STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G193	A. BUILDING 00 B. WING	08/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13711 BENNETTSVILLE RD MEMPHIS, IN 47143

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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	This visit was for the investigation of complaint #IN00270862. Complaint #IN00270862 - Substantiated. Federal/state deficiency related to the allegation is cited at W192. Survey Dates: August 21 and 22, 2018. Facility Number: 000723 Provider Number: 15G507 AIMS Number: 100234760 This deficiency reflects a state finding in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/7/18.	W 0000		
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure the facility staff were trained to ensure client A received medical treatment in a timely manner (medication and medical evaluation at an Urgent Care center) and to report incidents of urgent care visits in writing in a timely manner to supervisory/administrative staff. Findings include: During observations at the facility on 8/21/18 at 1:15 PM, Area Supervisor/AS #1 was asked if any of the clients residing in the facility had any	W 0192	**W192: Staff training:** for employees who work with clients, training must focus on skills and competencies directed toward client's health needs **Corrective Action: (Specific):** All staff working at the home will be re-trained on the Operation Standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual's rights and incident reporting policy.	09/21/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	medical issues recently. AS #1 stated, "[Client A] had a UTI (urinary tract infection)." AS #1 indicated the UTI had been resolved. The facility's incident reports, incidents reported to the Bureau of Developmental Disabilities Services/BDDS, and investigations were reviewed at 2:30 PM on 8/21/18. There were no incident reports which documented client A had been treated for a UTI/urinary tract infection by medical personnel at a local Urgent Care center. During observations at the facility on 8/21/18 at 5:15 PM, client A was interviewed. Client A was asked if he had been sick. Client A stated, "Yeah, I was sick little bit. Still take medicine for it." Staff #1 was interviewed on 8/21/18 at 5:20 PM and indicated client A had no signs or symptoms of his UTI after a course of antibiotics. Staff #1 indicated he had taken client A for treatment of the UTI at a local Urgent Care center. Review of client A's record was done on 8/22/18 at 11:58 AM. The record indicated an August 2018 MAR/Medication Administration Record which documented he had been given ciprofloxacin (generic of Cipro) 500 mg/milligrams twice daily starting on 8/13/18 at 8:00 PM and ending on 8/18/18 at 8:00 AM for a total of 10 doses. The MAR documented the prescription origin date was 8/11/2018. The client's record contained a copy of the original prescription of Cipro dated 8/11/18 from an Urgent Care center. The record review indicated a "Daily Narrative Section" in which staff on all three shifts of personnel documented client A's activities. There was a narrative note by staff #3 dated 8/10/18 which indicated, from 6:00 AM until 2:00 PM,		All staff at the location will be retrained on the Medication Administration Policy. All staff in the location will be retrained on notifying the nurse in a timely manner. All staff in the location will be retrained on ensuring to follow nursing orders. **How others will be identified: (Systemic):** The residential Manager will follow up with all nursing issues in a timely manner. The nurse will follow up with the residential manager for any nursing issues if the residential manager hasn't followed up in a timely manner. **Measures to be put in place:** All staff working at the home will be re-trained on the Operation Standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual's rights and incident reporting policy. All staff at the location will be retrained on the Medication Administration Policy. All staff in the location will be retrained on notifying the nurse in a timely manner. All staff in the location will be retrained on ensuring to follow nursing orders. **Monitoring of Corrective Action:** The residential Manager	

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	client A had urinated 5 times. There was no mention the client had expressed any symptoms of a UTI (burning sensation or not being able to urinate). A note dated by staff #4 on 8/11/18 from 6:00 PM until 8:00 PM indicated an unnamed staff had taken client A to "Urgent Care for complaints of stomach & (and) urination issues." A note by staff #4 dated 8/12/18 from 2:00 PM until 4:00 PM indicated client A had ridden with an unnamed staff to Urgent Care to "drop off a urine sample." Client A came back to the facility and went with another unnamed staff to a local pharmacy to pick up medications. Interview with LPN #1 on 8/22/18 at 2:33 PM indicated she had spoken with client A and staff #1 on the afternoon of 8/10/18 during psychiatric appointments which ended at 5:45 PM. Client A had stated it "burned when [he urinated]." Staff was instructed to take client A to Urgent Care first thing in the morning. Interview with LPN #1 on 8/22/18 at 2:38 PM indicated a local pharmacy had confirmed to her client A's Cipro medication had been picked up on 8/12/18 and the time was unknown. The interview indicated the first recorded dosage of the Cipro to client A was 8:00 PM on 8/13/18. The LPN did not know why staff had not started the medication on 8/12/18 when it had been picked up from the local pharmacy. There was no incident report/IR to review for the Urgent Care visit in the facility's administrative office, so Quality Improvement staff #1 asked the facility's AS to find any IRs concerning client A and forward them to the office. Staff #1 was interviewed on 8/22/18 at 2:35 PM. Staff #1 indicated he had told the facility's Residential Manager/RM #2 on 8/10/18 the LPN had instructed the facility to take client A to		will follow up with all nursing issues in a timely manner. The nurse will follow up with the residential manager for any nursing issues if the residential manager hasn't followed up in a timely manner.	

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	Urgent Care first thing the following day. Staff #1 indicated he took client A to Urgent Care on 8/11/18 at 6:00 PM and he did not know why the RM had not ensured client A was seen for treatment earlier in the day (8/11/18). An IR dated 8/22/18 indicated (reviewed 3:10 PM 8/22/18) by staff #1 indicated client A had been taken to Urgent Care on 8/11/18 at 6:00 PM. This federal tag relates to complaint #IN00270862. 9-3-3(a)			