

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2012
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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR MEMPHIS, IN 47143
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W0000	<p>This visit was for the investigation of Complaint #IN00106374 and Complaint #IN00106903.</p> <p>Complaint #IN00106374 - Substantiated, Federal and State deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W158, and W186.</p> <p>Complaint #IN00106903 - Substantiated, Federal and State deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W158, W186, W192, W318 and W340.</p> <p>Unrelated deficiency cited.</p> <p>Survey Dates: April 12, 13, 19, 23 and 25, 2012</p> <p>Facility Number: 004615 Provider Number: 15G723 AIM Number: 200528230</p> <p>Surveyor: Jo Anna Scott, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 5/18/12 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview, the facility's governing body failed to meet the Condition of Participation: Governing Body for 3 of 3 sampled clients (clients A, B and C) and 3 additional clients (clients D, E and F). The governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of clients, provided sufficient staffing to meet the clients' needs and trained staff to properly use a magnet/vagus nerve stimulator.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented written policy and procedure to prevent neglect of client A in regard to bolting (leaving premise or work site) behavior. Please see W122. The governing body failed to meet the Condition of Participation: Facility Staffing. The governing body failed to 	W0102	<p>Corrective Action: (Specific) The QMRP will develop a Behavior Support Plan for Client A for bolting (leaving premise or workshop) behavior. All staff will be trained on Client A's Behavior Support Plan. The Program Coordinator will be retrained that all individuals in this home must be supervised at all times to meet the individuals' needs, and the staffing pattern will be a minimum of three (3) staff on the day shift, three (3) on the evening shift, and two (2) on the night shift. All staff will be retrained on the use and safety measures for the magnet to be used with a vagus nerve stimulator.</p> <p>How others will be identified: (Systemic) Behavior Support Plans are completed on clients when a client behavior warrants a BSP. Staffing patterns are developed according to the guidelines for staffing ratios during the initial licensure of the home or the needs of the clients change. The nursing staff trains staff when medical conditions occur on each client.</p> <p>Measures to be put in place: The QMRP will develop a Behavior Support Plan for Client A for bolting (leaving premise or workshop) behavior. All staff will be trained on Client A's Behavior</p>	06/05/2012			

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	<p>exercise operating direction over the facility to prevent neglect of clients A, B, C, D, E and F in regards to providing sufficient staffing to meet the clients' needs. Please see W158.</p> <p>3. The governing body failed to meet the Condition of Participation: Health Care Services. The governing body failed to exercise general policy and operating direction over the facility to ensure staff followed safety measures for the magnet to be used with a vagus nerve stimulator for client C. Please see W318.</p> <p>4. The governing body failed to exercise operating direction over the facility to ensure staff implemented policies to prevent neglect of client A, failed to ensure sufficient staffing was in place to meet the needs of clients A, B, C, D, E and F, and failed to ensure staff properly used the magnet/vagus nerve stimulator for client C. Please see W104.</p> <p>This federal tag relates to complaints #IN00106374 and #IN00106903.</p> <p>9-3-1(a)</p>		<p>Support Plan. The Program Coordinator will be retrained that all individuals in this home must be supervised at all times to meet the individuals' needs, and the staffing pattern will be a minimum of three (3) staff on the day shift, three (3) on the evening shift, and two (2) on the night shift. All staff will be retrained on the use and safety measures for the magnet to be used with a vagus nerve stimulator.</p> <p>Monitoring of Corrective Action: The Director of Supervised Group Living will review all Individual Support Plans and Behavior Support Plans to ensure that client behaviors, such as bolting, are addressed in the plans. The Executive Director will review all staffing patterns to ensure compliance of the reimbursement guidelines for the individuals in this home. The Nurse will ensure that staff are trained when hired on the use and safety measures for the magnet to be used with a vagus nerve simulator.</p>		

