

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126
--	--

(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 the investigation of complaint #IN00097075. This visit resulted in an Immediate Jeopardy.</p> <p>Complaint #IN00097075: Substantiated, Federal/state deficiencies related to the allegations are cited at W102, W104, W122, W149, W189 and W331.</p> <p>Dates of Survey: September 20, 21, 22, 23, 26 and 30, 2011</p> <p>Facility Number: 011664 Provider Number: 15G746 Aim Number: 200902010</p> <p>Surveyors: Jo Anna Scott, Medical Surveyor III-Team Leader Dottie Navetta, RN, Public Health Nurse Surveyor III Steve Corya, Medical Surveyor Supervisor</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 10/5/11 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:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(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	
W0102	<p>The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client A), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility to implement written policy and procedure to prevent neglect of a client diagnosed with seizures while taking a bath/shower. The governing body neglected to ensure staff were sufficiently trained to supervise client A while bathing.</p> <p>Findings include:</p> <p>The governing body neglected to exercise operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections. The governing body neglected to implement written policy and procedures that prohibit staff to client neglect for 1 of 4 sampled clients (client A). Please see W122.</p> <p>The governing body failed to exercise general policy and operating direction over the facility to ensure the facility implemented written policy and procedures to prevent neglect of client A while taking a bath. The governing body</p>	W0102	<p><b>Corrective Action: (Specific)</b> A bathing assessment has been completed on each consumer. A Bathing and Showering Protocol has been put in place that states: "All consumers that have been diagnosed with a seizure disorder must have one-on-one supervision while in the bath or shower. It is acceptable for the consumer to draw the bathroom curtains to ensure privacy. At no time, is the staff to leave the consumer unattended in the bathroom during bath/shower time. In addition, all consumers who are unable to sit up unassisted in the tub or call for help when needed, will be required to have one on one assistance that follows the protocol. At anytime a change occurs in the health status of the individual, the Bathing Assessment will be required to be completed, risk plans will be updated, and this protocol will be implemented as needed." Staff have been trained on the Bathing &amp; Showering Protocol.</p> <p><b>How others will be identified: (Systemic)</b> All consumers at admission and when a change occurs in their health status will have a Bathing Assessment completed. The type of supervision needed for the consumers will be based on the</p>	10/30/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(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	
W0104	<p>neglected to ensure the facility provided supervision for clients diagnosed with seizures while bathing. Please see 104.</p> <p>9-3-1(a)</p> <p>This federal tag relates to complaint #IN00097075.</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p>		<p>information obtained in the Bathing Assessment.</p> <p><b>Measures to be put in place:</b> A bathing assessment has been completed on each consumer. A Bathing and Showering Protocol has put in place that states: " All consumers that have been diagnosed with a seizure disorder must have one-on-one supervision while in the bath or shower. It is acceptable for the consumer to draw the bathroom curtains to ensure privacy. At no time, is the staff to leave the consumer unattended in the bathroom during bath/shower time. In addition, all consumers who are unable to sit up unassisted in the tub or call for help when needed, will be required to have one on one assistance that follows the protocol. At anytime a change occurs in the health status of the individual, the Bathing Assessment will be required to be completed, risk plans will be updated, and this protocol will be implemented as needed." Staff have been trained on the Bathing &amp; Showering Protocol.</p> <p><b>Monitoring of Corrective Action:</b> Random bathing observations will be conducted by Management Staff to ensure the Bathing &amp; Showering Protocol is being followed on all consumers.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Based on record review and interview for 1 of 4 sampled clients (client A), the governing body failed to exercise operating direction over the facility to implement written policy/procedures which prohibit staff to client neglect. The governing body failed to provide sufficient staff training to ensure staff were supervising client A while bathing.</p> <p>Findings include:</p> <p>The governing body neglected to exercise general policy and operating direction over the facility to ensure the facility implemented written policy and procedure in regards to the bathing of clients with seizures for 1 of 4 sampled clients (client A). Please see W149.</p> <p>The governing body failed to exercise operating direction over the facility to ensure staff were sufficiently trained on supervising client A while bathing. Please see W189.</p> <p>9-3-1(a)</p> <p>This federal tag relates to complaint #IN00097075.