

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000000	<p>This visit was for an annual fundamental recertification and state licensure survey.</p> <p>Dates of Survey: September 17, 18, 19, 22, 23 and 24, 2014</p> <p>Facility Number: 000693 Provider Number: 15G157 AIM Number: 100234510</p> <p>Surveyor: Jo Anna Scott, QIDP</p> <p>The following deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/7/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p>			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130			
(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			
	<p>Based on record review and interview for 1 of 4 sampled clients (client #4) and 2 additional clients (clients #5 and #7), the governing body failed to exercise operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent abuse and neglect, failed to report an allegation of neglect and failed to complete an investigation within 5 working days.</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 clients #4, #5 and #7 in regard to incidents of client to client aggression and eloping. Please see W149. The governing body failed to exercise general policy and operating direction over the facility to ensure an allegation of neglect by client #7 had been reported to BDDS (Bureau of Developmental Disabilities Services). Please see W153. The governing body failed to exercise general policy and operating direction over the facility to ensure an investigation of an allegation of neglect 	W000104	<p>W104: The governing body must exercise general policy, budget and operating direction over the facility. Corrective Action: (Specific): The Behavior Support Plans for client's #4, #5 and #7 will be reviewed in regards to physical aggression, threats to harm self and elopement to determine if any programming changes need to be made. If a change to client's #4, #5 and #7 behavior support plan are made; those changes will be implemented after approval from guardian and HRC if indicated. The clinical supervisor will be in-serviced on reporting all incidents of abuse neglect are reported to BDDS per policy and procedure and that all allegations of neglect are investigated and completed within the 5 working days. How others will be identified: (Systemic): The behavior support plans for all other consumers in the home will be reviewed and changes will be made if necessary. The Program Manager will review incident reports and investigations at least weekly to ensure that all reports required are filed with BDDS and that all investigations are completed within 5 working days per policy and procedure. The QIDP will complete weekly visits to the home to review behavior documentation the effectiveness of all behavior support plans. Measures to be put in place: The Behavior Support Plans for</p>	10/24/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130
---	---

(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
W000126	<p>by client #7 was completed within 5 working days. Please see W156.</p> <p>9-3-1(a)</p> <p>483.420(a)(4) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent</p>		<p>client's #4, #5 and #7 will be reviewed in regards to physical aggression, threats to harm self and elopement to determine if any programming changes need to be made. If a change to client's #4, #5 and #7 behavior support plan are made; those changes will be implemented after approval from guardian and HRC if indicated. The clinical supervisor will be in-serviced on reporting all incidents of abuse neglect are reported to BDDS per policy and procedure and that all allegations of neglect are investigated and completed within the 5 working days. Monitoring of Corrective Action: The behavior support plans for all other consumers in the home will be reviewed and changes will be made if necessary. The Program Manager will review incident reports and investigations at least weekly to ensure that all reports required are filed with BDDS and that all investigations are completed within 5 working days per policy and procedure. The QIDP will complete weekly visits to the home to review behavior documentation the effectiveness of all behavior support plans. Completion date: 10/24/14</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130			
(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			
	<p>of their capabilities.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client #1), the facility failed to ensure the client's finances were kept according to recommended procedures.</p> <p>Findings include:</p> <p>The financial records of the money kept in the home were reviewed on 9/22/14 at 4:00 PM. Client #1's cash kept in the home was counted by staff #2, HM (Home Manager) and indicated client #1 had \$45.41 cash and 1 \$40.00 RFMS (Resident Account Family Member Statement) check dated 9/4/14 and 1 RFMS check dated 9/17/14. The account ledger for September, 2014 indicated client #1 had not taken money out of the home during the month.</p> <p>The procedures dated 12/4/13 to be followed by residential managers in regards to consumer's finances were reviewed 9/23/14 at 2:30 PM. The procedures were listed as follows: "There is to be no more than \$50.00 at any one time in the consumer's finances. There should never be any un-cashed checks from their RFMS accounts. These should be cashed when received. If the client's balance is getting close</p>	W000126	<p>W126: The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.