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W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (clients A, B and C) and 3 additional clients (clients D, E and F), the governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent neglect of clients, provided sufficient staffing to meet the clients' needs and trained staff to properly use a magnet/vagus nerve stimulator.</p> <p>Findings include:</p> <ol style="list-style-type: none"> The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented written policy and procedure to prevent neglect of client A in regard to bolting (leave premise or work site) behavior. Please see W149. The governing body failed to exercise operating direction over the facility for clients A, B, C, D, E and F in regards to providing sufficient staffing. Please see W186. The governing body failed to exercise 	W0104	<p>Corrective Action: (Specific) The QMRP will develop a Behavior Support Plan for Client A for bolting (leaving premise or workshop) behavior. All staff will be trained on Client A's Behavior Support Plan. The Program Coordinator will be retrained that all individuals in this home must be supervised at all times to meet the individuals' needs, and the staffing pattern will be a minimum of three (3) staff on the day shift, three (3) on the evening shift, and two (2) on the night shift. All staff will be retrained on the use and safety measures for the magnet to be used with a vagus nerve stimulator.</p> <p>How others will be identified: (Systemic) Behavior Support Plans are completed on clients when a client behavior warrants a BSP. Staffing patterns are developed according to the guidelines for staffing ratios during the initial licensure of the home or the needs of the clients change. The nursing staff trains staff when medical conditions occur on each client.</p> <p>Measures to be put in place: The QMRP will develop a Behavior Support Plan for Client A for bolting (leaving premise or workshop) behavior. All staff will be trained on Client A's Behavior</p>	06/05/2012			

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	<p>operating direction over the facility to ensure staff followed safety measures with the magnet to be used with a vagus nerve stimulator. Please see W340.</p> <p>This federal tag relates to complaints #IN00106374 and #IN00106903.</p> <p>9-3-1(a)</p>		<p>Support Plan. The Program Coordinator will be retrained that all individuals in this home must be supervised at all times to meet the individuals' needs, and the staffing pattern will be a minimum of three (3) staff on the day shift, three (3) on the evening shift, and two (2) on the night shift. All staff will be retrained on the use and safety measures for the magnet to be used with a vagus nerve stimulator.</p> <p>Monitoring of Corrective Action: The Director of Supervised Group Living will review all Individual Support Plans and Behavior Support Plans to ensure that client behaviors, such as bolting, are addressed in the plans. The Executive Director will review all staffing patterns to ensure compliance of the reimbursement guidelines for the individuals in this home. The Nurse will ensure that staff are trained when hired on the use and safety measures for the magnet to be used with a vagus nerve simulator.</p>		

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 3 of 3 sampled clients (clients A, B and C) and 3 additional clients (clients D, E and F). The facility failed to implement written policy and procedure to prevent neglect of clients (client A) and failed to provide sufficient staffing to meet the clients' needs (clients A, B, C, D, E and F).</p> <p>Findings include:</p> <ol style="list-style-type: none"> The facility failed to implement written policy and procedure to prevent neglect of client A in regard to bolting (leave premise or work site) behavior. Please see W149. The facility failed for clients A, B, C, D, E and F to provide sufficient staffing to meet the clients' needs. Please see W186. <p>This federal tag relates to complaints #IN00106374 and #IN00106903.</p> <p>9-3-2(a)</p>	W0122	<p>Corrective Action: (Specific) The QMRP will develop a Behavior Support Plan for Client A for bolting (leaving premise or workshop) behavior. All staff will be trained on Client A's Behavior Support Plan. The Program Coordinator will be retrained that all individuals in this home must be supervised at all times to meet the individuals' needs, and the staffing pattern will be a minimum of three (3) staff on the day shift, three (3) on the evening shift, and two (2) on the night shift.</p> <p>How others will be identified: (Systemic) Behavior Support Plans are completed on clients when a client behavior warrants a BSP. Staffing patterns are developed according to the guidelines for staffing ratios during the initial licensure of the home or the needs of the clients change.</p> <p>Measures to be put inplace: The QMRP will develop a Behavior Support Plan for Client A for bolting (leaving premise or workshop) behavior. All staff will be trained on Client A's Behavior Support Plan. The Program Coordinator will be retrained that all individuals in this home must be supervised at all times to meet the individuals' needs, and the staffing pattern will be a</p>	06/05/2012			

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			<p>minimum of three (3) staff on the day shift, three (3) on the evening shift, and two (2) on the night shift.</p> <p>Monitoring of Corrective Action: The Director of Supervised Group Living will review all Individual Support Plans and Behavior Support Plans to ensure that client behaviors, such as bolting, are addressed in the plans. The Executive Director will review all staffing patterns to ensure compliance of the reimbursement guidelines for the</p>		

