

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR 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
W 0000 Bldg. 00	<p>This visit was for the investigation of Complaint #IN00195966.</p> <p>Complaint #IN00195966: Substantiated, Federal/State deficiencies related to the allegation are cited at W149, W156, and W249.</p> <p>Survey dates: March 18, 22, 24, 28 and 29, 2016.</p> <p>Facility Number: 004615 Provider Number: 15G723 AIM Number: 200528230</p> <p>These federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 4/5/16.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 2 of 2 sampled clients (A</p>	W 0149	W149: The facility must develop	04/28/2016

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: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR 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 B), and for 5 of 10 investigations of abuse/neglect reviewed, the facility failed to ensure the facility's neglect policy was implemented.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on the evening of March 18, 2016 from 5:15 PM until 7:45 PM. Clients C and A were observed to be at the facility with Home Manager/HM #1. Client B was at a local emergency room having his ankle evaluated with staff #2 in attendance. HM #1 indicated on 3/18/16 at 5:25 PM client B had accidentally twisted his ankle while helping client D move his belongings to a vehicle in preparation for client D's leaving the facility to go to supported living on 3/18/16 and his ankle was being evaluated. Client C was observed doing chores and conversing with HM #1 and the surveyor. Client A was resting in his bedroom. HM #1 indicated (3/18/16 5:40 PM) client A had been in a local hospital for evaluation of an injury to his left eye from 3/15 to 17/16; arriving home between 4:00 PM and 5:00 PM on 3/17/16. Client A was resting in his room when the surveyor was introduced to him by HM #1 on 3/18/16 at 5:45 PM. Client A's left eye was surrounded by blue and purple bruising. Client A</p>		<p>and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. .</p> <p>Corrective Action: (Specific): All staff at the home will be in-serviced on the operation standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment or violation of an individual's rights, client A and B's as well as all other clients in the home behavior support plan.</p> <p>How others will be identified: (Systemic): The Residential Manager will be at the home at least five times weekly to ensure that all client program plans are being implemented as written. The Behavior Clinician will be at the home at least twice weekly to ensure that all client program plans are being implemented as written. The QIDP will be at the home at least weekly to ensure that all client program plans are being implemented as written.</p> <p>Measures to be put in place: All staff at the home will be in-serviced on the operation standard for reporting and investigating</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/29/2016
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR 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 to HM #1 he was in pain and he was given 2 325 milligrams/mg. of acetaminophen at 6:00 PM on 3/18/16.</p> <p>Review of the facility's Bureau of Developmental Disabilities Services/BDDS reports and investigations on 3/24/16 at 9:00 AM and 3/28/16 at 3:45 PM indicated the following:</p> <p>1. A BDDS report dated 3/16/16 indicated an incident on 3/14/16 wherein client A had sustained a black eye. "On 3.14.16 [client B] told staff that [client A] was on the floor in his room, when staff went to check on [client A] they found him lying in his room on the floor and his eye was bruised. When asked what happened, [client A] said that [client B] (housemate) had hit him. [Client B] was asked about the incident and said that he didn't hit him, he heard the noise and went to check on him and that is when he told staff that [client A] was on the floor, the nurse was called and 24 hour head tracking was started. The next day, 3.15.16, the nurse went to the home to assess [client A] and saw that his face was swollen and sent him to the Urgent Care for eval (evaluation). Once at the Urgent Care, they diagnosed [client A] with a frontal sinus fracture and an acute bleed to his brain and sent [client</p>		<p>allegations of abuse, neglect, exploitation, mistreatment or violation of an individual's rights, client A and B's as well as all other clients in the home behavior support plan.</p> <p>Monitoring of Corrective Action: The Residential Manager will be at the home at least five times weekly to ensure that all client program plans are being implemented as written. The Behavior Clinician will be at the home at least twice weekly to ensure that all client program plans are being implemented as written. The QIDP will be at the home at least weekly to ensure that all client program plans are being implemented as written.