

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/15/2012	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0000	<p>This visit was for a full annual recertification and state licensure survey.</p> <p>This visit was conducted in conjunction with the post certification revisit (PCR) for the investigation of complaint #IN00107684 completed on May 4, 2012.</p> <p>Dates of Survey: June 11, 12, 13, 14 and 15, 2012.</p> <p>Facility Number: 000677 Provider Number: 15G140 AIMS Number: 100234420</p> <p>Surveyor: Dotty Walton, Medical Surveyor III.</p> <p>The following federal deficiencies reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review completed 6/22/12 by Ruth Shackelford, Medical Surveyor III.</p>			W0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/15/2012	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
W0104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 4 of 4 sampled clients (A, B, C, D), and 3 additional clients (E, F, G) the facility's Governing Body failed to exercise general policy and operating direction over the facility by failing to keep the home in good repair.</p> <p>Findings include:</p> <p>During observations on 6/11/12 from 4:00 PM until 7:00 PM, clients A, B, C, D, E, F, and G were observed to live in the facility.</p> <p>Environmental tours of the facility on 6/12/12 at 10:00 AM and 1:25 PM indicated the east exit door's lock did not function properly and the ceiling of the extra bedroom in the upstairs had stains on the ceiling.</p> <p>Interview with maintenance personnel on 6/12/12 at 10:30 AM indicated the east entry/exit door's lock did not function properly.</p> <p>Interview with the Program Coordinator on 6/14/12 at 2:30 PM indicated the facility's roof shingles had been repaired</p>	W0104	<p><b>Corrective Action: (Specific)</b> The maintenance crew will repair/replace the east exit door's lock The stained ceiling in the extra upstairs room has already been repaired/repainted.</p> <p><b>How others will be identified: (Systemic)</b> Maintenance check lists are filled out monthly and sent to the Environmental Services Manager. The Environmental Services Manager assigns a maintenance staff to repair or replace items that are damaged or in need of repair that are listed on the checklists. Maintenance requests are sent to the Environmental Services Manager as soon as a repair is needed in the homes. The Environmental Services Manager assigns to maintenance staff to repair the damaged or dysfunctional items.</p> <p><b>Measures to be put in place:</b> The maintenance crew will repair/replace the east exit door's lock The stained ceiling in the extra upstairs room has already been repaired/repainted.</p> <p><b>Monitoring of Corrective Action:</b> Maintenance check lists are filled out monthly and sent to the Environmental Services Manager. The Environmental Services Manager assigns a maintenance staff to repair or</p>	07/15/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/15/2012
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250		
(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	
	on 6/12/12. The interview indicated the ceiling in the extra upstairs room had water damage/staining due to the faulty roof shingles.  9-3-1(a)		replace items that are damaged or in need of repair that are listed on the checklists. Maintenance requests are sent to the Environmental Services Manager as soon as a repair is needed in the homes. The Environmental Services Manager assigns maintenance staff to repair the damaged or dysfunctional items.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/15/2012	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250			
(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			
W0120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client.</p> <p>Based on observation, record review and interview, for 4 of 4 sampled clients (A, B, C, D), and two additional clients (F and G), the facility failed to ensure the day services providers were apprised of changes in clients' programming in regards to mealtime objectives and dining plans.</p> <p>Findings include:</p> <p>Clients A, B, C, D, E, and G were observed eating lunch at their day program on 6/12/12 at 11:50 AM until 12:30 PM. Client A ate his meal in a fast manner, did not sit his sandwich down between bites, did not chew and swallow before taking another bite of food and did not sip fluids throughout the meal. Clients B, E, and G ate in a fast manner without prompting to slow their eating pace. Client C was looking about the room and not at his meal. He was not redirected. Client D's meal consisted of a sandwich cut into bite sized pieces and melon pieces. He ate the sandwich and melon with his fingers in a rapid manner without prompting to slow his pace and drink during the meal.</p>	W0120	<p><b>Corrective Action: (Specific)</b> The QDDP will be retrained that workshop staff are to be retrained on all client dining plans and any revisions of the dining plan. The QDDP will be retrained that workshop staff are to be trained on client mealtime goals to ensure mealtime safety for the clients. The QDDP will train the Program Coordinator that workshop staff are to be trained on all current client dining plans, as well as revisions of the dining plans. The QDDP will retrain the Program Coordinator that workshop staff are to be trained on client mealtime goals to ensure mealtime safety for the clients. The QDDP and Program Coordinator will train the workshop staff on all current dining plans and all revisions, as well as the goals for mealtime safety.</p> <p><b>How others will be identified: (Systemic)</b> All workshops are trained by the QDDP, the Program Coordinator, or the Nurse on client dining plans before being admitted to the workshop. Workshop staff are also trained on dining plan revisions the QDDP, Program Coordinator or the Nurse. The QDDP or the Program Coordinator train all workshop</p>	07/15/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/15/2012