</p>	W0104	<p><b>Corrective Action: (Specific)</b> A bathing assessment has been completed on each consumer. A Bathing and Showering Protocol has been put in place that states: "All consumers that have been diagnosed with a seizure disorder must have one-on-one supervision while in the bath or shower. It is acceptable for the consumer to draw the bathroom curtains to ensure privacy. At no time, is the staff to leave the consumer unattended in the bathroom during bath/shower time. In addition, all consumers who are unable to sit up unassisted in the tub or call for help when needed, will be required to have one on one assistance that follows the protocol. At anytime a change occurs in the health status of the individual, the Bathing Assessment will be required to be completed, risk plans will be updated, and this protocol will be implemented as needed." Staff have been trained on the Bathing &amp; Showering Protocol.</p> <p><b>How others will be identified:</b> All consumers at admission and when a change occurs in their health status will have a Bathing Assessment completed. The type of supervision needed for the consumers will be based on the information obtained in the Bathing Assessment.</p> <p><b>Measures to be put in place:</b> A bathing assessment has been completed on each consumer. A</p>	10/30/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(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	The facility must ensure that specific client protections requirements are met.  Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (client A). The facility	W0122	Bathing and Showering Protocol has been put in place that states: "All consumers that have been diagnosed with a seizure disorder must have one-on-one supervision while in the bath or shower. It is acceptable for the consumer to draw the bathroom curtains to ensure privacy. At no time, is the staff to leave the consumer unattended in the bathroom during bath/shower time. In addition, all consumers who are unable to sit up unassisted in the tub or call for help when needed, will be required to have one on one assistance that follows the protocol. At anytime a change occurs in the health status of the individual, the Bathing Assessment will be required to be completed, risk plans will be updated, and this protocol will be implemented as needed." Staff has been trained on the Bathing & Showering Protocol. <b>Monitoring of Corrective Action:</b> Random bathing observations will be conducted by Management Staff to ensure the Bathing & Showering Protocol is being followed on all consumers.  <b>Corrective Action: (Specific)</b> A bathing assessment has been completed on each consumer. A Bathing and Showering Protocol has been put in place that states: "All consumers that have been	10/30/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(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>neglected to implement written policy and procedure to prevent neglect of a client with a history of multiple seizures in regards to supervision while taking a bath.</p> <p>This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 9/21/11 at 12:40 PM. The Immediate Jeopardy began on 9/18/11 when the facility failed to ensure client A had constant supervision while taking a bath. The Executive Director was notified of the Immediate Jeopardy on 9/21/11 at 12:40 PM regarding client A being left unattended while taking a bath, of being found non-responsive in the bathtub and being transported to the hospital by ambulance where he was pronounced dead.</p> <p>The Immediate Jeopardy was removed on 9/26/11 at 8:10 AM through observation, interview and record review. The facility provided a plan of correction on 9/21/11 at 7:09 PM. The plan indicated the facility had placed all three Support Associates that were present during the incident on Administrative Leave pending the results of a thorough investigation. The plan indicated the facility had developed and implemented a Bathing Assessment to identify individuals that are at risk during the bathing/showering as it</p>		<p>diagnosed with a seizure disorder must have one-on-one supervision while in the bath or shower. It is acceptable for the consumer to draw the bathroom curtains to ensure privacy. At no time, is the staff to leave the consumer unattended in the bathroom during bath/shower time. In addition, all consumers who are unable to sit up unassisted in the tub or call for help when needed, will be required to have one on one assistance that follows the protocol. At anytime a change occurs in the health status of the individual, the Bathing Assessment will be required to be completed, risk plans will be updated, and this protocol will be implemented as needed." Staff has been trained on the Bathing &amp; Showering Protocol.</p> <p><b>How others will be identified: (Systemic)</b> All consumers at admission and when a change occurs in their health status will have a Bathing Assessment completed. The type of supervision needed for the consumers will be based on the information obtained in the Bathing Assessment.</p> <p><b>Measures to be put in place:</b> A bathing assessment has been completed on each consumer. . A Bathing and Showering Protocol has been put in place that states: "All consumers that have been diagnosed with a seizure disorder must have</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(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>related to a seizure diagnosis. The plan indicated the facility had developed and implemented a Bathing Protocol that clearly defined the required supervision of individuals with a seizure diagnosis. All staff that work in this home will be trained prior to their shift. Each individual with a seizure diagnosis will have an updated Health Care Plan that specifically addresses the assistance required during bathing/showering. All staff that work in the home will be trained prior to their shift on the updated Health Care Plan and the Bathing Protocol. The plan indicated the facility implemented Administrative Observations to monitor the implementation of the Bathing Protocol, following the updated Health Care Plan.