</p> <p>Corrective Action: (Specific) The residential manager and all staff in the home will be in-serviced on the procedures in regards to client finances, cashing checks immediately and making sure that no client has more than \$50.00 in the home account. Client #1's checks have been cashed and the home account has no more than \$50.00 in it.</p> <p>How others will be identified: (Systemic) The residential manager will review all client finances in the home at least weekly to ensure that there is no un-cashed check and that no client account has more than \$50.00 in it. The clinical supervisor will review the client finances at least weekly to ensure that there is no un-cashed check and that no client account has more than \$50.00 in it.</p> <p>Measures to be put in place: The residential manager and all staff in the home will be in-serviced on the procedures in regards to client finances, cashing checks immediately and</p>	10/24/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000149	<p>to \$50.00, please take them shopping."</p> <p>Interview with staff #2, HM, on 9/22/14 at 4:15 PM indicated she did not know why client #1 had two uncashed RFMS checks. Staff #2, HM, indicated client #1 went home with her mother a lot and they never took money from her account.</p> <p>Interview with administrative staff #1 on 9/23/14 at 2:30 PM indicated the home should not have had uncashed checks and the client should have had opportunities to spend her money.</p> <p>9-3-2(a)</p> <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. Based on record review and interview for 1 of 4 sampled clients (client #4) and 2 additional clients (clients #5 and #7), the facility neglected to implement their Abuse/Neglect/Exploitation Policy and Procedure in regard to client to client aggression, incidents of elopement and threats of suicide.</p> <p>Findings include:</p>	W000149	<p>making sure that no client has more than \$50.00 in the home account. Client #1's checks have been cashed and the home account has no more than \$50.00 in it.</p> <p>Monitoring of Corrective Action: The residential manager will review all client finances in the home at least weekly to ensure that there is no un-cashed check and that no client account has more than \$50.00 in it. The clinical supervisor will review the client finances at least weekly to ensure that there is no un-cashed check and that no client account has more than \$50.00 in it. Completion date: 10/24/14</p> <p>W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Corrective Action: (Specific): The Behavior Support Plans for client's #4, #5 and #7 will be reviewed in regards to physical aggression, threats to harm self and elopement to determine if</p>	10/24/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130			
(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			
	<p>The facility internal incident reports and BDDS (Bureau of Developmental Disability Services) incident reports were reviewed on 9/17/14 at 1:45 PM and on 9/18/14 at 9:30 AM. The internal reports were as follows:</p> <ol style="list-style-type: none"> 8/14/14 - Client #5 cut her arm with broken glass on purpose. 911 was called and client #5 was taken to hospital. 8/12/14 - Client #7 scratched her arm with a pencil on purpose. First aid was applied. 12 to 15 scratches from elbow to wrist on inside of arm. 8/6/14 - "[Client #5] just came back from running down the road for the second time. Staff were both in the kitchen and were talking to each other. I [staff #6] started singing a song and [staff #3] was laughing at me. [Client #5] was mad at staff for talking to each other and laughing at each other. She took off down the road again yelling and screaming and slammed the front door. [Staff #4] went after [client #5] and never let her out of sight. [Staff #2, HM] also drove over to help with [client #5]. [Staff #2, HM] didn't let her out of sight. Staff safely redirected [client #5] back to [name of home]." 8/4/14 - "Dishes being done by [client #5] in the kitchen and [client #6] was walking through and [client #5] 		<p>any programming changes need to be made. If a change to client's #4, #5 and #7 behavior support plan are made; those changes will be implemented after approval from guardian and HRC if indicated. The clinical supervisor will be in-serviced on reporting all incidents of abuse neglect are reported to BDDS per policy and procedure and that all allegations of neglect are investigated within the 5 working days. The facility continues to search for alternate placement for client #5 and BDDS has sent a referral packet out to other providers.</p> <p>How others will be identified: (Systemic): The behavior support plans for all other consumers in the home will be reviewed and changes will be made if necessary. The Program Manager will review incident reports and investigations at least weekly to ensure that all reports required are filed with BDDS and that all investigations are completed within 5 working days per policy and procedure. The QIDP will complete weekly visits to the home to review behavior documentation the effectiveness of all behavior support plans.</p> <p>Measures to be put in place: The Behavior Support Plans for client's #4, #5 and #7 will be reviewed in regards to physical aggression, threats to harm self</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130			
(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			
