STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G127	A. BUILDING 00 B. WING	01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	1031 WEST ST NEW ALBANY, IN 47150

(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 a focused fundamental recertification and state licensure survey. Survey Dates: January 8, 9, 10 and 11, 2019. Facility Number: 000664 Provider Number: 15G127 AIMS Number: 100234310 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/25/19.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3) and 4 additional clients (#4, #5, #6 and #7), the facility's governing body failed to ensure the carpeting in the facility's upstairs bedroom areas was clean and well maintained, the fire door's magnet was in proper working order, the flooring in the west upstairs bathroom was not stained, the security gate on the east stairway was in good order, and the floor tile in the downstairs office area was well maintained. Findings include: On 1/8/19 from 4:00 PM until 5:15 PM and on 1/9/19 from 5:50 AM until 7:56 AM, clients #1, #2, #3, #4, #5, #6 and #7 were at the living facility. The tile flooring in the downstairs office area was	W 0104	1.The facility will insure the upstairs flooring and office flooring in the facility remain clean and well maintained. The facility will contract a cleaning company to service the upstairs area by 20 February 2019. 2.The Facility will ensure the fire door magnet is in proper working order and serviceable. The facility will contract with Koorsen Fire and Security to have repairs made by 20 February 2019. 3.The facility will remove broken security gate and install a new security gate on the east stairwell.	02/10/2019

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

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	stained. The door magnet which was to hold/release the fire door leading from the dining room to the staircase to the upstairs bedroom was non functional. At 6:00 AM on 1/9/19, the upstairs bedroom area carpeting in clients #1, #3, #4, and #7's bedrooms was stained. The carpeting in the upstairs hallway was stained. The flooring around the toilet in the west upstairs bathroom was discolored. The safety gate across the top of the second bedroom stairway was open, bent and would not latch securely. Interview with Direct Support Personnel/DSP #3 on 1/9/19 at 6:10 AM indicated client #7 had kicked the upstairs safety gate and broke it. The interview indicated parts had been ordered for the fire door. DSP #3 had worked at the facility for four years and could not remember when the upstairs carpeting had been cleaned. 9-3-1(a)		Persons Responsible: Program Manager, Business Manager, Area Supervisor, QIDP, Residential Manager, and DSP.	
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 3 sampled clients (#1, #2, and #3) and 5 additional clients (#4, #5, #6, #7 and #8), the facility failed to ensure the facility's neglect/abuse/mistreatment policy was implemented regarding client to client abuse and financial exploitation by facility staff towards clients #1, #2, #3, #4, #5, #6, #7 and #8. Findings include: The facility's BDDS/Bureau of Developmental Disabilities Services reports, investigations and incident reports were reviewed on 1/8/19 at 2:42	W 0149	Spend Down Funds: Any spend down of $100 or more is the responsibility of the area supervisor and must be spent within 5 business days. All receipts for the spend down purchases must be returned to the business manager once purchases have been completed. Any outstanding checks will be redeposited after 30 days.	02/10/2019

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	PM and 4:15 PM and on 1/9/19 at 10:40 AM and indicated the following: On 1/3/19 at 7:00 AM, client #1 threw his breakfast at the dining room window and punched the junction (electrical box) on the wall. 1/2/19 at 6:00 PM, client #7 hit client #6, cursed, hit walls and broke a picture. 12/20/18 at 7:30 AM, client #7 was redirected to take the picture to his room. Client #7 hit walls, knocked a hat out of a peer's hand, threw things, kicked at and spit on staff. YSIS (You're Safe, I'm Safe/facility approved behavioral management techniques) were used to control client #7's behavior. 12/4/18, client #5 was suspended from workshop for touching a female friend inappropriately. Seating arrangements were changed. 12/2/18 at 8:50 AM, client #7 hit client #2 on his arm/back and hit walls. 11/26/18 at 9:40 AM, client #3 thought staff had taken his phone charger. Client #3 smashed a coffee mug, kicked and threw items. 11/16/18 at 7:00 PM, client #5 was hit by client #7. Client #7 knocked his medications onto the floor and spit on staff. 11/10/18 3:30 AM, client #1 was not asleep, he was anxious and aggressive. Client #1 awakened client #4 and hit him. Staff tried calling other staff, but could not reach them. 911 was called by staff. The police assisted with client #1 and advised client #1 to stay away from others. Relief staff arrived and client #1 went to sleep. 11/5/18 at 7:00 PM, client #3 made suicidal threats and was admitted to an inpatient facility. He was released on 11/6/18 with behavioral medication adjustments.		Spend Downs will be dispersed in the order of preference listed below •through use of Spend Down P-cards •through checks approved by the business manager and executive director All employees will be trained on the revised standard and disciplinary action will be given if the standard is not followed. The Facility will ensure that the abuse neglect and exploitation policy is followed. 2 clients involved in the client to client event have both obtained CIH wavers and are awaiting placement. Persons Responsible: Program Manager, QA, Business Manager, Area Supervisor, QIDP, Residential Manager, and DSP.	