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250		
(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>Review of client A's record on 6/12/12 at 9:30 AM indicated a dining plan dated 4/01/12 which indicated client A was to be monitored at meals because he ate fast. The review indicated a mealtime goal dated 6/1/12 which included methodology to ensure client A ate in a safe manner. The meal objective contained the following steps to be implemented using verbal prompting: take a single bite, chew and swallow before taking another bite, drink throughout the meal, and wipe his mouth with his napkin.</p> <p>Review of client B's record on 6/12/12 at 9:50 AM indicated a dining plan dated 6/01/12 which indicated client B was to be assisted cutting foods and drinking (especially hot liquids) due to his "EPS (extrapyramidal side effects) tremors [hand tremors]."</p> <p>Review of client C's record on 6/12/12 at 8:50 AM indicated a dining plan dated 4/01/12 which indicated client C was to be monitored at meals because he had a history of choking. The dining plan indicated client C was to be free of distractions during meals, was to be encouraged to take small bites, and take sips of fluids during the meal. He was to be prompted to cut food into bite sized pieces and was require staff assistance. The review indicated a mealtime goal</p>		<p>mealtime goals. <b>Measures to be put in place:</b> The QDDP will be retrained that workshop staff are to be retrained on all client dining plans and any revisions of the dining plan. .The QDDP will be retrained that workshop staff are to be trained on client mealtime goals to ensure mealtime safety for the clients. The QDDP will train the Program Coordinator that workshop staff are to be trained on all current client dining plans, as well as revisions of the dining plans. The QDDP will retrain the Program Coordinator that workshop staff are to be trained on client mealtime goals to ensure mealtime safety for the clients. The QDDP and Program Coordinator will train the workshop staff on all current dining plans and all revisions, as well as the goals for mealtime safety. <b>Monitoring of Corrective Action</b> The Nurse or the Program Coordinator will monitor the meals at the workshop and at the home to ensure the dining plans and mealtime goals are being followed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/15/2012	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250			
(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>dated 6/1/12 which included methodology to ensure client C ate in a safe manner. The meal objective contained the following steps to be implemented using verbal prompting: sit upright and at the table, take a single bite, chew and swallow before taking another bite, drink throughout the meal, and wipe his mouth with his napkin.</p> <p>Review of client D's record on 6/12/12 at 10:50 AM indicated a dining plan/DP dated 4/01/12 which indicated client D was to be monitored and assisted in cutting foods into bite sized pieces. The DP indicated client D was legally blind and required reminders to sit up straight, slow down his eating pace, take small bites and chew his food.</p> <p>Review of client F's record on 6/12/12 at 2:00 PM indicated a dining plan dated 4/01/12 which indicated client F tended to swallow his food without chewing it first. He was to be verbally prompted to chew prior to swallowing. The review indicated a mealtime goal dated 6/1/12 which included methodology to ensure client F ate in a safe manner. The meal objective contained the following steps to be implemented using verbal prompting: take a single bite, chew and swallow before taking another bite, drink throughout the meal, and wipe his mouth</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/15/2012	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250			
(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 his napkin.</p> <p>Review of client G's record on 6/12/12 at 2:15 PM indicated a dining plan dated 5/05/11 which indicated client G was to be encouraged to slow his eating pace with verbal prompting. The review indicated a mealtime goal dated 6/1/12 which included methodology to ensure client G ate in a safe manner. The meal objective contained the following steps to be implemented using verbal prompting: take a single bite, chew and swallow before taking another bite, place an appropriate amount of food on his fork, and drink throughout the meal.</p> <p>Records were reviewed at the day program on 6/12/12 at 3:30 PM. The review indicated clients A, B, C, D, F and G's dining plans and mealtime goals were not the most recent. Client A's dining plan was dated 10/12/08 and his 6/1/12 mealtime goal was not at the day program. There was no 6/1/12 dining plan available for workshop staff for client B. Client C's dining plan was dated 6/14/09 and his 6/1/12 meal goal was not available. Client D's most recent available dining plan was dated 4/14/09. Clients F and G had dining plans which were undated. Their mealtime goals of 6/1/12 were not available at the workshop. Interview with workshop</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/15/2012	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250			
