

| | | | | | | | |
|---|--|---|---|--|--|---|--|
| 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 07/31/2013 | |
| 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 | | | |
| W000000 | <p>This visit was for an annual recertification and state licensure survey.</p> <p>Dates of Survey: July 29, 30 and 31, 2013.</p> <p>Surveyor: Dotty Walton, QIDP</p> <p>Facility Number: 004615 AIM Number: 200528230 Provider Number: 15G723</p> <p>The following deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review completed 8/8/13 by Ruth Shackelford, 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: 15G723 | | X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____ | | X3) DATE SURVEY COMPLETED 07/31/2013 | |
| 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 | | | |
| W000189 | <p>483.430(e)(1) STAFF TRAINING PROGRAM 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.</p> <p>Based on observation, record review and interview for 1 additional client (#4), the facility failed to ensure the staff sufficiently monitored him according to his health needs.</p> <p>Findings include:</p> <p>During observations at the facility on the evening of 7/29/13 from 2:30 PM until 4:00 PM, client #4 was on the back deck of the facility having a beverage and looking at a magazine. The patio door (had no screen) was left open so staff could look out from the kitchen/dining room to see the client. No staff were in the kitchen preparing a meal or doing other kitchen tasks during the observation time frame. Staff checked on client #4 but did not stay with him. At 3:15 PM, staff #1 came to the deck and spoke to the surveyor. Staff #1 looked at client #4 and stated "he is having a seizure." Staff left the area and client #4 was not checked on by facility staff from 3:30 PM until 4:00 PM. Client #4 had a seizure during this time frame unobserved by staff. Client #4 wore a hard shell helmet to protect</p> | W000189 | <p>W189: 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. Corrective Action: (Specific): All staff will be in-serviced on the risk plan for client #4 and remaining with client #4 when outside on the patio. How others will be identified: (Systemic): The Residential Manager will conduct site visits at the home at varying times at least weekly to ensure that program plans and risk plans are being followed as written. Measures to be put in place: All staff will be in-serviced on the risk plan for client #4 and remaining with client #4 when outside on the patio. Monitoring of Corrective Action: The Residential Manager will conduct site visits at the home at varying times at least weekly to ensure that program plans and risk plans are being followed as written. Completion date: 08/30/13</p> | 08/30/2013 | | | |

| 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 07/31/2013 |
|---|---|---|---|----------------------|---|
| 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>himself from the possibility from falling during a seizure.</p> <p>Review of client #4's record on 7/30/13 at 10:20 AM indicated an ISP/Individual Support Plan dated 4/13. The ISP indicated the client's diagnoses included, but were not limited to, Cerebral Palsy, Seizure Disorder. The client wore a seizure helmet except when sleeping or bathing. The record review indicated staff should monitor the client due to seizure activity and a history of falls.</p> <p>Interview with staff #1 on 7/29/13 at 3:15 PM indicated client #4 liked to sit on the deck and staff checked on him every 15 minutes.</p> <p>Supervisory staff #2 (7/30/15 2:20 PM) was interviewed regarding monitoring the client's seizures/falls. This interview indicated client #4 should be within staff's line of sight at all times to monitor seizure activity and assist with ambulation as needed (stairs, uneven surfaces) to prevent falls.</p> <p>9-3-3(a)</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 07/31/2013 | |
| 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 | | | |
| W000231 | <p>483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance.</p> <p>Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to ensure the clients' programs contained objectives which had measurable criteria.</p> <p>Findings include:</p> <p>Review of client #1's record on 7/30/13 at 10:45 AM indicated an Individual Support Plan/ISP dated 8/22/12. The ISP contained an objective to "improve on identifying currency skills." The objective indicated the following steps the client would have to accomplish with verbal prompting.</p> <p>Methodology: "Staff will with verbal prompts show [client #1] a few different currencies. Staff will with verbal prompts have [client #1] point to a specific coin currency. Staff will with verbal prompts have [client #1] point to a specific paper currency. A successful trial will be documented when [client #1] points to each one of the correct currency with 2 prompts or less." Data collection for the objectives did not</p> | W000231 | <p>W231: The objectives of the individual program plan must be expressed in behavioral terms that provide measureable indices of performance. Corrective Action: (Specific): Client # 1, 2, 3 as well as all other clients in the home have had their goal for improving the identification of currency revised to reflect what specific bills and/or coins they will be identifying.</p> <p>How others will be identified: (Systemic): The Residential Manager and Program Manager will ensure that program plans are written to provide measureable indices of performance for all consumers. Measures to be put in place: Client # 1, 2, 3 as well as all other clients in the home have had their goal for improving the identification of currency revised to reflect what specific bills and/or coins they will be identifying. Monitoring of Corrective Action: The Residential Manager and Program Manager will ensure that program plans are written to provide measureable indices of performance for all consumers. Completion date: 08/30/13</p> | 08/30/2013 | | | |