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	BDDS report on 11/1/18 for an incident on 11/1/18 at 7:40 AM, client #7 "smacked [client #4] on the right cheek." No injuries were noted. BDDS reports dated 10/24/18 indicated on 10/24/18 at 8:00 AM, incidents of financial exploitation (missing client money or property) were found when staff did an audit of client accounts: Client #1 was missing $5.30. Client #2 was missing $12.10. Client #5 was missing $14.11. Client #4 was missing $14.30. Client #6 was missing $22.11. Client #7 was missing $23.00. Client #3 was missing $45.00. An investigation dated October 25--November 6, 2018 conducted by Quality Assurance Manager/QAM #1 was reviewed and indicated the following: The investigation was initiated after an audit of client finances indicated the possibility of missing client funds. The following was determined after the investigation: The investigation's factual findings indicated former Residential Manager/RM #2 had access to the safe which contained client funds. The investigation determined RM #2 had deposited client funds into her personal account and made online purchases for them. The investigation determined items said to have been purchased for clients and refunds for items could not be accounted for. The investigation determined former RM #2 managed the clients' money and received spend down checks for them directly from the business manager. The investigation could not determine who had taken the clients'			

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	money or property. "Conclusion It is substantiated [client #8] is missing $45.95; [client #6] is missing $22.10; [client #7] $22.55; [client #4] $14.00; [client #5] $14.11; [client #1] $5.30; and [client #2] $13.99; and [client #3] $961.55. It is substantiated [client #1] purchased an iPad for $434.39 which is now missing. It is substantiated [client #5] purchased two nightstands for $62.06 which are now missing." The police had been notified of the theft on 10/24/18. The "Investigation Peer Review" dated 11/6/18 which accompanied the investigation indicated the following recommendations: Reimburse missing funds. The agency's policies (clients' Bill of Rights and Grievance Procedure) be reviewed with the clients. Continue to follow up with police dept. on report status. The following reimbursements to clients were made according to review of Residential Fund Management Services Statements for the clients. Client #8 $45.95 on 11/23/18; Client #6 $22.10 on 11/23/18; client #7 on 11/23/18 $22.55; client #4 $14.00 on 11/23/18; client #5 $76.17 on 11/23/18; client #1 $439.69 on 11/23/18; client #2 $13.99 on 11/23/18; and client #3 $961.55 on 12/5/18. A BDDS follow report dated 11/26/18 indicated former RM #2 was suspected of taking the clients' money/property but this was not confirmed. RM #2 no longer worked at the facility.			