</p> <p>The Immediate Jeopardy was removed on 9/26/11 at 8:50 AM after observation, interview and record review. It was determined the facility had implemented a plan of action to remove the Immediate Jeopardy and the steps taken removed the immediacy of the problem. During observations on 9/22/11 at 5:53 PM to 7:30 PM, on 9/23/11 at 6:30 PM to 8:05 PM and on 9/26/11 at 6:55 AM to 8:30 AM, a staff assisted a client with a seizure diagnosis while taking a bath with an administrator monitoring. The record review conducted on 9/22/11 at 1:30 PM</p>		<p>one-on-one supervision while in the bath or shower. It is acceptable for the consumer to draw the bathroom curtains to ensure privacy. At no time, is the staff to leave the consumer unattended in the bathroom during bath/shower time. In addition, all consumers who are unable to sit up unassisted in the tub or call for help when needed, will be required to have one on one assistance that follows the protocol. At anytime a change occurs in the health status of the individual, the Bathing Assessment will be required to be completed, risk plans will be updated, and this protocol will be implemented as needed." Staff has been trained on the Bathing &amp; Showering Protocol.</p> <p><b>Monitoring of Corrective Action:</b> Random bathing observations will be conducted by Management Staff to ensure the Bathing &amp; Showering Protocol is being followed on all consumers.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(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 Bathing Assessment had been completed for clients B, C and D and the staff had been trained on the Bathing Protocol.</p> <p>While the Immediate Jeopardy was removed on 9/26/11, the facility remained out of compliance at the Condition level (Client Protections) in that the facility needed to complete the Plan of Correction in regard to the monitoring by administrative staff to ensure all staff have been trained.</p> <p>Findings include:</p> <p>The facility neglected to implement their written policy to prevent staff neglect of client A in regards to staff monitoring for seizures while the client was taking a bath. Please see W149.</p> <p>This federal tag relates to complaint #IN00097075.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(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>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 4 sampled clients (client A), the facility neglected to implement written policy and procedures to prevent neglect of a client with a history of seizures to be supervised while taking a bath.</p> <p>Findings include:</p> <p>The record review of the facility incident reports was conducted 9/20/11 at 1:35 PM. The reports indicated the following incident for client A:</p> <p>9/18/11 - 5:45 PM - "Consumer was taking a bath when associate [staff #3] entered the bathroom and found the consumer face down non-responsive in the bathtub. Consumer removed from bathtub and CPR (Cardiopulmonary Resuscitation) initiated. Associate (staff #4) called 911. EMS arrived and transported consumer to (name of hospital) where he was pronounced dead. Autopsy is being performed per coroner's recommendation."</p> <p>The written witness statement provided by staff #3, undated, for the incident of 9/18/11 referring to client A being found unresponsive in the bathtub was reviewed</p>	W0149	<p><b>Corrective Action: (Specific)</b> All staff have been trained on the Bathing and Showering Protocol that has been put in place. All staff will be retrained on the abuse and neglect policy that states that neglect –emotional/physical as follows: "1. Failure to provide goods and /or services necessary for the individual to avoid physical harm. 2. Failure to provide the support necessary to an individual's physiological and social well being. 3. Failure to meet the basic need requirements such as food, shelter, clothing, and to provide a safe environment" The nurse will be in-serviced on including safety measures during bathing/showering in all risk plans for clients with seizure disorders. The risk plans for all consumers with seizure diagnosis have been updated to include bathing and showering protocols. All staff has been in-serviced on the updated risk plans.</p> <p><b>How others will be identified: (Systemic)</b> All staff upon initial training and annually will be trained on the Bathing and Showering Protocol and the abuse, neglect and exploitation policy. All risk plans are completed by the nurse upon admission of all clients. The risk plans are updated when clients' health status changes.</p>	10/30/2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(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 9/21/11 at 9:00 AM and indicated he had been preparing medication for an outing and was in the medication room while client A was taking a bath. The statement indicated he went to the bathroom to check on client A and found him slumped over in the tub and the client was unresponsive. Staff #3's statement indicated he removed Client A from the tub with assistance from staff #4 and started CPR (Cardiopulmonary Resuscitation).