

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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 |
|--------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|----------------------|
| W0000              | <p>This visit was for a full recertification and state licensure survey.</p> <p>This visit was in conjunction with a post certification revisit (PCR) to the investigation of complaint #IN00106374 and complaint #IN00106903 completed on 4/25/12.</p> <p>Complaint #IN00106374 - Not Corrected.</p> <p>Complaint #IN00106903 - Not Corrected.</p> <p>Dates of Survey: June 4, 5, 6, 7 and 8, 2012</p> <p>Facility Number: 004615<br/>Provider Number: 15G723<br/>AIMS Number: 2005289230</p> <p>Surveyors:<br/>Jo Anna Scott, Medical Surveyor III - Team Leader<br/>Paula Chika, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 6/20/12 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.

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PERCEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|
|                          |                                                                                                                              |                     |                                                                                                                          |                            |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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                                                           |  |                                             |  |
| W0102                                                                     | <p>483.410<br/>GOVERNING BODY AND MANAGEMENT<br/>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 1 of 3 sampled clients (client C). 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 of clients.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>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 C in regard to behavior. Please see W122.</li> <li>The governing body failed to implement written policy and procedure to prevent neglect of client C in regard to 1 to 1 staffing and wound care. The governing body failed to implement written policy and procedure to prevent neglect of client C in regard to the client's behavior. Please see W104.</li> </ol> | W0102                                                           | <p><b>W 102:</b> The facility must ensure that specific governing body and management requirements are met.</p> <p><b>Corrective Action: (Specific)</b><br/>The Abuse, Neglect, and Exploitation Policy and Procedure were revised to include preventing and addressing neglect in regard to client's behavior. All staff was re-trained on the revised Abuse and Neglect Policy and Procedure. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were re-trained on client C's revised BSP. Client C was referred to Wound Care for evaluation and treatment.</p> <p><b>How others will be identified: (Systemic):</b> The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective.</p> <p><b>Measures to be put in place:</b></p> | 07/08/2012                                                                     |  |                                             |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                        | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                        |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                      |                                             |
| (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 |                                             |
|                                                                           | 9-3-1(a)                                                                                                               |                                                                 | <p>The Abuse, Neglect, and Exploitation Policy and Procedure were revised to include preventing and addressing neglect in regard to client's behavior. All staff was re-trained on the revised Abuse and Neglect Policy and Procedure. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were re-trained on client C's revised BSP. Client C was referred to Wound Care for evaluation and treatment.</p> <p><b>Monitoring of Corrective Action:</b> The Operations Manager and Program Coordinator will review all internal incident reports and ensure that all programmatic changes occur and that IDT meetings are held. In addition, they will ensure that all staff are trained on the Abuse and Neglect Policy and Procedures and all individual programming plans.</p> <p><b>Completion Date: 7/8/12</b></p> |                      |                                             |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                                             |
| (X4) ID PREFIX TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |                                             |
| W0104                                                                     | <p>483.410(a)(1)<br/>GOVERNING BODY<br/>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (client C), 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.</p> <p>Findings include:</p> <p>1. 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 C in regard to behavior. Please see W149.</p> <p>9-3-1(a)</p> | W0104                                                           | <p><b>W 104:</b> The governing body must exercise general policy, budget and operating direction over the facility.</p> <p><b>Corrective Action: (Specific)</b><br/>The Abuse, Neglect, and Exploitation Policy and Procedure was revised to include preventing and addressing neglect in regard to clients behavior. All staff was re-trained on the revised Abuse and Neglect Policy and Procedure. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were re-trained on client C's revised BSP.</p> <p><b>How others will be identified: (Systemic):</b> The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective.</p> <p><b>Measures to be put in place:</b><br/>The Abuse, Neglect, and Exploitation Policy and Procedure was revised to include preventing</p> | 07/08/2012           |                                             |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                        | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                        |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                      |                                             |
| (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>and addressing neglect in regard to clients behavior. All staff was re-trained on the revised Abuse and Neglect Policy and Procedure. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were re-trained on client C's revised BSP</p> <p><b>Monitoring of Corrective Action:</b> The Operations Manager and Program Coordinator will review all internal incident reports and ensure that all programmatic changes occur and that IDT meetings are held. In addition, they will ensure that all staff is trained on the Abuse and Neglect Policy and Procedures and all individual programming plans.</p> <p><b>Completion Date: 7/8/12</b></p> |                      |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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                                                           |  |                                             |  |
| W0122                                                                     | <p>483.420<br/>CLIENT PROTECTIONS<br/>The facility must ensure that specific client protections requirements are met.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (client C), the facility failed to meet Condition of Participation: Client Protections. The facility failed to implement written policy and procedure to prevent neglect of client C in regards to Self Injurious Behavior (SIB) picking. The facility also failed to develop a policy and procedure which clearly defined neglect which indicated how the facility would prevent and/or address issues of neglect in regards to clients' behavior.</p> <p>Findings include:</p> <p>The facility failed to implement written policy and procedure to prevent neglect of client C in regards to SIB (picking). The facility also failed to develop a policy and procedure which clearly defined neglect to indicate how the facility would prevent and/or address issues of neglect in regards to client's behavior. Please see W149.</p> <p>9-3-2(a)</p> | W0122                                                           | <p><b>W 122:</b> The facility must ensure that specific client protections requirements are met.</p> <p><b>Corrective Action: (Specific)</b><br/>The Abuse, Neglect, and Exploitation Policy and Procedure was revised to include preventing and addressing neglect in regard to clients behavior. All staff was re-trained on the revised Abuse and Neglect Policy and Procedure. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were re-trained on client C's revised BSP.</p> <p><b>How others will be identified: (Systemic):</b> The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective.</p> <p><b>Measures to be put in place:</b><br/>The Abuse, Neglect, and Exploitation Policy and Procedure was revised to include preventing and addressing neglect in regard to clients behavior. All staff was</p> | 07/08/2012                                                                     |  |                                             |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                        | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                        |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      |                                             |
| (X4) ID PREFIX TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>re-trained on the revised Abuse and Neglect Policy and Procedure. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were re-trained on client C's revised BSP</p> <p><b>Monitoring of Corrective Action:</b> The Operations Manager and Program Coordinator will review all internal incident reports and ensure that all programmatic changes occur and that IDT meetings are held. In addition, they will ensure that all staff are trained on the Abuse and Neglect Policy and Procedures and all individual programming plans.</p> <p><b>Completion Date: 7/8/12</b></p> |                      |                                             |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                      |                                             |
| (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 |                                             |
| W0130                                                                     | <p>483.420(a)(7)<br/>PROTECTION OF CLIENTS RIGHTS<br/>The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p>Based on observation, interview and record review for 2 of 3 sampled clients (clients B and C) and for 1 additional client (E), the facility failed to ensure clients' privacy was maintained during dressing, bathing, toileting and passing medications.</p> <p>Findings include:</p> <p>1. During the 6/4/12 observation period between 4:05 PM and 6:15 PM, at the group home, at 6:00 PM, client E told staff at the dining room table he was going to the bathroom. Client E went to the bathroom and used the toilet without closing the door. Staff #1, #7 and #12 did not prompt and/or encourage the client to close the bathroom door.</p> <p>During the 6/5/12 observation period between 6:12 AM and 8:35 AM, at the group home, at 6:15 AM, client E was in in his wheelchair dressing with the door open in his bedroom. Staff #2, who was in the hallway, spoke to the client, but did not close and/or encourage client E to close his bedroom door while dressing.</p> | W0130                                                           | <p><b>W 130:</b> The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs.</p> <p><b>Corrective Action: (Specific)</b><br/>The Operations Manager for Supported Group Living will retrain all staff, including the Program Coordinator, that all clients will have privacy while dressing, bathing, toileting and passing medications, specifically clients B, D and E as well as all other individuals in the home.</p> <p><b>How others will be Identified: (Systemic)</b> The Operations Manager for Supported Group Living and the Program Coordinator will monitor all aspects of ADIs to ensure that each individuals' privacy is obtained. This would also include privacy in the bedroom while dressing, in the bathroom while toileting and showering, and in the medication room while passing medications.</p> <p><b>Measures to be put in place:</b><br/>The Operations Manager for</p> | 07/08/2012           |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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>At 6:23 AM, client B walked from his bedroom to the bathroom to the other side of the group home without any clothes on while putting on a pull up/adult incontinent brief. Staff #3, who was sitting on the couch, saw client B walk by, but did not redirect the client to put on clothes and/or redirect the client to return to his bedroom. At 6:55 AM, staff #11 had client B go to the bathroom to change his shorts as they were wet. Client B pulled his shorts off with the door open. Staff #11 did not close and/or encourage client B to close the bathroom door until, staff #11 asked the client to pull off his pull up to change.</p> <p>2. During the medication pass on 6/5/12 at 6:35 AM to 7:30 AM, client D walked into the medication room while client B was receiving his medication. Staff #2 was mixing the Miralax in water. Staff #2 indicated this was to be given because of constipation. Staff #2 did not redirect client B to leave the room and did not close the medication room door.</p> <p>Interview with administrative staff #2 and LPN #1 on 6/7/12 at 10:30 AM indicated facility staff should have encouraged clients B and E to close the bathroom and/or bedroom doors when dressing to protect their privacy.</p> |                                                                 | <p>Supported Group Living will retrain all staff, including the Program Coordinator, that all clients will have privacy while dressing, bathing, toileting and passing medications, specifically clients B, D and E as well as all other individuals in the home.</p> <p><b>Monitoring of Corrective Action:</b> The Operations Manager for Supported Group Living and the Program Coordinator will monitor all aspects of ADIs to ensure that each individuals' privacy is obtained. This would also include privacy in the bedroom while dressing, in the bathroom while toileting and showering, and in the medication room while passing medications.</p> <p><b>Completion date: 7/8/12</b></p> |                                                                                |  |                                             |  |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PERCEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|
|                          | 9-3-2(a)                                                                                                                     |                     |                                                                                                                          |                            |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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                                                           |  |                                             |  |
| W0140                                                                     | <p>483.420(b)(1)(i)<br/>CLIENT FINANCES</p> <p>The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p>Based on record review and interview for 2 of 3 sampled clients (clients A and B), the facility failed to ensure there was an accurate accounting of funds kept in the home and the Resident Fund Management Services (RFMS) account.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Review of client A's internal incident report was conducted on 6/4/12 at 2:00 PM. The report dated 5/28/12 indicated client A had \$50+ in his in house account on 5/25/12. There was an audit done on 5/28/12 that indicated there was no money in the in house account. There was no indication the \$50+ had been received by client A.</li> <li>2. Client B's financial records were reviewed on 6/6/12 at 1:52 PM. Client B's 4/12 Resident Fund Management Services (RFMS) account sheet indicated \$200.00 was withdrawn from the client's RFMS account on 4/17/12 for clothing. Client B's financial records indicated the facility did not have receipts for the \$200.00 withdrawal/purchase.</li> </ol> | W0140                                                           | <p><b>W 140:</b> The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.</p> <p><b>Corrective Action: (Specific)</b><br/>All staff have been retrained on the finance policy and ensuring that all receipts are obtained to verify each purchase. All staff have been retrained that each clients' finances are to be audited daily and all transactions accurately recorded on the finance ledger including receipts.</p> <p><b>How others will be identified: (Systemic)</b> A financial review has been completed of all individuals accounts and balance according to the RFMS Account.</p> <p><b>Measures to be put in place:</b><br/>All staff have been retrained on the finance policy and ensuring that all receipts are obtained to</p> | 07/08/2012                                                                     |  |                                             |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                             | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                             |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      |                                             |
| (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>Interview with administrative staff #3 on 6/6/12 at 2:17 PM indicated he was not able to locate receipts for the 4/17/12 purchase. Administrative staff #3 indicated the \$200.00 was given to the client's mother to make the clothing purchase for client B and client B's mother had not turned the receipts into the group home.</p> <p>9-3-2(a)</p> |                                                                 | <p>verify each purchase. All staff have been retrained that each clients' finances are to be audited daily and all transactions accurately recorded on the finance ledger including receipts.</p> <p><b>Monitoring of Corrective Action:</b> The Operations Manager of Supervised Group Living and the Program Coordinator will review each Individuals' financial records to ensure that all accounts balance and that consumers are signing receipts for all withdraws or purchases.</p> <p><b>Completion date: 7/8/12</b></p> |                      |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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                                                           |  |                                             |  |
| W0149                                                                     | <p>483.420(d)(1)<br/>STAFF TREATMENT OF CLIENTS<br/>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (C), the facility failed to implement its policy and procedures to prevent neglect in regard to the client's self-injurious behavior which resulted in injuries.</p> <p>Findings include:</p> <p>During the 6/4/12 observation period between 4:05 PM and 6:15 PM and the 6/5/12 observation period between 6:12 AM and 8:35 AM, at the group home, client C had an ace bandage wrapping on his left leg which went from above the client's left knee to above his left ankle. During the 6/5/12 observation period, client C had two open areas on his left leg. One area was on client C's knee and the second area was on the client's lower leg/shin area. The area on the lower leg/shin had a 3 inch red area/line around a 1 to 1 and 1/2 inch open area which were irregular in shape. The open area had layers of skin missing which was red in color and wet looking in the center. Outside the large area on client C's shin, the client had 3 small pinpoint red scabs to the side of the shin area. Client C's</p> | W0149                                                           | <p><b>W 149:</b> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p><b>Corrective Action: (Specific)</b><br/>Client C was referred to Wound Clinic for evaluation and treatment. All staff were retrained on current wound care procedures. The Abuse and Neglect Policy and Procedure was revised to include preventing and addressing neglect in regards to client's behavior. All staff were retrained on the revised Abuse and Neglect Policy and Procedure. All staff were retrained on scheduling follow-up medical as needed. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were retrained on client C's revised BSP. Client C was referred to Wound Care for evaluation and treatment. All staff were retrained on current wound care treatment. Staff will complete skin observation daily and document findings on Skin Assessment Sheet and will report any areas to the nurse. The nurse will review Skin</p> | 07/08/2012                                                                     |  |                                             |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                             |