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W0149	<p>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.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (clients A, B and C) and 3 additional clients (clients D, E and F), the facility failed to implement their Abuse/Neglect/Exploitation Policy and Procedure in regard to having sufficient staffing to provide for the clients' needs and to prevent neglect of client A in regard to the client's elopement behavior.</p> <p>Findings include:</p> <p>1. During the observation period on 4/13/12 from 3:00 PM to 8:00 PM, client F was the only client in the home with staff #2, Program Coordinator (PC) from 3:00 PM to 3:35 PM. Client A arrived at the home at 3:35 PM from his day program. Staff #2, PC, indicated on 4/13/12 at 3:15 PM she would have to be Client A's 1:1 (one to one staff) and client #4's until someone else came in to work. Staff #2, PC, indicated there was a shortage of staff until they could get some new people trained. Clients B, C, D and E arrived home from their day program at 3:55 PM with two staff. The third staff arrived at 4:00 PM.</p>	W0149	<p>Corrective Action: (Specific) The Program Coordinator will be retrained that the staffing pattern at this home must be sufficient to implement each client's Behavior Support. The Program Coordinator will be trained that Client A's BSP must have the 1 on 1 on 1 staffing as stated in the BSP. All staff will be retrained on Client A's BSP. How others will be identified: (Systemic) Staffing patterns are developed at time of licensure for the homes and when client behaviors and health status warrant a staffing change. Measures to be put in place: The Program Coordinator will be retrained that the staffing pattern at this home must be sufficient to implement each client's Behavior Support. The Program Coordinator will be trained that Client A's BSP must have the 1 on 1 on 1 staffing as stated in the BSP. All staff will be retrained on Client A's BSP. Monitoring of Corrective Action: Staffing patterns are approved by the Executive Director when client behaviors and client health status change.</p>	06/05/2012			

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	<p>The record review for client A was conducted on 4/12/12 at 6:20 PM. The record indicated his Behavior Support Plan (BSP) dated 1/13/12 had the following target behaviors:</p> <p>Physical Aggression - Hitting, kicking, pushing, scratching, clenching fists and biting.</p> <p>Verbal Disruption - Yelling, Screaming, Cursing, intense crying tantrums.</p> <p>Property Destruction - Throwing items, kicking furniture, slamming doors.</p> <p>Verbal Threats - Statement or physically suggest harm.</p> <p>Non-Compliance - Refused to comply within three verbal prompts.</p> <p>Food Foraging, Stealing - Seeking out and consuming food.</p> <p>Bolting - Leaving premise, work site.</p> <p>Skin Picking - repeatedly picking skin.</p> <p>Theft - Stealing food or peers items.</p> <p>Lying - Telling an untrue story about self or others.</p> <p>The BSP indicated client A was to have a 1:1 staffing while in the home during waking hours. Client A did not have 1:1 staffing from 3:35 PM to 3:55 PM.</p> <p>Interview with staff #2, PC, on 4/12/12 at 5:00 PM indicated the home manager had transferred to another home and they were short of staff. Staff #2, PC, indicated she</p>						

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	<p>was working in the home to help cover the shortage of staff. Staff #2, PC, indicated the staffing level for the home was 2 staff for the overnight shift, 3 staff for the first shift and 3 staff for the second shift.</p> <p>Review of the facility time cards for the period of 4/7/12 through 4/11/12 was conducted on 4/12/12 at 3:00 PM. The time cards indicated the facility did not have sufficient staffing to provide the 1:1 staffing for client A and to provide for the needs of clients B, C, D, E and F on 4/9/12, 4/10/12, and 4/11/12. The staffing levels were as follows:</p> <p>4/9/12 - 1 staff from 12:00 AM to 6:00 AM 2 staff from 8:00 AM to 4:00 PM 1 staff from 4:00 PM to 12:00 AM</p> <p>4/10/12 - 2 staff from 6:00 AM to 8:00 AM 2 staff from 8:00 AM to 4:00 PM 1 staff from 4:00 PM to 12:00 AM</p> <p>4/11/12 - 1 staff from 12:00 AM to 8:30 AM 1 staff from 8:30 AM to 4:00 PM 2 staff from 3:45 PM to 5:30 PM</p>				

