

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/22/2021	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL			STREET ADDRESS, CITY, STATE, ZIP CODE  725 CARR ST MILAN, IN 47031		
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W 0000  Bldg. 00	<p>This visit was for a pre-determined full annual recertification and state licensure survey. This visit included a Covid-19 focused infection control survey.</p> <p>This visit was in conjunction with the investigation of Complaint #IN00333573 and Complaint #IN00323803.</p> <p>Survey dates: 1/19/21, 1/20/21, 1/21/21 and 1/22/21.</p> <p>Facility Number: 000623 Provider Number: 15G080 AIMS Number: 100233870</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #15068 and #27547 on 2/4/21.</p>		W 0000		
W 0104  Bldg. 00	<p>483.410(a)(1) <b>GOVERNING BODY</b></p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation, record review and interview for 1 additional client (G), the facility's governing body failed to exercise operating direction over the facility to ensure client G's bedroom was free of the smell of urine.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 1/19/21 from 3:22 PM to 6:30 PM and 1/20/21 from 6:28 AM to 8:13 AM. The observations</p>		W 0104	<p><b>W104:</b> The governing body must exercise general policy, budget and operating direction over the facility.</p> <p><b>Corrective Action:</b></p> <ul style="list-style-type: none"> <li>The Residential Manager will complete weekly checks to monitor for cleanliness and condition of the home.</li> </ul> <p><b>(Attachment A)</b></p>	02/21/2021

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.

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	<p>indicated the following:</p> <p>-On 1/19/20 at 3:30 PM, client G was in his room lying on a mattress on the floor. Client G's bedroom did not have a bed frame or dresser. Client G's bedroom had a strong urine odor. Staff #4 stated client G had numerous beds, but would "use the bathroom, like dripping wet" on his furniture during the night. Staff #4 indicated client G would pile his clothes up on the floor and urinate on his clothes. Staff #4 indicated client G's behavior plan allowed for his clothes to be stored locked, but one clean change of clothes was always available in client G's bedroom. If more were needed other clean laundry was maintained in the spare bedroom that was locked adjacent to client G's bedroom. Staff #4 indicated client G's bed frame and dresser had to be removed due to the odor of urine from the furniture.</p> <p>-On 1/19/20 at 5:07 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked how long client G had not had a bed frame and dresser in his room. The QIDP stated, 'I would say a week. The old ones have not been taken off. He has had many, many, beds, mattress, clothes, bedding, mattress covers. He digs at them and rips at them. If you notice, there are no curtains. He has his days and nights turned around. He is doing better with his sleeping pattern. The dresser is outside too, because he would pee in it. They tried or we're trying to put things up on the shelf so he doesn't have the drawers to use and pee in. We've had several med (medication) changes. He actually is doing better and heading the right direction with it. It's all part of his Autism. When we first got him he would not do routine lab work. We had to do a PRN (sedation), so we got</p>		<ul style="list-style-type: none"> <li>·Area Supervisor completes a weekly check to monitor for cleanliness and condition of the home. <b>(Attachment B)</b></li> <li>·A site review will be completed monthly to monitor the cleanliness of the home. <b>(Attachment C)</b></li> <li>·Staff trained on the cleaning schedule for client (G) room. <b>(Attachment D)</b></li> <li>·Program Manager placed a work order for replacement of client (G) broken bed frame. <b>(Attachment E)</b></li> <li>·Daily observations by Rescare Management will be implemented to ensure client (G) room is clean and has no odor for no less than 30 days and then 3 times weekly for an additional 30 days. <b>(Attachment F)</b></li> </ul> <p><b>Monitoring of Corrective Action:</b></p> <ul style="list-style-type: none"> <li>·The Program Manager will report to the Program Director any concerns noted on the weekly checks and site reviews.</li> <li>·Daily check observation will be sent to the Program Manager for monitoring and to ensure completion daily.</li> </ul> <p><b>Completion Date:</b> 2-21-21</p>	

