

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G271	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2012
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 1504 15TH ST BEDFORD, IN 47421		
(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 recertification and state licensure survey.</p> <p>Survey Dates: April 24, 25 and 26, 2012</p> <p>Facility Number: 000791 Provider Number: 15G271 AIM Number: 100243580</p> <p>Surveyor: Steven Schwing, Medical Surveyor III</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality review completed on April 26, 2012 by Dotty Walton, 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: 15G271		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2012	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 1504 15TH ST BEDFORD, IN 47421			
(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			
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 record review and interview for 1 of 8 clients who attended an outside services day program/workshop (#3), the facility failed to ensure the services met the needs of the client.</p> <p>Findings include:</p> <p>A review of the facility's incident/investigative reports was conducted on 4/24/12 at 11:49 AM. On 4/18/12 at 4:30 PM, client #3 was on a trip with an outside services day program (DP) returning home from a Self Advocates event. The van stopped at a gas station on the way back to the facility. Client #3 was leaning on the van door when client #1 opened the door from the outside (DP #1 was on the driver's side of the van with another client). DP #1 was told client #3 fell out of the van. There was no staff who witnessed the incident. Client #1 indicated she did not mean to make her fall; she indicated she was just opening the door for client #3. Client #3 had a skinned elbow and indicated her right hip hurt. The report indicated, "Took a look, just a little pink, no red mark, but [client #3] couldn't walk on it, so helped her back into van." DP #1</p>	W0120	<p>Corrective Action:</p> <ul style="list-style-type: none"> Client #3 has been discharged to rehabilitation facility; alternative day programming will be sought upon return to Group Home (Attachment A). LARC has been inserviced on Health Emergency procedures, Out of Town trips, and Abuse and Neglect and their responsibility to follow all regulations, policies, procedures (Attachment B). <p>How we will identify others:</p> <p>Program Coordinators will review workshop training to ensure that workshop staff have been trained on High Risk plans, Emergency procedures, Out of Town trips and that client needs are being met..</p> <p>Measures to be put in place:</p>	05/03/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G271		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2012	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 1504 15TH ST BEDFORD, IN 47421			
(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>contacted the home manager who indicated to meet her at the hospital. A review of The Emergency Room Visit Form, dated 4/18/12, was conducted on 4/24/12 at 11:49 AM. The form indicated client #3 had a right hip fracture.</p> <p>Interviews conducted by the group home Program Coordinator (PC) were completed separately from the day program investigation on 4/18/12 and reviewed with the incident/investigative reports:</p> <p>-An interview with client #1 from another group home indicated the following, "Did you see [client #3] fall? No, I was on the other side of green van with [DP #1] we were smoking. [DP #2 and #3] were inside gas station. [DP #1, #2 and #3] picked up [client #3]. She couldn't get in van by herself."</p> <p>-An interview with client #2 from another group home indicated, "[DP #1 and DP #2] picked her up off the ground."</p> <p>-An interview with client #5 indicated, "She [client #3] was standing and [DP #2] and [DP #1] were holding her up. She [client #3] said it hurt really bad and she couldn't walk or stand by herself."</p> <p>-An interview with client #6 indicated, "[DP #1, #2 and #3] were helping her inside van. [Client #3] couldn't stand up. It was hard for her to even sit."</p> <p>-An interview with client #7 indicated,</p>		<p>Weekly Active treatment observations (Attachment C) will be performed by supervisory staff to ensure that workshop is meeting client needs. Receipt of Annual ISP (Attachment D) will be given to workshop and returned to Program coordinator verifying workshop staff training.</p> <p>Monitoring of Corrective Action:</p> <p>Active Treatment observations will be performed weekly at the workshop by supervisory personnel, and workshop incident reports will be reviewed by Director of Supervised Group Living, Quality Assurance Director, and Safety committee. Monthly meetings will be held at LARC to review and discuss client needs, incidents, Emergency Health plans, and the needs of the clients.</p> <p>Completion Date: 5-3-2012</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G271	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 1504 15TH ST BEDFORD, IN 47421
---	--

(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>"She [client #3] was facing the (side) van door. I opened the door from the outside of van and [client #3] slipped down and landed on her hip...[DP #2 and #3] were inside getting drinks with everyone but [client #3] and me. [DP #1] was out on the other side of van smoking by herself... [Client #3] couldn't move so [DP #2 and #1] helped her back into van. [DP #1 called [staff #1] and told her that [client #3] missed a step getting out of van."</p> <p>-An interview with client #1 indicated, "[DP #2 and #3] were inside. [DP #1] was smoking by herself. [Client #4] went inside and told [DP #2].... They all helped her in van. She said she was hurting. [DP #1] told her that [staff #1] would help her out of van at group home."</p> <p>-An interview with staff #6 indicated, "[DP #1] called GH (group home), told [staff #1] and [staff #6] that they (group) were in Mooresville at gas station; [client #3] had fallen out of van when another client had opened van door; reported that [client #3] hurt her hip & could not walk but there were no marks yet. [Staff #1] told [DP #1] that they should take [client #3] to hospital (group was already in van on way back). I, [staff #6], and [staff #1] had both answered phone when [DP #1] called. I stayed on the phone and heard the whole conversation. [Staff #1] did tell [DP #1] they should have called the ambulance but the group was already</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G271		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2012	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 1504 15TH ST BEDFORD, IN 47421			
(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>back in van, so [staff #1] met them at hospital."</p> <p>A review of the day program investigative report, dated 4/25/12, was reviewed on 4/26/12 at 6:50 AM. The investigation indicated the purpose of the investigation, "[Client #3] was a participant in a Self Advocates event in [name of city]. On the return trip, [client #3] fell while exiting the van. The fall resulted in her breaking her right hip. This review is being conducted as an allegation of neglect... The collective group was 15 clients and three staff, in two vehicles. The van [client #3] was in had 11 clients and one staff." The report indicated, "[Client #3] was participating in Self Advocates event in [name of city]. On the return trip, the group stopped at a gas station. It appears that [client #3] was the last person to exit the van. Her house mate, [client #7] was trying to be helpful and opened the second passenger door. [Client #3] reports she must have been leaning on the door when [client #7] opened it. [Client #3] fell from the van and landed on her right side on the concrete. [Name of day program provider] staff did not witness the fall. [DP #1] was the staff assigned to the van [client #3] fell from." The report indicated, "Substantiated, the findings support the event as described/allegation,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G271	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 1504 15TH ST BEDFORD, IN 47421
---	--