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	<p>PM 1 staff from 10:00 PM to 12:00 AM</p> <p>Review of the Abuse/Neglect/Exploitation Policy and Procedure (undated) was done on 4/12/12 at 1:00 PM. The Policy defined Neglect - Emotional/Physical as follows: "1. Failure to provide goods and/or services necessary for the individual to avoid physical harm. 2. Failure to provide the support necessary to an individual's psychological and social well being. 3. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment."</p> <p>2. Review of the facility incident reports was conducted on 4/12/12 at 11:00 AM. The Bureau of Developmental Disability Services (BDDS) report dated 3/28/12 indicated Client A had gone to the local recreational center with his one to one staff on the evening of 3/27/12. Client A went into the locker room to use the restroom and his one to one staff staff stayed outside the door to provide him privacy. Client A exited the locker room by the back door. The investigation indicated the staff was unaware of the locker room having a back door. The police were contacted and the client was</p>				

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	<p>found walking along a busy parkway. The 1 to 1 staff was placed on administrative leave pending the investigation.</p> <p>Interview with staff #4, administrator, on 4/12/12 at 2:30 PM indicated the investigation had been completed and the findings indicated the staff was reinstated and client A was to use a different restroom that did not have an exit door to the outside in the future. Staff #4, administrator, indicated they did not feel the staff was at fault because the staff person did not think a locker room would have a door to the outside. There was no indication the staff had been retrained on 1 to 1 guidelines for client A.</p> <p>Review of the Abuse/Neglect/Exploitation Policy and Procedure (undated) was done on 4/12/12 at 1:00 PM. The Policy defined Neglect - Program Implementation/Intervention as follows: "1. Failure to provide goods and/or services necessary for the individual to avoid physical harm. 2. Intentional failure to implement a support plan, inappropriate application of intervention, etc. which may result in jeopardy without qualified person notification/review."</p> <p>This federal tag relates to complaints</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR MEMPHIS, IN 47143		
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	#IN00106374 and #IN00106903. 9-3-2(a)				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2012
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W0158	<p>483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met.</p> <p>Based on record review and interview for 3 of 3 sampled clients (clients A, B and C) and 3 additional clients (clients D, E and F), the facility failed to meet the Condition of Participation: Facility Staffing. The facility failed to provide sufficient staff to supervise and monitor the clients in regards to clients' health and behavioral needs.</p> <p>Findings include:</p> <p>The facility failed to provide sufficient staffing to supervise clients' (A, B, C, D, E and F) training needs and behaviors. Please see W186.</p> <p>The facility failed to provide documentation staff were trained in regards to the Vagus Nerve Stimulator (VNS) magnet for client C being stored too close to the VNS. Please see W192.</p> <p>This federal tag relates to complaints #IN00106374 and #IN00106903.</p> <p>9-3-3(a)</p>	W0158	<p>Corrective Action: (Specific) The Program Coordinator will be retrained that all individuals in this home must be supervised at all times to meet the individuals' needs, and the staffing pattern will be a minimum of three (3) staff on the day shift, three (3) on the evening shift, and two (2) on the night shift. The Program Coordinator will also be retrained on Client A's BSP and the need for 1:1 staffing.</p> <p>How others will be identified: Staffing patterns are developed according to the guidelines for staffing ratios during the initial licensure of the home or the needs of the clients change. The Program Coordinator will review the needs of the consumers who reside in the home at least on an annual basis or when significant changes in the condition of the individuals occur, and determine the appropriate staffing ratios.</p> <p>Measures to be put in place: The Program Coordinator will be retrained that all individuals in this home must be supervised at all times to meet the individuals' needs, and the staffing pattern will be a minimum of three (3) staff on the day shift, three (3) on the evening shift, and two (2) on the night shift. The Program Coordinator will also be retrained on Client A's BSP and the need</p>	06/05/2012	

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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR MEMPHIS, IN 47143
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			for 1:1 staffing. Monitoring of Corrective Action: Staffing patterns are developed according to the guidelines for staffing ratios during the initial licensure of the home or the needs of the clients change. The Program Coordinator will review the needs of the consumers who reside in the home at least on an annual basis or when significant changes in the condition	