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	<p>a baseline. We've made tiny, tiny progress overtime". The QIDP was asked about G's behavior support plan. The QIDP stated, "Yes, and many addendums where we changed things and trained staff. Our APS (adult protective services) [person] was instrumental in him moving here. She has been here and said this is the best life he's had. He is on the waiver list. He is scheduled to move to one of the support living waivers, I think 2/15/21". The QIDP was asked why client G was moving out of the home. The QIDP stated, "To get him to fit into the group home setting. He was here a year in September. We (interdisciplinary team) thought he would be better suited with less people in the environment for now".</p> <p>Morning observation:</p> <p>-On 1/20/21 at 6:28 AM, client G was in his bedroom.</p> <p>-On 1/20/21 at 6:33 AM, staff #2 was preparing for the morning medication administration routine. Staff #4 entered the medication administration room to obtain soap and shampoo to assist client G with his morning routine. Client G's bedroom had a strong urine odor.</p> <p>-On 1/20/21 at 8:04 AM, staff #2 was interviewed about client G's strong urine odor coming from his room. Staff #2 stated, "I feel the urinating in his room is due to his past with family. We keep his clothes in the spare bedroom but he will take them, pile them up and pee on them. I've seen him physical go after staff for trying to help him wash them". Client G was lying on his mattress with his cover pulled over his head. Client G's bedroom had a strong urine odor.</p>			

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	<p>On 1/20/21 at 12:11 PM, client G's record was reviewed. The record indicated the following:</p> <p>-Individual Support Plan (ISP) dated 10/25/20, indicated the following diagnosis but not limited to: "Autism (lifelong, nonprogressive neurological disorder), Disruptive Mood Dysregulation (frequent temper outbursts) D/O (disorder), Impulse Control Disorder (failure to resist a temptation, an urge, or an impulse), Intermittent Explosive Disorder (explosive outbursts of anger and violence) and Primary Insomnia (difficulty in falling and staying asleep at night)".</p> <p>-Behavior Support Plan (BSP) dated 10/25/20 indicated client G's targeted behaviors included the following:</p> <p>-"Aggression, defined as: Making growling/grunting/screeching sounds. Grabbing others hands and/or arms, digging his nails in and/or scratching others. Throwing or breaking items. Charging towards others, pushing and shoving others, and biting others.</p> <p>-Disrobing, defined as: Any instance where [client G] undresses in an environment that is not private (bathroom/bedroom)</p> <p>-Non-Compliance, defined as: Unwillingness to follow simple directions, requests, or prompts from staff such as completing his chores, hygiene, goals, getting off the van, etc.</p> <p>-PICA, defined as: Any time [client G] eats a non-food item.</p> <p>-Elopement, defined as: Leaving the property of</p>				

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<b>W 0149 Bldg. 00</b>	<p>the group home or day program without line of sight of staff, taking off from staff while in the community.</p> <p>-Autistic Tendencies, defined as: Ritualistic compulsions that disrupt/delay his participation in tasks/activities, i.e. straightening items that are out of place, playing in the toilet bowl water, repetitive stepping going backwards and forwards, attempts to block stimulation by putting hands on both sides of head covering ears, turtling (placing head inside shirt).</p> <p>-Masturbation with Injury, defined as: Any time [client G] engages in rectal masturbation that causes injury. (Putting fingers in rectum causing bleeding).</p> <p>-Insomnia, defined as: Inability to fall asleep or stay asleep".</p> <p>On 1/20/21 at 3:04 PM, the QIDP was interviewed. The QIDP was asked what environmental plan was in place to address the urine odor in client G's bedroom. The QIDP stated, "They go in daily and clean. I've seen them clean. It could be from past urination. I understand the environmental issue". The QIDP was asked if the daily cleaning of client G's bedroom had been effective in addressing the urine odor. The QIDP indicated daily cleaning was not effective at addressing the odor of urine smell in client G's bedroom.</p> <p>9-3-1(a)</p> <p><b>483.420(d)(1) STAFF TREATMENT OF CLIENTS</b> The facility must develop and implement written policies and procedures that prohibit</p>			

