STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G127	A. BUILDING 00 B. WING	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	1031 WEST ST NEW ALBANY, IN 47150

(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
W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included the investigation of Complaint #IN00212137. Complaint #IN00212137: Substantiated. Federal/state deficiencies related to the allegations are cited at W104 and W148. Survey Dates: December 5, 6, 7, 8, and 9, 2016. Facility Number: 000664 Provider Number: 15G127 AIMS Number: 100234310 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/28/16.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.			

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

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	Based on record review and interview for 1 of 4 sampled clients (A), the facility's governing body failed to exercise general policy, budget and operating direction over the facility to ensure the client's personal finances/resources were monitored when discrepancies arose to prevent his benefits from being discontinued. Findings include: Client A's financial records were reviewed on 12/05/16 at 2:00 PM. The client's RFMS/Resident Account Family Member Statement for the time period of 12/01/2015 to 12/01/16 indicated a balance of $444.17. The statement indicated the last social security benefit payment ($805.00) was credited to his RFMS account on 5/03/16. Client A's account continued to be debited for "care costs" (liability payments) on 6/06/16 for $827.00 and on 9/21/16 for $650.00. The facility's accounting staff was interviewed on 12/06/16 at 12:30 PM regarding client A's social security benefits. The interview indicated during a transition period from one accounting staff to another client A's social security and medicaid benefits had been interrupted (discontinued). The agency	W 0104	**W104:** The governing body must exercise general policy, budget and operating direction over the facility. **Corrective Action: (Specific):** Client A's Medicaid benefits were re-instated. The Business Manager had developed a tracking spreadsheet with all re-determination dates to ensure that all required documentation is sent to Medicaid timely to prevent loss of benefits. **How others will be identified: (Systemic):** The office coordinator maintains all documentation received from Medicaid and ensures that a copy is placed in each client's file that is stored in the business office. All requests for documentation from the Medicaid office are followed up on immediately and submitted prior to the deadline. All Medicaid calls for re-determination are placed on the calendar in the business office.	01/09/2017

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	had received a letter from social security in May of 2016 which indicated client A's benefits would cease as of August 1, 2016 and the agency had 60 days to address/correct the situation. The letter had not been given to the new accounting staff and there was no back up system in place to catch the error to address client A's situation. The benefits had ceased as of 8/1/2016. When the agency contacted the local social security office it was found that client A's social security number was being used by other individuals and he was the victim of identity theft. The agency had sent documentation (reviewed 12/07/16 at 9:00 AM) to the social security office on 10/04/2016 ("Statement of Claimant or Other Person") refuting the wages as not actually being client A's but belonging to persons unknown. A document received from the social security office dated 12/01/2016 indicated the client's case had been reviewed and his benefits were being reinstated. As of 12/08/2016, the social security payment had not yet resumed. Client A's medicaid benefit had not resumed at the time of the survey but was expected to at any time. This federal tag relates to complaint #IN00212137.		**Measures to be put in place:** Client A's Medicaid benefits were re-instated. The Business Manager had developed a tracking spreadsheet with all re-determination dates to ensure that all required documentation is sent to Medicaid timely to prevent loss of benefits. **Monitoring of Corrective Action:** The office coordinator maintains all documentation received from Medicaid and ensures that a copy is placed in each client's file that is stored in the business office. All requests for documentation from the Medicaid office are followed up on immediately and submitted prior to the deadline. All Medicaid calls for re-determination are placed on the calendar in the business office. **Completion Date: 1/09/2017**	