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W0186	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>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.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (clients A, B and C) and 3 additional clients (clients D, E and F), the facility failed to ensure there were sufficient direct care staff to manage and supervise clients' physical and behavioral needs.</p> <p>Findings include:</p> <p>During the observation period on 4/12/12 from 4:45 PM to 5:30 PM client A had a 1 to 1 staff and they were getting ready to go to the recreation center to workout. Staff #6 indicated on 4/12/12 at 5:00 PM client A needed to have 1 to 1 staffing because of behavior. Clients B and D were using motorized wheelchairs, while client E was using a wheelchair that he propelled by using one leg. Client C was wearing a helmet. Staff #2 indicated on 4/12/12 at 5:00 PM client C had to have a helmet because of the seizures he had when there were loud noises. Staff #6 was assigned to work with client A and</p>	W0186	<p>Corrective Action: (Specific) The Program Coordinator will be retrained that all individuals in this home must be supervised at all times to meet the individuals' needs, and the staffing pattern will be a minimum of three (3) staff on the day shift, three (3) on the evening shift, and two (2) on the night shift. The Program Coordinator will also be retrained on Client A's BSP and the need for 1:1 staffing.</p> <p>How others will be identified: Staffing patterns are developed according to the guidelines for staffing ratios during the initial licensure of the home or the needs of the clients change. The Program Coordinator will review the needs of the consumers who reside in the home at least on an annual basis or when significant changes in the condition of the individuals occur, and determine the appropriate staffing ratios.</p> <p>Measures to be put in place: The Program Coordinator will be retrained that all individuals in this home must be supervised at all times to meet the individuals'</p>	06/05/2012	

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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR MEMPHIS, IN 47143		
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	<p>staff #2 was the only staff working with clients B, C, D, E and F.</p> <p>During the observation period on 4/13/12 from 3:00 PM to 8:00 PM, client D was the only client in the home with staff #2, Program Coordinator (PC), from 3:00 PM to 3:35 PM. Client A arrived home at 3:35 PM from his day program. Client A did not have a 1:1 staff and the PC indicated she would have to be the 1:1 with client A. Clients B, C, E and F arrived at the home at 3:55 PM from their day program with 2 staff. The third staff did not arrive until 4:00 PM.</p> <p>The record review for client A was conducted on 4/12/12 at 6:20 PM. The record indicated his Behavior Support Plan (BSP) dated 1/13/12 had the following target behaviors:</p> <p>Physical Aggression - Hitting, kicking, pushing, scratching, clenching fists and biting.</p> <p>Verbal Disruption - Yelling, screaming, cursing, intense crying tantrums.</p> <p>Property Destruction - Throwing items, kicking furniture, slamming doors.</p> <p>Verbal Threats - Statement or physically suggest harm.</p> <p>Non-Compliance - Refused to comply within three verbal prompts.</p> <p>Food Foraging - Stealing, seeking out</p>		<p>needs, and the staffing pattern will be a minimum of three (3) staff on the day shift, three (3) on the evening shift, and two (2) on the night shift. The Program Coordinator will also be retrained on Client A's BSP and the need for 1:1 staffing.</p> <p>Monitoring of Corrective Action: Staffing patterns are developed according to the guidelines for staffing ratios during the initial licensure of the home or the needs of the clients change. The Program Coordinator will review the needs of the consumers who reside in the home at least on an annual basis or when significant changes in the condition of the individuals occur, and determine the appropriate staffing ratios.</p>		

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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR MEMPHIS, IN 47143
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	<p>and consuming food.</p> <p>Bolting - Leaving premise, work site.</p> <p>Skin Picking - repeatedly picking skin.</p> <p>Theft - Stealing food or peers items.</p> <p>Lying - Telling an untrue story about self or others.</p> <p>The BSP indicated client A was to have a 1 to 1 staffing while in the home during waking hours.</p> <p>Review of the facility time cards for the period of 4/7/12 through 4/11/12 was conducted on 4/12/12 at 3:00 PM. The time cards indicated the facility did not have sufficient staffing to provide the 1 to 1 staffing for client A and to provide for the needs of clients B, C, D, E and F. Review of the time cards for five days indicated there were three days that had insufficient staffing. Staff #2, PC, indicated on 4/12/12 at 5:00 PM the staffing level for the home was 2 staff for the overnight shift, 3 staff for the first shift and 3 staff for the second shift. The staffing levels for the three days are as follows:</p> <p>4/9/12 - 1 staff from 12:00 AM to 6:00 AM</p> <p>2 staff from 8:00 AM to 4:00 PM</p> <p>1 staff from 4:00 PM to 12:00 AM</p>			