</p> <p>The written witness statement provided by staff #4, undated, for the incident of 9/18/11 was reviewed on 9/21/11 at 9:00 AM and indicated she had assisted client A in preparing the water for the tub, but left client A alone for "approximately" 2 minutes. The statement indicated she assisted staff #3 with getting client A out of the tub and called 911 while staff #3 did CPR. The statement did not indicate why she left client A alone.</p> <p>The written witness statement provided by staff #5, undated, for the incident of 9/18/11 was reviewed on 9/21/11 at 9:00 AM and indicated he was with clients B and D outside on the patio.</p> <p>The Frequent Seizure Record for client A for the month of September was reviewed on 9/21/11 at 10:30 AM. The report</p>		<p><b>Measures to be put in place:</b></p> <p>All staff has been trained on the Bathing and Showering Protocol that has been put in place. All staff will be retrained on the abuse and neglect policy that states that neglect –emotional/physical as follows:          “1. Failure to provide goods and /or services necessary for the individual to avoid physical harm.          2. Failure to provide the support necessary to an individual’s physiological and social well being.          3. Failure to meet the basic need requirements such as food, shelter, clothing, and to provide a safe environment”          Staff who do not follow the abuse, neglect, and exploitation policy will be terminated.</p> <p>The nurse will be in-serviced on including safety measures during bathing/showering in all risk plans for clients with seizure disorders. The risk plans for all consumers with seizure diagnosis have been updated to include bathing and showering protocols. All staff has been in-serviced on the updated risk plans.</p> <p><b>Monitoring of Corrective Action:</b> The nurse will observe bathing/showering when at the home to ensure the risk plans are being followed accordingly. The</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(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 A had seizures on the following dates:</p> <p>9/2/11 - Duration 20 - 30 seconds 9/6/11 - Duration 35 seconds 9/6/11 - Duration 4 - 5 minutes 9/6/11 - Duration 30 seconds 9/6/11 - Duration 2 minutes 9/10/11 - Duration 20 seconds 9/18/11 - Duration 30 seconds</p> <p>The report indicated the seizure type was generalized tonic-clonic defined as "Entire body becomes rigid followed by jerking of entire body. Seizure ends with a period in which the person appears exhausted, quiet and sometimes falls asleep."</p> <p>The facility internal incident reports were reviewed on 9/20/11 at 1:35 PM. The incident reports indicated client A had seizures with the duration listed on the following dates in August:</p> <p>8/4/11 - 25 seconds 8/6/11 - 45 seconds 8/6/11 - no time 8/6/11 - 30 seconds 8/9/11 - no time 8/10/11 - no time 8/10/11 - 15 seconds 8/13/11 - 45 seconds 8/18/11 - no time "[client A] had 3 seizures in a 24 hour period."- Client A was taken to ER (emergency room). 8/23/11 - 20 seconds</p>		DOHS will conduct random visits to the site to observe bathing/showering times to ensure protocols are being followed.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126
--	--

(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>8/24/11 - 35 seconds 8/29/11 - 45 seconds</p> <p>The facility Bureau of Developmental Disability Services (BDDS) incident reports were reviewed on 9/20/11 at 2:20 PM. Client A had one report in August dated 8/18/11, reported 8/19/11, indicating "[Client A] had three seizures within 24 hours so he was taken to the ER (emergency room) for an evaluation. The ER physician stated [client A] had low sodium levels. [Client A] has been transferred and admitted to (name of hospital) so he could be closer to his neurologist. Discharged on 8/20/11. [Client A] is to resume activity and to avoid excessive fluid intake. [Client A] is also to take a solution chloride pill two times a day. [Client A] followed up with his PCP (primary care physician) and it went well."</p> <p>The second BDDS report reviewed with the incident date of 9/18/11, submitted 9/19/11 indicated the following: "On 9/18/11, at approximately 5:45 PM, [client A], consumer, was taking his evening bath when Support Associate, staff #3, entered the bathroom to check on him and found him face down and unresponsive in the bath tub., [Staff #3] proceeded to remove him from the bath tub and began CPR (cardiopulmonary</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126
--	--

(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>resuscitation), Support Associate, [staff #4], called 911 and EMS was dispatched to the residence. The EMS arrived at the home and continued CPR and transported the consumer to (name of hospital) where he was pronounced dead. An autopsy is being performed per coroner's recommendation. A formal (sic) has been initiated and Support Associate, [staff #4] has been placed on administrative leave pending the results of the investigation."</p> <p>The risk plan in the record for client A, undated, was reviewed on 9/21/11 at 3:00 PM. The risk plan for Seizure Disorder indicated the following for client A:</p> <p>"History: [Client A] has a history of seizures. His seizure type is clonic tonic, and are currently controlled with Felbatol and Trileptal, and VNS (Vagal Nerve Stimulus).</p> <p>Goal: [Client A] will remain seizure free through February 2010.</p> <p>Action Plan:</p> <ol style="list-style-type: none"> <li>1. Support staff will administer daily prescribed anti-seizure medication (Felbatol and Trileptal) as ordered by neurologist, and should seizure occur staff will swipe the magnet over the VNS to reduce the duration and severity of the seizure activity.</li> <li>2. Support staff will monitor and document all seizure activity and report to the nurse, (fill out seizure report to be</li> </ol>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126
