informed consent to lock the client's hearing aids, and/or have the facility's Human Rights Committee review the rights restriction. 9-3-2(a) FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YLH311 Facility ID: 000635 If continuation sheet Page 5 of 13

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 15G096 01/17/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2745 WINDEMERE DR COMMUNITY ALTERNATIVES SW IN EVANSVILLE. IN 47725 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG W0210 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. W0210 02/16/2013 Based on record review and interview for W210: Individual Program Plan 1 of 4 sampled clients (#2), the client's A Physical Therapy interdisciplinary team (IDT) failed to Evaluation was completed for re-assess the client's mobility skills in Client #2 on January 17, 2013. regard to falls. Recommendations are to continue exercises in the home. An IDT has been Findings include: completed to discuss recommendations for Client #2 The facility's reportable incident reports related to PT Evaluation. **Operations Manager and** and/or internal incident reports were Program Coordinator will be reviewed on 1/8/13 at 12:45 PM. The retrained on addressing falls with reportable incident reports and/or internal the team (IDT Meeting) to ensure incident reports indicated the following: that appropriate preventatives and steps are put in place to limit the potential for continued falls. -7/19/12 "At 10:03 am on 07/19/12 [client Nurse will be retrained on #2] fell on the ground. The nurse and requesting Physical Therapy QMRP (Qualified Mental Retardation Evaluation if the IDT indicates a Professional) checked to make sure that pattern of falls. The Program Coordinator [client #2] was okay. [Client #2] will complete home visits on a informed them that her back was hurting weekly basis to ensure that all from the fall. 911 was called, and [client client's plans are appropriate for #2] was taken to the ER (emergency their needs. The Operation Manager room) to be evaluated...." A 7/27/12 will complete home visits on a follow-up report indicated a fall monthly basis to ensure that all prevention plan was being put in place for client's plans are appropriate for client #2. their needs. The Nurse will complete monthly visits to the home to -8/13/12 "[Client #2] tripped over her ensure that all clients' plans are FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YLH311 Facility ID: 000635 If continuation sheet Page 6 of 13