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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR MEMPHIS, IN 47143			
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	<p>4/10/12 - 2 staff from 12:00 AM to 8:00 AM 2 staff from 8:00 AM to 4:00 PM 1 staff from 4:00 PM to 12:00 AM</p> <p>4/11/12 - 1 staff from 12:00 AM to 8:30 AM 1 staff from 8:30 AM to 3:45 PM 2 staff from 3:45 PM to 5:30 PM 1 staff from 10:00 PM to 12:00 AM</p> <p>Interview with staff #6 on 4/12/12 at 6:05 PM indicated when they had to work short staffed, they often did not have time to train on goals or assist with the personal needs of the clients. Staff #6 indicated 2 of the clients needed total assistance when transferring and with personal needs.</p> <p>Interview with staff #2, PC, on 4/12/12 at 5:00 PM indicated the home manager had transferred to another home and they were short of staff. Staff #2, PC, indicated she was working in the home to help cover the shortage of staff. There was no documentation to show the time the PC worked in the home.</p> <p>This federal tag relates to complaints #IN00106374 and #IN00106903.</p> <p>9-3-3(a)</p>						

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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR MEMPHIS, IN 47143
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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR MEMPHIS, IN 47143		
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W0192	<p>483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client C), the facility failed to ensure the Vagus Nerve Stimulator (VNS) magnet was stored a safe distance from the VNS.</p> <p>Findings include:</p> <p>The facility's Bureau of Developmental Disability Services (BDDS) incident reports were reviewed on 4/12/12 at 10:00 AM. The BDDS report dated 4/9/12 for client C had the following information: "On 4/9/12 [client C] arrived at [day program] to attend the program. When [client C] arrived staff noticed immediately that he had his mouth fully open with his tongue curled up into the back of his throat. They also noted he was tense in the neck and shoulders with his muscles hardened and stiff. His pupils were fully responsive and he was moving his arms and legs fine which ruled out a seizure. Staff then noted that [client C's] VNS magnet was attached to his helmet and hanging down touching his VSN (sic) implant in his chest. Staff immediately removed this from his helmet away from the implant. 10 minutes after VNS magnet was removed staff noted [client</p>	W0192	<p>Corrective Action: (Specific) The facility nurse and all staff will be retrained on the appropriate storage of the VNS Magnet for client C. In addition, the VNS Magnet has been fastened to the rear of the helmet by the use of Velcro for easy access to the magnet and to prevent the magnet from being placed in front of the VNS when not in use.How others will be identified: (Systemic) All individuals that have a VNS will have the VNS Magnet located in an area that is easily accessible and be kept where it will interfere with the device when not being used.Measures to be put in place: The facility nurse and all staff will be retrained on the appropriate storage of the VNS Magnet for client C. In addition, the VNS Magnet has been fastened to the rear of the helmet by the use of Velcro for easy access to the magnet and to prevent the magnet from being placed in front of the VNS when not in use.Monitoring of Corrective Action: The Program Coordinator will monitor all staff to ensure that the magnet is kept in a place that is readily accessible and that will not</p>	06/05/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2012	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR MEMPHIS, IN 47143			
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	<p>C] closed his jaw and had some decrease in his neck and jaw muscles. [Client C] then started pointing to his forehead repetitively (sic). [Name of provider] nurse arrived and decided to take him to the ER (emergency room) to be examined."</p> <p>Review of client C's record was conducted on 4/12/12 at 6:15 PM. The Individualized Support Plan dated 3/30/12 did not indicate how the VNS was to be stored and how the staff was to ensure the magnet was available when needed. There was no documentation in the record indicating where the magnet should be stored and how the VNS magnet was to be used.</p> <p>Interview with staff #3, administrator, on 4/12/12 at 7:00 PM indicated client C's neurologist had recommended the magnet be placed at the back on the inside of the helmet to ensure it was always quickly available. The facility failed to provide documentation the neurologist had recommended putting the magnet in the helmet.</p> <p>Interview with direct care staff #7 on 4/12/12 at 7:15 PM indicated the magnet had been hard to reach inside the back of the helmet because it was hard to get the helmet off when client C was having a</p>						