| (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>knee had about a half inch open area which was red in color. During the 6/5/12 observation period, staff #3 applied Bactroban (antibiotic) ointment on 2 small gauze squares and laid the gauze squares on top of the open areas of client C's shin/lower leg and knee. The staff then wrapped gauze strips around the client's left leg times two and then wrapped client C's left leg with ace wrapping.</p> <p>During the 6/4/12 and 6/5/12 observation period, client C had one to one staffing (one staff to one client). Specifically during the above mentioned 6/4/12 observation period, staff #3 was client C's one to one staff. Staff #3 did not consistently stay within arms reach of client C during the observation period as staff #3 would leave the client unsupervised to go into another room or client C would enter and/or leave the living room and staff #3 would not be with the client. During the above mentioned 6/5/12 observation period, staff #3 stayed in the bathroom with client C while the client showered. At 8:29 AM, staff #2 walked client C out to the van. Client C was placed in the front seat of the van. Staff #1 and #2 then assisted clients D and E to load the van. Clients D and E were placed in the back seat of the van and client A, who was in wheelchair</p> |                                                                 | <p>Assessment Sheets at site visits and complete skin assessment weekly. The nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. If client C is being transported with other individuals there will be a least 2 staff present during transport period. Staff will complete an Incident Report for any skin picking behavior that results in an open area and document the behavior on the A-B-C Tracking sheet. Nurse will be retrained on completing accurate documentation of assessment completed on any wound in nursing notes. All orders have been clarified orders. Salicylic AC kit 6% lotion to body BID has been received. Bactroban and Mupirocin have been discontinued. The Salicylic AC kit cleanser has been discontinued. Cordran tape has been discontinued. "Wound care (Use ointment, 2x(by) 2 pad, wrap any wound open or bleeding)" once daily, has been discontinued. Nurse will be retrained on clarifying wound care orders as needed and ensuring 90-day recertification orders are accurate for client C as well as all other clients in the home. Nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse</p> |                      |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      |                                             |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                      |                                             |
| (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>was placed in the middle section of the van between the back and front seats. Staff #2 then got into the driver's seat of the van. Only one staff was present in the van with clients A, C, D and E.</p> <p>Interview with staff #3 on 6/5/12 at 6:42 AM and 8:22 AM stated client C had one to one staffing due to the client's behaviors of "food foraging and skin picking." Staff #3 indicated client C had one to one staffing during waking hours and the facility staff were to stay with the client even while he was in the bathroom to prevent the client from picking. Staff #3 indicated client C had 2 open areas on his left leg. Staff #3 indicated the client's leg was covered/wrapped due to the client's picking. Staff #3 indicated staff applied medication to the open areas and covered them three times a day. Staff #3 indicated client C had picked the areas over the past weekend while the client was in the bathroom unsupervised. Interview with staff #3 indicated the client had gone to Special Olympics in a different city on 6/1, 6/2 and 6/3/12.</p> <p>The facility's internal incident reports, reportable incident reports and/or investigations were reviewed on 6/4/12 at 2:51 PM. The facility's internal incident reports, reportable incident reports and/or investigations indicated the following:</p> |                                                                 | <p>of any open wounds. The nurse will be retrained on completion of weekly skin checks and assessment and measurement of any wounds for client C. The Risk Plan for client C has been revised and all staff trained. Client C's Behavior Support Plan has been revised to include 1:1 staffing definition, while at the home, in the community, at workshop and while riding on the van with others. A 15-minute check sheet has been implemented and staff have been retrained on its completion. All staff will be retrained on You're Safe, I'm Safe.</p> <p><b>How others will be identified: (Systemic)</b> The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective. In addition, the nurse will review all Physician's Orders to ensure there accuracy as transcribed on the MAR.</p> <p><b>Corrective Action: (Specific)</b> Client C was referred to Wound Clinic for evaluation and treatment. All staff were retrained on current wound care</p> |                      |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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>-5/11/12 Client C was "picking skin" and staff tried to block.</p> <p>-4/30/12 Facility staff verbally prompted client C to stop picking. The facility's internal incident reports and/or reportable incident reports neglected to indicate any additional documentation/incident reports in regard to the client's recent self-injurious behavior of skin picking.</p> <p>Client C's record was reviewed on 6/5/12 at 12:54 PM. Client C's Nurses Observation Records indicated the following (not all inclusive):</p> <p>-1/6/12 Client C had an open wound to mid forehead and left knee.</p> <p>-1/11/12 "...Client has open wounds on FH (forehead), (L) (left) middle finger &amp; (and) (L) knee from picking..."</p> <p>-1/19/12 "...Client has open areas to lips, open area to FH &amp; (L) knee..."</p> <p>-1/25/12 "...skin pink, warm &amp; dry, open wound to (L) knee &amp; (L) middle finger knuckle..."</p> <p>-1/27/12 "...skin pink, warm &amp; dry, open wound to (L) knee &amp; (L) middle finger</p> |                                                                 | <p>procedures. The Abuse and Neglect Policy and Procedure was revised to include preventing and addressing neglect in regards to client's behavior. All staff were retrained on the revised Abuse and Neglect Policy and Procedure. All staff were retrained on scheduling follow-up medical as needed. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were retrained on client C's revised BSP. Client C was referred to Wound Care for evaluation and treatment. All staff were retrained on current wound care treatment. Staff will complete skin observation daily and document findings on Skin Assessment Sheet and will report any areas to the nurse. The nurse will review Skin Assessment Sheets at site visits and complete skin assessment weekly. The nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. If client C is being transported with other individuals there will be a least 2 staff present during transport period. Staff will complete an Incident Report for any skin picking behavior that results in an open area and document the behavior on the A-B-C Tracking sheet. Nurse will be retrained on completing accurate documentation of</p> |                                                                                |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      |                                             |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      |                                             |
| (X4) ID PREFIX TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>knuckle...."</p> <p>-3/5/12 "...Open area to (L) knee from SIB (self-injurious behavior), discoloration to LLL (Left lower leg) mostly calf...."</p> <p>-3/24/12 "...(L) knee wrapped (with) ace bandage,...."</p> <p>-4/6/12 "...On 4/412 [name of doctor] D/C (discontinued) Bactrim &amp; skin cleanser...."</p> <p>-4/10/12 "Home visit,...superficial abrasion noted to left lower leg area cleaned &amp; dressed 4 cm (centimeter) x 3 cm. Also has sm (small) pen area to (L) 3rd (third) finger 1 cm dia (diameter)...."</p> <p>-5/1/12 "Home Visit...skin W/D/I (warm/dry/intact),...Area remains open to (L) (lower) leg approx (approximately) 3 cm x 2.5 cm also small scab to (L) knee...."</p> <p>-5/8/12 "...area remains open to (L) (lower) leg, he has been picking at it again...."</p> <p>-5/15/12 "Home visit,...skin W/D/I except for area on (L) (lower) leg...."</p> <p>-6/1/12 "Home visit, chart review,</p> |                                                                 | <p>assessment completed on any wound in nursing notes. All orders have been clarified orders. Salicylic AC kit 6% lotion to body BID has been received. Bactroban and Mupirocin have been discontinued. The Salicylic AC kit cleanser has been discontinued. Cordran tape has been discontinued. "Wound care (Use ointment, 2x(by) 2 pad, wrap any wound open or bleeding)" once daily, has been discontinued. Nurse will be retrained on clarifying wound care orders as needed and ensuring 90-day recertification orders are accurate for client C as well as all other clients in the home. Nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. The nurse will be retrained on completion of weekly skin checks and assessment and measurement of any wounds for client C. The Risk Plan for client C has been revised and all staff trained. Client C's Behavior Support Plan has been revised to include 1:1 staffing definition, while at the home, in the community, at workshop and while riding on the van with others. A 15-minute check sheet has been implemented and staff have been retrained on its completion. All staff will be retrained on You're</p> |                      |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                        | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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>monthly note completed. 0 acute issues."</p> <p>Client C's nursing notes neglected to indicate any additional documentation, assessment and/or care in regard to client C's open areas on the client's left leg.</p> <p>Client C's 6/12 Medication Administration records (MARs) indicated facility staff were to apply Bactroban cream 2% to affected areas twice a day. The 6/12 MAR also indicated Client C had an order for Mupirocin ointment 2 % (substitute for Bactroban) "Apply to open area on legs twice daily." The 6/12 MARs indicated facility staff initialed they were applying both creams two times a day. Client C's 6/12 MARs ad orders for Salicylic AC Kit lotion to apply to the client's entire body for itching two times a day. Client C's 6/12 MAR also indicated client C had another order for Salicylic AC Kit 6% lotion (same as above) "Apply to affected areas twice daily." The 6/12 MAR indicated facility staff initialed they were applying each duplicate order two times a day. Client C's 6/12 MAR indicated client C had an order for Salicylic AC Kit 6% lotion (antiseptic cleanser) "Use cleanser in shower once each day." Client C's 6/12 MAR indicated the facility staff was not using the antiseptic cleanser as no initials were documented on the 6/12 MAR thus far.</p> |                                                                 | <p>Safe, I'm Safe.</p> <p><b>Monitoring of Corrective Action:</b> The Operations Manager of Supervised Group Living, Program Coordinator, and the Nurse will review all new Physician's Orders and ensure that they are accurately transcribed on the MAR and all relevant Program Plans are updated to reflect the changes.</p> <p><b>Completion Date: 7/8/12</b></p> |                                                                                |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                 |                                                                                                                 |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                 |                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (X4) ID PREFIX TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>No time for administering/applying the cleanser was documented on the 6/12 MAR. Client C's 6/12 MAR indicated client C had an order "Wound Care-Use Cordran Tape on any wound that is scabbed." The 6/12 MAR indicated facility staff were initialing Cordran tape was being applied to scabbed wounds at 6:30 AM. Client C's 6/12 MAR indicated client C was to receive "Wound Care (Use ointment, 2 x (by) 2 pad, wrap any wound open or bleeding)" once daily at 6:30 AM not three times a day. Client C's 6/12/ MAR indicated a 1/8/2010 order "Ace Wrap-Keep leg covered to prevent picking AM and PM." The 6/12 MARs indicated facility staff were only initialing/documenting client C's legs were being covered two times daily versus three times daily which contradicted the order for "Wound Care (Use ointment, 2 x (by) 2 pad, wrap any wound open or bleeding)" once daily at 6:30 AM.</p> <p>Client C's 4/3/12 Physician order indicated "D/C Bactrim (antibiotic), Mupirocin &amp; antiseptic skin cleanser as client does not have MRSA (Methicillian Resistant Staphylococcus Aureus)."<br/>Client C's 5/23/12 physician's 90 day recertification orders indicated the above discontinued orders were still on the 5/12 physician's orders the pharmacy prints</p> |                                                                 |                                                                                                                 |                                                                                |  |                                             |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 |                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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>out. The 5/23/12 recertification orders indicated client C's doctor signed the 90 day orders thus indicating the 4/3/12 discontinued orders should be continued. Client C's 5/12 nurse notes did not indicate the facility sought clarification in regard to the client's orders for his skin.</p> <p>Client C's 8/26/11 Doctor's Orders and Progress Notes indicated client C had a history of having wound care. The 8/26/11 order indicated the client had been seen at a wound clinic for an open wound on client C's left lower leg. The 8/26/11 order indicated "Your treatment at the Wound Program is complete and you do not need a return visit...."</p> <p>Client C's 6/29/11 Dermatology note indicated client C was a "deep picker-digs skin x (times) 20 yrs (years)." The 6/29/11 form indicated client C was diagnosed "Severe erosions (due to) picking...."</p> <p>Client C's 5/1/12 Annual Resident Physical form indicated client C was seen by his doctor on 5/1/12. The 5/1/12 form indicated the facility neglected to inform and/or have client C's doctor assess the open areas on the client's left leg on 5/1/12 as there was no mention of any open areas, on client C, on the form.</p> <p>Client C's 6/12 Antecedent Behavior</p> |                                                                 |                                                                                                                 |                                                                                |  |                                             |  |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>Consequence Analysis for low-Frequency Behavior (data sheets) indicated client C demonstrated "Skin Picking: Scratching, breaking skin, and causing bleeding etc." on 6/3/12 at 11:15 AM to 11:30 AM and on 6/3/12 at 4:00 PM to 4:10 PM. The 6/12 behavior data sheet indicated the behavior occurred in the van and in the shower. The 6/12 behavior data sheet indicated staff "blocked" the attempt when the client was in the shower at 4:00 PM. The 6/12 data sheet also indicated client C demonstrated the skin picking behavior on 6/2/12 at 7:30 PM to 7:35 PM. The 6/12 behavior data sheet indicated client C was in the bathroom when the behavior occurred.</p> <p>Client C's Monthly Program Team Review indicated client C demonstrated skin picking one time in 4/2012 and two times in 3/2012. The 3/12 monthly note indicated "He is still taking food and picking...."</p> <p>Client C's 1/13/12 ISP (Individual Support Plan) indicated client C's diagnoses included, but were not limited to, Prader Willi and Impulse Control Disorder. Client C's 1/13/12 ISP Medical Input sheet indicated "...His (client C's) wounds from picking r/t (related to) Prader-Willi (rare genetic disorder with insatiable appetite) are wrapped daily and</p> |               |                                                                                                                 |                      |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>as needed by staff and measured by nurse weekly...." The facility's nurse notes and record indicated the facility neglected to monitor/measure client C's wounds weekly to determine if the client's wound was improving.</p> <p>Client C's 5/18/12 nursing care plan/problem area indicated "Problem: Risk for skin infection r/t self inflicted wounds related to dx (diagnosis) of Prader-Willi...2. Staff will monitor and encourage [client C] to not pick skin. 3) Staff will report any breaks in skin to nurse immediately, and nursing services will record and document findings. PCP (Primary Care Physician) will be notified of any breaks in the skin...6) Skin checks will be completed at bathing times, and upon awaking. 7) Staff will be trained on all aspects of [client C's] care...." The facility neglected to monitor the client's skin picking, perform skin checks/assessments, neglected to report any breaks/area getting bigger to the nurse, and neglected to notify the client's PCP of any new areas/breaks in skin. Client C's ISP and/or nursing problems areas indicated the facility neglected to develop a wound care problem which specifically indicated how facility staff were to care for the client's open wounds/areas.</p> |               |                                                                                                                 |                      |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (X4) ID PREFIX TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID PREFIX TAG                                                   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE                                                           |  |                                             |  |