</p> <p>Completion date: 4/28/2016</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR 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>A] to (name/city) hospital for further evaluation.</p> <p>Upon arrival to the ER (Emergency Room), [client A] was assessed and admitted to the hospital for further evaluation. An investigation has been initiated into the incident...."</p> <p>The investigation into the BDDS reported incident on 3/16/16 indicated the two clients had conflicting stories regarding how the black eye to client A happened. The investigation indicated client B had been put on line of sight staff supervision on 3/5/16 after an elopement. The exact manner in which client A had sustained the injury could not be determined according to the investigation. It was substantiated there were no other witnesses to the incident and this conflicted with the supervision level (line of sight) client B was to have from staff. The investigation determined client B was not being supervised according to his revised (after 3/5/16 incident) BSP/Behavior Support Plan or supervising staff would have witnessed/intervened in the incident of 3/14/16.</p> <p>Interview with Quality Assurance staff #1 on 3/29/16 at 3:20 PM indicated staff #3 and #4 had not been supervising client B according to the newly initiated line of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR 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>sight guidelines when the incident occurred on 3/14/16 with he and client A.</p> <p>2. An investigation dated 3/6-9/16 indicated client B had eloped from the facility around 1:05 AM on 3/6/16. Staff #5 had checked on client B on between 12:30 AM and 12:45 AM and he was in his bedroom. At 1:05 AM, staff went back to check on client B and he was gone and his window was open. The investigation indicated client B had a history of elopement and was to be checked on every 15 minutes when sleeping. The client "was found almost 3 hours later approximately 3 miles from the home."</p> <p>3. An investigation dated 1/14-21/16 indicated client B had eloped from the facility through his window (bedroom) on 1/14/16 without staff's knowledge exact time was unknown. The client hitched a ride and went to a local department store where he bought two toys and stole two others. The client went to a local gas station and had the attendant call his group home. The gas station attendant called the local police at 1:02 AM on 1/14/16. Staff #5 and #8 who were on duty at the time of the elopement were busy doing medication audits and did not discover client B was missing until the gas station called them between 1:02 and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/29/2016	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR 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>1:14 AM on 1/14/16.</p> <p>4. An investigation dated 1/11/16 indicated client B had the behaviors of head butting and spitting on staff #7. According to the summary findings of the investigation, staff #7 had intervened with the behaviors using "unnecessary and unapproved moves of YSIS (You're Safe I'm Safe/behavior management techniques), grabbing [client B] from around the waist and putting him on the ground, and holding his arms on the ground...."</p> <p>Interview with Quality Assurance staff #1 on 3/29/16 at 3:20 PM indicated staff #7 had been terminated by the agency for inappropriate physical holds during the behavior with client B.</p> <p>5. An investigation dated 1/5-11/16 indicated staff #6 had made client A stand outside in the cold inappropriately dressed. The investigation substantiated the allegation of client A standing outside in the cold.</p> <p>Interview with Quality Assurance staff #1 on 3/29/16 at 3:20 PM indicated staff #6 had been terminated by the agency for having client A stand outside.</p> <p>Interview with QIDP-d (Qualified</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR 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>Intellectual Disabilities Professional-designee) on 3/18/16 at 6:00 PM indicated staff had not been conducting the line of sight behavior management supervision with client B on the evening of 3/14/16 when the injury to client A had occurred. The interview indicated the agency had policies and procedures in regards to staff to client neglect and reporting procedures which were taught to staff upon hire and as needed.</p> <p>The "Abuse/Neglect/Exploitation Policy and Procedure" component of the agency's 08/01/07 Operational Policy and Procedure Manual (revised 01/09/2015) was reviewed on 3/24/2016 at 10:00 AM. The review indicated the agency prohibited staff neglect of clients. The policy indicated all allegations would be investigated and addressed. The definition of neglect was as follows:</p> <p>"F. Neglect--Program Implementation/Intervention Definition: 1. Failure to provide goods and/or services necessary for the individual to avoid physical harm. 2. Intentional failure to implement a support plan, inappropriate application of intervention, etc. which may result in jeopardy without qualified person</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR 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