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	<p><b>mistreatment, neglect or abuse of the client.</b> Based on record review and interview for 19 of 19 incident reports affecting client A, client B and former client H, the facility failed to implement its policy and procedures for prohibiting Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights to 1) address former client H's continued pattern of elopement behavior, and 2) address the pattern of falls for clients A, B and former client H.</p> <p>Findings include:</p> <p>1) On 1/19/21 at 2:08 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and Investigative Summaries was completed. The reports indicated:</p> <p>-BDDS report dated 4/3/20 indicated, "[Former client H] is assessed as an elopement risk and has a BSP (Behavior Support Plan) to address elopement... Staff continued to encourage [former client H] to return to the home until he was out of sight of staff. [Former client H] was out of eyesight of staff for appropriately (sic) 20 minutes... Staff called another staff and [former client H] was found at the corner of [street name] and [highway name] about ¾ mile from the group home...".</p> <p>Investigation summary dated 4/7/20 indicated, "Factual findings: ...6. [Former client H] was gone from the group home and out of sight of staff for appropriately (sic) 20 minutes...".</p> <p>-BDDS report dated 5/13/20 indicated, "... When the staff came back into the living room [former client H] was sitting on the couch eating the bag</p>	W 0149	<p><b>W149:</b> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p><b>Corrective Action:</b></p> <ul style="list-style-type: none"> <li>·All staff retrained on the Abuse and Neglect Policy. (<b>Attachment G</b>)</li> <li>·All BDDS reportable incidents are reviewed by Rescare Management during Peer Review.</li> <li>·QIDP conducts IDT team meetings following a reportable incident to discuss the incident, outcomes and plans for what can be put in place to prevent future incidents.</li> <li>·Quality Assurance Coordinator tracks all incident, BDDS and internal reports into a database. The database will be used to track patterns or trends with incidents and will be utilized during peer reviews and quarterly safety meetings.</li> <li>·Area Supervisor and QIDP will review all ISP and BSP's during monthly staff meetings to ensure we are being proactive to prevent incidents.</li> <li>·Former client (H) moved to waiver setting 10/20/20.</li> <li>·QIDP will update BSP's annually and as needed.</li> </ul> <p><b>Monitoring of Corrective</b></p>	02/21/2021

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	<p>of peanuts. Staff asked [former client H] about the peanuts and [former client H] got upset. [Former client H] got up from the couch ran out the front door and down the road. Staff called another staff that lives in town and that staff went to look for [former client H]. Staff found [former client H] walking on [street name] down from the home. Staff returned [former client H] to the house. He (former client H) had no injuries. [Former client H] was gone from the home for approximately 10 minutes".</p> <p>Investigation summary dated 5/19/20 indicated, "Factual Findings:.... 7. [Former client H] was gone from the group home and out of sight of staff for appropriately (sic) 10 minutes".</p> <p>-BDDS report dated 6/12/20 indicated, "... At about 10:20 PM, [former client H] was upset and ran out the front door, down the driveway and processed (sic) to run down the road. Staff call(ed) 911 for assistance. Police officers located [former client H] at about 10:30 PM and brought him back to the home...".</p> <p>Investigation summary dated 6/18/20 indicated, "Factual findings:.... 7. [Former client H] was gone from the group home and out of sight of staff for appropriately (sic) 10 minutes. Police returned [former client H] to the group home and purchased him a soft drink to get him out of the police car".</p> <p>-BDDS report dated 6/28/20 indicated, "The home had just finished having dinner. Another client was in the kitchen cabinets getting out food and [former client H] yelled at him to get out of the cabinets. Staff told [former client H] 'don't yell at him, I don't want him to attack you'. [Former client H] got mad and 'stormed' out the</p>			<p><b>Action:</b></p> <ul style="list-style-type: none"> <li>· The Program Manager will review all Individual Support Plans and Behavior Support Plans to ensure plans meet all needs of the individuals served.</li> <li>· IDT meeting forms are sent to the Program Manager for review.</li> <li>· Abuse and Neglect Policy will be trained annually and reviewed monthly with all staff.</li> <li>· Rescare Administration will have monthly meetings to discuss trends and patterns with individuals.</li> </ul> <p><b>Completion Date:</b> 2/21/21</p>	