|                                                                           | Client C's 5/9/12 Behavior Support Plan (BSP) indicated client C demonstrated skin picking behavior defined as "scratching areas of his body and breaking the skin to the point that it bleeds, this includes opening existing sores." The 5/9/12 BSP indicated client C had "Enhanced Supervision." The BSP indicated "[Client C] will have a 1:1 staffing during all waking hours while at the home. 1:1 staff is defined as being within arms length of him. During sleep hours staff will be continuing to check on [client C] using 15 minute bedroom checks. When he is in the bathroom staff will remain outside the door with the door unlocked. Once 5 minutes have elapsed staff will knock on the door, if he does not respond staff will open the door and check on [client C]. While he is the shower, staff will be in the bathroom with him prompting good hygiene and checking every five minutes to ensure he is not picking at his skin...." Client C's 5/9/12 BSP indicated client C's door would stay open enough for staff to do 15 minute checks. Client C's 5/9/12 BSP and/or 1/13/12 ISP indicated the facility neglected to clearly define the client's one on one supervision as the ISP and/or BSP did not indicate how the client was to be monitored when in the community, riding in the van with others, and/or at the day program. Client C's 6/12 data sheets |                                                                 |                                                                                                                 |                                                                                |  |                                             |  |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>and/or record indicated the facility neglected to monitor/conduct 15 minute checks with client C as there was no documentation to ensure 15 minutes checks were being done at night to prevent the client from picking his skin.</p> <p>The facility's 6/5/12 Operation Employee Punch Correction/Adjustments/Days-Off Request/Hours Allocation Form was reviewed on 6/5/12 at 3:00 PM. The facility's time request cards indicated staff #4 worked the following times during the Special Olympics event/outing:</p> <p>6/1/12 6 AM to 10 PM<br/>6/2/12 6 AM to 10 PM<br/>6/3/12 6 AM to 10 PM</p> <p>The facility's 6/4/12 time request card indicated staff #2 went to the special olympics event. The time request card indicated staff #2 worked the following times at the Special Olympics event:</p> <p>6/1/12 6 AM to 10 PM<br/>6/2/12 6 AM to 10 PM<br/>6/3/12 6 AM to 10 PM</p> <p>The facility only provided time cards for 2 staff who went on the out of town event. Interview with administrative staff #1 on 6/5/12 at 3:00 PM indicated staff #4 was client C's one on one staff person for the</p> |               |                                                                                                                 |                      |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>Special Olympics event. Administrative staff #1 indicated 3 staff went to the out of town event on 6/1, 6/2 and 6/3/12.</p> <p>The facility's training records were reviewed on 6/5/12 at 3:05 PM. The facility's 1/5/12 Inservice Sign-in Sheet for "Demonstration of how to apply wrap by nurse (LPN #2) wound care" indicated three staff had been trained in regard to client C's wound care. The 1/5/12 inservice record indicated the facility neglected to ensure staff #2, #3, #4, #5, #7, #8, #9, #10 and #11 were trained in regard to client C's wound care needs.</p> <p>Interview with the Program Coordinator (PC) on 6/5/12 at 3:50 PM indicated client C had one to one staffing due to food foraging and skin picking.</p> <p>Interview with client C on 6/5/12 at 8:10 AM indicated client C caused the areas on his legs. Client C stated "I opened it up." Client C indicated the open wound on the lower part of his left leg was scar tissue. Client C indicated facility staff applied Bactroban on the open areas and covered the areas with gauze. Client C stated he had the open areas for "6 weeks." When asked if client C was seeing a doctor in regard to the wound on his lower leg, client C stated No, but I used to."</p> |               |                                                                                                                 |                      |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                    |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                  |                      |                                             |
| (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>Interview with staff #3 on 6/5/12 at 8:10 AM and at 8:22 AM indicated client C had the open areas on his legs longer than 6 weeks. Staff #3 stated client C was to be monitored "throughout the night" with 15 minute checks. Staff #3 indicated she did not know where the 15 minute checks were documented and/or kept. Staff #3 indicated client C went to the workshop with staff from another group home. Staff #3 indicated she thought the client was to have one to one staffing while at the workshop as well. Staff #3 indicated facility staff were to block client C from picking wounds. Staff #3 stated "Can't put in Your Safe, I'm Safe (behavior intervention technique)." Staff #3 indicated client she felt client C would pick at night as well.</p> <p>Interview with staff #2 on 6/5/12 at 8:30 AM indicated client C was to have one on one staffing when he was at the group home, in the community and at the workshop. When asked why she was the only staff in the van with clients A, C, D and E, staff #2 indicated she was leaving to take client C to another city for a doctor's appointment after she dropped clients A, D and E at work.</p> <p>Interview with LPN #1 on 6/5/12 at 1:32 PM indicated Bactroban Cream and</p> |                                                                 |                                                                                                                 |                      |                                             |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>Mupirocin ointment were the same thing. LPN #1 stated they were "duplicate orders" and one of them would need to be discontinued from the MAR. LPN #1 indicated client C's MAR included duplicate Salicylic orders for the lotion as well. LPN #1 indicated one of the orders should be discontinued as well as staff were signing both medications. When asked if the cleanser should be used, LPN #1 first indicated no as the cleanser had been discontinued by the doctor on 4/3/12. LPN #1 indicated the doctor had signed the 5/25/12 order which put the medication back in effect. LPN #1 indicated clarification needed to be obtained in regard to the client's treatments for the open wounds. LPN #1 indicated facility staff should not be using the Cordran Tape on client C's wound as the client did not have a scab. LPN #1 indicated she was sure the staff were not using the Cordran Tape, but did not know why the staff were initialing they were applying. LPN #1 stated "It looks bad. Worse than when I seen it last week. Will get him back to wound care clinic." LPN #1 indicated she was not aware of the regression with the area until 6/5/12 when she saw the area with the surveyors. When asked when client C picked, LPN #1 stated "At night, They have called me." LPN #1 indicated there was no wound care protocol/care plan in place</p> |               |                                                                                                                 |                      |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                    |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                  |                      |                                             |
| (X4) ID PREFIX TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>until 6/5/12.</p> <p>Interview with workshop staff #3 and #4 on 6/6/12 at 9:12 AM indicated client C would try to pick his skin at the workshop. Workshop staff #3 and #4 indicated client C now had a designated staff person after the client attempted to elope from the workshop in 5/12.</p> <p>Interview with client C's guardian on 6/6/12 at 9:27 PM indicated client C would pick his skin when he became angry, would go to the bathroom and go to shower. When asked if client C would pick his skin at night, client C's guardian stated "Yes, Probably."</p> <p>Interview with LPN #1 and administrative staff #2 on 6/7/12 at 10:30 AM indicated client C demonstrated SIB of skin picking due to his Prader Willi diagnosis. LPN #1 indicated she had just taken over the nursing duties of the group home since 4/12. LPN #1 indicated she was still in the process of trying to get the medications straightened out. Administrative staff #2 and LPN #1 indicated client C should have one on one staffing at the workshop and in the community. Administrative staff #2 indicated she would need to clarify the 1 to 1 staffing on the client's enhanced supervision protocol. LPN #1 indicated</p> |                                                                 |                                                                                                                 |                      |                                             |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 C had a wound on his finger and knee in 4/12. LPN #1 stated client C's knee had a scab and the area was the "size of an eraser head." LPN #1 indicated nursing staff should be measuring the wound and document about the wound. LPN #1 indicated she saw client C's wounds on 5/29/12 and it did not look like it looked on 6/5/12. LPN #1 indicated she did not document her assessment of the wound on 5/29/12. LPN #1 indicated she would start assessing client C's wound and measure the wound. LPN #1 indicated client C's doctor was not notified in regard to the client's open areas. LPN #1 indicated she did not know why the doctor did not document anything about client C's wounds at the annual physical examination. LPN #1 indicated facility staff should have called her over the weekend about client C's picking/wounds. LPN #1 stated she should be called "If picking excessively." LPN #1 and administrative staff #2 indicated they were not sure how client C's wounds were getting worse, from picking, as the client was on one to one staffing during waking hours. LPN #1 indicated she would need to train staff in regard to client C's wound care. LPN #1 indicated facility staff were changing the client's ace wrapping and gauze three times a day. LPN #1 indicated client C did not have an order to</p> |               |                                                                                                                 |                      |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>change the wrapping 3 times a day. Administrative staff #2 indicated facility staff were doing it three times a day as client C had requested it be done three times a day. LPN #1 indicated client C was seen by a doctor on 6/5/12 and the client was diagnosed with cellulitis to the lower leg/open area. LPN #1 indicated client C was started on an antibiotic and Bactroban was to continue. LPN #1 indicated client C was to go to the wound care doctor today 6/7/12. LPN #1 indicated she developed a form for staff to document 15 minute checks on 6/6/12.</p> <p>The facility's policy and procedures were reviewed on 6/7/12 at 10:07 AM. The facility's 1/1/12 policy entitled Abuse/Neglect/Exploitation Policy and Procedure indicated Neglect was defined as "...1. Failure to provide goods and services necessary to 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...." The facility's 1/1/12 policy also indicated failure to provide necessary medical attention or failure to administer medications as prescribed could also be considered neglect.</p> |               |                                                                                                                 |                      |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|----------------------|
|                    | 9-3-2(a)                                                                                                               |               |                                                                                                                 |                      |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      |                                             |
| (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 |                                             |
| W0154                                                                     | <p>483.420(d)(3)<br/>STAFF TREATMENT OF CLIENTS<br/>The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 1 of 15 incident reports reported to Bureau of Developmental Disabilities Services (BDDS), the facility failed to ensure an investigation was conducted for the client to client abuse between clients B and D.</p> <p>Findings include:</p> <p>The record review of the BDDS incident reports was conducted on 6/4/12 at 2:00 PM. The BDDS report with the submitted date of 4/24/12 indicated the following:</p> <p>"[Client B] and [client D] were in the van with staff when [client B] started having behaviors. [Client B] unbuckled his seat belt and started hitting [client D]. He also bit his finger breaking the skin. Staff pulled the van over to intervened (sic) and separated the clients, [client B] got into the rear of the van with staff. He was still agitated and began throwing paper out of the van window. A member of the community saw the incident and called the police. Police came to the scene and advised [client B] to stay in his seat in the van and buckle up. Due to [client D] being bit (sic), staff felt he</p> | W0154                                                           | <p><b>W 154</b> The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p><b>Corrective Action: (Specific)</b><br/>The Quality Assurance Team will be retrained that all allegations of abuse (including Client to Client abuse), neglect and exploitation and injuries of unknown origin are thoroughly investigated. The Operations Manager of Supervised Group Living and the Program Coordinator will be retrained that all allegations of abuse (including Client to Client abuse), neglect and exploitation are reported to the Quality Assurance Team and that a Client to Client Investigation has been completed within 5 days of the alleged incident.</p> <p><b>How others will be identified: (Systemic)</b> All allegations of abuse neglect and exploitation will be reported to the Director of Quality Assurance. The Director of Quality Assurance will ensure that all allegations of abuse, neglect and exploitation are investigated, and the results of the investigation reported to the Executive Director within 5 work days of the alleged incident.</p> | 07/08/2012           |                                             |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                    | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      |                                             |
| (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>needed to go to the ER (Emergency room) for evaluation. [Client D] was transported to the ER via ambulance and staff accompanied him. [Client B] was transported back to the group home in the van safely."</p> <p>Interview with Quality Assurance (QA) staff on 6/4/12 at 3:00 PM indicated there should have been an investigation on the client to client abuse between clients B and D, but it had not been completed.</p> <p>9-3-2(a)</p> |                                                                 | <p><b>Measures to be put in place:</b><br/>The Quality Assurance Team will be retrained that all allegations of abuse (including Client to Client abuse), neglect and exploitation are thoroughly investigated. The Program Coordinator and the QMRP will be retrained that all allegations of abuse (including Client to Client abuse), neglect and exploitation and injuries of unknown origin are reported to the Quality Assurance Team and that a Client to Client Investigation has been completed within 5 days of the alleged incident.</p> <p><b>Monitoring of Corrective Action:</b> The Executive Director reviews all investigations to ensure that all allegations of abuse (including Client to Client abuse), neglect and exploitation are thoroughly investigated and that a Client to Client investigation was completed within 5 days of the alleged incident.</p> <p><b>Completion date: 7/8/12</b></p> |                      |                                             |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                      |                                             |
| (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 |                                             |
| W0159                                                                     | <p>483.430(a)<br/>QUALIFIED MENTAL RETARDATION PROFESSIONAL<br/>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on record review and interview for 2 of 3 sampled clients (clients A and C) and 2 additional clients (clients D and E), the facility's Qualified Mental Retardation Professional (QMRP) failed to coordinate with the workshop staff in regard to conducting team meetings and to communicate staffing changes.</p> <p>Findings include:</p> <p>The record review for client A was conducted on 6/5/12 at 2:00 PM. The record indicated the Interdisciplinary Team Meeting (IDT) dated 3/16/12 for client A reviewing the Individualized Support Plan (ISP) and the Behavior Support Plan (BSP) dated 4/27/11 was not attended by the day program staff. The record did not have any other IDT meeting notes for client A. There were no other IDT meeting notes for client A.</p> <p>The record review for client C was conducted on 6/5/12 at 12:54 PM. The record for client C did not include any IDT meetings with the day program staff.</p> <p>The record review for client D was</p> | W0159                                                           | <p><b>W 159:</b> Each client's active treatment program must be integrated, coordinated and monitored by a qualified developmental disability professional.</p> <p><b>Corrective Action: (Specific)</b><br/>The Qualified Developmental Disability Professional will be retrained to ensure that all members of the IDT are invited to participate in meetings which involve the clients' behavioral needs. The QDDP will be retrained to ensure that client programs are reviewed, monitored and assessments/reassessments are obtained when needed to address the clients' identified needs. The QDDP will ensure that open communications is consistent between the day program and the home.</p> <p><b>How others will be identified: (Systemic)</b> The Qualified Developmental Disability Professional will be retrained to ensure that all members of the IDT are invited to participate in meetings which involve the clients' behavioral needs. The</p> | 07/08/2012           |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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>conducted on 6/5/12 at 3:00 PM. The record for client D did not include any IDT meetings with the day program staff.</p> <p>The record review for client E was conducted on 6/5/12 at 3:45 PM. The record for client E did not include any IDT meetings with the day program staff.</p> <p>Interview with workshop staff #3 and #4 on 6/6/12 at 9:12 AM indicated clients C and D attended the workshop. Workshop staff #3 and #4 indicated the communication with the group home could be improved. Workshop staff #3 and #4 indicated they did not know who the manager was at the group home as the last time they called the group home, the group home did not have a manager.</p> <p>Interview with Administrative Staff #2 on 6/7/12 at 3:30 PM indicated the workshop staff were invited to the annual meetings to review the clients' progress for the year. Administrative Staff #2 indicated the day program staff did not attend the quarterly meetings.</p> <p>Interview with Workshop Staff #2, on 6/7/12 at 10:30 AM indicated the communication between the workshop staff and the home needed to be improved for clients A and E. Workshop Staff #2 indicated they were not sure who was to</p> |                                                                 | <p>QDDP will be retrained to ensure that client programs are reviewed, monitored, and assessments are obtained when needed to address the clients' identified needs.</p> <p><b>Measures to be put in place:</b><br/>The Qualified Developmental Disability Professional will be retrained to ensure that all members of the IDT are invited to participate in meetings which involve the clients' behavioral needs. The QDDP will be retrained to ensure that client programs are reviewed, monitored and assessments/reassessments are obtained when needed to address the clients' identified needs.</p> <p><b>Monitoring of Corrective Action:</b> The Qualified Developmental Disability Professional will be retrained to ensure that all members of the IDT are invited to participate in meetings which involve the clients' behavioral needs. The QDDP will be retrained to ensure that client programs are reviewed, monitored, and assessments/reassessments are obtained when needed to address the clients' identified needs.</p> <p><b>Completion date: 7/8/12</b></p> |                                                                                |  |                                             |  |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>be contacted if there was a problem because of all the staff changes that the home has been having. Workshop Staff #2 indicated they were not notified of appointments until the client did not come to work.</p> <p>9-3-3(a)</p> |               |                                                                                                                 |                      |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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                                                           |  |                                             |  |