--------------------	--	---------------	---	----------------------

W 0156 Bldg. 00	notification/review." This federal tag relates to Complaint #IN00195966. 9-3-2(a) 483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 1 of 10 investigations reviewed (clients A and B), the facility failed to ensure the results of the investigation were completed and reviewed by the administrator in five working days. Findings include: Review of the facility's Bureau of Developmental Disabilities	W 0156	W156: The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Corrective Action: (Specific): The Quality Assurance Manager will be in-serviced on the completion of	04/28/2016
--------------------	--	--------	--	------------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR 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>Services/BDDS reports and investigations on 3/24/16 at 9:00 AM and 3/28/16 at 3:45 PM indicated the following:</p> <p>A BDDS report dated 3/16/16 indicated an incident on 3/14/16 wherein client A had sustained a black eye. "On 3.14.16 [client B] told staff that [client A] was on the floor in his room, when staff went to check on [client A] they found him lying in his room on the floor and his eye was bruised. When asked what happened, [client A] said that [client B] (housemate) had hit him. [Client B] was asked about the incident and said that he didn't hit him, he heard the noise and went to check on him and that is when he told staff that [client A] was on the floor, the nurse was called and 24 hour head tracking was started. The next day, 3.15.16, the nurse went to the home to assess [client A] and saw that his face was swollen and sent him to the Urgent Care for eval (evaluation). Once at the Urgent Care, they diagnosed [client A] with a frontal sinus fracture and an acute bleed to his brain and sent [client A] to (name/city) hospital for further evaluation.</p> <p>Upon arrival to the ER (Emergency Room), [client A] was assessed and admitted to the hospital for further evaluation. An investigation has been</p>		<p>thorough investigations and that the results of the investigation are reported to the administrator within 5 working days for the date of the incident.</p> <p>How others will be identified: (Systemic): The Program Manager will meet with QA at least weekly to ensure that the results of investigations are reported to the administrator within 5 working days.</p> <p>Measures to be put in place: The Quality Assurance Manager will be in-serviced on the completion of thorough investigations and that the results of the investigation are reported to the administrator within 5 working days for the date of the incident.</p> <p>Monitoring of Corrective Action: The Program Manager will meet with QA at least weekly to ensure that the results of investigations are reported to the administrator within 5 working days.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR 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>initiated into the incident...."</p> <p>The investigation into the BDDS reported incident on 3/16/16 indicated the two clients had conflicting stories regarding how the black eye to client A happened. The investigation indicated client B had been put on line of sight staff supervision on 3/5/16 after an elopement. The exact manner in which client A had sustained the injury could not be determined according to the investigation. It was substantiated there were no other witnesses to the incident and this conflicted with the supervision level (line of sight) client B was to have from staff. The investigation determined client B was not being supervised according to his revised (after 3/5/16 incident) BSP/Behavior Support Plan or supervising staff would have witnessed/intervened in the incident of 3/14/16.</p> <p>Interview with Quality Assurance staff #1 on 3/29/16 at 3:20 PM indicated it was difficult to interview all relevant staff in the 5 working days according to the guidelines for timeliness. In order for the investigation to be thorough it was late.</p> <p>This federal tag relates to Complaint #IN00195966.</p>		<p>Completion date: 04/28/2016</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/29/2016	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR 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			