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	Interview with Quality Assurance Coordinator/QAC #1 on 1/8/19 at 2:30 PM indicated clients #1, #2, #3, #4, #5, #6, #7 and #8 had been reimbursed the missing money/property by the facility. Interview with QAM #1 on 1/11/19 at 1:00 PM indicated the facility's policy prohibited abuse/neglect/exploitation of clients. Abuse also meant abuse between clients (physical aggression). The Agency's "Operation Standard Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or Violation of an Individual's Rights" dated 3/08/2018 was reviewed on 1/09/19 at 11:00 AM and indicated the agency prohibited, reported, investigated and implemented corrective measures in regards to abuse/neglect/exploitation/mistreatment of the clients it served. The review of the agency's policy indicated, in part, the following: ..."ResCare strictly prohibits abuse, neglect, exploitation, mistreatment or violation of an Individual's rights....Program Implementation/Intervention: Failure to provide goods and/or services necessary for the individual to avoid physical harm and /or intentional failure to implement a support plan, inappropriate application of intervention, etc. which may result in jeopardy without qualified person notification/review.... Any situation involving weapons, regardless if abuse, neglect, mistreatment or violation of an Individual's rights is suspected, will be immediately investigated. All employees receive training upon hire regarding definitions/causes of different types of, how to identify, prevent, document, remedial			

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	action to be taken, timely debriefing following the incident and how to report abuse, neglect, exploitation, mistreatment or violation of an Individual's rights, as well as what to expect from an investigation. All employees receive this training upon hire and annually, thereafter. Procedures: 1. Any ResCare staff person who suspects an individual is the victim of abuse, neglect, exploitation or mistreatment of an individual should immediately notify the Program Manager, and then complete an Incident Report. The Program Manager will then notify the Executive Director immediately. 2. The Program Manager, or designee, will report the suspected abuse, neglect, exploitation, mistreatment or violations of Individual's rights with 24 hours of the initial report to the appropriate contacts... 3. Any person who is suspected of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights toward an individual will be immediately suspended until the allegation can be fully investigated... 4. The Program Manager will assign an investigative team. A full investigation will be conducted by investigators who have received training from Labor Relations Association and ResCare's internal procedures on investigations. ResCare will not allow for nepotism during the conducting, directing, reviewing or other managerial activity of an investigation into an allegation of abuse, neglect, exploitation or mistreatment, by prohibiting friends and relatives of an alleged perpetrator from engaging in these managerial activities. One of the investigators will			

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	complete a detailed investigative case summary based on witness statements and other evidence collected. The report will be maintained in a confidential, secured file at the office. The investigation file will include the following components: a clear statement indicating why the investigation/review is being conducted along with the nature of the allegations/event (e.g., allegation of neglect, etc.), a clear statement of the event or alleged event in a time-line format including what, where, and when the event happened or is alleged to have happened, Identification by name and title of all involved parties or alleged involved parties including any victim(s) or alleged victim(s), all staff assigned to the victim(s) or alleged victim(s) at the time of the incident, all alleged perpetrators, when indicated; and all actual or potential witnesses to the event or alleged event, signed and dated statements from all involved parties, including all actual and potential witnesses to the event or alleged event, a statement describing all record and other document review associated with the event or alleged event, copies of all records and other documents reviewed that provide evidence supporting the finding of the investigation or review, if there are any discrepancies/conflicts between the evidence gathered, the discrepancy is resolved and/or explained, a determination if rights have been violated, if services and/or care were not provided or were not appropriately provided, if agency policies and/or procedures were not followed, and/or if any federal or state regulations were not followed, a clear statement of substantiation or non-substantiation of any allegation that includes a description/summary of the evidence that result in the finding, a definitive description of all corrective actions developed and implemented and/or to be implemented as a result of the investigation or review, including			

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	completion dates for each corrective action, the signature, name and title of the person completing the investigation and the date the investigation was completed. 5. An investigative peer review committee chosen by the Executive Director will meet to discuss the outcome of the investigation and to ensure that a thorough investigation has been completed. Members of the committee must include at least one of the investigators, the Executive Director or designee, Program Manager, QA representative and a Human Resources representative." 9-3-2(a)			
W 0225 Bldg. 00	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include, as applicable, vocational skills. Based on observation, record review and interview, for 1 of 3 sampled clients (#1), the facility failed to ensure a vocational skills evaluation was conducted with client #1. Findings include: Client #1 was observed to remain at the facility on 1/9/19 at 8:40 AM after clients #4, #5, #6 and #7 left for day program/workshop. During observations at the day service/workshop on 1/9/19 at 9:25 AM, client #1 was absent and not receiving day services No alternative day services were observed to be provided for client #1. Client #1's record was reviewed on 1/10/19 at 11:00 AM. The review indicated no assessment of vocational skills for client #1.	W 0225	The Facility will ensure a comprehensive functional assessment is complete including a vocational skills evaluation is completed for client. Persons Responsible: Program Manager, Area Supervisor, QIDP.	02/10/2019