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G096			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED - 01/17/2013		
NAME OF	PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP CODE 2745 WINDEMERE DR			E	
СОММЦ	COMMUNITY ALTERNATIVES SW IN				SVILLE, IN 47725		
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shoelace and fell receiving an abrasion to her left knee. [Client #2] has a fall prevention plan that remains appropriate. Staff will continue to monitor as a precautionary measure."			appropriate for their medi needs. Persons Responsible: P Coordinator, Operations Manager, Home Nurse				
	at [name of wor assessed by the on her right kne and antibiotic o applied[Clien prevention plan remain appropr follow-up repor "counseled to w -10/22/12 "[Cli shoes in her bed an open area or #2] is safe. She in place and it r time"	0/5/12 "[Client #2] tripped over a chair [name of workshop]. [Client #2] was assessed by the nurse. She has a scrape in her right knee. Scrape was cleaned and antibiotic ointment and band aid were oplied[Client #2] does have a fall revention plan in place and it does smain appropriate." A 10/16/12 ollow-up report indicated client #2 was counseled to watch her surroundings." 0/22/12 "[Client #2] tripped over her noes in her bedroom and fell resulting in in open area on her right knee. [Client 2] is safe. She has a fall prevention plan a place and it remains appropriate at this					
	report indicated resident for 8pr sitting on her bo resident what h explained she to scab on her right	0/22/12 internal incident I "Staff went to get n med pass. Resident was edroom floor, staff asked appened & (and) resident ripped over shoes. The nt knee was re-opened Resident also explained as hurting"					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G096		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		00	(X3) DATE SURVEY COMPLETED 01/17/2013	
			2745 W	/INDEMERE DR	E	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETIC DATE
at 12:36 PM. Cl Individual Suppo- client #2 was at 11/3/12 ISP indi High Risk Plant Client #2's recor a physical therap 7/16/12. The PT client had been s client's mobility The 7/16/12 PT client #2 no long #2's record and/o indicate the clien mobility re-asses falls. Interview with a 1/10/13 at 11:20 was at risk for fa #2 indicated client indicated client	lient #2's 11/3/12 ort Plan (ISP) indicated risk for falls. The cated client #2 had a for falls. d indicated the client had by (PT) evaluation on T evaluation indicated the seen by PT to increase the in her spine and hips. evaluation indicated ger needed PT. Client or 11/3/12 ISP did not nt's IDT had client #2's ssed due to the client's dministrative staff #2 on AM indicated client #2 alls. Administrative staff ent #2 was last seen by PT ministrative staff #2 #2's mobility had not been					
	ITY ALTERNATIV SUMMARY S (EACH DEFICIEN REGULATORY OR Client #2's record at 12:36 PM. Client #2 was at 11/3/12 ISP indid High Risk Plant Client #2's record a physical therap 7/16/12. The PT client had been so client's mobility The 7/16/12 PT client #2 no long #2's record and/of indicate the client mobility re-asset falls. Interview with a 1/10/13 at 11:20 was at risk for fa #2 indicated client indicated client re-assessed in ref	OVIDER OR SUPPLIER ITY ALTERNATIVES SW IN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Client #2's record was reviewed on 1/9/13 at 12:36 PM. Client #2's 11/3/12 Individual Support Plan (ISP) indicated client #2 was at risk for falls. The 11/3/12 ISP indicated client #2 had a High Risk Plan for falls. Client #2's record indicated the client had a physical therapy (PT) evaluation on 7/16/12. The PT evaluation indicated the client had been seen by PT to increase the client's mobility in her spine and hips. The 7/16/12 PT evaluation indicated client #2 no longer needed PT. Client #2's record and/or 11/3/12 ISP did not indicate the client's IDT had client #2's mobility re-assessed due to the client's falls. Interview with administrative staff #2 on 1/10/13 at 11:20 AM indicated client #2 was at risk for falls. Administrative staff #2 indicated client #2 was last seen by PT on 7/16/12. Administrative staff #2 indicated client #2's mobility had not been re-assessed in regard to the client's falls.	15G096 B. WI OVIDER OR SUPPLIER ITY ALTERNATIVES SW IN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Client #2's record was reviewed on 1/9/13 at 12:36 PM. Client #2's 11/3/12 Individual Support Plan (ISP) indicated client #2 was at risk for falls. 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Client #2's 11/3/12 Individual Support Plan (ISP) indicated client #2 was at risk for falls. The TAG 11/3/12 ISP indicated client #2 had a High Risk Plan for falls. The Client #2's record indicated the client had a physical therapy (PT) evaluation on 7/16/12. The PT evaluation indicated the client had been seen by PT to increase the client's mobility in her spine and hips. The 7/16/12 PT evaluation indicated client #2 no longer needed PT. Client #2's record and/or 11/3/12 ISP did not indicate the client's IDT had client #2's mobility re-assessed due to the client's falls. Interview with administrative staff #2 on 1/10/13 at 11:20 AM indicated client #2 was at risk for falls. Administrative staff #2 indicated client #2's mobility had not been re-assessed in regard to the client's falls.	15G096 B. WING OVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP COD 2745 WINDEMERE DR EVANSVILLE, IN 47725 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDERS PLANOF CORREC (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDERS PLANOF CORREC (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Client #2's record was reviewed on 1/9/13 at 12:36 PM. Client #2's 11/3/12 D PROVIDERS PLANOF CORREC (EACH DEFICIENCY) Individual Support Plan (ISP) indicated client #2's record indicated the client had a physical therapy (PT) evaluation on 7/16/12. The PT evaluation indicated the client #2's record indicated the client had a physical therapy (PT) evaluation on 7/16/12. The PT evaluation indicated client #2 no longer needed PT. Client #2's record and/or 11/3/12 ISP did not indicate the client's IDT had client #2's mobility re-assessed due to the client's falls. Interview with administrative staff #2 on 1/10/13 at 11:20 AM indicated client #2 was at risk for falls. Administrative staff #2' indicated client #2 was last seen by PT on 7/16/12. Administrative staff #2 indicated client #2's mobility had not been re-assessed in regard to the client's falls.	15G096 B. WING OTIDER OR SUPPLIER OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ITY ALTERNATIVES SW IN STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) PREFIX Client #2's record was reviewed on 1/9/13 TAG at 12:36 PM. Client #2's 11/3/12 Individual Support Plan (ISP) indicated Individual Support Plan (ISP) indicated elient #2's record indicated the client had a physical therapy (PT) evaluation on 7/16/12. The PT evaluation indicated the Client #2's record and/or 11/3/12 ISP did not indicated indicate the client's IDT had client #2's mobility re-assessed due to the client's falls. Interview with administrative staff #2 on 1/10/13 at 11:20 AM indicated client #2 was at risk for falls. Administrative staff #2 indicated client #2's mobility had not been re-assessed in regard to the client's falls.