	<p>provoked [client #6] by telling her to get out of kitchen. [Client #5] and [client #6] were screaming, yelling and cussing each other out. They wouldn't stop for about 10 minutes. Staff asked [client #6] to go into her room."</p> <p>5. 8/4/14 - "Staff stopped at [name of drugstore] to pick up med's. [Staff #7] stayed in the van with clients and [staff #8] went inside to pick up med's (medicine). [Client #5] and [client #4] started screaming and yelling. [Client #5] said 'I will beat your a-- [client #4].' Both were screaming and yelling at each other. Staff told [client #4] to move up to the front of the van to prevent any further incidents. After staff returned to [address of home] and clients were getting off the van, [client #5 and client #4] started yelling at each other [Client #5] yelled 'come on and hit me b----' and [client #4] struck [client #5]. At that point both girls were down on the ground. Both girls had minor injury."</p> <p>The BDDS reports reviewed were as follows:</p> <p>1. 9/12/14 - "Staff was on the phone with the nurse asking a question about medication for a client. [Client #5] asked staff to use the phone and got upset when they told her she would have to wait until they were off the phone with the nurse.</p>		<p>and elopement to determine if any programming changes need to be made. If a change to client's #4, #5 and #7 behavior support plan are made; those changes will be implemented after approval from guardian and HRC if indicated. The clinical supervisor will be in-serviced on reporting all incidents of abuse neglect are reported to BDDS per policy and procedure and that all allegations of neglect are investigated within the 5 working days. The facility continues to search for alternate placement for client #5 and BDDS has sent a referral packet out to other providers.</p> <p>Monitoring of Corrective Action: The behavior support plans for all other consumers in the home will be reviewed and changes will be made if necessary. The Program Manager will review incident reports and investigations at least weekly to ensure that all reports required are filed with BDDS and that all investigations are completed within 5 working days per policy and procedure. The QIDP will complete weekly visits to the home to review behavior documentation the effectiveness of all behavior support plans. Completion date: 10/24/14</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130			
(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			
	<p>[Client #5] became verbally aggressive and ran out of the home. Staff followed but [client #5] was moving too fast and got out of line of sight. She was out of sight for about one minute and did not travel more than a quarter of a mile away from the home. When she returned home staff told [client #5] she would have to go to the ER (emergency room) to be examined because staff lost sight of her. [Client #5] became very upset again and ran to her room and locked the door saying she was going to kill herself. Staff got the keys to unlock the door. During this time [client #5] had broke (sic) a light bulb and was trying to cut herself with the glass. She managed to make a small cut on arm between wrist and elbow. Staff had gotten into the room and took the glass away from [client #5]. They attempted to provide first aid but [client #5] was resisting. Staff called the nurse who instructed them to call 911. EMT's (Emergency Medical Technician) arrived at the home to examine [client #5]. They decided to transport her to the hospital for further examination. The hospital physician and psychiatrist agreed to admit [client #5] to [name of hospital], a psychiatric inpatient unit."</p> <p>2. 8/30/14 - "On 8/30/14 [client #7] left the group home due to an argument with staff. The manager and nurse were notified and staff got in their vehicle to</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130
---	---

(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
	<p>follow [client #7]. Staff kept [client #7] in sight and followed her to private property near the group home where she sat down. Staff asked [client #7] to get in the car so staff could take her home. When the police arrived [client #7] told them she would not return home and stated that she wanted to hurt herself. The police called EMS due to claims of [client #7] wanting to hurt herself. EMS arrived on the scene to examine [client #7]. [Client #7] then started complaining of chest pain. EMS transported [client #7] to the [name of hospital] where she was admitted to the Behavior Health Unit for further evaluation."</p> <p>3. 8/14/14 - "[Client #5] arrived home from workshop and began to insist to be taken out in the community. Staff were assisting with dinner preparation and redirected her to wait until dinner was finished. [Client #5] went to her room and locked herself inside. Staff immediately followed [client #5] and used the master key for the bedroom to get inside. When staff entered the room [client #5] had used a piece of broken glass to cut her arm. Her arm was bleeding, staff immediately provided first aid and called 911 then notified the nurse and manager to advise them of the situation. The 911 operator forwarded the call to the [name of police department]. The police arrived with the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130
---	---

(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