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	An interview was conducted with the QIDP/Qualified Intellectual Disability Professional on 1/10/19 at 10:59 AM. The interview indicated client #1 did not currently have a job or attend a day program. The QIDP indicated client #1 refused to be evaluated by the local Vocational rehabilitation counselors. The interview indicated client #1 had attended public school and a day program with a school like atmosphere was being sought for him. 9-3-4(a)			
W 0252 Bldg. 00	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. Based on record review and interview for 3 of 3 sampled clients (#1, #2, and #3), the facility failed to ensure the clients' money objectives were measurable. Findings include: Client #1's record was reviewed on 1/10/19 at 11:00 AM. The review indicated an objective in his 4/30/18 ISP/Individual Support Plan to identify coins when presented with a group of coins with 2 verbal prompts. The objective's methodology or data collection did not specify which coins were being trained upon. Client #2's record was reviewed on 1/10/19 at 12:34 PM. The review indicated an ISP dated 4/27/18. The ISP contained a training objective to identity coins with 3 verbal prompts. The objective's methodology or data collection did not specify which coins were being trained upon.	W 0252	The Facility will ensure the client individual program plan includes measurable objectives covering client's money. Persons Responsible: Program Manager, Area Supervisor, QIDP, Residential Manager, and DSP	02/10/2019

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	Client #3's record was reviewed on 1/10/19 at 10:30 AM. The review indicated an objective in his 6/13/18 ISP/Individual Support Plan to state various coin values with 2 verbal prompts. The objective's methodology or data collection did not specify which coins were being trained upon. An interview was conducted with the QIDP/Qualified Intellectual Disability Professional on 1/10/19 at 3:00 PM. The interview indicated the way the money objectives were written it was not possible to know which coins the clients could or could not identify. 9-3-4(a)			
W 0259 Bldg. 00	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. Based on record review and interview, for 1 of 3 sampled clients (#1), the facility failed to ensure an annual comprehensive functional assessment/CFA was completed for client #1. Findings include: Client #1's record was reviewed on 1/10/19 at 11:00 AM. The review indicated no CFA for client #1. An interview was conducted with the QIDP/Qualified Intellectual Disability Professional on 1/10/19 at 10:59 AM. The interview indicated client #1's CFA had not been completed since client #1's transfer into the facility in September of 2018.	W 0259	The Facility will ensure at least annually a comprehensive function assessment is reviewed by the interdisciplinary team for relevancy and updated as needed. Persons Responsible: Program Manager, Business Manager, Area Supervisor, QIDP, Residential Manager, and DSP.	02/10/2019

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	9-3-4(a)			
W 0484 Bldg. 00	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview for 3 of 3 sampled clients (#1, #2, and #3, and 4 additional clients (#4, #5, #6 and #7), the facility failed to ensure the clients had complete table service during their evening meal. Findings include: On 1/8/19 at 4:38 PM the evening meal of pizza, milk and mixed vegetables was served to clients #1, #2, #3, #4, #5, #6 and #7. Client #3 had set the table under the direction of staff #4. The table was set with a plate, a glass and a fork for each client. There were no table knives or spoons on the table for clients to use. An interview was conducted with the QIDP/Qualified Intellectual Disability Professional on 1/10/19 at 3:00 PM. The interview indicated the clients should have complete table service.	W 0484	The Facility will ensure that dining areas are equipped with table chairs, eating utensils and dishes to meet the developmental needs of each client to include a complete table service consisting of a plate, a glass a fork, spoon and knife for clients use, and all staff is trained on these expectations. Persons Responsible: Program Manager, Business Manager, Area Supervisor, QIDP, Residential Manager, and DSP.	02/10/2019
	9-3-8(a)			
W 9999 Bldg. 00	STATE FINDINGS: The following Community Residential Facilities for Persons with Developmental Disabilities Rules were not met.	W 9999	1.The Facility will ensure that all staff prior to assuming their residential responsibilities that a Mantoux, tuberculosis skin test or chest x-ray is completed. The facility will ensure residential staff	02/10/2019