| | | | |
|--|---|--|---|
| 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 07/31/2013 |
|--|---|--|---|

| | |
|---|--|
| 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>indicate which bills or coins the client was learning.</p> <p>Review of client #2's record on 7/30/13 at 11:30 AM indicated an ISP dated 10/16/12. The ISP contained an objective to "improve on identifying currency skills." The objective indicated the following steps the client would have to accomplish with verbal prompting. Methodology: "Staff will with verbal prompts show [client #2] a few different currencies. Staff will with verbal prompts have [client #2] point to a specific coin currency. Staff will with verbal prompts have [client #2] point to a specific paper currency. A successful trial will be documented when [client #2] points to each one of the correct currency with 2 prompts or less." Data collection for the objectives did not indicate which bills or coins the client was learning.</p> <p>Review of client #3's record on 07/30/13 at 2:30 PM indicated an ISP dated 10/16/12. The ISP contained an objective to "improve on identifying currency skills." The objective indicated the following steps the client would have to accomplish with verbal prompting. Methodology:</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 07/31/2013 |
|--|---|--|---|

| | |
|---|--|
| 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>"Staff will with verbal prompts show [client #3] a few different currencies. Staff will with verbal prompts have [client #3] point to a specific coin currency. Staff will with verbal prompts have [client #3] point to a specific paper currency. A successful trial will be documented when [client #3] points to each one of the correct currency with 2 prompts or less." Data collection for the objectives did not indicate which bills or coins the client was learning.</p> <p>Interview with staff #1 on 7/30/13 at 11:00 AM was conducted. The interview indicated it was unknown which coins or bills clients #1, #2, and #3 were learning.</p> <p>9-3-4(a)</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 07/31/2013 |
| 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 | |
| W000240 | <p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3), and 3 additional clients (#4, #5 and #6), the facility failed to ensure the clients' programs contained methods to employ regarding the clients' individual needs in regards to evacuating the facility in times of emergency.</p> <p>Findings include:</p> <p>During observations at the facility on the evening of 7/29/13 from 4:00 PM until 6:00 PM, clients #1, #2, #3, #4, #5 and #6 were home. Client #6 mobilized himself by means of an electric wheelchair. Client #5 used a manual wheelchair and had a walker/cane in his room available for use. Client #1 was observed to be non-verbal and required prompting to participate in activity. Client #4 walked about the facility wearing a hard shell helmet to protect himself from the possibility from falling during a seizure.</p> <p>During breakfast observations on 7/30/13 from 6:15 AM until 6:45 AM, client #1 ate cereal, milk and one half of a raisin bagel with creamed cheese prepared by staff #4. Client #1 ate his bagel quickly, took his dishes to the sink and left the</p> | W000240 | <p>W240: The individual program plan must describe relevant interventions to support the individual toward independence. Corrective Action: (Specific): The dining plan for client # 1 has been revised to include history of choking, leaving the dining area with food in his mouth and a specific plan for staff to implement to assist client #1 in finishing his meal in the kitchen where he is supervised. All clients' fire assessments will be reviewed and revised as needed and if necessary program plans will be revised to include changes in regards to fire evacuation drills to ensure that training programs are implemented if indicated.</p> <p>How others will be identified: (Systemic): Fire drills will be reviewed at least quarterly by the program manager and any drill lasting over 2 minutes will be investigated and a corrective action plan will be implemented as indicated. The residential manager will conduct visits to the home at least weekly at random times to ensure that program plans are being implemented as written. Measures to be put in place: The dining plan for client # 1 has been revised to include</p> | 08/30/2013 | |