(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>supervisory staff indicated the residential facility was in the process of getting the new plans to the workshop and would be training soon.</p> <p>Interview with Qualified Developmental Disabilities Professional-designee/Program Coordinator staff #1 on 6/12/12 at 2:45 PM indicated the workshop staff had not been inserviced on the new dining and mealtime plans for clients A, B, C, D, F and G.</p> <p>9-3-1(a)</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/15/2012	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250			
(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			
W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on observation, record review and interview, for 4 of 4 sampled clients (A, B, C, D), and two additional clients (F and G), the Qualified Developmental Disabilities Professional/QDDP failed to coordinate with the day services provider by failing to ensure revisions to their dining and mealtime programs were available to all day service staff. The QDDP failed to ensure all day service staff were trained clients' mealtime needs so as to ensure mealtime safety for those clients who ate quickly, did not chew properly and had a history of choking (client C). The QDDP failed to integrate methods to deal with client noncompliance (client A) during mealtime.</p> <p>Findings include:</p> <p>1. During evening observations at the facility on 6/11/12 from 4:00 PM until 7:00 PM, client A was observed during his evening meal. Client A ate at a fast pace, did not chew his food and swallow to clear his mouth before taking more bites of food. Client A continued in this</p>	W0159	<p><b>Corrective Action: (Specific)</b> The QDDP will be retrained that workshop staff are to be retrained on all client dining plans and any revisions of the dining plan. The QDDP will be retrained that workshop staff are to be trained on client mealtime goals to ensure mealtime safety for the clients. The QDDP will train the Program Coordinator that workshop staff are to be trained on all current client dining plans, as well as revisions of the dining plans. The QDDP will retrain the Program Coordinator that workshop staff are to be trained on client mealtime goals to ensure mealtime safety for the clients. The QDDP and Program Coordinator will train the workshop staff on all current dining plans and all revisions, as well as the goals for mealtime safety. The QDDP will be retrained that methods need to be developed to deal with client noncompliance during mealtime. An IDT will be held with client A to develop a goal with methodology where he will set his fork down and chew food well before picking his fork back up to take another bite. The goal will be tracked for effectiveness. The goal will be changed if necessary. The</p>	07/15/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/15/2012
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250		
(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>manner throughout the meal. He ate quickly without cutting the foods into appropriate sized pieces and ignored staff #7's and LPN #1's verbal prompting to "slow down." On 6/12/12 from 6:35 AM until 6:50 AM, client A ate dry cereal with milk in a rapid manner; he would take bites of food without swallowing the previous bite. He ignored verbal prompting from staff #6 to slow down and swallow his food.</p> <p>Review of client A's record on 6/12/12 at 9:30 AM indicated a dining plan dated 4/01/12 which indicated client A was to be monitored at meals because he ate fast. The review indicated a mealtime goal dated 6/1/12 which included methodology to ensure client A ate in a safe manner. The meal objective contained the following steps to be implemented using verbal prompting: take a single bite, chew and swallow before taking another bite, drink throughout the meal, and wipe his mouth with his napkin. There was no methodology to address the client's ignoring of staff's prompting to following the steps of his mealtime program. Interview with LPN #1 and Program Coordinator #3 on 6/11/12 at 6:50 PM indicated client A ignored all verbal attempts at staff redirection to eat in a safe manner.</p>		<p>Program Coordinator and the QDDP will train all home staff and workshop staff on Client A's revised mealtime goal. <b>How others will be identified: (Systemic)</b> All workshops are trained by the QDDP, the Program Coordinator, or the Nurse on client dining plans before being admitted to the workshop. Workshop staff are also trained on dining plan revisions the QDDP, Program Coordinator of the Nurse. The QDDP develops m <b>Measures to be put in place:</b> The QDDP will be retrained that workshop staff are to be retrained on all client dining plans and any revisions of the dining plan. The QDDP will be retrained that workshop staff are to be trained on client mealtime goals to ensure mealtime safety for the clients. The QDDP will train the Program Coordinator that workshop staff are to be trained on all current client dining plans, as well as revisions of the dining plans. The QDDP will retrain the Program Coordinator that workshop staff are to be trained on client mealtime goals to ensure mealtime safety for the clients. The QDDP and Program Coordinator will train the workshop staff on all current dining plans and all revisions, as well as the goals for mealtime safety. The QDDP will be retrained that methods need to be developed to deal with client</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/15/2012	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>2. Clients A, B, C, D, E, and G were observed eating lunch at their day program on 6/12/12 at 11:50 AM until 12:30 PM. Client A ate his meal in a fast manner, did not sit his sandwich down between bites, did not chew and swallow before taking another bite of food and did not sip fluids throughout the meal. Clients B, E, and G ate in a fast manner without prompting to slow their eating pace. Client C was looking about the room and not at his meal. He was not redirected. Client D's meal consisted of a sandwich cut into bite sized pieces and melon pieces. He ate the sandwich and melon with his fingers in a rapid manner without prompting to slow his pace and drink during the meal.