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	9-3-1(a)			
W 0148 Bldg. 00	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. Based on interview and record review for 1 of 4 sampled clients (A), the facility failed to ensure the client's legally appointed representative was informed of the agency's measures to resume the client's social security and medicaid benefits. Findings include: Client A's financial records were reviewed on 12/05/16 at 2:00 PM. The client's RFMS/Resident Account Family Member Statement for the time period of 12/01/2015 to 12/01/16 indicated a balance of $444.17. The statement indicated the last social security benefit payment ($805.00) was credited to his RFMS account on 5/03/16. Client A's account continued to be debited for "care costs" (liability payments) on 6/06/16 for $827.00 and on	W 0148	**W148:** The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition, including, but not limited to, serious illness, accident, death, abuse or unauthorized absence. **Corrective Action:** **(Specific):** Client A's guardian was notified when the letter from social security was received and she was provided weekly updates from the Business Manager on the progress of getting Client A's benefits re-instated since his benefits were lost. Client A moved to the waiver program.	01/09/2017

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	9/21/16 for $650.00. The facility's accounting staff was interviewed on 12/06/16 at 12:30 PM regarding client A's social security benefits. The interview indicated during a transition period from one accounting staff to another client A social security and medicaid benefits had been interrupted (discontinued). The agency had received a letter from social security in May of 2016 which indicated client A's benefits would cease as of August 1, 2016 and the agency had 60 days to address/correct the situation. The letter had not been given to the new accounting staff and there was no back up system in place to catch the error to address client A's situation. The benefits had ceased as of 8/1/2016. When the agency contacted the local social security office it was found that client A's social security number was being used by other individuals and he was the victim of identity theft. The agency had sent documentation (reviewed 12/07/16 at 9:00 AM) to the social security office on 10/04/2016 ("Statement of Claimant or Other Person") refuting the wages as not actually being client A's but belonging to persons unknown. Client A's guardian was interviewed on		**How others will be identified: (Systemic):** The Office Coordinator will be re-trained on ensuring that notification to parents and/or guardians is timely and updates are provided as often as requested by parents/guardians. The Business Manager will follow up with the Office Coordinator at least weekly and more often as indicated to ensure that notifications to parent's/guardians are completed timely and as often as requested. **Measures to be put in place:** Client A's guardian was notified when the letter from social security was received and she was provided weekly updates from the Business Manager on the progress of getting Client A's benefits re-instated since his benefits were lost. Client A moved to the waiver program. **Monitoring of Corrective Action:** The Office Coordinator will be re-trained on ensuring that notification to	

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	12/08/16 at 12:54 PM. The guardian indicated client A was in the process of moving into a supported living site (four days from the actual move) when it was discovered his benefits had ceased. He was unable to move to the site with a new provider because of the lack of funds. The guardian indicated client A or the guardian (who, until recently, had been Health Care Power of Attorney) had not been informed of the current status of the agency's actions in getting the client's benefits reinstated. A document (reviewed 12/07/16 at 9:00 AM) received from the social security office dated 12/01/2016 indicated the client's case had been reviewed and his benefits were being reinstated. The interview with the guardian indicated no knowledge of the client's social security being resumed. The interview indicated the guardian would have appreciated any good news concerning client A especially since this would affect his anticipated move to a less restrictive environment. This federal tag relates to complaint #IN00212137. 9-3-2(a)		parents and/or guardians is timely and updates are provided as often as requested by parents/guardians. The Business Manager will follow up with the Office Coordinator at least weekly and more often as indicated to ensure that notifications to parent's/guardians are completed timely and as often as requested. **Completion date: 01/09/2017**	