| | | | | | | | |
|---|---|---|--|--|--|---|--|
| 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 07/31/2013 | |
| 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>kitchen/dining room. He went to his room with food in his mouth and one fourth of the serving of bagel in his hand and laid in his bed. Staff #5 followed client #1, took the remaining bagel and threw it away in the trash can in the bathroom next door to client #1's bedroom.</p> <p>A review of the facility's evacuation drills with clients #1, #2, #3, #4, #5, and #6 was conducted on 7/29/13 at 3:39 PM and indicated the following:</p> <p>-On 3/23/13 from 1:00 AM until 1:08 AM, a sleeptime evacuation drill was conducted with six clients and one staff. The comment/response section on the drill form indicated clients #4 and #6 required physical assistance and clients #1, #2, #3, and #5 evacuated unassisted. There was no information explaining why clients required eight minutes to evacuate the facility.</p> <p>-On 10/26/12 from 1:00 AM to 1:10 AM, a sleeptime evacuation drill was conducted with six clients and one staff. The comment/response section on the drill form indicated clients #1, #4 and #6 required physical prompting and clients #5, #2 and #3 required verbal prompting. There was no information explaining why clients required ten minutes to evacuate the facility.</p> | | <p>history of choking, leaving the dining area with food in his mouth and a specific plan for staff to implement to assist client #1 in finishing his meal in the kitchen where he is supervised. All clients' fire assessments will be reviewed and revised as needed and if necessary program plans will be revised to include changes in regards to fire evacuation drills to ensure that training programs are implemented if indicated. Monitoring of Corrective Action: Fire drills will be reviewed at least quarterly by the program manager and any drill lasting over 2 minutes will be investigated and a corrective action plan will be implemented as indicated. The residential manager will conduct visits to the home at least weekly at random times to ensure that program plans are being implemented as written. Completion date: 08/30/13</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 07/31/2013 |
|--|---|--|---|

| | |
|---|--|
| 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>Review of client #6's record on 7/30/13 at 10:30 AM indicated an Individual Support Plan/ISP dated 5/18/12. The ISP indicated the client's diagnosis included, but was not limited to, spastic quadriplegia and he used a motorized wheelchair for mobility. Interview with staff #5 on 7/30/13 at 11:00 AM indicated staff used a Hoyer Lift (mechanical device) to position client #6 from his motorized wheelchair to his bed or bathchair if only one staff was available. Client #6 required two staff to reposition him without the Hoyer Lift. The record review indicated no methodology (no level of prompting required) for staff to use with client #6 during fire evacuation drills. There was no information in regards to staffing levels required for safe evacuation or what a single staff would do in times of emergency.</p> <p>Review of client #5's record on 7/30/13 at 10:10 AM indicated an Individual Support Plan/ISP dated 12/02/12. The ISP indicated the client's diagnoses included, but were not limited to, seizures, brain injury and right side paralysis. He used a manual wheelchair and a left handed walker-cane (small walker held by one hand and used in cane fashion) for mobility. The record review indicated no</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 07/31/2013 |
|--|---|--|---|

