

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/06/2013	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W000000	<p>This visit was for a post certification revisit (PCR) to the recertification and state licensure survey completed on 10/18/13.</p> <p>This visit was in conjunction with the investigation of complaint #IN00139622.</p> <p>Dates of survey: November 25, 26, 27 and December 6, 2013.</p> <p>Facility Number: 000709 Provider Number: 15G175 AIMS Number: 100243190</p> <p>Surveyor: Jo Anna Scott, QIDP</p> <p>The following deficiencies reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed December 13, 2013 by Dotty Walton, QIDP.</p>			W000000			

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: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/06/2013	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 1 of 4 sampled clients (client A), the governing body failed to ensure the client's room was free of clutter and the refrigerator light was working.</p> <p>Findings include:</p> <p>During the environmental observation on 11/25/13 at 3:30 PM it was noted client A's bedroom floor had 2 inches to 4 inches of paper torn in small pieces covering the entire floor space. The bed was unmade and a bean bag chair was stacked on top of the bed with the blankets and bedspread also piled on top of bed. The kitchen was checked at 3:45 PM and the refrigerator light was not working.</p> <p>Interview with staff #2, home manager, was conducted on 11/25/13 at 3:50 PM. Staff #2, home manager, stated "[client A] liked to shred paper and was constantly looking for magazines and paper to tear up." Staff #2 stated "[client A] would have a behavior if he wasn't allowed to tear up paper and refused to clean up the paper." Staff #2 stated they cleaned the room 4 times a week and had to do it</p>	W000104	<p>W104: The governing body must exercise general policy, budget, and operating direction over the facility. Corrective Action: (Specific) Staff will be in-serviced on assisting client A in cleaning his room of all paper after he is finished shredding and looking through it to ensure that his room remains free of clutter. The refrigerator light has been replaced How others will be identified: (Systemic) The Residential Manager will complete observations at the home at least five times weekly to ensure that client A's rooms remains free of clutter and that staff are assisting client A in cleaning his room after client A finishes shredding and looking through his paper. The Residential Manager will also ensure that the appliances are in working order during visits. The Program Manager will complete observations at the home at least weekly to ensure that all appliances are in working order, that Client A's room is free of clutter and that staff are assisting Client A in clearing his room of paper after client A is finished shredding and looking through it. Measures to be put in place: Staff will be in-serviced on assisting client A in cleaning his room of all</p>	01/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/06/2013
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>when client A was out of the home because "he would get upset and become physically aggressive." Staff #2, home manager, indicated the refrigerator had the light bulb replaced recently but needed a new switch.</p> <p>This deficiency was cited on 10/18/13. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>9-3-1(a)</p>		<p>paper after he is finished shredding and looking through it to ensure that his room remains free of clutter. The refrigerator light has been replaced Monitoring of Corrective Action: The Residential Manager will complete observations at the home at least five times weekly to ensure that client A's rooms remains free of clutter and that staff are assisting client A in cleaning his room after client A finishes shredding and looking through his paper. The Residential Manager will also ensure that the appliances are in working order during visits. The Program Manager will complete observations at the home at least weekly to ensure that all appliances are in working order, that Client A's room is free of clutter and that staff are assisting Client A in clearing his room of paper after client A is finished shredding and looking through it. Completion date: 01/05/14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W000369	<p>483.460(k)(2) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.</p> <p>Based on observation of 18 doses of medication administered with one error, record review and interview for 1 of 4 sampled clients (client D), the facility failed to ensure the medication administration was done without error.</p> <p>Findings include:</p> <p>During the observation period on 11/26/13 from 6:15 AM to 9:30 AM, the medication pass started at 7:00 AM. Client D received his medication at 7:20 AM. The medication client D received was as follows:</p> <p style="padding-left: 40px;">Actorvastatin - 20 mg (milligram) for high cholesterol</p> <p style="padding-left: 40px;">Nexium - 40 mg for gastroesophageal reflux disease</p> <p style="padding-left: 40px;">Sertraline - 100 mg for anxiety</p> <p style="padding-left: 40px;">Systane gel for dry eye.