</p> <p>Review of client A's record on 6/12/12 at 9:30 AM indicated a dining plan dated 4/01/12 which indicated client A was to be monitored at meals because he ate fast. The review indicated a mealtime goal dated 6/1/12 which included methodology to ensure client A ate in a safe manner. The meal objective contained the following steps to be implemented using verbal prompting: take a single bite, chew and swallow before taking another bite, drink throughout the meal, and wipe his mouth with his napkin.</p> <p>Review of client B's record on 6/12/12 at</p>		<p>noncompliance during mealtime. An IDT will be held with client A to develop a goal with methodology where he will set his fork down and chew food well before picking his fork back up to take another bite. The goal will be tracked for effectiveness. The goal will be changed if necessary. The Program Coordinator and the QDDP will train all home staff and workshop staff on Client A's revised mealtime goal.</p> <p><b>Monitoring of Corrective Action:</b> The Nurse or the Program Coordinator will monitor the meals at the workshop and at the home to ensure the dining plans and mealtime goals are being followed. ealtime goals that are individualized and revised as needed for all clients.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/15/2012	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250			
(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>9:50 AM indicated a dining plan dated 6/01/12 which indicated client B was to be assisted cutting foods and drinking (especially hot liquids) due to his "EPS (extrapyramidal side effects) tremors [hand tremors]."</p> <p>Review of client C's record on 6/12/12 at 8:50 AM indicated a dining plan dated 4/01/12 which indicated client C was to be monitored at meals because he had a history of choking. The dining plan indicated client C was to be free of distractions during meals, was to be encouraged to take small bites, and take sips of fluids during the meal. He was to be prompted to cut food into bite sized pieces and was require staff assistance. The review indicated a mealtime goal dated 6/1/12 which included methodology to ensure client C ate in a safe manner. The meal objective contained the following steps to be implemented using verbal prompting: sit upright and at the table, take a single bite, chew and swallow before taking another bite, drink throughout the meal, and wipe his mouth with his napkin.</p> <p>Review of client D's record on 6/12/12 at 10:50 AM indicated a dining plan/DP dated 4/01/12 which indicated client D was to be monitored and assisted in cutting foods into bite sized pieces. The</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250
---	--

(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>DP indicated client D was legally blind and required reminders to sit up straight, slow down his eating pace, take small bites and chew his food.</p> <p>Review of client F's record on 6/12/12 at 2:00 PM indicated a dining plan dated 4/01/12 which indicated client F tended to swallow his food without chewing it first. He was to be verbally prompted to chew prior to swallowing. The review indicated a mealtime goal dated 6/1/12 which included methodology to ensure client F ate in a safe manner. The meal objective contained the following steps to be implemented using verbal prompting: take a single bite, chew and swallow before taking another bite, drink throughout the meal, and wipe his mouth with his napkin.</p> <p>Review of client G's record on 6/12/12 at 2:15 PM indicated a dining plan dated 5/05/11 which indicated client G was to be encouraged to slow his eating pace with verbal prompting. The review indicated a mealtime goal dated 6/1/12 which included methodology to ensure client G ate in a safe manner. The meal objective contained the following steps to be implemented using verbal prompting: take a single bite, chew and swallow before taking another bite, place an appropriate amount of food on his fork,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250
---	--

(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>and drink throughout the meal.</p> <p>Records were reviewed at the day program on 6/12/12 at 3:30 PM. The review indicated clients A, B, C, D, F and G's dining plans and mealtime goals were not the most recent. Client A's dining plan was dated 10/12/08 and his 6/1/12 mealtime goal was not at the day program. There was no 6/1/12 dining plan available for workshop staff for client B. Client C's dining plan was dated 6/14/09 and his 6/1/12 meal goal was not available. Client D's most recent available dining plan was dated 4/14/09. Clients F and G had dining plans which were undated. Their mealtime goals of 6/1/12 were not available at the workshop.</p> <p>Interview with workshop supervisory staff on 6/12/12 at 3:45 PM indicated the residential facility was in the process of getting the new plans to the workshop and would be training soon.</p> <p>Interview with Qualified Developmental Disabilities Professional-designee/Program Coordinator staff #1 on 6/12/12 at 2:45 PM indicated the workshop staff had not been given or inserviced on the new dining and mealtime plans for clients A, B, C, D, F and G.</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250