| | |
|---|--|
| 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>methodology (no level of prompting required) for staff to use with client #5 during fire evacuation drills. There was no information in regards to staffing levels required for safe evacuation or what a single staff would do in times of emergency.</p> <p>Review of client #1's record on 7/30/13 at 10:45 AM indicated a Behavior Support Plan/BSP dated 11/08/12 and an ISP dated 8/22/12. The ISP and BSP indicated the client's diagnoses included, but were not limited to, Autism, Behavior Disorder and Communication Disorder. The record review indicated no methodology (no level of prompting required) for staff to use with client #1 during fire evacuation drills. There was no information in regards to staffing levels required for safe evacuation or what a single staff would do in times of emergency. The record review indicated a dining plan dated 7/09/13. The dining plan indicated client #1 had a history of food foraging but did not include the information regarding client #1's past history of choking after leaving the dining area.</p> <p>Review of client #4's record on 7/30/13 at 10:20 AM indicated an ISP dated 4/13. The ISP indicated the client's diagnoses included, but were not limited to,</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 07/31/2013 |
|--|---|--|---|

| | |
|---|--|
| 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>Cerebral Palsy, Seizure Disorder. The client wore a seizure helmet except when sleeping or bathing. The record review indicated no methodology (no level of prompting required) for staff to use with client #4 during fire evacuation drills. There was no information in regards to staffing levels required for safe evacuation or what a single staff would do in times of emergency.</p> <p>Review of client #2's record on 7/30/13 at 11:30 AM indicated a BSP dated 10/21/12 and an ISP dated 10/16/12. The ISP and BSP indicated the client's diagnoses included, but were not limited to, ADHD (Attention Deficit Hyperactivity Disorder) and IED (Intermittent Explosive Disorder). The record review indicated no methodology (no level of prompting required) for staff to use with client #2 during fire evacuation drills. There was no information in regards to staffing levels required for safe evacuation or what a single staff would do in times of emergency.</p> <p>Review of client #3's record on 07/30/13 at 2:30 PM indicated a BSP dated 10/21/12 and an ISP dated 10/16/12. The ISP and BSP indicated the client's diagnoses included, but were not limited to, ADHD (Attention Deficit</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 07/31/2013 |
|---|---|---|---|----------------------|---|
| 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>Hyperactivity Disorder) and IED (Intermittent Explosive Disorder). The record review indicated no methodology (no level of prompting required) for staff to use with client #3 during fire evacuation drills. There was no information in regards to staffing levels required for safe evacuation or what a single staff would do in times of emergency.</p> <p>Interview with staff #1 on 7/30/13 at 3:15 PM indicated the clients' ISPs/BSPs contained no methods for staff to use in regards to evacuating the premises during an emergency. The interview indicated client #4 did not react well to loud noises (sometimes was "startled" into a seizure) and this should be taken into consideration when conducting an evacuation drill with the fire alarm. There was no indication what adaptive equipment to use, what prompt levels were required and how many staff were needed to evacuate the clients in time of an emergency in a timely manner.</p> <p>9-3-4(a)</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 07/31/2013 | |
| 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 | | | |
| W000448 | <p>483.470(i)(2)(iv) EVACUATION DRILLS</p> <p>The facility must investigate all problems with evacuation drills, including accidents. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), and 3 additional clients (#4, #5 and #6), the facility failed to investigate issues noted during evacuation drills.</p> <p>Findings include:</p> <p>A review of the facility's evacuation drills with clients #1, #2, #3, #4, #5 and #6 was conducted on 7/29/13 at 3:39 PM and indicated the following:</p> <p>-On 3/23/13 from 1:00 AM until 1:08 AM, a sleeptime evacuation drill was conducted with six clients and one staff. The comment/response section on the drill form indicated clients #4 and #6 required physical assistance and clients #1, #2, #3, and #5 evacuated unassisted. There was no information explaining why clients required eight minutes to evacuate the facility. There was no documentation the facility investigated the response time of eight minutes.</p> <p>-On 10/26/12 from 1:00 AM to 1:10 AM, a sleeptime evacuation drill was conducted with six clients and one staff. The comment/response section on the drill form indicated clients #1, #4 and #6</p> | W000448 | <p>W448: The facility must investigate all problems with evacuation drills, including accidents. Corrective Action: (Specific): All clients' fire assessments will be reviewed and revised if needed and if necessary program plans will be revised to include changes in regards to fire evacuation drills to ensure that training programs are implemented if indicated.</p> <p>How others will be identified: (Systemic): All clients' fire assessments will be reviewed on a quarterly basis to ensure that any changes and or training programs are implanted as indicated. Fire drills will be reviewed at least quarterly by the program manager and any drill lasting over 2 minutes will be investigated and a corrective action plan will be implemented as indicated. Measures to be put in place: All clients' fire assessments will be reviewed and revised if needed and if necessary program plans will be revised to include changes in regards to fire evacuation drills to ensure that training programs are implemented if indicated. Monitoring of Corrective Action: All clients fire assessments will be reviewed on a quarterly basis to</p> | 08/30/2013 | | | |