--	--

(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>taken to the neurologist apt. (appointments).</p> <p>3. Staff will provide protection for [client A] during a seizure. Floor mat will be kept in place at bedside with [client A] is (sic) abed.</p> <p>4. Anti-seizure blood levels should be checked every 6 months and more often as indicated (increased seizure activity, toxicity signs dizziness, lethargy, staggering gait). Staff will follow Blood Work Monitoring Protocol for tracking blood work values.</p> <p>5. Staff will monitor for and report seizure activity to the nurse.</p> <p>6. Staff will swipe magnet over VNS in order to reduce severity and duration of seizure activity. RISK OF SUPPORT: Life threatening rash (Stevens-Johnson Syndrome), diploid (double vision), dizziness, ataxia (loss of motor coordination), insomnia, nausea, (risks associated with use of Lamictal). Dizziness, headache, insomnia, nausea, vomiting, anorexia, infection, jaundice, aplastic anemia, (risks associated with the use of Felbatol).</p> <p>RISK OF NONSUPPORT: Increased seizure activity, increased severity of seizures possibly resulting in status epilepticus and death."</p> <p>The risk plan did not indicate a bathing</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126
--	--

(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>procedure for staff to follow.</p> <p>Interview with the on call nurse staff #7, Licensed Practical Nurse (LPN), on 9/22/11 at 12:37 PM indicated the risk plan was completed by a nurse that was no longer employed and she did not know why the risk plan did not include the bathing procedure of not leaving a client diagnosed with seizures alone while bathing. Staff #7, LPN indicated clients with seizures should be encouraged to take showers instead of baths in a tub of water. Staff #7, LPN indicated clients with seizures should never be left unattended in a bath tub.</p> <p>Interview with staff #3 on 9/22/11 at 11:53 AM indicated they were going to go grocery shopping that evening and he was trying to get the 7:00 PM meds ready to take with them. Staff #3 indicated they were trying to get the showers out of the way before they left because the men would refuse if they waited until they got back. Staff #3 indicated client A was assisted by staff #4 with preparing the bath water. Staff #3 indicated he did not know why staff #4 left client A alone in the bathroom while he was in the tub. Staff #3 indicated he finished preparing the meds and got towels to take into the bathroom for client B. Staff #3 indicated the bathroom door was ajar and he saw</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(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 A's feet going the wrong direction in the tub. Staff #3 indicated client A's toes were touching the bottom of the tub. Staff #3 indicated client A was bent a little to the side and he was face down in the water with just the crown of his head out. Staff #3 stated he had passed staff #4 on his way to the bathroom and he "thought" staff #5 was outside on the patio. Staff #3 indicated he did have seizure training when he was hired, but he didn't remember being told they were not to leave clients diagnosed with seizures alone while taking baths. Staff #3 indicated they were to be sure they provided the clients with privacy when they were bathing but they were to stay in the vicinity when client A was taking a bath. Staff #3 indicated clients B and C are diagnosed with a history of seizures and they were to provide privacy while they were bathing and to stay in the vicinity. Staff #3 indicated they were not told they needed to stay in the room.</p> <p>Interview with staff #5 on 9/22/11 at 10:47 AM indicated he was outside in the courtyard with clients B and D. Staff #5 indicated he did assist staff #4 getting shampoo from a top shelf of the supply cabinet but he went back to patio after assisting staff #4. Staff #5 indicated he could not see the bathtub from the patio even if the door to the bathroom had been</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(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>left open. Staff #5 indicated he heard staff #3 yell for help and when he got to the bathroom staff #3 and #4 were in the bathroom with client A on the floor. Staff #5 indicated staff #3 started CPR. Staff #5 indicated he called 911, but gave the phone to staff #4 when the operator started asking questions and he thought staff #4 would know the answers better that he would because he had only been there working for one month. Staff #5 indicated the staff wasn't assigned to certain clients. He indicated there were four clients and 3 staff and they just help each other. Staff #5 indicated he had some seizure training when he was hired but he didn't remember being told to stay in the bathroom when clients with seizures were taking baths. Staff #5 indicated clients A, B and C all had seizure diagnoses but he did not think they had to stay in the bathroom while they bathed. Staff #5 indicated they were supposed to stay close by to assist.