| W0210                                                                     | <p>483.440(c)(3)<br/>INDIVIDUAL PROGRAM PLAN<br/>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.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (C), the client's interdisciplinary team (IDT) failed to assess and/or re-assess a client's fluid restriction in regard to the client's urinary incontinence and/or to rule out any medical concerns in regard to the client's incontinence.</p> <p>Findings include:</p> <p>During the 6/5/12 observation period between 6:12 AM and 8:35 AM, at the group home, client C was sitting on an incontinent pad in the front seat of the group home's van.</p> <p>The facility's reportable incident reports and/or internal incident reports were reviewed on 6/4/12 at 2:51 PM. The facility's 5/17/12 internal incident report indicated "[Client C] intentionally p...in the backseat of my car and then refused to exit vehicle after being instructed to exit vehicle."</p> <p>Interview with staff #2 on 6/5/12 at 8:30</p> | W0210                                                           | <p><b>W 210:</b> 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.</p> <p><b>Corrective Action: (Specific)</b><br/>The Program Coordinator and the Nurse will be retrained on performing accurate assessments or reassessments to address the individual's programmatic needs as well as healthcare needs. The Program Coordinator and the Nurse will review and revise the current assessments for Client C as it pertains to fluid restriction and incontinence. After the assessments are completed, the Individual's Support Plans will be revised and updated to include the necessary changes to ensure each individual's needs are being met. The team agreed to add inappropriate urination to his BSP. All staff have been retrained on accurate documentation of his A-B-C-Tracking sheet.</p> | 07/08/2012                                                                     |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                      |                                             |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                      |                                             |
| (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>AM indicated the incontinent pad was on the van seat so client C would not urinate on the seat. Staff #2 indicated this was a new behavior with client C.</p> <p>Interview with workshop staff #3 and #4 on 6/6/12 at 9:12 AM indicated client C would urinate on himself. The workshop staff stated client C would do this "intentionally" as part of a behavior. Workshop staff #3 and #4 stated "He pees a lot. Not sure how he does it." Workshop staff #3 and #4 indicated client C's fluids were limited. Workshop staff #3 and #4 indicated when client C was incontinent, the client would be incontinent of a large amount of urine. Workshop staff #3 and #4 indicated client C would be incontinent of a large amount of urine, and then an hour later be incontinent of another large amount of urine.</p> <p>Client C's record was reviewed on 6/5/12 at 12:54 PM. Client C's Nurses Observation Records indicated the following:</p> <p>-5/15/12 "...cont (continue) to have urinary incont. (incontinence) issues related to behaviors."</p> <p>-5/1/12 "...Pt (patient) has had issues (with) incontinence, ex (example) [name</p> |                                                                 | <p><b>How others will be identified:</b><br/><b>(Systemic)</b> The Program Coordinator and Nurse will review all the Comprehensive Functional Assessments to ensure that all remain current and address each clients needs. IDT meetings will be held if any modifications of the Individual Support Plans are needed.</p> <p><b>Measures to be put in place:</b><br/>The Program Coordinator and the Nurse will be retrained on performing accurate assessments or reassessments to address the individual's programmatic needs as well as healthcare needs. The Program Coordinator and the Nurse will review and revise the current assessments for Client C as it pertains to fluid restriction and incontinence. After the assessments are completed, the Individual's Support Plans will be revised and updated to include the necessary changes to ensure each individual's needs are being met. The team agreed to add inappropriate urination to his BSP. All staff have been retrained on accurate documentation of his A-B-C-Tracking sheet.</p> <p><b>Monitoring of Corrective Action:</b> The Operations Manager of Supervised Group Living, Program Coordinator, and the Nurse will monitor all individuals program plans and assess and</p> |                      |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 |                                                                                                                                       |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                       | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 |                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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 shopping center] and bed. Will cont to monitor."</p> <p>Client C's 5/16/12 Progress Note indicated client C was caught taking two Ensure (supplement drinks) out of the refrigerator in staff's office.</p> <p>Client C's 5/4/12 IDT Meeting note indicated "The team met to discuss [client C's] BSP, and inappropriate urination. The team discussed [client C's] increased measures of inappropriate urination. The team agreed to add the inappropriate urination to his BSP as a part of his incentive plan that is linked to his verbal aggression."</p> <p>Client C's 6/12 Antecedent-Behavior-Consequence Analysis for Low-Frequency Behavior (behavior data sheet) indicated the facility did not track client C's incontinence/inappropriate urination.</p> <p>Client C's 6/12 Fluid Intake tracking sheet indicated client C was on a fluid restriction and received the following:</p> <p>-2 cups (16 ounces) of coffee and 1/2 cup of juice (4 ounces) at breakfast.</p> <p>-1/4 cup of juice (2 ounces) with morning medications.</p> |                                                                 | <p>reassess as needed to ensure that all individuals plan remain effective and appropriate.</p> <p><b>Completion date: 7/8/12</b></p> |                                                                                |  |                                             |  |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>-2 cups (16 ounces) of flavored water at snack time.</p> <p>-2 cups flavored water at lunch.</p> <p>-1/2 cup choice at 3:00 PM snack.</p> <p>-1/4 cup juice at 4 PM medications</p> <p>-1/2 cup of milk and 1/2 cup of client's choice for dinner.</p> <p>-1/2 cup of client's choice for bedtime snack.</p> <p>The above mentioned 6/12 fluid intake form indicated the facility staff documented "Nf" for not in the facility when the client was at the workshop for the morning snack, lunch and 3 PM fluid consumption amounts.</p> <p>Client C's 3/12 to 5/12 Nursing Monthly Summaries and/or record did not indicate client C's IDT assessed/ruled out medical reasons for client C's urinating large amounts of urine while on a fluid restriction. Client C's record and/or 5/4/12 IDT note did not indicate the client's IDT re-assessed client C's fluid restriction to determine if client C was getting more fluids than indicated as the above mentioned fluid restriction sheet only indicated staff was initialing the</p> |               |                                                                                                                 |                      |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 |                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (X4) ID PREFIX TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 was given the actual amount of fluids at the specified times. The fluid restriction sheet did not indicate when and/or if the client consumed extra fluids. Client C's record and/or 1/13/12 Individual Support Plan did not clearly indicate why client C's fluids were limited/restricted.</p> <p>Interview with client C's guardian on 6/6/12 at 9:27 PM stated client C's urinating on himself was "fairly new." Client C's guardian indicated client C's urinating on himself was behavioral as the client would urinate on himself on purpose at the group home.</p> <p>Interview with administrative staff #2 and LPN #1 on 6/7/12 at 10:30 AM indicated client C was on a fluid restriction. Administrative staff #2 and LPN #1 indicated client C received fluids at certain times during the day. Administrative staff #2 and LPN #1 indicated client C was demonstrating urinary incontinence as well. Administrative staff #2 and LPN #1 indicated client C's urinary incontinence was behavioral. Administrative staff #2 and LPN #1 indicated client C's fluids were being tracked on the fluid intake sheet. LPN #1 indicated the fluid intake sheet did not indicate the actual amounts of fluids the client took in as the sheet</p> |                                                                 |                                                                                                                 |                                                                                |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                 |                                                                                                                 |                      |                                             |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                    |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                  |                      |                                             |
| (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 the client only received the specified allowed amounts.</p> <p>Administrative staff #2 and LPN #1 indicated the 6/12 fluid intake sheet did not indicate if client C was consuming extra fluid amounts. LPN #1 indicated client C's record did not indicate medical reasons had been looked at since the client would be incontinent of urine.</p> <p>Administrative staff #2 and LPN #1 indicated they were not aware client C would be incontinent of a large amount of urine. Administrative staff #2 and LPN #1 indicated client C should not be urinating large amounts of fluids as the client was on a fluid restriction.</p> <p>Administrative staff #2 indicated client C's fluid restriction was being followed at the workshop as well even though it was not being documented on the fluid intake sheet. Administrative staff #2 indicated client C was probably taking in more fluid than what was documented.</p> <p>Interview with staff #1, by phone, on 6/7/12 at 1:08 PM indicated client C was incontinent of urine. Staff #1 stated "When he goes, it's normally a lot."</p> <p>9-3-4(a)</p> |                                                                 |                                                                                                                 |                      |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (X4) ID PREFIX TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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                                                           |  |                                             |  |
| W0227                                                                     | <p>483.440(c)(4)<br/>INDIVIDUAL PROGRAM PLAN<br/>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review and interview for 1 of 3 sample clients (client B), the facility failed to ensure his behavioral needs were addressed.</p> <p>Findings include:</p> <p>During the morning observation period on 6/5/12 from 6:22 AM to 8:05 AM, client B was observed at 6:25 AM to stand in the living room doorway without any clothes on and put on a pair of pull-ups. Client B went across the living room to the other side of the house and waited outside the bathroom door with only the pull-ups on. Client B went into the bathroom and got out a pair of shorts and a shirt from the closet in the bathroom and put them on and returned to his bedroom and laid down on his bed that was still wet. The sheets on client B's bed had been urinated on during the night and had not been changed.</p> <p>Client B laid down on the wet sheets in his clean clothes and came back into the living room with the back of his shirt and pants wet. Staff #2 indicated on 6/5/12 at 6:25 AM that client B would remove his</p> | W0227                                                           | <p><b>W 227:</b> The individual program plan states the specific objectives necessary to meet the clients' needs, as identified by the comprehensive assessment required by paragraph (c) (3) of this section</p> <p><b>Corrective Action: (Specific)</b><br/>Client B's assessments have been reviewed in regards to inappropriate urination. Client B's Behavior Support Plan and A-B-C Tracking Sheet will be revised to include targeted behavior of inappropriate urination. All staff will be trained on client B's revised Behavior Support Plan. Client B's clothes have been relocated to an upper shelf in his closet. Staff have been inserviced on maintaining cleanliness in client B's bedroom, including ensuring he has clean dry bedding after each incontinence episode.</p> <p><b>How others will be identified: (Systemic)</b> The Program Coordinator and Nurse will review all the Comprehensive Functional Assessments to ensure that all remain current and address each clients needs. IDT meetings will</p> | 07/08/2012                                                                     |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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>wet pull-ups, throw them away and would then go to bathroom on the other side of the house to get his clothes. Staff #2 indicated client B could not keep his clothes in his room because he would urinate on them.</p> <p>The record review for client B was conducted on 6/5/12 at 10:30 AM. The Behavior Support Plan (BSP) dated 8/22/11 indicated client B had the following target behaviors:<br/>                     "Physical Aggression - Any time [client B] pinches, scratches or grabs clothes/body parts of another person that would cause injury.<br/>                     Property Destruction - Any time [client B] grabs items and throws them, pulls wall hangings down pulls the fire alarm, turns light switches on and off, or opens and shuts doors."<br/>                     The plan did not address client B urinating on the clothes that were left in his room.</p> <p>Interview with the Program Coordinator (PC) on 6/6/12 at 8:00 AM indicated client B had to keep his clothes in the bathroom across the hall because he didn't like his clothes kept in his room and would urinate on them if they were left in the room. The PC indicated the client had a toileting goal, but the urination on his clothes had not been addressed.</p> |                                                                 | <p>be held if any modifications of the Individual Support Plans are needed.</p> <p><b>Measures to be put in place:</b><br/>                     Client B's assessments have been reviewed in regards to inappropriate urination. Client B's Behavior Support Plan and A-B-C Tracking Sheet will be revised to include targeted behavior of inappropriate urination. All staff will be trained on client B's revised Behavior Support Plan. Client B's clothes have been relocated to an upper shelf in his closet. Staff have been inserviced on maintaining cleanliness in client B's bedroom, including ensuring he has clean dry bedding after each incontinence episode.</p> <p><b>Monitoring of Corrective Action:</b> The Operations Manager of Supervised Group Living, Program Coordinator, and the Nurse will monitor all individuals program plans and assess and reassess as needed to ensure that all individuals plan remain effective and appropriate.</p> <p><b>Completion date: 7/8/12</b></p> |                                                                                |  |                                             |  |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|----------------------|
|                    | 9-3-4(a)                                                                                                               |               |                                                                                                                 |                      |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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                                                           |  |                                             |  |
| W0240                                                                     | <p>483.440(c)(6)(i)<br/>INDIVIDUAL PROGRAM PLAN<br/>The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (C), the client's Individual Support Plan (ISP), failed to indicate how facility staff were to monitor the client outside the group home and/or to clearly define when client C was to have one on one staffing (one staff to one client) to meet the behavioral needs of the client.</p> <p>Findings include:</p> <p>1. During the 6/4/12 observation period between 4:05 PM and 6:15 PM and the 6/5/12 observation period between 6:12 AM and 8:35 AM, at the group home, client C had one to one staffing. Specifically during the above mentioned 6/4/12 observation period, staff #3 was client C's one to one staff. Staff #3 did not consistently stay within arms reach of client C during the observation period as staff #3 would leave the client unsupervised to go into another room or client C would enter and/or leave the living room and staff #3 would not be with the client. During the above mentioned 6/5/12 observation period, staff #3 stayed in the bathroom with client</p> | W0240                                                           | <p><b>W 240:</b> The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p><b>Corrective Action: (Specific)</b><br/>Client C's Behavior Support Plan has been revised to include 1:1 staffing definition while at home, in the community, at the workshop and while riding in the van with others. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. All staff have been retrained on client C's Behavior Support Plan. The Risk Plan for client C has been revised and all staff trained. A 15-minute check sheet has been implemented and staff have been retrained on its completion. The Behavior Support Plan for client C has been revised to include specific procedures for using You're Safe, I'm Safe. All staff have been retrained on You're Safe, I'm Safe.</p> <p><b>How others will be identified: (Systemic)</b> All clients will be assessed for medical issues requiring methodologies for care and treatment. When a clients'</p> | 07/08/2012                                                                     |  |                                             |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      |                                             |