	<p>ambulance and [client #5] was taken to the ER. The wounds on the arm were superficial and no treatment was needed. A psychological evaluation was completed but the physician did not feel that inpatient admission was warranted...."</p> <p>4. 8/11/14 - "The residents were preparing to sit down to evening dinner. The staff were following the one to one protocol as stated in the BSP, [client #5] became verbally aggressive with staff concerning a date night she wanted to arrange with a peer at another home. Staff were providing verbal redirection in accordance with the BSP. [Client #5] continued her verbal aggression as she walked outside to the front yard. She was very loud and using profanities as the staff continued to redirect her behavior. The neighbors overheard the profanity and called the police to intervene. The police arrived and redirected [client #5] to go inside the home. The residential manager arrived on site and also redirected [client #5] to go inside the home. [Client #5] complied and went back into the home as staff continued the one to one support. The police left without any charges being filed. [Client #5] then calmed down and continued with the routine of the evening."</p> <p>5. 8/5/14 - "[Client #5] wanted to know where a particular staff was and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130
---	---

(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
	<p>when the staff at the home told her that the staff she was asking about was out of the home on an errand [client #5] began to yell at staff. [Client #5] then told the staff that she was going to leave and started walking out of the home into the yard. Staff attempted to redirect [client #5] back to the house but [client #5] refused and kept walking. Staff kept [client #5] in line of sight and continued to attempt redirection while she contacted the residential manager. The residential manager immediately left to go to the home to assist and contacted the program manager while en route. The staff at the home was unable to leave the house to follow [client #5] because there were 2 other house mates at the home. Before the residential manager and program manager made it to the home from the main office [client #5] returned to the home. [Client #5] suffered no injury as a result of the incident, was dressed appropriately for the weather and has safe pedestrian skills. The home and surrounding area is in a sub division with no main intersections or busy streets close. The Program Manager discussed the incident with [client #5] when she arrived explaining that it is not safe for her to leave the home when she is upset and discussed other options such as going to her room to calm down or sitting out back on the swing...."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130
---	---

(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
	<p>6. 8/9/14 - "[Client #7] had an appointment to speak to her therapist. [Client #7] told her therapist she was having conflicts with her family that were creating thoughts of suicide. The therapist developed a safety plan for [client #7]. If she is having thoughts of self injury or suicide she is to tell staff and to call the crisis line. [Client #7] should talk to a support staff that she trusts. Her therapist asked that she be transported to [name of hospital] for further evaluation. The doctor at [name of hospital] supported the safety plans developed by the therapist. She was instructed to follow up with her outpatient mental health provider...".</p> <p>7. 7/3/14 - "[Client #4 and client #5] got into a verbal argument with each other over [client #4's] boyfriend. Staff redirected both girls per the BSP's but before they could get the girls completely redirected away from each other [client #5] bit [client #4] on her leg and elbow. The bit (sic) did not break the skin and [client #5] received no injury as a result of the incident. The staff were able to separate the ladies and redirect them away from each other. [Client #4] called 911 and the [name of police department] arrived at the home. The police spoke with both the girls and when they checked for any recent problems or outstanding legal issues they noted that</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130
---	---

(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
	<p>[client #5] has an outstanding warrant from [name of county] for failure to pay court costs, fines and fees. The police arrested [client #5] and booked her into the [name of county] county jail."</p> <p>8. 6/13/14 - "[Client #7] and [client #5] were upset and began yelling at each other. This behavior escalated until the ladies started smacking each other. [Client #7] bit [client #5's] thumb and [client #5] was taken to ER for evaluation."</p> <p>9. 4/23/14 - "[Client #4] was on the phone with her father and became upset and started yelling. [Client #5] slapped [client #4] for yelling and then ran. [Client #4] ran after her and [client #5] bit [client #4] multiple times. Both individuals were separated and redirected to their rooms to calm down. [Client #4] was taken to the ER for evaluation. The ER physician assessed [client #4], diagnosed her with multiple superficial human bite wounds to right shoulder, right arm, left hand and right ankle...."</p> <p>10. 4/3/14 - "[Client #4] was on the phone at dinner and was asked by staff to end her call until after dinner. [Client #4] refused to hang up and became physically aggressive towards staff and [client #5]. [Client #4] then hit [client #5] in the mouth with a closed fist and [client #5's] bottom lip became swollen. Redirection techniques were used to separate the two</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130
---	---

(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