</p> <p>Interview with staff #4 on 9/22/11 at 3:00 PM indicated on 9/18/11 they were going to go shopping and they were trying to get the baths done before they left. Staff #4 indicated she checked the water temperature and prepared the bath water. Staff #4 indicated they were supposed to allow the clients with seizures privacy but they were supposed to stay in the vicinity.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(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>Staff #4 indicated she left the room door half opened and left the room for a couple of minutes. Staff #4 stated she could not remember why she left but she "knew it was only for a couple of minutes." Staff #4 indicated they were going grocery shopping. Staff #4 indicated she did not remember receiving any seizure training. Staff #4 indicated they were to allow the clients with seizures privacy, but they were to stay close when they were in the bath tub.</p> <p>The Individual Support Plan (ISP) for client A was reviewed on 9/21/11 at 9:45 AM . The ISP dated 11/13/10 indicated client A had the following formal training goal:</p> <p>"[Client A] will wash hair with one verbal prompt 75% of trials.." The methodology indicated the following:</p> <p>"Verbally prompt [client A] to wash hair during bathing.</p> <p>STAFF MUST BE IN BATHROOM WITH [client A] DUE TO SEIZURE DISORDER. GIVE [CLIENT A] PRIVACY BUT BE THERE FOR SAFETY."</p> <p>Client A had a staff inservice sign-in sheet dated 1/3/11 reviewed on 9/21/11 at 3:00 PM indicating "[Client A] can take shower or bath but area must be covered. HM (House Manager) will show staff</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/30/2011	
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126			
(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>how to cover area." There was nothing in chart to indicate what "cover area" meant.</p> <p>Interview with staff #1, Program Coordinator on 9/21/11 at 4:45 PM indicated she did not know what the inservice meant since she had only worked in the home a few weeks and was not here in January.</p> <p>Client A had a staff inservice sign-in sheet dated 2/14/11 reviewed on 9/21/11 at 3:05 PM indicating "All shifts, one staff is to be where they can see [client A] at all times." A staff inservice sign-in sheet dated 2/25/11 reviewed on 9/21/11 at 3:10 PM indicated "[Client A] has a staff for each shift. There is a schedule for what staff is assigned to [client A]. This staff must keep [client A] in line of sight at ALL TIMES. If this is not followed, corrective action will be taken." The inservices had been signed by staff #4.</p> <p>Interview with staff #6, Administrative staff, on 9/20/11 at 2:00 PM indicated he did not know what the procedure the house was to use when the client that had multiple seizures and wanted to take a bath. Staff #6, Administrative staff, indicated the staff were to provide privacy, but he was not sure how they were to provide supervision.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(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 #7, Program Coordinator, on 9/21/11 at 4:45 PM indicated the the staff were to provide privacy for the clients with seizures when they were in the bathroom and the staff were to stay with the client.</p> <p>The facility Abuse/Neglect/Exploitation Policy and Procedure with a revised date of 7/1/10 was reviewed on 9/20/11 at 2:29 PM. The policy defined neglect - emotional/physical as follows:</p> <p>"1. Failure to provide goods and/or services necessary for the individual to avoid physical harm.</p> <p>2. Failure to provide the support necessary to an individual's physiological and social well being.</p> <p>3. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment."</p> <p>The policy defined neglect - program implementation/intervention as follows:</p> <p>"1. Failure to provide goods and/or services necessary for the individual to avoid physical harm."</p> <p>This federal tag relates to complaint #IN00097075.</p> <p>9-3-2(a)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126
--	--

(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
W0189	<p>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview for 1 of 4 sampled clients (client A), the facility failed to ensure staff working on evening shift on 9/18/11 were trained on bathing protocol for clients with a seizure diagnosis.</p> <p>Findings include:</p> <p>The staff training records were reviewed on 9/20/11 at 4:44 PM. . The records indicated staff #4 had been hired on 1/19/09. The record indicated staff #4 had her annual training on 6/29/11. The records indicated she had been trained on Social Role Valorization, Emergency Procedures, Vehicle Safety and Site Maintenance, CPR (Cardiopulmonary Resuscitation), Incident Management Documentation, Quality Measure Systems, Health &amp; Safety Quiz, Dietary Inservice Quiz, Supporting a non-abusive, non-neglectful environment, Supportive Routines/Person Center Planning intro to</p>	W0189	<p><b>Corrective Action: (Specific)</b> A bathing assessment has been completed on each consumer. A Bathing and Showering Protocol has been put in place that states: "All consumers that have been diagnosed with a seizure disorder must have one-on-one supervision while in the bath or shower. It is acceptable for the consumer to draw the bathroom curtains to ensure privacy. At no time, is the staff to leave the consumer unattended in the bathroom during bath/shower time. In addition, all consumers who are unable to sit up unassisted in the tub or call for help when needed, will be required to have one on one assistance that follows the protocol. At anytime a change occurs in the health status of the individual, the Bathing Assessment will be required to be completed, risk plans will be updated, and this protocol will be implemented as needed." Staff has been trained on the Bathing &amp; Showering Protocol.</p>	10/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126