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	460 IAC 9-3-3 Facility Staffing (e) Prior to assuming residential job duties and annually thereafter, each residential staff person shall submit written evidence that a Mantoux (5TU, PPD) tuberculosis skin (TB) test or chest x-ray was completed. The result of the Mantoux shall be recorded in millimeter of induration with the date given, date read, and by whom administered. If the skin test result is significant (ten (10) millimeters or more), then a chest film shall be done with other physical and laboratory examinations as necessary to complete a diagnosis. Prophylactic treatment shall be provided as per diagnosis for the length of time prescribed by the physician. THIS STATE RULE WAS NOT MET AS EVIDENCED BY: Based on record review and interview for 1 of 5 personnel records reviewed (RM/Residential Manager) #1), the facility failed to obtain a chest x-ray or other physical and laboratory examinations as necessary to obtain a diagnosis after RM #1 had a Mantoux test of 10 mm/millimeters. Findings include: On 1/8/19 at 12:30 PM, the facility staff personnel records were reviewed and indicated the following: -RM #1 was hired on 10/22/18. RM #1's record indicated an 10/25/18 Mantoux skin test with a reading of 10 mm. There were no follow-up evaluations available in her record to indicate a diagnosis or to ensure RM #1 was free of communicable disease.		with a Mantoux skin test reading of ten millimeters or more follow up with an evaluation ensuring affected staff is free of communicable disease. 2.The Facility will ensure active treatment goals are met pertaining to day services, vocational or educational programming as deemed beneficial to the clients development. Persons Responsible: Program Manager, Business Manager, Area Supervisor, QIDP, Residential Manager, DSP.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G127	A. BUILDING 00 B. WING	01/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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On 1/8/19 at 12:50 PM, an interview with the facility's Director of Nursing/DON was conducted. The DON indicated RM #1 had not been sent for further evaluations after the 10/25/18 10 mm Mantoux test results were obtained.

On 1/8/19 from 4:00 PM until 5:15 PM and on 1/9/19 from 5:50 AM until 7:56 AM, RM #1 was observed to be in the facility working with clients #1, #2, #3, #4, #5, #6 and #7.

9-3-3(e)

460 IAC 9-3-4 Active Treatment Services.

(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.

This state rule was not met as evidenced by:

Based on observation, record review and interview, the facility failed to meet the active treatment needs pertaining to day services programming for 3 of 3 sampled clients (#1, #2, and #3).

Findings include:

Clients #1, #2, and #3 were observed to remain at the facility on 1/9/19 at 8:40 AM after clients #4, #5, #6 and #7 left for day program/workshop. During observations at the day service/workshop

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	on 1/9/19 at 9:25 AM, clients #1, #2, and #3 were absent and not receiving day services. No alternative day services were observed to be provided for clients #1, #2, and #3. Client #1's record was reviewed on 1/10/19 at 11:00 AM. The review indicated no review of vocational skills for client #1. Client #2's record was reviewed on 1/10/19 at 12:34 PM. The review indicated no indepth evaluations of client #2's vocational needs. Review of client #3's record on 1/10/19 at 10:30 AM indicated an Assessment of Pre-Requisite Vocational Skills contained in the CFA/Comprehensive Functional Assessment dated 4/6/18. The assessment indicated client #3 could perform simple work like parts assembly with minimal supervision. An interview was conducted with the QIDP/Qualified Intellectual Disability Professional on 1/10/19 at 10:47 AM. The interview indicated client #3 had been involved with Vocational rehabilitation services and had job trials in the community. The interview indicated client #3 did not currently have a job or attend a day program. The QIDP indicated client #2 had worked at two different workshops but currently did not have a community job or attend a day program. The QIDP indicated client #1 did not have a community job or attend a day program. The interview indicated client #1 had attended public school and a day program with a school like atmosphere was being sought for him. 9-3-4(b)(1)(2)			