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W 0149 Bldg. 00	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 record review and interview for 2 of 10 investigations reviewed, affecting 4 of 4 sampled clients (A, B, C and D), and 4 additional clients (E, F, G and H), the facility failed to ensure their policies prohibiting abuse and neglect were implemented. Findings include: Facility investigations/incidents and those incidents reported to the BDDS (Bureau of Developmental Disabilities Services) were reviewed on 12/05/16 at 2:15 PM and on 12/08/16 at 12:45 PM and indicated the following: 1. An investigation dated July 24-27, 2016 indicated when staff #6 arrived on 7/24/16 at 7:55 AM, the door to the facility was open and third shift staff #6 was not there. The investigation indicated staff #6 had clocked in on 7/23/16 at 11:58 PM but he had not clocked out. Client G indicated when he got up there was no staff at the facility. Client G indicated he made coffee and breakfast for the clients and called the house manager. How long the clients (A, B, C, D, E, F, and G) had been left alone	W 0149	**W149:** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. **Corrective Action: (Specific):** All staff at the home will be re-trained on the Operation Standard for reporting and investigating abuse, neglect, exploitation, mistreatment or violation of client rights. **How others will be identified: (Systemic):** All client Behavior Support Plans will be reviewed to determine if any changes need to be made. All staff at the home will be re-trained on all clients Behavior Support Plans. The QIDP will visit the home at least weekly to ensure that all client plans are being followed as written and make any necessary changes as indicated.	01/09/2017

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	was unknown. 2. The review of incidents indicated the following client to client episodes of aggression: 11/4/16, client C hit clients A and F. 10/23/16, client E hit clients C and G. 10/17/16, clients B and C hit each other. 10/17/16, client B became loud at the dinner table which upset client D. Clients B and D yelled and kicked each other under the table. 9/14/16, client C hit client E with the palm of his hand. 9/12/16 at 9:00 AM on the van ride to workshop, clients C and G were physically aggressive twice. 9/8/16, client C cursed client D so client D hit client C. 8/29/16, clients A and B were verbally aggressive and client C hit client B. 8/23/16, client C hit client E on the arm. 8/19/16, client C hit client B. 8/10/16, clients D and G hit each other with their lunch boxes, client G's right hand was scratched. 7/4/16 at 5:30 PM, client G was cooking and client C was in the kitchen. The clients knocked the eyeglasses off of each other. 6/21/16, client C slapped client E. 5/23/16, client G was cooking dinner and asked client C to leave the kitchen. Client C hit the wall, client G scratched client C		**Measures to be put in place:** All staff at the home will be re-trained on the Operation Standard for reporting and investigating abuse, neglect, exploitation, mistreatment or violation of client rights. **Monitoring of Corrective Action:** All client Behavior Support Plans will be reviewed to determine if any changes need to be made. All staff at the home will be re-trained on all clients Behavior Support Plans. The QIDP will visit the home at least weekly to ensure that all client plans are being followed as written and make any necessary changes as indicated. **Completion date: 01/09/2017**	

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	in the face and knocked off client C's eyeglasses. The incident report by staff #5 indicated the clients "wrestled" for 15 seconds. 4/13/16, client C was "agitated" after breakfast and attempted to hit clients A and B. Client C hit a picture frame and cut his finger. Interview with Quality Assurance staff #1 on 12/08/16 at 2:00 PM indicated staff should not have abandoned the clients at the facility. This incident had been investigated as neglect of duties and the staff had been terminated. The interview indicated the agency prohibited client to client aggression. The agency's Operational Standard "Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or Violation of an Individual's Rights" revision date of 1/2016 was reviewed on 12/07/16 at 10:00 AM. The review indicated the agency prohibited staff neglect/abuse/exploitation of clients. The policy indicated all allegations would be investigated and addressed. The Operation's Standard included, in part, the following: "[The agency] strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights. These include and are defined as any of the			

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	15G127	A. BUILDING 00 B. WING	12/09/2016

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	following:...hitting...the infliction of physical pain...verbal abuse including screaming, swearing, name-calling, belittling, damaging an individual's self-respect or dignity... denial of...Medical treatment or care...." 9-3-2(a)			
W 0159 Bldg. 00	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on record review and interview for 2 of 4 sampled clients (A and C), the facility's Qualified Intellectual Disabilities Professional/QIDP) failed to monitor clients' programs at the workshop. Findings include: Client A's record was reviewed on 12/05/16 at 2:00 PM. Client A's monthly reviews had been signed/reviewed by the QIDP for August 2016 on 12/05/16. The October 2016 monthly had been signed by the QIDP on 11/30/16. There was no evidence client A had been monitored by a QIDP at the workshop except for	W 0159	**W159:** Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. **Corrective Action: (Specific):** The QIDP will be re-trained on timely completion of the monthly summary for each client and monitoring client's progress at workshop. **How others will be**	01/09/2017