| (X4) ID PREFIX TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>C while the client showered. At 8:29 AM, staff #2 walked client C out to the van. Client C was placed in the front seat of the van. Staff #1 and #2 then assisted clients D and E to load the van. Clients D and E were placed in the back seat of the van and client A, who was in wheelchair was placed in the middle section of the van between the back and front seats. Staff #2 then got into the driver's seat of the van. Only one staff was present in the van with clients A, C, D and E.</p> <p>Interview with staff #3 on 6/5/12 at 6:42 AM and 8:22 AM stated client C had one to one staffing due to the client's behaviors of "food foraging and skin picking." Staff #3 indicated client C had one to one staffing during waking hours and the facility staff were to stay with the client even while he was in the bathroom to prevent the client from picking. Staff #3 indicated client C had picked the areas over the past weekend while the client was in the bathroom unsupervised.</p> <p>Interview with staff #3 indicated the client had gone to Special Olympics in a different city on 6/1, 6/2 and 6/3/12, the past weekend.</p> <p>Client C's record was reviewed on 6/5/12 at 12:54 PM. Client C's 6/12 Antecedent Behavior Consequence Analysis for low-Frequency Behavior (data sheets)</p> |                                                                 | <p>Behavior Support Plan has been revised for medical issues, Care Plans will be developed for those medical issues.</p> <p><b>Measures to be put in place:</b><br/>Client C's Behavior Support Plan has been revised to include 1:1 staffing definition while at home, in the community, at the workshop and while riding in the van with others. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. All staff have been retrained on client C's Behavior Support Plan. The Risk Plan for client C has been revised and all staff trained. A 15-minute check sheet has been implemented and staff have been retrained on its completion. The Behavior Support Plan for client C has been revised to include specific procedures for using You're Safe, I'm Safe. All staff have been retrained on You're Safe, I'm Safe.</p> <p><b>Monitoring of Corrective Action:</b> All ISP's and BSP's will be reviewed by the Operations Manager of Supervised Group Living, Program Coordinator, and Nurse to ensure that Care Plans have been developed for all medical issues.</p> |                      |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 |                                                                                                                 |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 |                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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 client C demonstrated "Skin Picking: Scratching, breaking skin, and causing bleeding etc." on 6/3/12 at 11:15 AM to 11:30 AM and on 6/3/12 at 4:00 PM to 4:10 PM. The 6/12 behavior data sheet indicated the behavior occurred in the van and in the shower. The 6/12 behavior data sheet indicated staff "blocked" the attempt when the client was in the shower at 4:00 PM. The 6/12 data sheet also indicated client C demonstrated the skin picking behavior on 6/2/12 at 7:30 PM to 7:35 PM. The 6/12 behavior data sheet indicated client C was in the bathroom when the behavior occurred.</p> <p>Client C's Monthly Program Team Review indicated client C demonstrated skin picking one time in 4/2012 and two times in 3/2012. The 3/12 monthly note indicated "He is still taking food and picking...."</p> <p>Client C's 1/13/12 ISP (Individual Support Plan) indicated client C's diagnosis included, but were not limited to, Prader Willi and Impulse Control Disorder. Client C's 1/13/12 ISP Medical Input sheet indicated "...His (client C's) wounds from picking r/t (related to) Prader-Willi (rare genetic disorder with insatiable appetite)...."</p> <p>Client C's 5/18/12 nursing care</p> |                                                                 | <p><b>Completion Date: 7/8/12</b></p>                                                                           |                                                                                |  |                                             |  |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>plan/problem area indicated "Problem: Risk for skin infection r/t self inflicted wounds related to dx (diagnosis) of Prader-Willi...2. Staff will monitor and encourage [client C] to not pick skin...."</p> <p>Client C's 5/9/12 Behavior Support Plan (BSP) indicated client C demonstrated skin picking behavior defined as "scratching areas of his body and breaking the skin to the point that it bleeds, this includes opening existing sores." The 5/9/12 BSP indicated client C had "Enhanced Supervision." The BSP indicated "[Client C] will have a 1:1 staffing during all waking hours while at the home. 1:1 staff is defined as being within arms length of him. During sleep hours staff will be continuing to check on [client C] using 15 minute bedroom checks. When he is in the bathroom staff will remain outside the door with the door unlocked. Once 5 minutes have elapsed staff will knock on the door, if he does not respond staff will open the door and check on [client C]. While he is the shower, staff will be in the bathroom with him prompting good hygiene and checking every five minutes to ensure he is not picking at his skin...." Client C's 5/9/12 BSP indicated client C's door would stay open enough for staff to do 15 minute check. Client C's 5/9/12 BSP and/or 1/13/12 ISP indicated the facility</p> |               |                                                                                                                 |                      |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>failed to clearly define the client's one on one supervision as the ISP and/or BSP did not indicate how the client was to be monitored when in the community, riding in the van with others, and/or at the day program.</p> <p>The facility's 6/5/12 Operation Employee Punch Correction/Adjustments/Days-Off Request/Hours Allocation Form was reviewed on 6/5/12 at 3:00 PM. The facility's time request cards indicated staff #4 worked the following times during the Special Olympics event/outing:</p> <p>6/1/12 6 AM to 10 PM<br/>6/2/12 6 AM to 10 PM<br/>6/3/12 6 AM to 10 PM</p> <p>The facility's 6/4/12 time request card indicated staff #2 went to the special olympics event. The time request card indicated staff #2 worked the following times at the Special Olympics event:</p> <p>6/1/12 6 AM to 10 PM<br/>6/2/12 6 AM to 10 PM<br/>6/3/12 6 AM to 10 PM</p> <p>The facility only provided time cards for 2 staff who went on the out of town event. Interview with administrative staff #1 on 6/5/12 at 3:00 PM indicated staff #4 was client C's one on one staff person for the</p> |               |                                                                                                                 |                      |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>Special Olympics event. Administrative staff #1 indicated 3 staff went to the out of town event on 6/1, 6/2 and 6/3/12.</p> <p>Interview with the Program Coordinator (PC) on 6/5/12 at 3:50 PM indicated client C had one to one staffing due to food foraging and skin picking.</p> <p>Interview with staff #3 on 6/5/12 at 8:10 AM and at 8:22 AM indicated client C went to the workshop with staff from another group home. Staff #3 indicated she thought the client was to have one to one staffing while at the workshop as well. Staff #3 indicated facility staff were to block client C from picking wounds. Staff #3 stated "Can't put in Your Safe, I'm Safe (behavior intervention technique)." Staff #3 indicated client she felt client C would pick at night as well.</p> <p>Interview with staff #2 on 6/5/12 at 8:30 AM indicated client C was to have one on one staffing when he was at the group home, in the community and at the workshop. When asked why she was the only staff in the van with clients A, C, D and E, staff #2 indicated she was leaving to take client C to another city for a doctor's appointment after she dropped clients A, D and E at work.</p> <p>Interview with workshop staff #3 and #4</p> |               |                                                                                                                 |                      |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>on 6/6/12 at 9:12 AM indicated client C would try to pick his skin at the workshop.</p> <p>Interview with client C's guardian on 6/6/12 at 9:27 PM indicated client C would pick his skin when he became angry, would go to the bathroom and go to shower.</p> <p>Interview with LPN #1 and administrative staff #2 on 6/7/12 at 10:30 AM indicated client C demonstrated SIB of skin picking due to his Prader Willi diagnosis. LPN #1 and administrative staff #2 indicated they were not sure how client C's wounds were getting worse, from picking, as the client was on one to one staffing during waking hours. Administrative staff #2 and LPN #1 indicated client C was to have one on one staffing during waking hours. Administrative staff #2 indicated client C's 5/19/12 BSP did not clearly indicate how client C was to be monitored outside the group home (in the van, community and at the workshop). Administrative staff #2 indicated client C's ISP did not clearly define client C's one on one staffing.</p> <p>9-3-4(a)</p> |               |                                                                                                                 |                      |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PERCEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|
|                          |                                                                                                                              |                     |                                                                                                                          |                            |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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                                                           |  |                                             |  |
| W0249                                                                     | <p>483.440(d)(1)<br/>PROGRAM IMPLEMENTATION</p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (client B), the facility failed to implement the client's Individual Support Plan (ISP) objectives when formal and/or formal training opportunities existed.</p> <p>Findings included:</p> <p>1. During the 6/4/12 observation period between 4:05 PM and 6:15 PM, at the group home, client B sat in a rocker chair rocking without an activity, sat and wiped his nose on his arm, and/or sat and looked around without being redirected to participate in a more meaningful activity except to do a puzzle which lasted less than 1 minute and to work on a money goal which the client refused. Staff #1, #7 and/or staff #12 did not offer and/or redirect client B to participate any additional training and/or activity.</p> <p>During the 6/5/12 observation period between 6:12 AM and 8:35 AM, at the</p> | W0249                                                           | <p><b>W 249: As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives defines in the individual program plan.</b></p> <p><b>Corrective Action: (Specific):</b><br/>Client B's Active Treatment schedule has been revised and all staff have been re-trained on the new schedule. All staff has been re-trained on Client B's Individual Support Plan (ISP) objectives and how to effectively run program goals with client B.</p> <p><b>How others will be identified: (Systemic)</b> The Operations Manager of Supervised Group Living and Program Coordinator will monitor active treatment to</p> | 07/08/2012                                                                     |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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>group home, client B sat in the rocking chair and rocked and/or sat without an activity. Staff #2 and #11 did not redirect client B to participate in a more meaningful activity and/or training. During the above mentioned 6/4 and 6/5/12 observation periods, client B was non-verbal in communication in that the client did not speak. Facility staff did not implement any communication training with the client.</p> <p>The record review for client B was conducted on 6/5/12 at 10:30 AM. The Individual Support Plan (ISP) dated 8/22/11 indicated client B had the following formal training goals:</p> <ol style="list-style-type: none"> <li>1. Point to currency stated</li> <li>2. Remain in the medication room and take his medications.</li> <li>3. Improve his communication.</li> <li>4. Improve his eating.</li> <li>5. Improve his dental teeth brushing skills.</li> <li>6. Improve his toileting skills.</li> <li>7. Improve his domestic skills.</li> </ol> <p>The Active Treatment Schedule, undated, for client B indicated the following activities:</p> <p>7:00 AM to 8:00 AM - Meds<br/>8:00 AM to 9:00 AM - Morning Choices: Wake up<br/>10:00 AM to 11:00 AM - Chores<br/>11:00 AM to 12:00 PM - Cooking,</p> |                                                                 | <p>ensure that Active Treatment Schedules are followed and staff are effectively running program goals for Client B as well as all other clients in the home.</p> <p><b>Measures to be put in place:</b><br/>Client B's Active Treatment schedule has been revised and all staff have been re-trained on the new schedule. All staff has been re-trained on Client B's Individual Support Plan (ISP) objectives and how to effectively run program goals with client B.</p> <p><b>Monitoring of Corrective Action:</b> The Operations Manager of Supervised Group Living and Program Coordinator will monitor active treatment to ensure that Active Treatment Schedules are followed and staff are effectively running program goals for Client B as well as all other clients in the home.</p> <p><b>Completion Date: 7/8/12</b></p> |                                                                                |  |                                             |  |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>outing or activity</p> <p>12:00 PM to 1:00 PM - Lunch</p> <p>1:00 PM to 2:00 PM - Chores</p> <p>2:00 PM to 3:00 PM - Daily Goals</p> <p>3:00 PM to 4:00 PM - Noting listed</p> <p>4:00 PM to 5:00 PM - Meal</p> <p>Preparation/Communication</p> <p>5:00 PM to 6:00 PM -</p> <p>Unwind/Snack/Meds</p> <p>6:00 PM to 7:00 PM - Supper</p> <p>7:00 PM to 8:00 PM - Evening</p> <p>Choices; Domestic/Rights</p> <p>8:00 PM to 9:00 PM - Rec.</p> <p>(recreation)/leisure</p> <p>9:00 PM - Sleep</p> <p>Interview with Administrative staff #2 on 6/6/12 at 11:30 AM indicated client B did not attend a day program because of his agitation when he got into a different environment. Staff #2 indicated they were able to get him to take out trash, but he did not assist with any other household chores. Staff #1, interviewed on 6/5/12 at 8:00 AM indicated client B usually went back to bed in the mornings and got up for lunch. Staff #1 indicated client B would only participate in any activity a short time.</p> <p>9-3-4(a)</p> |               |                                                                                                                 |                      |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PERCEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETION<br>DATE |
|--------------------------|------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------|----------------------------|
|                          |                                                                                                                              |                     |                                                                                                                          |                            |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                      |                                             |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                      |                                             |
| (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 |                                             |
| W0252                                                                     | <p>483.440(e)(1)<br/>PROGRAM DOCUMENTATION<br/>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>Based on interview and record review for 1 of 3 sampled clients (C), the facility failed to document 15 minute checks and failed to document skin assessments/checks on the client as indicated by the client's Individual Support Plan (ISP and/or Behavior Support Plan (BSP).</p> <p>Findings include:</p> <p>Client C's record was reviewed on 6/5/12 at 12:54 PM. Client C's 5/18/12 nursing care plan/problem area indicated "Problem: Risk for skin infection r/t self inflicted wounds related to dx (diagnosis) of Prader-Willi...2. Staff will monitor and encourage [client C] to not pick skin. 3) Staff will report any breaks in skin to nurse immediately, and nursing services will record and document findings. PCP (Primary Care Physician) will be notified of any breaks in the skin...6) Skin checks will be completed at bathing times, and upon awaking...."</p> <p>Client C's 5/9/12 Behavior Support Plan (BSP) indicated client C demonstrated</p> | W0252                                                           | <p><b>W 252: Data Relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</b></p> <p><b>Corrective Action: (Specific)</b><br/>Client C's Behavior Support Plan has been revised to include 1:1 staffing definition while at home, in the community, at the workshop and while riding in the van with others. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. All staff have been retrained on client C's Behavior Support Plan. The Risk Plan for client C has been revised and all staff trained. A 15-minute check sheet has been implemented and staff have been retrained on its completion. The Behavior Support Plan for client C has been revised to include specific procedures for using You're Safe, I'm Safe. All staff have been retrained on You're Safe, I'm Safe.</p> <p><b>How others will be identified: (Systemic)</b> All clients will be</p> | 07/08/2012           |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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                                                           |  |                                             |  |
|                                                                           | skin picking behavior defined as "scratching areas of his body and breaking the skin to the point that it bleeds, this includes opening existing sores." The 5/9/12 BSP indicated client C had "Enhanced Supervision." The BSP indicated "[Client C] will have a 1:1 staffing during all waking hours while at the home. 1:1 staff is defined as being within arms length of him. During sleep hours staff will be continuing to check on [client C] using 15 minute bedroom checks. When he is in the bathroom staff will remain outside the door with the door unlocked. Once 5 minutes have elapsed staff will knock on the door, if he does not respond staff will open the door and check on [client C]. While he is the shower, staff will be in the bathroom with him prompting good hygiene and checking every five minutes to ensure he is not picking at his skin...." Client C's 5/9/12 BSP indicated client C's door would stay open enough for staff to do 15 minute check. Client C's 6/12 data sheets and/or record indicated the facility failed to monitor/conduct 15 minute checks with client C as there was no documentation to ensure 15 minutes checks were being done at night to prevent the client from picking his skin. Client C's 6/12 data sheets and/or record also indicated the facility did not conduct body assessment checks when bathing and/or upon |                                                                 | assessed for medical issues requiring methodologies for care and treatment. When a clients' Behavior Support Plan has been revised for medical issues, Care Plans will be developed for those medical issues.<br><br><b>Measures to be put in place:</b><br>Client C's Behavior Support Plan has been revised to include 1:1 staffing definition while at home, in the community, at the workshop and while riding in the van with others. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. All staff have been retrained on client C's Behavior Support Plan. The Risk Plan for client C has been revised and all staff trained. A 15-minute check sheet has been implemented and staff have been retrained on its completion. The Behavior Support Plan for client C has been revised to include specific procedures for using You're Safe, I'm Safe. All staff have been retrained on You're Safe, I'm Safe.<br><br><b>Monitoring of Corrective Action:</b> All ISP's and BSP's will be reviewed by the Operations Manager of Supervised Group Living, Program Coordinator, and Nurse to ensure that Care Plans |                                                                                |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |                                                                                                                 |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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>awaking in the morning as there was no documentation of the checks/assessments.</p> <p>Interview with staff #3 on 6/5/12 at 8:10 AM and at 8:22 AM indicated client C had the open areas on his legs longer than 6 weeks. Staff #3 stated client C was to be monitored "throughout the night" with 15 minute checks. Staff #3 indicated she did not know where the 15 minute checks were documented and/or kept.</p> <p>Interview with LPN #1 and administrative staff #2 on 6/7/12 at 10:30 AM indicated client C demonstrated SIB of skin picking due to his Prader Willi diagnosis. LPN #1 and administrative staff #2 indicated the facility staff were not documenting 15 minute checks at night. LPN #1 and administrative staff #1 indicated the staff did not document the body assessments/checks at bath time and/or after client C got up in the morning. LPN #1 indicated she developed a form for staff to document 15 minute checks on 6/6/12.</p> <p>9-3-4(a)</p> |                                                                 | <p>have been developed for all medical issues.</p> <p><b>Completion Date: 7/8/12</b></p>                        |                                                                                |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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                                                           |  |                                             |  |