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	(A2) MULTIPLE C	COMPLETED	
	condenon	15G096	A. BUILDING	00	01/17/2013
		100000	B. WING		01/1//2013
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
COMMUNITY ALTERNATIVES SW IN					
COMMU		VES SW IN	EVANS	SVILLE, IN 47725	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
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TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W0264	483.440(f)(3)(iii)	NITORING & CHANGE			
	The committee should review, monitor and make suggestions to the facility about its				
		ograms as they relate to			
		sical restraints, time-out			
		on of painful or noxious			
		f inappropriate behavior,			
		ent rights and funds, and any			
	need to be addr	the committee believes			
		vation, interview and	W0264	W264: Program Monitoring	02/16/201
		or 1 of 4 sampled clients		and Change	02/10/201
		•			
		y failed to have its Human		- Staff will be retrained o	n
		ts Committee (HRC) review and/or		client rights including restrictio	ns
		king of a client's hearing		on personal property.	
	aids.	de:		- Program Coordinator a	nd
				Operations Manager will be retrained on ensuring that clien	nt
	Findings includ			rights are not being violated in	
				home.	
	During the 1/9/	13 observation period		- Program Coordinator a	nd
	between 4:55 A	M and 7:00 AM, at the		Operations Manager will be	
	group home, ad	ministrative staff #3		retrained on gaining approval	
	•	#3's hearing aid container		from the IDT, guardian and/or individual, and Human Rights	
		nedication closet and		Committee on any rights	
		ring aids to the client to		restrictions prior to	
	place in both ea	-		implementation.	
		u.s.		- An IDT will be complete	
	Client //21	nd 1 1/0/12		on Client #3 in regards to lock	
		rd was reviewed on 1/9/13		her hearing aids when not in u - Human Rights Commit	
		ient #3's 11/2/12		will review restriction of hearin	
		oort Plan (ISP) indicated		aids.	
		objective to wear her		- If the Human Rights	
	hearing aid and	correctly store her hearing		Committee approves, the	
	aid when not in	use. Client #3's 11/2/12		Individual Support Plan will be	
	ISP and/or obje	ctive did not indicate the		updated to include restriction a	ana
	-	aids were to be locked.		goal will be put into place to address this area for Client #3	
	1		1		·

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YLH311

Facility ID: 000635

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED 00 . BUILDING 15G096 01/17/2013 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2745 WINDEMERE DR COMMUNITY ALTERNATIVES SW IN EVANSVILLE, IN 47725 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG The Program Coordinator Client #3's 11/2/12 ISP did not indicate will complete home visits on a the facility's Human Rights Committee weekly basis to ensure that reviewed and/or approved the restriction client's rights are not being of locking the client's hearing aids. violated specifically related to personal possessions and that ISP's are appropriate including Interview with administrative staff #2 on HRC approval related to client 1/10/13 at 11:20 AM indicated he thought restrictions for all clients in the client #3's hearing aids were being locked home. The Operation Manager in the medication closet as the client will complete home visits on a would lose her hearing aids. monthly basis to ensure that Administrative staff #3 indicated the client's rights are not being facility did not have its Human Rights violated specifically related to Committee review the rights restriction. personal possessions and that ISP's are appropriate including HRC approval related to client 9-3-4(a) restrictions for all clients in the home. Persons Responsible: Program Coordinator, Operations Manager FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: YLH311 Facility ID: 000635 If continuation sheet Page 10 of 13

