

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 03/02/2018
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR MEMPHIS, IN 47143		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000  Bldg. 00	<p>This visit was for the investigation of complaint #IN00255122.</p> <p>Complaint #IN00255122: Substantiated, federal and state deficiency related to the allegation(s) is cited at W186.</p> <p>Dates of Survey: 2/28/18, 3/1/18 and 3/2/18.</p> <p>Facility Number: 004615 Provider Number: 15G723 AIMS Number: 200528230</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #15068 and #27547 on 3/14/18.</p>	W 0000		
W 0186  Bldg. 00	<p>483.430(d)(1-2) DIRECT CARE STAFF</p> <p>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.</p> <p>Based on record review and interview for 2 of 2 sampled clients (A and B) plus 2 additional clients (C and D), the facility failed to provide adequate staff to keep the ESN (Extensive Special Needs) home within ratio.</p> <p>Findings include:</p>	W 0186	<p><b>W186:</b> The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.</p> <p><b>Corrective Action: (Specific):</b> The site supervisor will be</p>	04/01/2018

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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclosed 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>15G723</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/02/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>RES CARE COMMUNITY ALTERNATIVES SE IN</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>13009 HORIZON DR</b> <b>MEMPHIS, IN 47143</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 3/1/18 at 10:00 AM. The BDDS reports indicated the following:</p> <p>BDDS report dated 2/13/18 indicated, "Arrived for an unannounced visit and found that all four customers (A, B, C and D) were in the home and only two staff were on duty. Staffing ratio should be 3 staff to 4 customers at this hour of the day."</p> <p>BDDS report dated 9/7/17 indicated, "BDDS Service Coordinator visited the home. There were only two staff on duty and all 4 clients were in the home. This does not meet the required staffing ratio of three staff for that shift. Staff appeared knowledgeable on the needs of the individuals and were appropriately assisting them."</p> <p>BDDS report dated 9/1/17 indicated, "I (BDDS Service Coordinator) arrived at the home to do a home review. I was met at the door by staff. I introduced myself and presented my identification. Staff welcomed me to the home and asked how they could help. I explained that I was here to do a home review and would need access to records and a place to review the records. Staff led me to the office. As staff was retrieving the record books I asked to see a schedule and I asked who was currently on duty. Staff indicated that they were the only one present and that all four of the customers were currently in the home. The required staff at that time of day is 3 staff. The home therefore was not correctly staffed to meet the needs of the customers."</p> <p>BDDS report dated 8/29/17 indicated, "BDDS Service Coordinator visited the home. There were only two staff on duty and all four residents were at home. This does not meet the required staffing</p>		<p>retrained on ensuring the staffing ratio for the location is per the regulations for an ESN home. The Site Supervisor will submit a schedule to the Area Supervisor daily to ensure the location is within ratio. The Area Supervisor will be submitting the schedule daily to the Program Manager and Executive Director to ensure the location is within ratio. The Area Supervisor will be retrained on ensuring the staffing ratios are consistent with the locations schedule per the regulations for the ESN home.</p> <p><b>How others will be identified:</b> <b>(Systemic):</b> The Site Supervisor will be in the home at least five times weekly and the Area Supervisor will be in the home at least twice weekly to ensure the staffing ratio is consistent with the schedule per the regulations for an ESN location. A member of the administration team will be in the home at least twice monthly for site observations.</p> <p><b>Measures to be put in place:</b> The site supervisor will be retrained on ensuring the staffing ratio for the location is per the regulations for an ESN home. The Site Supervisor will submit a schedule to the Area Supervisor daily to ensure the location is within ratio. The Area Supervisor will be submitting the schedule daily to the Program Manager and Executive Director to ensure the</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 03/02/2018