--	--

(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>Developmental Disabilities, Human Resources, Safe Driving Techniques Quiz, OSHA-Hazardous Communication. There was nothing in the training records to indicate she had been trained on seizures at her annual training.</p> <p>The staff training records for staff #3 indicated staff #3 had been hired on 7/6/11. The record indicated staff #3 had a Competency Test, Compliance Orientation, Safe Driving Quiz, Fire Safety Quiz on 7/12/11. Staff #3 had Emergency Disaster Test, Active Treatment and Proper Communication on 7/7/11, Individual Support Plan/Behavior Support Plan, Programming Developmental Disabilities, Normalization, You're Safe - I'm Safe, OSHA and Universal Precautions/Bloodborne Pathogens, Health &amp; Safety, Rights Quiz, Abuse and Neglect Detection and Prevention, CPR (Cardiopulmonary Resuscitation), Basic First Aid on 7/11/11, Core A, Core B, Dysphasia/Aspiration Quiz, Dehydration Quiz on 7/8/11 and Constipation Quiz and Seizure Training on 7/6/11.</p> <p>The staff training records for staff #5 indicated he had been hired on 8/1/11. The record indicated staff #5 had a Competency Test and Compliance Orientation on 8/1/11, Safe Driving Quiz,</p>		<p><b>How others will be identified: (Systemic)</b> All consumers at admission and when a change occurs in their health status will have a Bathing Assessment completed. The type of supervision needed for the consumers will be based on the information obtained in the Bathing Assessment.</p> <p><b>Measures to be put in place:</b> A bathing assessment has been completed on each consumer. A Bathing and Showering Protocol has been put in place that states: "All consumers that have been diagnosed with a seizure disorder must have one-on-one supervision while in the bath or shower. It is acceptable for the consumer to draw the bathroom curtains to ensure privacy. At no time, is the staff to leave the consumer unattended in the bathroom during bath/shower time. In addition, all consumers who are unable to sit up unassisted in the tub or call for help when needed, will be required to have one on one assistance that follows the protocol. At anytime a change occurs in the health status of the individual, the Bathing Assessment will be required to be completed, risk plans will be updated, and this protocol will be implemented as needed." Staff has been trained on the Bathing &amp; Showering Protocol.</p> <p><b>Monitoring of Corrective Action:</b> Random bathing</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126
--	--

(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>Fire Safety Quiz, Emergency Disaster Test, Active Treatment and Proper Communication, Individual Support Plan/Behavior Support Plan, Programming Developmental Disabilities, Normalization, You're Safe - I'm Safe on 8/3/11, OSHA and Universal Precautions/Bloodborne Pathogens, Health &amp; Safety, Rights Quiz, Abuse and Neglect Detection and Prevention, CPR, Basic First Aid on 8/4/11, Core A, Core B, Constipation Quiz, Seizure Training, Dysphasia/Aspiration Quiz, Dehydration Quiz on 8/5/11.</p> <p>Interview with staff #3 on 9/22/11 at 11:53 AM indicated he had seizure training when he was hired. Staff #3 indicated they were supposed to allow the clients privacy and stay in the area with clients diagnosed with seizures while they were taking baths. Staff #3 indicated the staff was supposed to stay where they could hear the client. Staff #3 indicated they were told they did not have to stay in the room while the client was bathing.</p> <p>Interview with staff #4 on 9/22/11 at 3:00 PM indicated she did not remember having the seizure training. Staff #4 indicated the clients were supposed to be allowed privacy and staff were to stay near clients diagnosed with seizures while taking baths. Staff #4 indicated staff did</p>		<p>observations will be conducted by Management Staff to ensure the Bathing &amp; Showering Protocol is being followed on all consumers.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126
--	--

(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>not have to stay in the room while the clients were taking baths.</p> <p>Interview with staff #5 on 9/22/11 at 10:47 PM indicated he had seizure training when he was hired. Staff #5 indicated privacy was always to be allowed but staff was supposed to keep an eye on the clients. Staff #5 indicated they were told they did not have to stay in the room while the client was bathing.</p> <p>Interview with staff #2, Program Coordinator on 9/21/11 at 4:45 PM indicated the staff were to stay in the bathroom with clients with seizures when they are bathing. Staff #2 indicated she did not know if the staff had been trained on staying in the same room with the clients while they are bathing.</p> <p>This federal tag relates to complaint #IN00097075.</p> <p>9-3-3(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011	
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126			