| W0268                                                                     | <p>483.450(a)(1)(i)<br/>CONDUCT TOWARD CLIENT<br/>These policies and procedures must promote the growth, development and independence of the client.</p> <p>Based on observation and interview for 1 of 3 sampled clients (B), the facility failed to ensure staff protected the client's dignity in regard to ensuring the client did not lay down in a wet bed.</p> <p>Findings include:</p> <p>During the 6/5/12 observation period between 6:12 AM and 8:35 AM, at the group home, staff #2 assisted client B to change and make his bed after the client was incontinent in the bed. Client B got back into his bed after he got dressed for the morning and assisted staff 2 to make his bed. Client B laid on his back and covered up with his covers. Client B then got up out of bed and walked back into the living room. Client B's shirt was wet from the neck to the end of the shirt from laying back down on the bed with a clean sheet on a wet mattress. Staff #2 did not prompt client B to change his shirt until the surveyor informed the client he was wet from laying down on the bed. Staff #2 did not wipe and/or clean client B's mattress off prior to placing a clean sheet on the client's bed.</p> | W0268                                                           | <p><b>W 268: These policies and procedures must promote the growth, development, and independence of the client</b></p> <p><b>Corrective Action: (Specific)</b><br/>Client B's assessments have been reviewed in regards to inappropriate urination. Client B's Behavior Support Plan and A-B-C Tracking Sheet will be revised to include targeted behavior of inappropriate urination. All staff will be trained on client B's revised Behavior Support Plan. Client B's clothes have been relocated to an upper shelf in his closet. Staff have been inserviced on maintaining cleanliness in client B's bedroom, including ensuring he has clean dry bedding after each incontinence episode.</p> <p><b>How others will be identified: (Systemic)</b> The Program Coordinator and Nurse will review all the Comprehensive Functional Assessments to ensure that all remain current and address each clients needs. IDT meetings will be held if any modifications of the Individual Support Plans are needed.</p> <p><b>Measures to be put in place:</b></p> | 07/08/2012                                                                     |  |                                             |  |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>Interview with administrative staff #2 and LPN #1 on 6/7/12 at 10:30 AM indicated client B was incontinent of urine and would wet the bed at night.</p> <p>Administrative staff #2 and LPN #1 indicated facility staff should have cleaned client B's bed prior to placing a clean on the bed so client B would not lay back down on a wet bed.</p> <p>9-3-5(a)</p> |               | <p>Client B's assessments have been reviewed in regards to inappropriate urination. Client B's Behavior Support Plan and A-B-C Tracking Sheet will be revised to include targeted behavior of inappropriate urination. All staff will be trained on client B's revised Behavior Support Plan. Client B's clothes have been relocated to an upper shelf in his closet. Staff have been inserviced on maintaining cleanliness in client B's bedroom, including ensuring he has clean dry bedding after each incontinence episode.</p> <p><b>Monitoring of Corrective Action:</b> The Operations Manager of Supervised Group Living, Program Coordinator, and the Nurse will monitor all individuals program plans and assess and reassess as needed to ensure that all individuals plan remain effective and appropriate.</p> <p><b>Completion date: 7/8/12</b></p> |                      |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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                                                           |  |                                             |  |
| W0295                                                                     | <p>483.450(d)(1)(i)<br/><b>PHYSICAL RESTRAINTS</b><br/>The facility may employ physical restraint only as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior for which the restraint is applied.</p> <p>Based on interview and record review for 1 of 3 sampled clients with restrictive interventions (C), the client's Behavior Support Plan (BSP) failed to indicate the specific physical interventions which could be utilized with client C when he demonstrated physical aggression and/or property destruction.</p> <p>Findings include:</p> <p>Client C's record was reviewed on 6/5/12 at 12:54 PM. Client C's 5/9/12 BSP indicated client C demonstrated physical aggression and property destruction. Client C's 5/9/12 BSP indicated if client C demonstrated the mentioned behaviors facility staff were to do the following:</p> <p>"-Immediately ensure the safety of [client C] and all those in his immediate environment.<br/>-Verbally redirect him to an area away from the source of his frustration. If he refuses, redirect others away from the situation.<br/>-Get in between him and any other peer whom he may be attempting to aggress.</p> | W0295                                                           | <p><b>W 295: The facility may employ physical restraints on as an integral part of an individual program plan that is intended to lead to less restrictive means of managing and eliminating the behavior of which the behavior is applied.</b></p> <p><b>Corrective Action: (Specific)</b><br/>Client C's Behavior Support Plan has been revised to include 1:1 staffing definition while at home, in the community, at the workshop and while riding in the van with others. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. All staff have been retrained on client C's Behavior Support Plan. The Risk Plan for client C has been revised and all staff trained. A 15-minute check sheet has been implemented and staff have been retrained on its completion. The Behavior Support Plan for client C has been revised to include specific procedures for using You're Safe, I'm Safe. All staff have been retrained on You're Safe, I'm Safe.</p> | 07/08/2012                                                                     |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                      |                                             |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      |                                             |
| (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>-Block physical aggression and continued property destruction.</p> <p>-If he is continuing to place himself or others in danger use the Your Safe I'm Safe procedures (physical behavior interventions) starting with the least restrictive procedures first." Client C's 5/9/12 BSP did not indicate the specific type of restraint/behavioral techniques staff could utilize with client C.</p> <p>Interview with administrative staff #2 and LPN #1 on 6/7/12 at 10:30 AM, indicated client C's BSP did not include the specific type of behavioral interventions which could be utilized with client C.</p> <p>Administrative staff #2 indicated facility staff used a one or two man hold with the client.</p> <p>9-3-5(a)</p> |                                                                 | <p><b>How others will be identified: (Systemic)</b> All clients will be assessed for medical issues requiring methodologies for care and treatment. When a clients' Behavior Support Plan has been revised for medical issues, Care Plans will be developed for those medical issues.</p> <p><b>Measures to be put in place:</b> Client C's Behavior Support Plan has been revised to include 1:1 staffing definition while at home, in the community, at the workshop and while riding in the van with others. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. All staff have been retrained on client C's Behavior Support Plan. The Risk Plan for client C has been revised and all staff trained. A 15-minute check sheet has been implemented and staff have been retrained on its completion. The Behavior Support Plan for client C has been revised to include specific procedures for using You're Safe, I'm Safe. All staff have been retrained on You're Safe, I'm Safe.</p> <p><b>Monitoring of Corrective Action:</b> All ISP's and BSP's will be reviewed by the Operations Manager of Supervised Group</p> |                      |                                             |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                        | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                       |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                        |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                     |                      |                                             |
| (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 |                                             |
|                                                                           |                                                                                                                        |                                                                 | Living, Program Coordinator, and Nurse to ensure that Care Plans have been developed for all medical issues.<br><br><b>Completion Date: 7/8/12</b> |                      |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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                                                           |  |                                             |  |
| W0331                                                                     | <p>483.460(c)<br/>NURSING SERVICES<br/>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (C), the facility's nursing services failed to meet the healthcare needs of the client in regard to monitoring, assessments and ensuring staff notified the nurse regarding changes in the client's health status. The facility's nursing services failed to ensure a client's doctor was notified of the client's open areas, to ensure physician orders were clarified/followed and or failed to ensure nursing care plans/risk plans were developed in regard to wound care.</p> <p>Findings include:</p> <p>During the 6/4/12 observation period between 4:05 PM and 6:15 PM and the 6/5/12 observation period between 6:12 AM and 8:35 AM, at the group home, client C had ace bandage wrapping on his left leg which went from above the client's left knee to above his left ankle. During the 6/5/12 observation period, client C had two open areas on his left leg. One area was on client C's knee and and the second area was on the client's lower leg/shin area. The area on the lower leg/shin had about a 3 inch red</p> | W0331                                                           | <p><b>W 331:</b> The facility nursing services must provide clients with nursing services in accordance with their needs. <b>Corrective Action: (Specific)</b> Client C was referred to Wound Clinic for evaluation and treatment. All staff were retrained on current wound care procedures. The Abuse and Neglect Policy and Procedure was revised to include preventing and addressing neglect in regards to client's behavior. All staff were retrained on the revised Abuse and Neglect Policy and Procedure. All staff were retrained on scheduling follow-up medical as needed. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were retrained on client C's revised BSP. Client C was referred to Wound Care for evaluation and treatment. All staff were retrained on current wound care treatment. Staff will complete skin observation daily and document findings on Skin Assessment Sheet and will report any areas to the nurse. The nurse will review Skin Assessment Sheets at site visits and complete skin assessment weekly. The nurse will be retrained on reporting open areas to physician and requesting an</p> | 07/08/2012                                                                     |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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>area/line around a 1 to 1 and 1/2 inch open area which was irregular in shape. The open area had layers of skin missing which were red in color and wet looking in the center. Outside the large area on client C's shin, the client had 3 small pinpoint red scabs to the side of the shin area. Client C's knee had about a half inch open area which was red in color. During the 6/5/12 observation period, staff #3 applied Bactroban (antibiotic) ointment on 2 small gauze squares and laid the gauze squares on top of the open areas of client C's shin/lower leg and knee. The staff then wrapped gauze strips around the client's left leg times two and then wrapped client C's left leg with ace wrapping.</p> <p>Interview with staff #3 on 6/5/12 at 6:42 AM and 8:22 AM indicated client C had 2 open areas on his left leg. Staff #3 indicated the client's leg was covered/wrapped due to the client's picking. Staff #3 indicated staff applied medication to the open areas and covered three times a day.</p> <p>Client C's record was reviewed on 6/5/12 at 12:54 PM. Client C's Nurses Observation Records indicated the following (not all inclusive):</p> <p>-1/6/12 Client C had an open wound to</p> |                                                                 | <p>appointment for evaluation. If client C is being transported with other individuals there will be a least 2 staff present during transport period. Staff will complete an Incident Report for any skin picking behavior that results in an open area and document the behavior on the A-B-C Tracking sheet. Nurse will be retrained on completing accurate documentation of assessment completed on any wound in nursing notes. All orders have been clarified orders. Salicylic AC kit 6% lotion to body BID has been received. Bactroban and Mupirocin have been discontinued. The Salicylic AC kit cleanser has been discontinued. Cordran tape has been discontinued. "Wound care (Use ointment, 2x(by) 2 pad, wrap any wound open or bleeding)" once daily, has been discontinued. Nurse will be retrained on clarifying wound care orders as needed and ensuring 90-day recertification orders are accurate for client C as well as all other clients in the home. Nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. The nurse will be retrained on completion of weekly skin checks and assessment and measurement of any wounds for client C. The</p> |                                                                                |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (X4) ID PREFIX TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>mid forehead and left knee.</p> <p>-1/11/12 "...Client has open wounds on FH (forehead), (L) (left) middle finger &amp; (and) (L) knee from picking..."</p> <p>-1/19/12 "...Client has open areas to lips, open area to FH &amp; (L) knee..."</p> <p>-1/25/12 "...skin pink, warm &amp; dry, open wound to (L) knee &amp; (L) middle finger knuckle..."</p> <p>-1/27/12 "...skin pink, warm &amp; dry, open wound to (L) knee &amp; (L) middle finger knuckle..."</p> <p>-3/5/12 "...Open area to (L) knee from SIB (self-injurious behavior), discoloration to LLL (Left lower leg) mostly calf..."</p> <p>-3/24/12 "...(L) knee wrapped (with) ace bandage,..."</p> <p>-4/6/12 "...On 4/412 [name of doctor] D/C (discontinued) Bactrim &amp; skin cleanser..."</p> <p>-4/10/12 "Home visit,...superficial abrasion noted to left lower leg area cleaned &amp; dressed 4 cm (centimeter) x 3 cm. Also has sm (small) pen area to (L) 3rd (third) finger 1 cm dia (diameter)..."</p> |                                                                 | <p>Risk Plan for client C has been revised and all staff trained. Client C's Behavior Support Plan has been revised to include 1:1 staffing definition, while at the home, in the community, at workshop and while riding on the van with others. A 15-minute check sheet has been implemented and staff have been retrained on its completion. All staff will be retrained on You're Safe, I'm Safe. <b>How others will be identified: (Systemic)</b> The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective. In addition, the nurse will review all Physician's Orders to ensure there accuracy as transcribed on the MAR.</p> <p><b>Corrective Action: (Specific)</b> Client C was referred to Wound Clinic for evaluation and treatment. All staff were retrained on current wound care procedures. The Abuse and Neglect Policy and Procedure was revised to include preventing and addressing neglect in regards to client's behavior. All staff were retrained on the revised Abuse and Neglect Policy and Procedure. All staff were retrained on scheduling follow-up medical as needed. Client C's</p> |                                                                                |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                      |                                             |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      |                                             |
| (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>-5/1/12 "Home Visit...skin W/D/I (warm/dry/intact),...Area remains open to (L) (lower) leg approx (approximately) 3 cm x 2.5 cm also small scab to (L) knee...."</p> <p>-5/8/12 "...area remains open to (L) (lower) leg, he has been picking at it again...."</p> <p>-5/15/12 "Home visit,...skin W/D/I except for area on (L) (lower) leg...."</p> <p>-6/1/12 "Home visit, chart review, monthly note completed. 0 acute issues."</p> <p>Client C's nursing notes failed to indicate any additional documentation, assessment and/or care in regard to client C's open areas on the client's left leg.</p> <p>Client C's 6/12 Medication Administration records (MARs) indicated facility staff were to apply Bactroban cream 2% to affected areas twice a day. The 6/12 MAR also indicated Client C had an order for Mupirocin ointment 2 % (substitute for Bactroban) "Apply to open area on legs twice daily." The 6/12 MARs indicated facility staff initialed they were applying both creams two times a day. Client C's 6/12 MARs had orders for Salicylic AC Kit lotion to apply to the</p> |                                                                 | <p>Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were retrained on client C's revised BSP. Client C was referred to Wound Care for evaluation and treatment. All staff were retrained on current wound care treatment. Staff will complete skin observation daily and document findings on Skin Assessment Sheet and will report any areas to the nurse. The nurse will review Skin Assessment Sheets at site visits and complete skin assessment weekly. The nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. If client C is being transported with other individuals there will be a least 2 staff present during transport period. Staff will complete an Incident Report for any skin picking behavior that results in an open area and document the behavior on the A-B-C Tracking sheet. Nurse will be retrained on completing accurate documentation of assessment completed on any wound in nursing notes. All orders have been clarified orders. Salicylic AC kit 6% lotion to body BID has been received. Bactroban and Mupirocin have been discontinued. The Salicylic AC kit cleanser has been discontinued. Cordran tape has been discontinued. "Wound care</p> |                      |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                      |                                             |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                      |                                             |