</p> <p>The physician's orders dated 11/1/13 through 11/30/13 for client D were reviewed on 11/26/13 at 9:00 AM. The orders indicated client D was to receive one drop of Systane solution at the morning medication pass. The Systane Gel was to be administered at the 8 PM</p>	W000369	<p>W369: The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Corrective Action: (Specific) All staff will be in-serviced on General Guidelines for Medication Administration Policy and Procedure. How others will be identified: (Systemic) The Residential Manager will make random visits to the home at least 3 times weekly to ensure that staff is following the General Guidelines for Medication Administration Policy and Procedure. The Program Manager and the Nurse will make random visits at least weekly to ensure that staff is following The General Guidelines for Medication Administration Policy and Procedure. Measures to be put in place: All staff will be in-serviced on General Guidelines for Medication Administration Policy and Procedure. Monitoring of Corrective Action: The Residential Manager will make random visits to the home at least 3 times weekly to ensure that staff is following the General Guidelines for Medication Administration Policy and Procedure. The Program</p>	01/05/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/06/2013
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>medication pass.</p> <p>An interview with staff #2, home manager on 11/26/13 at 9:00 am, stated the client was "to receive the gel in the evening and the solution in the mornings." Staff #2 stated "the wrong bottle was in the morning medication box for client D."</p> <p>9-3-6(a)</p>		<p>Manager and the Nurse will make random visits at least weekly to ensure that staff is following The General Guidelines for Medication Administration Policy and Procedure. Completion date: 01/05/14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/06/2013	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W000407	<p>483.470(a)(1) CLIENT LIVING ENVIRONMENT The facility must not house clients of grossly different ages, developmental levels, and social needs in close physical or social proximity unless the housing is planned to promote the growth and development of all those housed together.</p> <p>Based on observation, record review and interview for 1 for 4 sampled clients (client A), the facility failed to ensure the client was properly placed in regard to his social, behavioral and psychiatric needs.</p> <p>Findings include:</p> <p>During the observation period on 11/25/13 from 4:00 PM to 6:00 PM client A was observed walking around the house until 4:25 PM. The staff working with client A prompted him to go and clean his room. Client A stuck his fingers in his ears. Staff #2 stated "he does this when he doesn't want to do what is requested." At 4:37 PM client A was sitting at the dining table watching staff #3 and client C prepare dinner. Staff #2 prompted client A to assist in setting the table. Client A refused again by putting his fingers in his ears and looking away. At 5:05 PM client A again stuck his fingers in his ears when staff #2 prompted him to go to his room and make his bed. At 5:45 PM client A went to his room refusing to eat dinner with his peers.</p>	W000407	<p>W407: The facility must not house clients of grossly different ages, developmental levels and social needs in close physical or social proximity unless the housing is planned to promote growth and development of all those housed together. Corrective Action: (Specific): The interdisciplinary team has met to discuss placement for client A, submitted and received LOC, have submitted CIH waiver request paperwork to the state for review and continue to look for alternate placement for Client A.</p> <p>How others will be identified: (Systemic): The interdisciplinary team will continue to review all referrals thoroughly to ensure that client placement is planned to promote growth and development of all clients and that the ages, developmental levels and social needs of all clients are appropriate prior to admission. Measures to be put in place: The interdisciplinary team has met to discuss placement for client A, submitted and received LOC, have submitted CIH waiver request paperwork to the state for review and continue to look for alternate placement for Client A.</p>	01/05/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/06/2013	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>The Surveyor Worksheet dated 11/25/13 and reviewed on 11/25/13 at 1:00 PM indicated client A was younger than the other clients. Client A was born in 1989 and is 24 years old, client B was born in 1956 and is 57 years old, client C was born in 1946 and is 66 years old, client D was born in 1944 and is 69 years old, client E was born in 1949 and is 63 years old, client F was born in 1958 and is 55 years old and client G was born in 1959 and is 54 years old.