(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>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on record review and interview for 1 of 4 sampled clients (client A), the facility failed to ensure nursing services provided staff with sufficient information for staff on the care of clients with seizures.</p> <p>Findings include:</p> <p>The BDDS report reviewed on 9/20/11 at 1:35 PM with the incident date of 9/18/11, submitted 9/19/11 indicated the following: "On 9/18/11, at approximately 5:45 PM, [client A], consumer, was taking his evening bath when Support Associate, staff #3, entered the bathroom to check on him and found him face down and unresponsive in the bath tub., [Staff #3] proceeded to remove him from the bath tub and began CPR (cardiopulmonary resuscitation), Support Associate, [staff #4], called 911 and EMS was dispatched to the residence. The EMS arrived at the home and continued CPR and transported the consumer to (name of hospital) where he was pronounced dead. An autopsy is being performed per coroner's recommendation. A formal (sic) has been initiated and Support Associate, [staff #4] has been placed on administrative leave pending the results of the investigation."</p>	W0331	<p><b>Corrective Action: (Specific)</b> The nurse will be in-serviced on including safety measures during bathing/showering in all risk plans for clients with seizure disorders. The risk plans for all consumers with seizure diagnosis have been updated to include bathing and showering protocols. All staff has been in-serviced on the updated risk plans.</p> <p><b>How others will be identified: (Systemic)</b> All risk plans are completed by the nurse upon admission of all clients. The risk plans are updated when clients' health status changes.</p> <p><b>Measures to be put in place:</b> The nurse will be in-serviced on including safety measures during bathing/showering in all risk plans for clients with seizure disorders. The risk plans for all consumers with seizure diagnosis have been updated to include bathing and showering protocols. All staff has been in-serviced on the updated risk plans.</p> <p><b>Monitoring of Corrective Action:</b> The nurse will observe bathing/showering when at the home to ensure the risk plans are being followed accordingly. The DOHS will conduct random visits to the site to observe bathing/showering times to ensure protocols are being followed.</p>	10/30/2011			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126
--	--

(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>The risk plan in the record for client A, undated, was reviewed on 9/21/11 at 3:00 PM. The risk plan for Seizure Disorder indicated the following for client A:</p> <p>"History: [Client A] has a history of seizures. His seizure type is clonic tonic, and are currently controlled with Felbatol and Trileptal, and VNS (Vagal Nerve Stimulus).</p> <p>Goal: [Client A] will remain seizure free through February 2010.</p> <p>Action Plan:</p> <ol style="list-style-type: none"> <li>1. Support staff will administer daily prescribed anti-seizure medication (Felbatol and Trileptal) as ordered by neurologist, and should seizure occur staff will swipe the magnet over the VNS to reduce the duration and severity of the seizure activity.</li> <li>2. Support staff will monitor and document all seizure activity and report to the nurse, (fill out seizure report to be taken to the neurologist apt. (appointments)).</li> <li>3. Staff will provide protection for [client A] during a seizure. Floor mat will be kept in place at bedside with [client A] is (sic) abed.</li> <li>4. Anti-seizure blood levels should be checked every 6 months and more often as indicated (increased seizure activity, toxicity signs dizziness, lethargy, staggering gait). Staff will follow Blood</li> </ol>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  09/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA	STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126
--	--

(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>Work Monitoring Protocol for tracking blood work values.</p> <p>5. Staff will monitor for and report seizure activity to the nurse.</p> <p>6. Staff will swipe magnet over VNS in order to reduce severity and duration of seizure activity. RISK OF SUPPORT: Life threatening rash (Stevens-Johnson Syndrome), diploid (double vision), dizziness, ataxia (loss of motor coordination), insomnia, nausea, (risks associated with use of Lamictal). Dizziness, headache, insomnia, nausea, vomiting, am anorexia, infection, jaundice, aplastic anemia, (risks associated with the use of Felbatol),.</p> <p>RISK OF NONSUPPORT: Increased seizure activity, increased severity of seizures possibly resulting in status epilepticus and death."</p> <p>The risk plan did not indicate a bathing procedure for staff to follow.</p> <p>Interview with the on call nurse staff #7, Licensed Practical Nurse (LPN) on 9/22/11 at 12:37 PM indicated the risk plan was done by a nurse that was no longer employed and she did not know why the risk plan did not include the bathing procedure of not leaving a client diagnosed with seizures alone while bathing. Staff #7, LPN indicated clients</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/21/2011

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G746	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  09/30/2011
NAME OF PROVIDER OR SUPPLIER  RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP CODE 16609 SIMA GRAY RD HENRYVILLE, IN47126		
(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>with seizures should be encouraged to take showers instead of baths in a tub of water. Staff #7, LPN indicated clients with seizures should never be left unattended in a bath tub.</p> <p>This federal tag relates to complaint #IN00097075.</p> <p>9-3-6(a)</p>				