	<p>ladies. Another individual panicked and called the police. The police arrived and held [client #4] by the arms as she continued to be physically aggressive. The residential manager arrived to de-escalate the situation and calm the ladies. Staff applied an ice pack to [client #5's] bottom lip for swelling...."</p> <p>The BSP for client #5 was reviewed on 9/23/14 at 11:00 AM. The record book had two BSPs included. The BSP dated 8/7/14 indicated the following: "Due to an increase in physical aggression towards others, the team has decided that [client #5] will be 1:1 (one on one staffing) while in the home. Staff will be positioned within 5 feet of [client #5] at all times in the home. They should also be positioned between [client #5] and other roommates. [Client #5] should also be 5 feet away from other roommates while they are in the house. If there is a situation where there is not a way to keep her 5 feet away from the others, such as at the dinner table, staff should be positioned on each side of her to prevent her from getting to other roommates."</p> <p>The BSP dated 9/12/14 indicated the following addition: "Also the 1:1 will not be the staff member that [client #5] comes to get her requests filled. She will have to ask other staff members in the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130
---	---

(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
	<p>house if she needs anything. The 1:1 is there to provide protection for the other consumers and staff in the house. The 1:1 should not be giving [client #5] much attention at all while they are 1:1 with her. [Client #5] should not be getting extra attention so that being 1:1 does not become enjoyable for her. It is only in place for safety. She can talk to anyone else besides the 1:1. When [client #5] is in her room and there is (sic) no other clients around [client #5] is not 1:1. However, it starts back up immediately once she leaves that bedroom." The BSP dated 9/12/14 also included an addition of the following reactive procedures: "If [client #5] engages in threats - In the past when [client #5] has been making threats towards others she has reliably acted on those threats. To ensure that no one is getting injured the staff members will now implement YSIS (You're Safe I'm Safe) when she is threatening herself or others to prevent her from actually completing the chain of behaviors where someone gets hurt. Once she is calm staff should release the YSIS."</p> <p>The interview with staff #2, HM, on 9/23/14 at 11:00 AM indicated clients #4 and #7 usually went to their rooms when client #5 started having a behavior. Staff #2, HM indicated all the clients in the home had learned to clear out of the area</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130
---	---

(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
	<p>when client #5 started yelling. Staff #2, HM, indicated the BSP was changed again on 9/12/14 and they haven't had a chance to determine how it will work since client #5 went into the hospital on 9/12/14 and didn't return to the home until 9/19/14. Staff #2, HM, stated client #4 was "doing much better" and client #7 was refusing to go to work but "nothing compared" to client #5. Staff #2, HM, stated client #5 was "demanding of all the staff attention" and didn't want the other clients to get extra attention or special outings.</p> <p>Interview with client #7 on 9/22/14 at 2:00 PM stated she didn't like client #5 because she "was always starting fights." Client #7 indicated she didn't like to be called names and client #5 would call them names. Client #7 indicated she liked the home when client #5 was gone.</p> <p>The interview with administrative staff #1, on 9/22/14 at 2:30 PM indicated they were actively looking for other placement for client #5. Administrative staff #1 indicated client #5 had gone on a couple of visits to other homes.</p> <p>The Abuse/Neglect/Exploitation Policy dated 8/1/07 and revised 7/2/12 for the facility was reviewed on 9/24/14 at 2:30 PM. The policy indicated "ResCare staff</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130
---	---

(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
W000153	<p>actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and/or exploitation shall be reported and thoroughly investigated. Res Care strictly prohibits abuse, neglect and/or exploitation."</p> <p>9-3-2(a)</p> <p>483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, record review and interview for 1 additional client (client #7), the facility failed to report an allegation of neglect made by client #7 to the Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p>	W000153	<p>W153: The facility must ensure that all allegations of mistreatment, neglect or abuse as well as injuries of unknown source are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Corrective Action: (Specific):</p>	10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130			
(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			