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G096	A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/17/2013	
	NAME OF PROVIDER OR SUPPLIER		2745	T ADDRESS, CITY, STATE, ZIP CODE WINDEMERE DR ISVILLE, IN 47725		
(X4) ID PREFIX TAG W0484	(EACH DEFICIE REGULATORY O 483.480(d)(3)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE A CTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
W0484	DINING AREAS The facility must chairs, eating ut to meet the deve client. Based on obser record review ff (#1, #2, #3 and provide butter H cutting food. Findings includ During the 1/8/ between 4:00 P group home, fa encourage and/ place butter kni #1, #2, #3 and # lettuce, tomatoc hamburger bun PM, client #4 h her whole hamf asked client #4 hamburger cut her head yes. S #4's fork and at cut the hamburg and onions, in H let go of the for to cut the hamburger.	t equip areas with tables, ensils, and dishes designed elopmental needs of each vation, interview and for 4 of 4 sampled clients #4), the facility failed to chives to assist with	W0484	 W484: Dining Areas and Service Staff will be retrained of client rights including restriction related to knives in the home Staff will ensure that the clients have access to knives during meal times and to more use for safety of clients Program Coordinator at Operations Manager will be retrained on client rights in regards to knife restriction and allowing client's access during mealtimes with proper supervision. The Program Coordinator at client's rights are not being violated specific to being allow access to knives at meal times while supervised. The Operation Manager will complete home visits on at while supervised. The Operation Manager will complete home visits on at while supervised. The Operation Manager will complete home visits on at while supervised. The Operation Manager will complete home visits on at while supervised. The Operation Manager will complete home visits on at while supervised. The Operation Manager will complete home visits on at monthly basis to ensure that client's rights are not being violated specific to being allow access to knives at meal times while supervised. Persons Responsible: Prog Coordinator, Operations Manager will complete home visits on at while supervised. 	ons he hitor and d g ator a wed er a wed er a	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: YLH311

Facility ID: 000635

If continuation sheet Page 11 of 13

NTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-03	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G096	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED 01/17/2013	
NAME OF	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP (CODE		
COMML	JNITY ALTERNATIV	ES SW IN			INDEMERE DR VILLE, IN 47725			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
	lettuce, with a for #4 placed too m into her mouth. #4's fork to cut t quarters for the of #2, #3 and #4 als spoon to spread on their sandwice obtained a butter mayonnaise on t not offer and/or get and/or use a Client #2's recor at 12:36 PM. Cli Individual Suppoindicate the clien to butter knives. Client #1's recor at 1:16 PM. Clien not indicate the of access to butter I Client #4's recor 1/10/13 at 2:26 H ISP did not indic have access to b Client #3's recor at 3:10 PM. Clien	heir sandwich. Staff did encourage the clients to butter knife when needed. d was reviewed on 1/9/13 ient #2's 11/3/12 ort Plan (ISP) did not nt should not have access d was reviewed on 1/9/12 ent #1's 11/2/12 ISP did client should not have knives. d was reviewed on PM. Client #4's 11/10/12 eate the client should not utter knives. d was reviewed on 1/9/13 ent #3's 11/2/12 ISP did nt #3 should not have						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION 00	Č /	(X3) DATE SURVEY COMPLETED	
		15G096	A. BUILDING B. WING		01/17/2013		
NAME OF PROVIDER OR SUPPLIER		2745	ET ADDRESS, CITY, STATE, ZIF WINDEMERE DR	P CODE			
СОММО	NITY ALTERNATIV	/ES SW IN	EVA	NSVILLE, IN 47725			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE IE APPROPRIATE	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE	
	1/10/13 at 11:20	administrative staff #4 on) AM indicated butter ave been offered/placed meals.					
	9-3-8(a)						