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	15G127	A. BUILDING 00 B. WING	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	1031 WEST ST NEW ALBANY, IN 47150

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	quarterly or annual meetings. Client C's record was reviewed on 12/06/16 at 3:30 PM. Client C's monthly reviews had been signed/reviewed for August, September and October 2016 on 12/05/16 by QIDP #2. There was no evidence client C had been monitored by a QIDP at the workshop except for quarterly or annual meetings. Interview with Administrative staff #2 on 12/06/16 at 3:04 PM indicated no further information was available in regards to the QIDP's lack of monitoring client programs. 9-3-3(a)		**identified: (Systemic):** The Program Manager will visit the home at least weekly to ensure that all clients' program plans are being monitored, integrated and coordinated, that the QIDP is monitoring all clients at workshop and that all monthly summaries are being completed timely. **Measures to be put in place:** The QIDP will be re-trained on timely completion of the monthly summary for each client and monitoring client's progress at workshop. **Monitoring of Corrective Action:** The Program Manager will visit the home at least weekly to ensure that all clients' program plans are being monitored, integrated and coordinated, that the QIDP is monitoring all clients at workshop and that all monthly summaries are being completed timely. **Completion date: 01/09/2017**	

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W 0186 Bldg. 00	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 1 of 4 sampled clients (C), and 2 additional clients (E and G), the facility failed to ensure staff was available to direct clients' activities. Findings include: Observations were conducted at the facility on the evening of 12/05/16 from 4:15 PM until 6:30 PM. Client G was observed to cook dinner with staff #7 in attendance. Staff #4, the only other staff at the facility, did the medication administration and assisted clients with bathing. Clients C and E were in the kitchen area and were	W 0186	**W186:** The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. **Corrective Action: (Specific):** The Residential Manager will be in-serviced on ensuring that staffing ratios are consistent with the scheduled hours for the home. **How others will be identified: (Systemic):** The Area Supervisor will be at the home at least twice weekly to	01/09/2017

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	observed to be unable to independently pursue leisure activities with the other clients. Client G told client C repeatedly to leave the kitchen area. This continued with clients C and E being verbally redirected from the kitchen area until the meal was served at 5:47 PM. Facility investigations/incidents and those incidents reported to the BDDS (Bureau of Developmental Disabilities Services) were reviewed on 12/05/16 at 2:15 PM and on 12/08/16 at 12:45 PM and indicated a history of client C being in the kitchen when he was not the designated cook. 7/4/16 at 5:30 PM, client G was cooking and client C was in the kitchen. The clients knocked the eyeglasses off of each other. 5/23/16, client G was cooking dinner and asked client C to leave the kitchen. Client C hit the wall, client G scratched client C in the face and knocked off client C's eyeglasses. The incident report by staff #5 indicated the clients "wrestled" for 15 seconds. Interview with staff #7 on 12/05/16 at 5:30 PM indicated clients C and E required prompting to do activities and staff #4 was new and continuing to learn		ensure that staffing ratios are consistent with the scheduled hours for the home. The Program Manager will visit the home at least weekly to ensure that staffing ratios are consistent with the scheduled hours for the home. **Measures to be put in place:** The Residential Manager will be in-serviced on ensuring that staffing ratios are consistent with the scheduled hours for the home. The home schedule will be revised to ensure that there is at least two staff present in the morning to assist all individuals with morning routine and provide oversight and monitoring to all clients in the home. **Monitoring of Corrective Action:** The Area Supervisor will be at the home at least twice weekly to ensure that staffing ratios are consistent with the scheduled hours for the home. The Program Manager will visit the home at least weekly to ensure that staffing ratios are consistent with the scheduled hours for the home. **Completion date: 01/09/2016**	