| (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's entire body for itching two times a day. Client C's 6/12 MAR also indicated client C had another order for Salicylic AC Kit 6% lotion (same as above) "Apply to affected areas twice daily." The 6/12 MAR indicated facility staff initialed they were applying each duplicate order two times a day. Client C's 6/12 MAR indicated client C had an order for Salicylic AC Kit 6% lotion (antiseptic cleanser) "Use cleanser in shower once each day." Client C's 6/12 MAR indicated the facility staff were not using the antiseptic cleanser as no initials were documented on the 6/12 MAR thus far. No time for administering/applying the cleanser was documented on the 6/12 MAR. Client C's 6/12 MAR indicated client C had an order "Wound Care-Use Cordran Tape on any wound that is scabbed." The 6/12 MAR indicated facility staff were initialing Cordran tape was being applied to scabbed wounds at 6:30 AM. Client C's 6/12 MAR indicated client C was to receive "Wound Care (Use ointment, 2 x (by) 2 pad, wrap any wound open or bleeding)" once daily at 6:30 AM not three times a day. Client C's 6/12/ MAR indicated a 1/8/2010 order "Ace Wrap-Keep leg covered to prevent picking AM and PM." The 6/12 MARs indicated facility staff were only initialing/documenting client C's legs were being covered two times daily</p> |                                                                 | <p>(Use ointment, 2x(by) 2 pad, wrap any wound open or bleeding)" once daily, has been discontinued. Nurse will be retrained on clarifying wound care orders as needed and ensuring 90-day recertification orders are accurate for client C as well as all other clients in the home. Nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. The nurse will be retrained on completion of weekly skin checks and assessment and measurement of any wounds for client C. The Risk Plan for client C has been revised and all staff trained. Client C's Behavior Support Plan has been revised to include 1:1 staffing definition, while at the home, in the community, at workshop and while riding on the van with others. A 15-minute check sheet has been implemented and staff have been retrained on its completion. All staff will be retrained on You're Safe, I'm Safe. <b>Monitoring of Corrective Action:</b> The Operations Manager of Supervised Group Living, Program Coordinator, and the Nurse will review all new Physician's Orders and ensure that they are accurately transcribed on the MAR and all relevant Program Plans are</p> |                      |                                             |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                    |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                  |                      |                                             |
| (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>versus three times daily which contradicted the order for "Wound Care (Use ointment, 2 x (by) 2 pad, wrap any wound open or bleeding)" once daily at 6:30 AM.</p> <p>Client C's 4/3/12 Physician order indicated "D/C Bactrim (antibiotic), Mupirocin &amp; antiseptic skin cleanser as client does not have MRSA (Methicillian Resistant Staphylococcus Aureus)."<br/>Client C's 5/23/12 physician's 90 day recertification orders indicated the above discontinued orders were still on the 5/12 physician's orders the pharmacy prints out. The 5/23/12 recertification orders indicated client C's doctor signed the 90 day orders thus indicating the 4/3/12 discontinued orders should be continued. Client C's 5/12 nurse notes did not indicate the facility's nurse sought clarification in regard to the client's orders for his skin.</p> <p>Client C's 5/1/12 Annual Resident Physical form indicated client C was seen by his doctor on 5/1/12. The 5/1/12 form indicated the facility's nurse failed to inform and/or have client C's doctor assess the open areas on the client's left leg on 5/1/12 as there was no mention of any open areas, on client C, on the form.</p> <p>Client C's 1/13/12 ISP (Individual</p> |                                                                 | <p>updated to reflect the changes.<br/><b>Completion Date: 7/8/12</b></p>                                       |                      |                                             |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>Support Plan) indicated client C's diagnoses included, but were not limited to, Prader Willi and Impulse Control Disorder. Client C's 1/13/12 ISP Medical Input sheet indicated "...His (client C's) wounds from picking r/t (related to) Prader-Willi (rare genetic disorder with insatiable appetite) are wrapped daily and as needed by staff and measured by nurse weekly...." The facility's nurse notes and record indicated the facility's nurse failed to monitor/measure client C's wounds weekly to determine if the client's wound was improving.</p> <p>Client C's 5/18/12 nursing care plan/problem area indicated "Problem: Risk for skin infection r/t self inflicted wounds related to dx (diagnosis) of Prader-Willi...2. Staff will monitor and encourage [client C] to not pick skin. 3) Staff will report any breaks in skin to nurse immediately, and nursing services will record and document findings. PCP (Primary Care Physician) will be notified of any breaks in the skin...6) Skin checks will be completed at bathing times, and upon awaking. 7) Staff will be trained on all aspects of [client C's] care...." The facility's nursing services failed to monitor the client's skin picking, perform skin checks/assessments, failed to report any breaks/area getting bigger to the nurse, and/or failed to notify the client's</p> |               |                                                                                                                 |                      |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>PCP of any new areas/breaks in skin.</p> <p>Client C's ISP and/or nursing problem areas indicated the facility's nursing services failed to develop a wound care problem which specifically indicated how facility staff were to care for the client's open wounds/areas.</p> <p>The facility's training records were reviewed on 6/5/12 at 3:05 PM. The facility's 1/5/12 Inservice Sign-in Sheet for "Demonstration of how to apply wrap by nurse (LPN #2) wound care" indicated three staff had been trained in regard to client C's wound care. The 1/5/12 inservice record indicated the facility's nursing services failed to ensure staff #2, #3, #4, #5, #7, #8, #9, #10 and #11 were trained in regard to client C's wound care needs.</p> <p>Interview with client C on 6/5/12 at 8:10 AM indicated client C caused the areas on his legs. Client C stated "I opened it up." Client C indicated the open wound on the lower part of his left leg was scar tissue. Client C indicated facility staff applied Bactroban on the open areas and covered the areas with gauze. Client C stated he had the open areas for "6 weeks." When asked if client C was seeing a doctor in regard to the wound on his lower leg, client C stated "No, but I used to."</p> |               |                                                                                                                 |                      |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>Interview with staff #3 on 6/5/12 at 8:10 AM and at 8:22 AM indicated client C had the open areas on his legs longer than 6 weeks.</p> <p>Interview with LPN #1 on 6/5/12 at 1:32 PM indicated Bactroban Cream and Mupirocin ointment were the same thing. LPN #1 stated they were "duplicate orders" and one of them would need to be discontinued from the MAR. LPN #1 indicated client C's MAR included duplicate Salicylic orders for the lotion as well. LPN #1 indicated one of the orders should be discontinued as well as staff were signing both medications. When asked if the cleanser should be used, LPN #1 first indicated no, as the cleanser had been discontinued by the doctor on 4/3/12. LPN #1 indicated the doctor had signed the 5/25/12 order which put the medication back in effect. LPN #1 indicated clarification needed to be obtained in regard to the client's treatments for the open wounds. LPN #1 indicated facility staff should not be using the Cordran Tape on client C's wound as the client did not have a scab. LPN #1 indicated she was sure the staff was not using the Cordran Tape, but did not know why the staff was initialing they were applying. LPN #1 stated "It looks bad. Worse than when I seen it last week. Will</p> |               |                                                                                                                 |                      |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>get him back to wound care clinic." LPN #1 indicated she was not aware of the regression with the area until 6/5/12 when she saw the area with the surveyors. LPN #1 indicated there was no wound care protocol/care plan in place until 6/5/12.</p> <p>Interview with LPN #1 and administrative staff #2 on 6/7/12 at 10:30 AM indicated client C demonstrated SIB of skin picking due to his Prader Willi diagnosis. LPN #1 indicated she had just taken over the nursing duties of the group home since 4/12. LPN #1 indicated she was still in the process of trying to get the medications straightened out. LPN #1 indicated client C had a wound on his finger and knee in 4/12. LPN #1 stated client C's knee had a scab and the area was the "size of an eraser head." LPN #1 indicated nursing staff should be measuring the wound and document about the wound. LPN #1 indicated she saw client C's wounds on 5/29/12 and it did not look like it looked on 6/5/12. LPN #1 indicated she did not document her assessment of the wound on 5/29/12. LPN #1 indicated she would start assessing client C's wound and measure the wound. LPN #1 indicated client C's doctor was not notified in regard to the client's open areas. LPN #1 indicated she did not know why the doctor did not document anything about client C's</p> |               |                                                                                                                 |                      |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>wounds at the annual physical examination. LPN #1 indicated facility staff should have called her over the weekend about client C's picking/wounds. LPN #1 stated she should be called "If picking excessively." LPN #1 indicated she would need to train staff in regard to client C's wound care. LPN #1 indicated facility staff were changing the client's ace wrapping and gauze three times a day. LPN #1 indicated client C did not have an order to change the wrapping 3 times a day. Administrative staff #2 indicated facility staff were doing it three times a day as client C had requested it be done three times a day. LPN #1 indicated client C was seen by a doctor on 6/5/12 and the client was diagnosed with cellulitis to the lower leg/open area. LPN #1 indicated client C was started on an antibiotic and Bactroban was to continue. LPN #1 indicated client C was to go to the wound care doctor today 6/7/12.</p> <p>9-3-6(a)</p> |               |                                                                                                                 |                      |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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                                                           |  |                                             |  |
| W0342                                                                     | <p>483.460(c)(5)(iii)<br/>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 direct care staff in detecting signs and symptoms of illness or dysfunction, first aid for accidents or illness, and basic skills required to meet the health needs of the clients.</p> <p>Based on observation, interview and record review for 1 of 3 sampled clients (C), the facility failed to ensure staff were trained in regard to the client's wound care needs, when to call the nurse, and/or to inform the doctor in regard to any open areas.</p> <p>Findings include:</p> <p>During the 6/4/12 observation period between 4:05 PM and 6:15 PM and the 6/5/12 observation period between 6:12 AM and 8:35 AM, at the group home, client C had ace bandage wrapping on his left leg which went from above the client's left knee to above his left ankle. During the 6/5/12 observation period, client C had two open areas on his left leg. One area was on client C's knee and the second area was on the client's lower leg/shin area. The area on the lower leg/shin had about a 3 inch red area/line around a 1 to 1 and 1/2 inch</p> | W0342                                                           | <p><b>W 342: 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 direct care staff in detecting signs and symptoms of illness or dysfunction, first aide in accidents or illness and basic skills required to meet the health needs of the clients.</b></p> <p><b>Corrective Action: (Specific)</b><br/>Client C was referred to Wound Clinic for evaluation and treatment. All staff were retrained on current wound care procedures. The Abuse and Neglect Policy and Procedure was revised to include preventing and addressing neglect in regards to client's behavior. All staff were retrained on the revised Abuse and Neglect Policy and Procedure. All staff were retrained on scheduling follow-up medical as needed. Client C's</p> | 07/08/2012                                                                     |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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>open area which was irregular in shape. The open area had layers of skin missing which were red in color and wet looking in the center. Outside the large area on client C's shin, the client had 3 small pinpoint red scabs to the side of the shin area. Client C's knee had about a half inch open area which was red in color. During the 6/5/12 observation period, staff #3 applied Bactroban (antibiotic) ointment on 2 small gauze squares and laid the gauze squares on top of the open areas of client C's shin/lower leg and knee. The staff then wrapped gauze strips around the client's left leg times two and then wrapped client C's left leg with ace wrapping.</p> <p>Interview with staff #3 on 6/5/12 at 6:42 AM and 8:22 AM staff #3 indicated client C had 2 open areas on his left leg. Staff #3 indicated the client's leg was covered/wrapped due to the client's picking. Staff #3 indicated staff applied medication to the open areas and covered three times a day.</p> <p>Client C's record was reviewed on 6/5/12 at 12:54 PM. Client C's 6/12 Medication Administration records (MARs) indicated facility staff were to apply Bactroban cream 2% to affected areas twice a day. The 6/12 MAR also indicated Client C had an order for Mupirocin ointment 2 %</p> |                                                                 | <p>Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were retrained on client C's revised BSP. Client C was referred to Wound Care for evaluation and treatment. All staff were retrained on current wound care treatment. Staff will complete skin observation daily and document findings on Skin Assessment Sheet and will report any areas to the nurse. The nurse will review Skin Assessment Sheets at site visits and complete skin assessment weekly. The nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. If client C is being transported with other individuals there will be a least 2 staff present during transport period. Staff will complete an Incident Report for any skin picking behavior that results in an open area and document the behavior on the A-B-C Tracking sheet. Nurse will be retrained on completing accurate documentation of assessment completed on any wound in nursing notes. All orders have been clarified orders. Salicylic AC kit 6% lotion to body BID has been received. Bactroban and Mupirocin have been discontinued. The Salicylic AC kit cleanser has been discontinued. Cordran tape has been discontinued. "Wound care</p> |                                                                                |  |                                             |  |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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 |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|
|                    | (substitute for Bactroban) "Apply to open area on legs twice daily." The 6/12 MARs indicated facility staff initialed they were applying both creams two times a day. Client C's 6/12 MARs ad orders for Salicylic AC Kit lotion to apply to the client's entire body for itching two times a day. Client C's 6/12 MAR also indicated client C had another order for Salicylic AC Kit 6% lotion (same as above) "Apply to affected areas twice daily." The 6/12 MAR indicated facility staff initialed they were applying each duplicate order two times a day. Client C's 6/12 MAR indicated client C had an order for Salicylic AC Kit 6% lotion (antiseptic cleanser) "Use cleanser in shower once each day." Client C's 6/12 MAR indicated the facility staff was not using the antiseptic cleanser as no initials were documented on the 6/12 MAR thus far. No time for administering/applying the cleanser was documented on the 6/12 MAR. Client C's 6/12 MAR indicated client C had an order "Wound Care-Use Cordran Tape on any wound that is scabbed." The 6/12 MAR indicated facility staff were initialing Cordran tape was being applied to scabbed wounds at 6:30 AM. Client C's 6/12 MAR indicated client C was to receive "Wound Care (Use ointment, 2 x (by) 2 pad, wrap any wound open or bleeding)" once daily at 6:30 AM not three times a day. Client C's |               | (Use ointment, 2x(by) 2 pad, wrap any wound open or bleeding)" once daily, has been discontinued. Nurse will be retrained on clarifying wound care orders as needed and ensuring 90-day recertification orders are accurate for client C as well as all other clients in the home. Nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. The nurse will be retrained on completion of weekly skin checks and assessment and measurement of any wounds for client C. The Risk Plan for client C has been revised and all staff trained. Client C's Behavior Support Plan has been revised to include 1:1 staffing definition, while at the home, in the community, at workshop and while riding on the van with others. A 15-minute check sheet has been implemented and staff have been retrained on its completion. All staff will be retrained on You're Safe, I'm Safe.<br><br><b>How others will be identified: (Systemic)</b> The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will |                      |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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>6/12/ MAR indicated a 1/8/2010 order "Ace Wrap-Keep leg covered to prevent picking AM and PM." The 6/12 MARs indicated facility staff were only initialing/documenting client C's legs were being covered two times daily versus three times daily which contradicted the order for "Wound Care (Use ointment, 2 x (by) 2 pad, wrap any wound open or bleeding)" once daily at 6:30 AM.</p> <p>Client C's 4/3/12 Physician order indicated "D/C Bactrim (antibiotic), Mupirocin &amp; antiseptic skin cleanser as client does not have MRSA (Methicillian Resistant Staphylococcus Aureus)."</p> <p>Client C's 5/23/12 physician's 90 day recertification orders indicated the above discontinued orders were still on the 5/12 physician's orders the pharmacy prints out. The 5/23/12 recertification orders indicated client C's doctor signed the 90 day orders thus indicating the 4/3/12 discontinued orders should be continued.</p> <p>Client C's 5/18/12 nursing care plan/problem area indicated "Problem: Risk for skin infection r/t self inflicted wounds related to dx (diagnosis) of Prader-Willi...2. Staff will monitor and encourage [client C] to not pick skin. 3) Staff will report any breaks in skin to nurse immediately, and nursing services</p> |                                                                 | <p>be reviewed at least quarterly to ensure that all plans remain effective. In addition, the nurse will review all Physician's Orders to ensure there accuracy as transcribed on the MAR.