(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>[Name of provider] definition of neglect states, in part, 'Any action or behavioral interventions that risks the physical or emotional safety and well being of an individual, and results in a potentially dangerous situation, whether purposeful, due to carelessness, inattentiveness, or omission of the responsible party. This includes, but is not limited to: Failure to provide appropriate supervision, care, or training. Failure to provide food and medical services as needed.'" The report indicated, "It is concluded that staff did not follow the Procedures for Overnight/Out of Town Trips. The procedures states, in part, 'The event planner should plan with each client's coordinator and support team members as indicated to determine the level of supervision necessary, including: risk plans, behavior plans, medical needs.' These documents were missing for [client #3] and her housemates. The Procedures for Overnight/Out of Town Trips states, in part, 'Trips for groups should be planned so that at least two staff can attend the event. Staff will be assigned a 'partnering system' of responsibility and be aware of where clients are at all times.' On the return trip, [DP #1] was the only staff in the van with 11 clients. When the group stopped at the gas station, there did not appear to be a clear and structured partnering system to supervise clients. It</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G271		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2012	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 1504 15TH ST BEDFORD, IN 47421			
(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>is unclear if staff were trained on Procedures for Overnight/Out of Town Trips. [Client #3's] Fall Risk Plan states, in part, 'Staff will encourage client to use handrails where stairs are present to assist with ambulation. Staff will encourage client to pick up foot during ambulation to prevent falling.' It appears that [DP #1] was on the opposite side of the van when [client #3] exited and fell. According to three client interviews, she was smoking with another client on the driver's side of the van. [DP #1] was not present to encourage [client #3] to pick up her feet, use handrails or provide assistance as she descended the van steps. [DP #1] reported that she was not sure if [client #3] had a Fall Risk Plan. [Client #3's] Fall Risk Plan was not followed. [Client #3's] medical information states, in part, that she is diagnosed with Osteopenia and has a history of falls. This medical information was not present on the trip. [Name of provider] Health Emergency Procedures state, in part, 'Seek medical advice immediately for possible fracture.' Due to her diagnosis of Osteopenia, [client #3's] bones may be prone to break easily. Staff did not follow [name of provider] Health Emergency Procedure. [Name of provider] Vehicle Safety and Emergency Procedures state, in part, 'For serious injuries, call 911 first, then call your supervisor or director.' Staff did not</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G271	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 1504 15TH ST BEDFORD, IN 47421
---	--

(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>appear to think [client #3's] fall resulted in serious injury."</p> <p>A review of client #3's record was conducted on 4/25/12 at 10:19 AM. Client #3's Risk Plan for falls, dated 9/16/11, indicated, "Staff will encourage client to pick up foot during ambulation to prevent falling. Staff will encourage client to use handrails where stairs are present to assist with ambulation." A review of her Physician's Orders, dated 3/5/12, indicated she had a diagnosis of Osteopenia. She was prescribed Fosamax to address Osteopenia. An Interdisciplinary Team (IDT) Meeting, dated 4/19/12, indicated the following, "...The current workshop/day program [name of provider] does not appear to be providing appropriate programming..."</p> <p>A review of DP #1's (employed at the group home and the day program) training documentation was reviewed on 4/26/12 at 10:49 AM. DP #1 received training on first aid on 12/9/08. DP #1 received training on client #3's medical conditions, medical needs and health care plans on 7/7/11.</p> <p>A review of email between the PC and administrative staff (AS) of the day program, dated 4/18/12 at 6:16 PM, was reviewed on 4/24/12 at 3:55 PM. The PC</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G271		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2012	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 1504 15TH ST BEDFORD, IN 47421			
(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>wrote, "[Client #3's] hip is broken. HCR (health care representative) has been notified." AS #1 responded, "Oh my. What happened?" The PC indicated, "No one told you? [Client #3] fell out of van during a pit stop in [name of city]. We are waiting on BDDS (Bureau of Developmental Disabilities Services) report and investigation. [Staff #1] was notified and had them meet her a closest ER, [name of hospital]. Tests were done and she was admitted for surgery in the morning. She will be in rehab 3 months at least." AS #1 did not reply to the PC's message.</p> <p>An interview with the day program Social Worker (SW) was conducted on 4/26/12 at 2:30 PM. The SW indicated the staff did not meet client #1's needs during the trip. The SW indicated the fall may have been prevented if DP #1 was on the passenger side of the van.</p> <p>An interview with the PC was conducted on 4/24/12 at 3:41 PM. The PC indicated the day program staff did not immediately notify their supervisor(s) of the incident. The PC indicated the staff were not immediately suspended. The PC indicated the day program staff were not deployed appropriately to meet the needs of the clients. The PC indicated the day program staff should have immediately</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G271	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/26/2012
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 1504 15TH ST BEDFORD, IN 47421		
(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>contacted 911 and client #3 should not have been moved. The PC indicated the day program staff were negligent for not supervising the clients appropriately and for not calling 911 when client #3 could not stand up.</p> <p>9-3-1(a)</p>				