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	15G127	A. BUILDING 00 B. WING	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	his duties. Sufficient staff should be available to provide support/redirection for clients. 9-3-3(a)			
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation and record review for 1 of 14 medications observed (client C), the facility failed to ensure the client received the correct dosage of a nasal spray for allergies (fluticasone). Findings include: Staff #1 was observed to administer medications to client C on 12/06/16 at 7:15 AM. Client C self administered fluticasone nasal spray one spray per nostril. Review of the fluticasone label on 12/06/16 at 7:24 AM indicated 2 sprays per nostril were to be administered.	W 0369	**W369:** The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. **Corrective Action:** **(Specific):** All staff working at the home will be re-trained on the Medication Administration Policies and Procedures. **How others will be identified: (Systemic):** The nurse will complete a medication observation at the home at least three times a week for the next 30 days	01/09/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G127	A. BUILDING 00 B. WING	12/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	1031 WEST ST NEW ALBANY, IN 47150

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	The client's physician's orders for 11/2016 were reviewed on 12/06/16 at 3:30 PM. The fluticasone's order was 2 sprays per nostril once daily. Interview with LPN #1 on 12/08/16 at 2:20 PM indicated there was an error in dosage with client C's fluticasone. Staff should have prompted client C to administer 2 sprays per nostril according to the label's instructions and the physician's orders. 9-3-6(a)		then at least weekly thereafter. **Measures to be put in place:** All staff working at the home will be re-trained on the Medication Administration Policies and Procedures. **Monitoring of Corrective Action:** The nurse will complete a medication observation at the home at least three times a week for the next 30 days then at least weekly thereafter. **Completion date: 01/09/2017**	
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview for 2 of 3 sampled clients, (A and B) who used adaptive equipment, the facility failed to ensure the clients had their hearing aids.	W 0436	**W436:** The facility must furnish, maintain in good repair and teach clients to use and make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces	01/09/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G127	A. BUILDING 00 B. WING	12/09/2016

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	Findings include: During observations at the facility on 12/05/16 from 4:15 PM until 6:30 PM and on 12/07/16 from 6:00 AM until 8:25 AM, clients A and B did not wear hearing aids. Staff were observed to repeat questions and answers to both clients during the observation periods. Client A's record was reviewed on 12/05/16 at 2:00 PM. The record indicated an ISP/Individual Support Plan dated 6/16/16 which had an objective for the client to change his hearing aid batteries. The record review indicated no data collection for 12/2016. Client B's record was reviewed on 12/06/16 at 1:50 PM. The client's 11/2/16 audio evaluation indicated his diagnosis included, but was not limited to, deafness in right ear. Interview with staff #1 (House Manager) indicated clients A and B were going to get new hearing aids soon. The clients did not have hearing aids at the time of the survey. Interview with Administrative staff #2 on 12/08/16 at 3:25 PM indicated client A wore bilateral hearing aids and client B was to wear a hearing aid in his right ear.		and other devises identified by the interdisciplinary team as needed by the client. **Corrective Action: (Specific**: Appointments will be scheduled for client's A and B to get new hearing aids. **How others will be identified: (Systemic):** The area supervisor will be in the home at least twice weekly for the next 30 days, then weekly thereafter to ensure all clients adaptive equipment is in the home and in good repair. **Measures to be put in place**: Appointments will be scheduled for client's A and B to get new hearing aids. **Monitoring of Corrective Action:** The area supervisor will be in the home at least twice weekly for the next 30 days, then weekly thereafter to ensure all clients adaptive equipment is in the home and	

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	15G127	A. BUILDING 00 B. WING	12/09/2016

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RES CARE COMMUNITY ALTERNATIVES SE IN	1031 WEST ST NEW ALBANY, IN 47150

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	9-3-7(a)		in good repair. **Completion date: 01/09/2017**	