W 0249 Bldg. 00	<p>9-3-2(a)</p> <p>483.440(d)(1) 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 record review and interview for 1 of 2 sampled clients (B), the facility failed to ensure a behavior management protocol (line of sight supervision) was implemented.</p> <p>Findings include:</p> <p>Review of the facility's Bureau of Developmental Disabilities Services/BDDS reports and investigations on 3/24/16 at 9:00 AM and 3/28/16 at 3:45 PM indicated the following:</p> <p>1. A BDDS report dated 3/16/16 indicated an incident on 3/14/16 wherein client A had sustained a black eye. "On 3.14.16 [client B] told staff that [client A] was on the floor in his room, when staff went to check on [client A] they found him lying in his room on the floor and his eye was bruised. When asked</p>	W 0249	<p>W249: As soon as the interdisciplinary team has formulated a client's individual program plan each client must receive 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>Corrective Action: (Specific): All staff at the home will be in-serviced on the operation standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment or violation of an individual's rights, client A and B's as well as all other clients in the home behavior support plan.</p> <p>How others will be identified:</p>	04/28/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/29/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR 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>what happened, [client A] said that [client B] (housemate) had hit him. [Client B] was asked about the incident and said that he didn't hit him, he heard the noise and went to check on him and that is when he told staff that [client A] was on the floor, the nurse was called and 24 hour head tracking was started. The next day, 3.15.16, the nurse went to the home to assess [client A] and saw that his face was swollen and sent him to the Urgent Care for eval (evaluation). Once at the Urgent Care, they diagnosed [client A] with a frontal sinus fracture and an acute bleed to his brain and sent [client A] to (name/city) hospital for further evaluation.</p> <p>Upon arrival to the ER (Emergency Room), [client A] was assessed and admitted to the hospital for further evaluation. An investigation has been initiated into the incident..."</p> <p>The investigation into the BDDS reported incident on 3/16/16 indicated the two clients had conflicting stories regarding how the black eye to client A happened. The investigation indicated client B had been put on line of sight staff supervision on 3/5/16 after an elopement. The exact manner in which client A had sustained the injury could not be determined according to the investigation. It was substantiated there were no other</p>		<p>(Systemic): The Residential Manager will be at the home at least five times weekly to ensure that all client program plans are being implemented as written. The Behavior Clinician will be at the home at least twice weekly to ensure that all client program plans are being implemented as written. The QIDP will be at the home at least weekly to ensure that all client program plans are being implemented as written.</p> <p>Measures to be put in place: All staff at the home will be in-serviced on the operation standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment or violation of an individual's rights, client A and B's as well as all other clients in the home behavior support plan.</p> <p>Monitoring of Corrective Action: The Residential Manager will be at the home at least five times weekly to ensure that all client program plans are being implemented as written. The Behavior Clinician will be at the home at least twice weekly to ensure that all client program plans are being implemented as written. The QIDP will be at the home at least weekly to ensure that all client program plans are being</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 03/29/2016	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR 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>witnesses to the incident and this conflicted with the supervision level (line of sight) client B was to have from staff. The investigation determined client B was not being supervised according to his revised (after 3/5/16 incident) BSP/Behavior Support Plan or supervising staff would have witnessed/intervened in the incident of 3/14/16.</p> <p>Interview with Quality Assurance staff #1 on 3/29/16 at 3:20 PM indicated staff #3 and #4 had not been supervising client B according to the newly initiated line of sight guidelines when the incident occurred on 3/14/16 with he and client A.</p> <p>Client B's record was reviewed on 3/18/16 at 6:25 PM and on 3/24/16 at 11:00 AM. The reviews indicated a BSP/Behavior Support Plan dated 9/17/15 which indicated client B had a history of elopement. The reviews indicated a BSP addendum dated 1/21/16 which added 15 minute checks for client B when he was asleep and window alarms for his bedroom. The window alarms were to be checked for working order at each shift of personnel for good working order.</p> <p>This federal tag relates to Complaint #IN00195966.</p>		<p>implemented as written.</p> <p>Completion date: 4/28/2016</p>				

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

PRINTED: 05/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G723	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 03/29/2016
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 13009 HORIZON DR 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	
	9-3-4(a)				