| 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 07/31/2013 |
|---|---|---|---|----------------------|---|
| 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>required physical prompting and clients #5, #2 and #3 required verbal prompting. There was no information explaining why clients required ten minutes to evacuate the facility. There was no documentation the facility investigated the response time of ten minutes.</p> <p>Interview with staff #1 on 7/30/13 at 3:15 PM indicated the issues with the length of time needed to evacuate clients during the sleeptime evacuation drills had not been assessed/investigated.</p> <p>9-3-7(a)</p> | | <p>ensure that any changes and or training programs are implanted as indicated. Fire drills will be reviewed at least quarterly by the program manager and any drill lasting over 2 minutes will be investigated and a corrective action plan will be implemented as indicated. Completion date: 08/30/13</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 07/31/2013 | |
| 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 | | | |
| W009999 | <p>State Findings</p> <p>The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.</p> <p>460 IAC 9-3-4 Active Treatment Services.</p> <p>(b) The provider shall obtain day services for each resident which: (1) meet the criteria and certification requirements established by the division of aging and rehabilitative services for all day service providers; (2) meet the resident's active treatment needs set forth in the resident's individual program plan as determined by the interdisciplinary team conference with preference for services in the least restrictive environment.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on observation, record review and interview, the facility failed to meet the active treatment needs pertaining to day services programming for 1 of 3 sampled clients (client #1).</p> <p>Findings include:</p> <p>Client #1 was observed at the group home</p> | W009999 | <p>W9999: Active treatment services. The provider shall obtain day services for each resident which: (1) meet the criteria and certification requirements established by the division of aging and rehabilitative services for all day service providers; (2) meet the resident's active treatment needs set forth in the resident's individualized program plan as determined by the interdisciplinary team conference with preferences for services in the least restrictive environment. Corrective Action: (Specific): Day service providers will be contacted to set up a meeting to discuss client #1's attendance to an alternative day service program.</p> <p>How others will be identified: (Systemic): The residential manager will contact day service providers for all clients upon admission to facilitate attendance in outside day service programs Measures to be put in place: Day service providers will be contacted to set up a meeting to discuss client #1's attendance to an alternative day service program. Monitoring of Corrective Action: The residential manager will contact day service providers for all clients upon admission to facilitate attendance in outside day service programs</p> | 08/30/2013 | | | |

| 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 07/31/2013 |
|---|--|---|---|----------------------|---|
| 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>on 7/29/13 from 1:30 PM until 3:30 P.M. During the observation client #1 sat in the living room in his rocking chair and watched television or rested in his bedroom, or engaged in hygiene activities. No alternative day service was observed to be provided.</p> <p>Client #1 was observed at the group home on 7/30/13 from 6:15 A.M. until 3:30 P.M. During the observation client #1 sat in the living room in his rocking chair and watched television, rested in his bed, had meals and did hygiene activities. No alternative day service was observed to be provided.</p> <p>Review of client #1's record on 7/30/13 at 10:45 AM indicated an ISP/Individual Support Plan dated 8/22/12. The record review indicated client #1 stayed home and did not attend an outside day service.</p> <p>Interview with staff #1 on 7/29/13 at 1:30 PM indicated client #1 did not attend an outside day program.</p> <p>9-3-4(b)(1)(2)</p> | | <p>Completion date: 08/30/13</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 07/31/2013 |
|--|---|--|---|

| | |
|---|--|
| 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 |
|--------------------------|--|---------------------|--|----------------------------|
| | | | | |