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 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>ratio of three staff for that shift."</p> <p>BDDS report dated 8/28/17 indicated, "The home was out of staff ratio with all four residents home and only two staff on duty working. ESN homes call for 3 staff to be working in the home at this time of day."</p> <p>BDDS report dated 8/27/17 indicated, "BDDS Service Coordinator visited the home. There were only two staff on duty and all four residents were at home. This does not meet the required staffing ratio of three staff for that shift."</p> <p>BDDS report dated 8/25/17 indicated, "BDDS Service Coordinator visited the home. There were only two staff on duty and all four residents were at home. This does not meet the required staffing ratio of three staff for that shift."</p> <p>Time sheets were reviewed on 3/2/18 at 11:00 AM. Time sheets dated 1/31/18 through 2/28/18 indicated the home had 1 staff on first shift on 2/12, 2/17 and 2/21. The home had 2 staff for first shift on 1/31, 2/1, 2/2, 2/3, 2/4, 2/5, 2/7, 2/9, 2/11, 2/13, 2/16, 2/18, 2/22, 2/23 and 2/24 (2018). The home had 1 staff on second shift on 1/31, 2/2, 2/3, 2/4, 2/5, 2/11, 2/12, 2/13, 2/16, 2/17, 2/18, 2/19, 2/20, 2/21, 2/22 and 2/24 (2018). The home had 2 staff on second shift on 2/1, 2/6, 2/7, 2/8, 2/13, 2/14, 2/18, 2/19, 2/20, 2/22, 2/24, 2/25, 2/26, 2/27 and 2/28 (2018). The home had 1 staff on 3rd shift on 1/31, 2/1, 2/2, 2/3, 2/4, 2/5, 2/11, 2/12, 2/13, 2/16, 2/17, 2/18, 2/20, 2/21, 2/22 and 2/24 (2018).</p> <p>Client B's record was reviewed on 3/1/18 at 4:00 PM. Client B's 2/28/18 BSP (Behavior Support Plan) indicated, "1-1 staffing (1 staff to 1 client): Due to a recent incident swallowing batteries and reporting that he will swallow personal care</p>		<p>location is within ratio. The Area Supervisor will be retrained on ensuring the staffing ratios are consistent with the locations schedule per the regulations for the ESN home.</p> <p><b>Monitoring of Corrective:</b> The Site Supervisor will be in the home at least five times weekly and the Area Supervisor will be in the home at least twice weekly to ensure the staffing ratio is consistent with the schedule per the regulations for an ESN location. A member of the administration team will be in the home at least twice monthly for site observations.</p> <p><b>Completion date:</b> 04.01.18</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>15G723</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/02/2018</b>	
NAME OF PROVIDER OR SUPPLIER <b>RES CARE COMMUNITY ALTERNATIVES SE IN</b>			STREET ADDRESS, CITY, STATE, ZIP COD <b>13009 HORIZON DR MEMPHIS, IN 47143</b>		
(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>products and cleaning supplies, cologne and cologne bottles; [client B] will be placed on 1:1 during all hours while in the home and in the community. 1:1 is defined as within 5 feet. The staff will not have any other responsibility to any other consumer unless there is imminent risk of harm to self or others."</p> <p>Staff #1 was interviewed on 2/28/18 at 5:05 PM. Staff #1 indicated there were 2 other staff working. Staff #1 was in the home with 2 other clients (A and D). Staff #1 indicated one staff was on an outing with a client and the other staff had to take client B to the emergency room. Staff #1 indicated the home generally does not have the correct staffing ratio. Staff #1 indicated several times they have had only 1 female staff in the home with 4 male clients. Staff #1 indicated they had been asked several times to go to other homes. Staff #1 indicated the facility will offer staff a \$50 bonus to go to another home. Staff #1 indicated if staff refuse to go to another home they will send staff home without pay.</p> <p>Area Supervisor (AS) #1 was interviewed on 3/1/18 at 2:00 PM. AS #1 indicated there are times when the home is understaffed. AS #1 stated she tries to cover the open gap but she "is only one person." AS #1 indicated in an emergency situation staff will be asked to put the home out of ratio by working in another home. AS #1 indicated they will be sent home if they refuse to go.</p> <p>Executive Director (ED) #1 was interviewed on 3/1/18 at 12:30 PM. ED #1 indicated ESN homes should be staffed with 3 staff on 1st and 2nd shift and 2 staff overnight.</p> <p>This federal tag relates to complaint #IN00255122.</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>15G723</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>03/02/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>RES CARE COMMUNITY ALTERNATIVES SE IN</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>13009 HORIZON DR</b> <b>MEMPHIS, IN 47143</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9-3-3(a)			