</p> <p>The BDDS (Bureau of Developmental Disabilities Services) reports for the period of 10/18/13 through 11/25/13 were reviewed on 11/25/13 at 1:30 PM. There were 3 reports for this period with 2 involving client A. The BDDS report dated 10/24/13 indicated the following: "Clients were getting haircuts. [Client A] was agitated. [Client A] started throwing objects and trying to hit staff. YSIS (Your Safe I'm Safe restraint) was used. The BDDS report dated 10/11/13 indicated the following: "[Client A] asked me for a cup of tea. I gave him a full cup of tea and he wanted me to pour him more. I told him it was already full. He started banging on the table and trying to throw things. I put him in YSIS and verbally redirected him to his room."</p> <p>The BSP (Behavior Support Plan) dated 10/26/13 indicated the behavioral history as follows: "[Client A] is a 24 year old male who is diagnosed with Autism. He moved to the (address) group home after living in and growing up in his mother's home. His mother has always been his primary caregiver and has taken care of [client A].</p>		<p>Monitoring of Corrective Action: The interdisciplinary team will review all referrals thoroughly to ensure that client placement is planned to promote growth and development of all clients and that the ages, developmental levels and social needs of all clients are appropriate prior to admission. Completion date: 01/05/14</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>[Client A] will visit his family during the holidays, but has little contact with them otherwise. Due to [client A's] behaviors he has not been successful in a day program and spends his days in the group home. (On 10/28/13 client A started attending a day program one day a week for as long as his behavior allows). He does best with structure and given activities to complete. [Client A] has a history of self-stimming (body rocking), physical aggression, property destruction and non-compliance. [Client A's] behaviors are often caused when he feels he is being ignored, by loud noises, and by being told 'no'. [Client A] recently started engaging more in leaving assigned areas and should be monitored closely. [Client A] is also a (sic) risk for seizures. The purpose of [client A's] behavior support plan is to assist [client A] with learning patience and learning other appropriate techniques to communicate when he is upset instead of engaging in target behaviors."</p> <p>The BSP indicated the target behaviors as follows:</p> <p>"Non-Compliance - any time he does not comply with or start complying with a programmatic request after 3 prompts spaced out at least 15 minutes apart."</p> <p>"Hyperactive - [client A] will continue to pace around and not focus on one particular task for any given amount of time regardless of prompting."</p> <p>"Inappropriate sexual behavior - Anytime he is physically attempting to touch others in their personal areas (e.g. breast, genitals etc) or rubbing on others."</p> <p>"Leaving assigned area - Anytime he leaves or attempts to leave a designated area without staff."</p> <p>"Physical Aggression - Anytime he hits, punches, stabs, slaps, kicks, pinches, pushes, spits, bites or throws objects at staff or peers, any time he makes contact with staff or peers and there is</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/06/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>the potential for the contact to cause injury or redness. This should include attempts to hit, drawing back a fist, or throwing objects that do not make contact with a client or staff."</p> <p>"Property Destruction - Anytime he is banging on walls, tables, doors, throwing items or any behavior that has the potential to damage property."</p> <p>"Verbal Disruption - Anytime he is yelling/grunting, etc. outside of times when he is playing or when he is visibly happy about something."</p> <p>"Self-Injury - Anytime he is hitting biting himself or other behaviors directed towards himself that could cause harm."</p> <p>The BSP indicated client A was to have a one to one staff with him during waking hours and was on 5 minute staff checks while asleep. If at any time he gets up in the night staff will resume the one to one until he is asleep.</p> <p>Interview with staff #3 on 11/25/13 at 5:00 pm stated "we don't go out to eat as often because [client A] has too many behaviors." Staff #3 stated "[client D] gets upset with [client A] and yells and tries to make [client A] be quiet."</p> <p>Interview with staff #4 on 11/26/13 at 8:30 AM indicated client A didn't participate in any projects with his peers. Staff #4 indicated client A refused to eat breakfast with them and usually only wanted to go on van rides and look for magazines or papers to tear up and scatter on the floor in his room.</p> <p>Interview with staff #2, home manager, indicated client #4 was attending the day program one day a week. Staff #2 indicated he did not stay but a couple of hours because of behaviors.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/06/2013
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	This deficiency was cited on 10/18/13. The facility failed to implement a systematic plan of correction to prevent recurrence. 9-3-7(a)				