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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR MEMPHIS, IN 47143		
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	<p>seizure. Staff #7 indicated the magnet had been hung from the ear piece on the helmet and this had allowed the magnet to cross over the VNS.</p> <p>Staff #3, administrator, indicated on 4/12/12 at 7:00 PM the staff are trained on the use of the magnet with the VNS but did not provide documentation.</p> <p>This federal tag relates to complaint #IN00106903.</p> <p>9-3-3(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2012	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR MEMPHIS, IN 47143			
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W0318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.</p> <p>Based on record review and interview, the facility's nursing services failed to meet the Condition of Participation: Health Care Services for 1 of 6 clients living in the home (client C). The nursing services failed to provide adequate training to direct care staff to prevent neglect of a client in regards to the magnet being stored far enough away from the Vagus Nerve Stimulator (VNS) when client C is not having a seizure.</p> <p>Findings include:</p> <p>The facility's Nursing services failed to ensure the direct care staff were trained on keeping client C's magnet stored a sufficient distance from the VNS. Please see W340.</p> <p>This federal tag relates to complaint #IN00106903.</p> <p>9-3-6(a)</p>	W0318	<p>Corrective Action: (Specific) The facility nurse and all staff will be retrained on the appropriate storage of the VNS Magnet for client C. In addition, the VNS Magnet has been fastened to the rear of the helmet by the use of Velcro for easy access to the magnet and to prevent the magnet from being placed in front of the VNS when not in use.</p> <p>How others will be identified: (Systemic) All individuals that have a VNS will have the VNS Magnet located in an area that is easily accessible and be kept where it will interfere with the device when not being used.</p> <p>Measures to be put in place: The facility nurse and all staff will be retrained on the appropriate storage of the VNS Magnet for client C. In addition, the VNS Magnet has been fastened to the rear of the helmet by the use of Velcro for easy access to the magnet and to prevent the magnet from being placed in front of the VNS when not in use.</p> <p>Monitoring of Corrective Action: The Program Coordinator will monitor all staff to ensure that the magnet is kept in a place that is readily accessible and that will not interfere will the proper use of the device.</p>	06/05/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/25/2012
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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR MEMPHIS, IN 47143
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W0340	<p>483.460(c)(5)(i) NURSING SERVICES</p> <p>Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client C), the facility's nursing services failed to ensure the direct care staff were trained to keep the magnet for the Vagus Nerve Stimulator (VNS) far enough away from the VNS except when needed for the client when he was having a seizure.</p> <p>Findings include:</p> <p>The facility's Bureau of Developmental Disability Services (BDDS) incident reports were reviewed on 4/12/12 at 10:00 AM. The BDDS report dated 4/9/12 for client C had the following information: "On 4/9/12 [client C] arrived at [day program] to attend the program. When [client C] arrived staff noticed immediately that he had his mouth fully open with his tongue curled up into the back of his throat. They also noted he was tense in the neck and shoulders with his muscles hardened and stiff. His pupils were fully responsive and he was moving his arms and legs fine which ruled out a seizure. Staff then noted that [client C's]</p>	W0340	<p>Corrective Action: (Specific) The facility nurse and all staff will be retrained on the appropriate storage of the VNS Magnet for client C. In addition, the VNS Magnet has been fastened to the rear of the helmet by the use of Velcro for easy access to the magnet and to prevent the magnet from being placed in front of the VNS when not in use.How others will be identified: (Systemic) All individuals that have a VNS will have the VNS Magnet located in an area that is easily accessible and be kept where it will interfere with the device when not being used.Measures to be put in place: The facility nurse and all staff will be retrained on the appropriate storage of the VNS Magnet for client C. In addition, the VNS Magnet has been fastened to the rear of the helmet by the use of Velcro for easy access to the magnet and to prevent the magnet from being placed in front of the VNS when not in use.Monitoring of Corrective Action: The Program Coordinator will monitor all staff to ensure that the magnet is kept in a place that is readily accessible</p>	06/05/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2012	
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	<p>VNS magnet was attached to his helmet and hanging down touching his VSN (sic) implant in his chest. Staff immediately removed this from his helmet away from the implant. 10 minutes after VNS magnet was removed staff noted [client C] closed his jaw and had some decrease in his neck and jaw muscles. [Client C] then started pointing to his forehead repetitively (sic). [Name of provider] nurse arrived and decided to take him to the ER (Emergency Room) to be examined."</p> <p>Review of client C's record was conducted on 4/12/12 at 6:15 PM. The Individualized Support Plan dated 3/30/12 did not indicate how the VNS was to be stored and how the staff was to ensure the magnet was available when needed. There was no documentation in the record indicating where the magnet should be stored and how the VNS magnet was to be used.</p> <p>Interview with staff #3, administrator on 4/12/12 at 7:00 PM indicated client C's neurologist had recommended the magnet be placed at the back on the inside of the helmet to ensure it was always quickly available. The facility failed to provide documentation the neurologist had recommended putting the magnet in the helmet.</p>		and that will not interfere will the proper use of the device.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/25/2012	
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	<p>Interview with direct care staff #7 on 4/12/12 at 7:15 PM indicated the magnet had been hard to reach inside the back of the helmet because it was hard to get the helmet off when client C was having a seizure. Staff #7 indicated the magnet had been hung from the ear piece on the helmet and this had allowed the magnet to cross over the VNS when client C was not having a seizure.</p> <p>Staff #3, administrator, indicated on 4/12/12 at 7:00 PM the staff are trained on the use of the magnet with the VNS but did not provide documentation.</p> <p>This federal tag relates to Complaint #IN00106903.</p> <p>9-3-6(a)</p>						