	<p>During the observation period on 9/17/14 from 3:45 PM to 7:05 PM, client #7 informed the surveyor that she had a cell phone that could take pictures. Client #7 indicated she had taken a picture of staff sleeping while she was waiting for her at a medical appointment. The picture showed someone sitting covered with a blanket; the picture did not show enough to determine if person was asleep.</p> <p>The facility incident reports and BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 9/18/14 at 9:30 AM. The facility did not have a report for the allegation made by client #7. The facility did provide an incident report on 9/23/14 at 2:30 PM indicating it was a late report.</p> <p>Interview with staff #2, HM (Home Manager) on 9/18/14 at 8:00 AM indicated client #7 had returned from the medical appointment on 9/10/14 indicating she had taken the picture of staff asleep. Staff #2, HM, indicated she notified the appropriate people immediately and the staff was placed on leave pending an investigation.</p> <p>Interview with administrative staff #1 on 9/23/14 at 2:30 PM indicated the allegation had not been reported to BDDS and an investigation had been</p>		<p>The clinical supervisor will be in-serviced on reporting all incidents of abuse neglect are reported to BDDS per policy and procedure and that all allegations of neglect are investigated and completed within the 5 working days.</p> <p>How others will be identified: (Systemic): The Program Manager will review incident reports and investigations at least weekly to ensure that all reports required are filed with BDDS and that all investigations are completed within 5 working days per policy and procedure.</p> <p>Measures to be put in place: The clinical supervisor will be in-serviced on reporting all incidents of abuse neglect are reported to BDDS per policy and procedure and that all allegations of neglect are investigated and completed within the 5 working days.</p> <p>Monitoring of Corrective Action: The Program Manager will review incident reports and investigations at least weekly to ensure that all reports required are filed with BDDS and that all investigations are completed within 5 working days per policy and procedure. Completion date: 10/24/14</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130			
(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
W000156	<p>started but the staff could not be reached until this past weekend.</p> <p>9-3-2(a)</p> <p>483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 5 investigations of client abuse and/or neglect, the facility failed to complete an investigation of staff falling asleep while on a medical appointment with client #7 within 5 working days.</p> <p>Findings include:</p> <p>The 5 facility investigations of allegations of staff abuse and/or neglect were reviewed on 9/18/14 at 1:00 PM. The reports provided did not include the allegation made by client #7 on 9/10/14 of staff sleeping while on a medical appointment with her.</p> <p>Interview with staff #2, HM (Home Manager) on 9/18/14 at 8:00 AM</p>			W000156	<p>W156: The results of all investigations must be reported to the administrator or designated representative or other officials in accordance with State law within five working days of the incident.</p> <p>Corrective Action: (Specific): The clinical supervisor will be in-serviced on reporting all incidents of abuse neglect are reported to BDDS per policy and procedure and that all allegations of neglect are investigated and completed within the 5 working days.</p> <p>How others will be identified: (Systemic): The Program Manager will review incident reports and investigations at least weekly to ensure that all reports</p>		10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W000210	<p>indicated the staff had been sent home that evening because of the allegation, but she did not have an outcome of the investigation.</p> <p>Interview with administrative staff #1 on 9/23/14 at 2:30 PM indicated the investigation was in process and they had been unable to reach the staff that had been accused of sleeping. Staff #1, indicated it was impossible to tell if the staff was asleep from the picture. Administrative staff #1 indicated they had not sent the allegation to BDDS (Bureau of Developmental Disabilities Services), but the investigation was in process. Administrative staff indicated they had been unable to reach the staff that had been removed from duty.</p> <p>9-3-2(a)</p> <p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 2 of 4 sampled clients (clients #1 and #3), the facility failed to ensure</p>			W000210	<p>required are filed with BDDS and that all investigations are completed within 5 working days per policy and procedure.</p> <p>Measures to be put in place: The clinical supervisor will be in-serviced on reporting all incidents of abuse neglect are reported to BDDS per policy and procedure and that all allegations of neglect are investigated and completed within the 5 working days.</p> <p>Monitoring of Corrective Action: The Program Manager will review incident reports and investigations at least weekly to ensure that all reports required are filed with BDDS and that all investigations are completed within 5 working days per policy and procedure. Completion date: 10/24/14</p> <p>W210: Within 30 days after admission, the interdisciplinary</p>		10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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	