</p> <p><b>Corrective Action: (Specific)</b><br/>Client C was referred to Wound Clinic for evaluation and treatment. All staff were retrained on current wound care procedures. The Abuse and Neglect Policy and Procedure was revised to include preventing and addressing neglect in regards to client's behavior. All staff were retrained on the revised Abuse and Neglect Policy and Procedure. All staff were retrained on scheduling follow-up medical as needed. Client C's Behavior Support Plan (BSP) was revised to include specific instruction to address Self Injurious Behavior (SIB) picking. All staff were retrained on client C's revised BSP. Client C was referred to Wound Care for evaluation and treatment. All staff were retrained on current wound care treatment. Staff will complete skin observation daily and document findings on Skin Assessment Sheet and will report any areas to the nurse. The nurse will review Skin Assessment Sheets at site visits and complete skin assessment</p> |                                                                                |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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>will record and document findings. PCP (Primary Care Physician) will be notified of any breaks in the skin...6) Skin checks will be completed at bathing times, and upon awaking. 7) Staff will be trained on all aspects of [client C's] care...."</p> <p>The facility's training records were reviewed on 6/5/12 at 3:05 PM. The facility's 1/5/12 Inservice Sign-in Sheet for "Demonstration of how to apply wrap by nurse (LPN #2) wound care" indicated three staff had been trained in regard to client C's wound care. The 1/5/12 inservice record indicated the facility neglected to ensure staff #2, #3, #4, #5, #7, #8, #9, #10 and #11 were trained in regard to client C's wound care needs.</p> <p>Interview with LPN #1 on 6/5/12 at 1:32 PM indicated Bactroban Cream and Mupirocin ointment were the same thing. LPN #1 stated they were "duplicate orders" and one of them would need to be discontinued from the MAR. LPN #1 indicated client C's MAR included duplicate Salicylic orders for the lotion as well. LPN #1 indicated one of the orders should be discontinued as well as staff were signing both medications. When asked if the cleanser should be used, LPN #1 first indicated no as the cleanser had been discontinued by the doctor on 4/3/12. LPN #1 indicated the doctor had</p> |                                                                 | <p>weekly. The nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. If client C is being transported with other individuals there will be a least 2 staff present during transport period. Staff will complete an Incident Report for any skin picking behavior that results in an open area and document the behavior on the A-B-C Tracking sheet. Nurse will be retrained on completing accurate documentation of assessment completed on any wound in nursing notes. All orders have been clarified orders. Salicylic AC kit 6% lotion to body BID has been received. Bactroban and Mupirocin have been discontinued. The Salicylic AC kit cleanser has been discontinued. Cordran tape has been discontinued. "Wound care (Use ointment, 2x(by) 2 pad, wrap any wound open or bleeding)" once daily, has been discontinued. Nurse will be retrained on clarifying wound care orders as needed and ensuring 90-day recertification orders are accurate for client C as well as all other clients in the home. Nurse will be retrained on reporting open areas to physician and requesting an appointment for evaluation. All staff will be retrained on accurate documentation of all behaviors and notifying the nurse of any open wounds. The nurse will be retrained on completion of</p> |                                                                                |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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>signed the 5/25/12 order which put the medication back in effect. LPN #1 indicated facility staff should not be using the Cordran Tape on client C's wound as the client did not have a scab. LPN #1 indicated she was sure the staff was not using the Cordran Tape, but did not know why the staff was initialing they were applying. LPN #1 stated "It looks bad. Worse than when I seen it last week. Will get him back to wound care clinic." LPN #1 indicated she was not aware of the regression with the area until 6/5/12 when she saw the area with the surveyors.</p> <p>Interview with LPN #1 and administrative staff #2 on 6/7/12 at 10:30 AM indicated client C demonstrated SIB of skin picking due to his Prader Willi diagnosis. LPN #1 indicated facility staff should have called her over the weekend about client C's picking/wounds. LPN #1 stated she should be called "If picking excessively." LPN #1 indicated she would need to train staff in regard to client C's wound care. LPN #1 indicated facility staff were changing the client's ace wrapping and gauze three times a day. LPN #1 indicated client C did not have an order to change the wrapping 3 times a day. Administrative staff #2 indicated facility staff was doing it three times a day as client C had requested it be done three times a day.</p> |                                                                 | <p>weekly skin checks and assessment and measurement of any wounds for client C. The Risk Plan for client C has been revised and all staff trained. Client C's Behavior Support Plan has been revised to include 1:1 staffing definition, while at the home, in the community, at workshop and while riding on the van with others. A 15-minute check sheet has been implemented and staff have been retrained on its completion. All staff will be retrained on You're Safe, I'm Safe.</p> <p><b>Monitoring of Corrective Action:</b> The Operations Manager of Supervised Group Living, Program Coordinator, and the Nurse will review all new Physician's Orders and ensure that they are accurately transcribed on the MAR and all relevant Program Plans are updated to reflect the changes.</p> <p><b>Completion Date: 7/8/12</b></p> |                                                                                |  |                                             |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                        | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                    |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                        |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                  |                      |                                             |
| (X4) ID PREFIX TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |                                             |
|                                                                           | 9-3-6(a)                                                                                                               |                                                                 |                                                                                                                 |                      |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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                                                           |  |                                             |  |
| W0382                                                                     | <p>483.460(l)(2)<br/><b>DRUG STORAGE AND RECORDKEEPING</b><br/>The facility must keep all drugs and biologicals locked except when being prepared for administration.</p> <p>Based on observation and interview for 1 of 3 sample clients (client B), the facility failed to ensure his medication was kept locked when staff left the medication room.</p> <p>Findings include:</p> <p>During the morning medication pass on 6/5/12 starting at 6:35 AM, client B's medication was removed from the closet at 7:20 AM. Staff #2 opened the locked box of medicine and left the room to go to the kitchen to get juice for client B. Staff #2 returned to the medication room and proceeded to prepare the medication for client B.</p> <p>Interview with staff #5, Licensed Practical Nurse (LPN), on 6/5/12 at 7:35 AM indicated the medicine box should not be left unlocked without a staff being in the room.</p> <p>9-3-6(a)</p> | W0382                                                           | <p><b>W 382: The facility must keep all drugs and biological locked except when being prepared for administration.</b></p> <p><b>Corrective Action: (Specific)</b><br/>All staff will be retrained on the facility's Medication Administration Policy and Procedures.</p> <p><b>How others will be identified: (Systemic)</b> All staff will be retrained on the facility's Medication Administration Policy and Procedures.</p> <p><b>Measures to be put in place:</b><br/>All staff will be retrained on the facility's Medication Administration Policy and Procedures.</p> <p><b>Monitoring of Corrective Action:</b> The Operations Manager for Supervised Group Living, Program Coordinator, and Nurse will monitor medication administration and retrain as needed.</p> <p><b>Completion Date: 7/8/12</b></p> | 07/08/2012                                                                     |  |                                             |  |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |  |                                                                                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                             |                      |
|---------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|--|--------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------|----------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |  | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |                      |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                 |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                             |                      |
| (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 |
| W0440                                                                     | <p>483.470(i)(1)<br/>EVACUATION DRILLS<br/>The facility must hold evacuation drills at least quarterly for each shift of personnel.</p> <p>Based on record review and interview for 5 of 5 clients living in the home (clients A, B, C, D and E), the facility failed to conduct evacuation drills quarterly.</p> <p>Findings include:</p> <p>The record review of evacuation drills was conducted on 6/5/12 at 9:00 AM. The record indicated the drills were conducted for the day shift for the time span of 6/5/11 through 6/5/12 were on 8/20/11 and 9/15/11 for clients A, B, C, D and E. The overnight shift only conducted drills on 7/27/11 and 10/10/11.</p> <p>Interview with the Program Coordinator (PC) on 6/5/12 at 2:30 PM indicated there was no other record of any other evacuation drills for clients A, B, C, D and E.</p> <p>9-3-7(a)</p> |                                                                 |  | W0440                                                                          | <p><b>W 440: The facility must hold evacuation drills at least quarterly for each shift of personnel. Corrective Action: (Specific)</b> The Program Coordinator will be retrained that evacuation drills must be completed at least quarterly for each shift of personnel. <b>How others will be identified: (Systemic)</b> The Program Coordinator will be retrained that evacuation drills must be completed at least quarterly for each shift of personnel. <b>Measures to be put in place:</b> The Program Coordinator will be retrained that evacuation drills must be completed at least quarterly for each shift of personnel. <b>Monitoring of Corrective Action:</b> The Operations Manager for Supervised Group Living will review each drill to ensure that they completed as indicated by regulation. <b>Completion Date: 7/8/12</b></p> |                                             | 07/08/2012           |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                      | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|---------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|---------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                      |                                             |
| (X4) ID PREFIX TAG                                                        | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |                                             |
| W0488                                                                     | <p>483.480(d)(4)<br/>DINING AREAS AND SERVICE<br/>The facility must assure that each client eats in a manner consistent with his or her developmental level.</p> <p>Based on observation, record review and interview for 4 of 5 clients (clients A, C, B, D and E) living in the home, the facility failed to ensure the client E ate in an appropriate manner. The facility failed to ensure clients A, B, D and E</p> <p>Findings include:</p> <p>1. The evening observation was conducted at 4:15 PM to 6:35 PM. Client E ate the evening meal at 5:52 PM and was sitting in a regular chair. The dinner consisted of fish sticks, salad, corn and biscuit. Client E ate on a regular plate and used regular silverware. Client E would bend and put his mouth to the edge of the plate to scoop the food into his mouth. The staff did not prompt client E to sit up straight while eating.</p> <p>The dining plan (undated) for client E was reviewed on 6/5/12 at 7:30 AM. The dining plan indicated he was on a regular diet. There was no indication client E needed assistance with filling his own plate.</p> <p>Interview with staff #2 on 6/5/12 at 7:00 AM indicated client E would put his</p> | W0488                                                           | <p><b>W 488: The facility must assure that each client eats in a manner consistent with his or her developmental level</b></p> <p><b>Corrective Action: (Specific)</b><br/>The Program Coordinator and the Nurse will be retrained on performing accurate assessments or reassessments to address the individual's programmatic needs as well as ensuring that each client eats in a manner that is consistent with his or her developmental level.</p> <p><b>How others will be identified: (Systemic)</b> The Program Coordinator and Nurse will review all the Comprehensive Functional Assessments to ensure that all remain current and address each clients needs. IDT meetings will be held if any modifications of the Individual Support Plans are needed. <b>Measures to be put in place:</b> The Program Coordinator and the Nurse will be retrained on performing accurate assessments or reassessments to address the individual's programmatic needs as well as ensuring that each client eats in a manner that is consistent with his or her developmental level.</p> <p><b>Monitoring of Corrective Action:</b> The Operations Manager of Supervised Group Living, Program Coordinator, and the</p> | 07/08/2012           |                                             |

|                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 |                                                                                                                                                                                                       |                                                                                |  |                                             |  |
|---------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------|--|---------------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 |                                                                                                                                                                                                       | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                   |  | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                 |                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |  |                                             |  |
| (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>mouth down to the plate to keep from losing any of the food from his fork. Staff #2 indicated he didn't always eat with his mouth down to the plate if it was something that wouldn't fall from the fork.</p> <p>2. During the 6/5/12 observation period between 6:12 AM and 8:35 AM, at the group home, the dining room table was set with bowls and spoons prior to clients A, B, D and E getting up in the morning as client C was laying on the couch with his eyes closed and client D was going to the bathroom with staff to get a shower. Clients A, B and E were still in their bedrooms. At 7:16 AM, staff #11 poured clients D and E's juice without encouraging the clients to pour their own juice and/or assist the clients to pour the juice hand over hand. Staff #11 prepared toast for the clients and carried the toast on individual saucers to the table without involving clients A, B, D, E and/or F. Staff #11 asked client D if he wanted jelly for his toast. Client G responded yes. Staff #11 retrieved the jelly, measured it out and placed it on client D's toast without encouraging the client to get his own jelly and/or assisting the client to place it on his toast. At 7:31 AM, client B came to the dining room table and independently put cereal into his bowl. Staff #11 poured 1/2 cup milk into a</p> |                                                                 | <p>Nurse will monitor all individuals program plans and assess and reassess as needed to ensure that all individuals plan remain effective and appropriate.</p> <p><b>Completion date: 7/8/12</b></p> |                                                                                |  |                                             |  |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (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>measuring cup and gave the milk to client B to pour into his bowl. Client B was able to independently pour the milk into his bowl. Staff #11 then measured and placed butter into client B's toast which was prepared by staff #11. Staff #11 then prompted client B to spread the butter on his toast. Client A served himself his own cereal and placed jelly on his own toast independently. Staff #11 poured client A's coffee, put cream and sugar in the client's coffee without encouraging the client to do it himself and/or assist the client with hand over hand assistance. At 7:32 AM, client B carried his cereal bowl to the sink and placed on the counter. Staff #11 picked up the bowl and redirected client B to finish his cereal. Staff #11 fed client B 3 bites of cereal and handed the client his juice to drink while standing at the kitchen sink. Staff #11 did not redirect client B to return to the dining room table to feed himself. Client D, who independently placed cereal into his bowl, staff #11 fed the client his toast as staff held the toast up to client D's mouth and the client would take a bite. Client D was able to hold and eat his cereal independently.</p> <p>Interview with administrative staff #2 and LPN #1 on 6/7/12 at 10:30 AM indicated clients should be encouraged to help with meal preparation to the extent they were</p> |               |                                                                                                                 |                      |

|                                                  |                                                                 |                                                              |                                             |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>15G723 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>06/08/2012 |
|--------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------|

|                                                                           |                                                                                |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|
| NAME OF PROVIDER OR SUPPLIER<br><br>RES CARE COMMUNITY ALTERNATIVES SE IN | STREET ADDRESS, CITY, STATE, ZIP CODE<br>13009 HORIZON DR<br>MEMPHIS, IN 47143 |
|---------------------------------------------------------------------------|--------------------------------------------------------------------------------|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------|---------------|-----------------------------------------------------------------------------------------------------------------|----------------------|
|                    | capable. LPN #1 and administrative staff #2 indicated staff should not be feeding clients B and D who were capable of feeding themselves.<br><br>9-3-8(a) |               |                                                                                                                 |                      |