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W0446	<p>483.470(i)(2)(ii) EVACUATION DRILLS</p> <p>The facility must make special provisions for the evacuation of clients with physical disabilities.</p> <p>Based on observation and interview for 3 of 6 clients (clients C, E and F) living in the home, the facility failed to ensure the ramp off the patio was safe for wheelchairs.</p> <p>Findings include:</p> <p>During the 4/13/12 observation at 7:30 PM, the home had two exit doors to use for evacuations. The back exit from the house went out to a patio that had a ramp to go down to get to ground level. The ramp from the patio at the back door of the home was blocked with a couple of lawn chairs and the bottom was not level with the ground. Part of the ground had washed away and one side of the ramp was 4 inches from the ground while the other side touched the ground. Clients C and F used motorized wheelchairs and client E used a regular wheelchair.</p> <p>Interview with staff #2, Program Coordinator (PC), on 4/13/12 at 7:35 PM indicated the back exit door was to be used for evacuation drills if the front door was blocked. Staff #2 indicated the lawn chairs had just been placed on the ramp. Staff #2, PC, indicated the people</p>	W0446	<p>Corrective Action: (Specific) The facility has received quotes to pour a concrete sidewalk that expands from the wheelchair ramp of the deck to the concrete of driveway to provide a safe evacuation from the home. The work will be completed by July 1, 2012.</p> <p>How others will be identified: (Systemic) The Program Coordinator will conduct evacuation drills per the facility's policy and review each drill to ensure that all evacuation plans are safe and ensure a successful evacuation during all conditions.</p> <p>Measures to be put in place: The facility has received quotes to pour a concrete sidewalk that expands from the wheelchair ramp of the deck to the concrete of driveway to provide a safe evacuation from the home. The work will be completed by July 1, 2012.</p> <p>Monitoring of Corrective Action: All drills and evacuation plans will be submitted to the facility's Quality Assurance Department for review. In addition, the Program Coordinator will conduct evacuation drills per the</p>	06/05/2012			

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	mowing the lawn would mow around the chairs if they were left in the yard and they were just on the ramp because they had just mowed. Staff #2, PC, indicated there needed to be some dirt added to make the exit from the ramp safe for the clients. 9-3-7(a)		facility's policy and review each drill to ensure that all evacuation plans are safe and ensure a successful evacuation during all		