	<p>comprehensive functional assessments were completed within 30 days of admission to the facility.</p> <p>Findings include:</p> <p>The CFAs (Comprehensive Functional Assessments) were reviewed for clients #1 and #3 on 9/23/14 at 11:00 AM. Client #1 and client #3 did not have a CFA on file.</p> <p>Interview with staff #2, HM (Home Manager), on 9/23/14 at 11:00 AM indicated client #1 and client #3 were admitted into the home in April, 2014 and the CFAs had not been done.</p> <p>9-3-4(a)</p>		<p>team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Corrective Action: (Specific): Client #1 and client #3 will have a CFA completed and on file in the home. The QIDP and the Residential Manager will be in-serviced on the completion of a CFA for all admissions within 30 days after admission to the facility.</p> <p>How others will be identified: (Systemic): The CFA for all other clients in the home will be reviewed to ensure completion. The Clinical Supervisor will review all assessments for all new admissions to ensure that all clients admitted to the facility have a CFA completed within 30 days of the admission date. The program manager will review all admission paperwork for all new admissions and ensure that all assessments including the comprehensive functional assessment is completed within the 30 day time frame of the admission date</p> <p>Measures to be put in place: Client #1 and client #3 will have a CFA completed and on file in the home. The QIDP and the Residential Manager will be in-serviced on the completion of a CFA for all admission within 30</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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	
W000259	<p>483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview for 1 of 4 sampled clients (client #4) and 3 additional clients (clients #5, #6 and #7), the facility failed to ensure the CFAs (Comprehensive Functional Assessments) were reviewed annually. Findings include:</p>	W000259	<p>days after admission to the facility.</p> <p>Monitoring of Corrective Action: The CFA for all other clients in the home will be reviewed to ensure completion. The Clinical Supervisor will review all assessments for all new admissions to ensure that all clients admitted to the facility have a CFA completed within 30 days of the admission date. The program manager will review all admission paperwork for all new admissions and ensure that all assessments including the comprehensive functional assessment is completed within the 30 day time frame of the admission date Completion date: 10/24/14</p> <p>W259: At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p> <p>Corrective Action: (Specific): Client #4, #5, #6 and #7's</p>	10/24/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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	
	<p>The record review of the CFAs was conducted on 9/23/14 at 11:00 AM. The record indicated the CFAs for clients #4, #5, #6 and #7 were dated 4/8/13.</p> <p>The interview with staff #2, HM (Home Manager) on 9/23/14 at 11:00 AM indicated the interdisciplinary team had not reviewed the CFAs for clients #4, #5, #6 and #7 this year. Staff #2, HM, indicated they were behind and it should have been done.</p> <p>9-3-4(a)</p>		<p>comprehensive functional assessments will be reviewed to ensure all assessments are accurate and up to date. Any changes to plans based on the comprehensive functional assessments will be implemented and staff will be trained on those changes. The QIDP and the Residential Manager will be in-serviced on the completion of a CFA for all consumers at least annually.</p> <p>How others will be identified: (Systemic): The CFA for all other clients in the home will be reviewed to ensure all assessments are up to date. Any changes to plans based on the comprehensive functional assessment will be implemented and staff will be trained on those changes. The QIDP will review client records on a monthly basis to ensure that all clients comprehensive functional assessments are completed at least annually.</p> <p>Measures to be put in place: Client #4, #5, #6 and #7's comprehensive functional assessments will be reviewed to ensure all assessments are accurate and up to date. Any changes to plans based on the comprehensive functional assessments will be implemented and staff will be trained on those changes. The QIDP and the Residential Manager will be</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130
---	---

(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
W000268	<p>483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation, record review and interview for 1 of 4 sampled clients (client #1), the facility failed to ensure the client's dignity in regard to the use of make-up.</p> <p>Findings include:</p> <p>During the observation period on 9/17/14 from 3:45 PM to 7:05 PM, client #1</p>	W000268	<p>in-serviced on the completion of a CFA for all admissions within 30 days after admission to the facility.</p> <p>Monitoring of Corrective Action: The CFA for all other clients in the home will be reviewed to ensure all assessments are up to date. Any changes to plans based on the comprehensive functional assessment will be implemented and staff will be trained on those changes. The QIDP will review client records on a monthly basis to ensure that all clients comprehensive functional assessments are completed at least annually. Completion date: 10/24/14</p> <p>W268: These policies and procedures must promote the growth, development and independence of the client.</p> <p>Corrective Action: (Specific): The QIDP will meet with the team to review assessments and develop a goal for client #1 to learn how to apply makeup correctly.</p>	10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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	