---	--

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250
---	--

(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
W0217	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include nutritional status.</p> <p>Based on observation, record review and interview for 1 of 4 sampled clients (B), the facility failed to ensure client B's tremors were assessed in regards to adaptive equipment usage during mealtime and other areas of daily living.</p> <p>Findings include:</p> <p>During evening observations at the facility on 6/11/12 from 4:00 PM until 7:00 PM, client B was observed during his evening meal. Client B was observed to use regular table service and a travel type coffee mug (without the lid) for his beverage. Client B was observed to have pronounced hand tremors as he filled his fork with food. At 6:40 PM, client B spilled koolaid when he reached for his mug and attempted to bring it to his mouth to drink. Client B left the table to dry off his clothes and staff assisted in drying the table.</p> <p>During observations of the medication administration on 6/12/12 at 7:33 AM, client B was given Chlorhexidine dental rinse by staff #8. He walked to the sink to use the rinse. His hand tremors caused the liquid to fly out of the cup.</p> <p>Review of client B's record on 6/12/12 at</p>	W0217	<p><b>Corrective Action: (Specific)</b> An assessment, which will include a nutritional assessment) will be completed on Client B for the usage of mealtime equipment or other supports which would assist him in regards to his severe hand tremors during meals and other activities of daily living. The use of the adaptive equipment, if recommended, will be included in his dining plan.</p> <p><b>How others will be identified: (Systemic)</b> Assessments, which includes nutritional assessments, are obtained within 30 days of admission to assess the use of any adaptive equipment.</p> <p><b>Measures to be put in place:</b> An assessment, which will include a nutritional assessment) will be completed on Client B for the usage of mealtime equipment or other supports which would assist him in regards to his severe hand tremors during meals and other activities of daily living. The use of the adaptive equipment, if recommended, will be included in his dining plan.</p> <p><b>Monitoring of corrective action:</b> The Program Coordinator or the Nurse will monitor the use of the adaptive equipment at meal time and other activities of daily living.</p>	07/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250
---	--

(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>9:50 AM indicated a dining plan dated 6/01/12 which indicated client B was to be assisted cutting foods and drinking (especially hot liquids) due to his "EPS (extrapyramidal side effects) tremors [hand tremors]." The record review did not indicate an assessment with recommendations for mealtime equipment or other supports which would assist him in regards to his severe tremoring during meals and other activities of daily living.</p> <p>LPN #1 indicated (6/11/12 6:45 PM) client B did not wish to use the lid on the travel type mug during the observation period. LPN #1 indicated client B's tremoring had not been as pronounced as it was during the evening meal. The interview indicated the client had no assessment with recommendations for adaptive equipment which could assist him with meals and oral hygiene.</p> <p>9-3-4(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  06/15/2012	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250			
(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			
W9999	<p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:</p> <p>460 IAC 9-3-1 Governing body</p> <p>Sec. 1. (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, for 1 of 8 reportable incidents reviewed (client E), the facility failed to immediately report a medication administration error in accordance with State Law.</p> <p>Findings include:</p> <p>The facility records were reviewed on 6/11/12 at 1:30 P.M. and 6/12/12 at 2:30 P.M. including the Bureau of Developmental Disabilities Services (BDDS) reports and medication error reports for the time period between 5/11</p>	W9999	<p><b>Corrective Action: (Specific)</b> The Quality Assurance team will be retrained that all state reportable medication errors will be reported to BDDS per State Law.</p> <p><b>How others will be identified: (Systemic)</b> The Quality Assurance team will report medication errors to BDDS per State Law.</p> <p><b>Measures to be put in place:</b> The Quality Assurance team will be retrained that all state reportable medication errors will be reported to BDDS per State Law.</p> <p><b>Monitoring of Corrective Action:</b> The Director of Supervised Group Living will ensure that all state reportable medications errors are reported to BDDS per State Law.</p>	07/15/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  15G140	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/15/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 402 PRESBYTERIAN MADISON, IN 47250
---	--

(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 5/12. The reports indicated the following:</p> <p>-a medication error report dated 3/31/12 for an incident on 3/30/12 at 7:00 A.M., indicated facility staff #10 failed to administer client E's (potassium supplement) Klor-Con 10 MEQ (milliequivalents) two tablets; she administered only one tablet at 7:00 A.M. on 3/30/12. There was no report sent to BDDS concerning the medication error.</p> <p>An interview conducted with the Program Coordinator (PC) on 6/14/12 at 2:10 PM indicated no evidence the medication error had been reported to BDDS.</p> <p>9-3-1(b)</p>			