	<p>arrived home from her day program wearing eye make-up with eye shadow that went up past the eye brow. Client #1 went on an outing with her mother at 5:45 PM with the eye make-up smeared.</p> <p>During the observation period on 9/18/14 from 5:45 AM to 8:00 AM, client #1 came to breakfast at 6:13 AM wearing eye make-up that covered the entire eye on the left side going past the eye brow. Client #1 was also wearing lipstick that was smeared outside the lip line.</p> <p>Interview with staff #2, Home Manager, HM, on 9/18/14 at 8:00 AM indicated client #1 put on her own make-up and never got it on correctly. Staff #2, HM, indicated client #1 did not like to have assistance applying the make-up.</p> <p>Interview with workshop staff #1 on 9/22/14 at 10:30 AM stated it was not unusual for client #1 to come to day program looking like a "clown."</p> <p>9-3-5(a)</p>		<p>How others will be identified: (Systemic): The residential manager and the staff will make sure that client #1 as well as all other clients in the home have their makeup applied correctly before they leave the home and assist if needed.</p> <p>Measures to be put in place: The QIDP will meet with the team to review assessments and develop a goal for client #1 to learn how to apply makeup correctly.</p> <p>Monitoring of Corrective Action: The residential manager and the staff will make sure that client #1 as well as all other clients in the home have their makeup applied correctly before they leave the home and assist if needed.</p> <p>Completion date: 10/24/14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/24/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130
---	---

(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
W000436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>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.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (client #2), the facility failed to ensure glasses were provided.</p> <p>Findings include:</p> <p>The record review for client #2 was conducted on 9/19/14 at 10:38 AM. The vision assessment dated 1/13/14 indicated client #2 required glasses. The recommendation indicated a prescription was written for "Primarily distant vision, may remove for close reading."</p> <p>During the observation period on 9/17/14 from 3:45 PM to 7:05 PM and on 9/18/14 from 5:45 AM to 8:00 AM, client #2 was not observed with glasses.</p> <p>Interview with staff #3, LPN (Licensed Practical Nurse) on 9/19/14 at 10:19 AM indicated client #2 did not have glasses when she moved into the home and the script for the glasses had just now been sent in to be filled. Staff #3, LPN, did</p>	W000436	<p>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 and other devices identified by the interdisciplinary team as needed by the client.</p> <p>Corrective Action: (Specific): Client #2's glasses have been obtained. The residential manager, staff and the nurse will be in-serviced on ensuring that all clients have all required adaptive equipment timely.</p> <p>How others will be identified: (Systemic): The nurse manager and the clinical supervisor will review all physician recommendations at least weekly to ensure that all clients have all required adaptive equipment in the home.</p> <p>Measures to be put in place: Client #2's glasses have been obtained. The residential manager, staff and the nurse will be in-serviced on ensuring that all</p>	10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130			
(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
W000440	<p>not indicate why the glasses had not been ordered.</p> <p>9-3-7(a)</p> <p>483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 4 of 4 sampled clients (clients #1, #2, #3 and #4) and 3 additional clients (clients #5, #6 and #7), the facility failed to conduct an evacuation drill on the overnight shift quarterly.</p> <p>Findings include:</p> <p>The record of evacuation drills were reviewed on 9/19/14 at 1:00 PM. The record indicated clients #1, #2, #3, #4, #5, #6 and #7 did not have an overnight shift evacuation drill conducted in October, November and December, 2013, and January, February and March, 2014.</p> <p>Interview with staff #2, HM (Home Manager) on 9/19/14 at 1:30 PM</p>			W000440	<p>clients have all required adaptive equipment timely.</p> <p>Monitoring of Corrective Action: The nurse manager and the clinical supervisor will review all physician recommendations at least weekly to ensure that all clients have all required adaptive equipment in the home. Completion date: 10/24/14</p> <p>W440: The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Corrective Action: (Specific): The residential manager will be in serviced on the completion of fire drills quarterly for each shift of personnel.</p> <p>How others will be identified: (Systemic) The Clinical Supervisor will review completed drills monthly to ensure that drills are being conducted at least quarterly for each shift of personnel.</p> <p>Measures to be put in place: The residential manager will be in serviced on including the completion of fire drills quarterly for each shift of personnel.</p>		10/24/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G157	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/24/2014
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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	
	<p>indicated there was an evacuation drill conducted on 1/29/14 at 7:00 AM that should have been done while the clients were sleeping. Staff #2, HM, indicated there was no record of any drills being conducted in October, November or December, 2013 on the overnight shift.</p> <p>9-3-7(a)</p>		<p>Monitoring of Corrective Action: The Clinical Supervisor will review completed drills monthly to ensure that drills are being conducted at least quarterly for each shift of personnel. Completion date: 10/24/14</p>		