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	<p>front door and out of sight of staff. Staff called 911 to report the elopement and obtain police assistance to return [former client H] to the home. [Name of sheriff's office] officer located [former client H] and returned him to the home...".</p> <p>Investigation summary dated 7/3/20 indicated, "... 7. [Former client H] was gone from the group home and out of sight of staff for appropriately (sic) 25-30 minutes. Police returned [former client H] to the group home and purchased him a soft drink and a pack of cigarettes...".</p> <p>-BDDS report dated 7/24/20 indicated, "[Former client H] came to staff and said he wanted to go to the store to get a soft drink. Staff explained that the other staff had just left to pick up other clients from the day program and he would need to wait until they returned. [Former client H] became upset and started (sic) he would go on his own and told staff to call the police and have him arrested. [Former client H] walked out the front door and processed (sic) to walk down the road out of sight of staff. Staff called 911 for assistance. [City] police department responded, called the home stating they had [former client H] and taking him to the gas station to purchase a soft drink. Police returned [former client H] to the home. He (former client H) was out of sight of staff for appropriately (sic) 35 minutes".</p> <p>Investigation summary dated 7/27/20 indicated, "Factual findings:... 7. [Former client H] was gone from the group home and out of sight of staff for appropriately (sic) 35 minutes. Police returned [former client H] to the group home and purchased him a soft drink".</p> <p>-BDDS report dated 7/25/20 indicated, "[Former</p>			

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	<p>client H] went to staff and said he wanted to go to the store to get a soft drink. Staff explained they were unable to go to the store but would go later. [Former client H] got upset and said he wanted to go now and was going by himself. [Former client H] walked out the door, staff tried to redirect not to leave but he continued to walk down the road. Staff watched [former client H] walk out of sight, went back inside the house and called the police. At about 12:10 PM, staff saw [former client H] walk into the yard without police. Staff called 911 to report [former client H] had returned to the home on his own".</p> <p>Investigation summary dated 7/27/20 indicated, "Factual Findings:... 7. [Former client H] was gone from the home for appropriately (sic) 45 minutes...".</p> <p>-BDDS report dated 8/4/20 indicated, "[Former client H] and staff was (sic) sitting on the front porch. [Former client H] asked staff to go get his money, the van keys and take him to the store. Staff walked inside the house got his money and keys and when staff walked back outside [former client H] was gone. Staff called 911 for assistance. Police found [former client H] and returned him to the group home. [Former client H] did not have any injuries. [Former client H] was out of eyesight of staff for appropriately (sic) 33 minutes".</p> <p>Investigation summary dated 8/6/20 indicated, "Factual findings:... 8. [Former client H] was gone from the group home and out of sight of staff for appropriately (sic) 33 minutes. Police returned [former client H] to the group home".</p> <p>-BDDS report dated 8/4/20 indicated, "[Former client H] was asleep in bed. He came out to the</p>				

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	<p>office talking about losing his pipe. Staff stated his pajamas were wet and she asked him if he had wet the bed. [Former client H] pulled a pack of cigarettes from the pocket of his pajamas pants and he was angry the cigarettes were wet.</p> <p>[Former client H] began to yell at staff to help him dry the cigarettes. Staff stated she told [former client H] he probably wet the bed because of all the soft drinks he has been buying and drinking. [Former client H] stated he was leaving and ran out the front door. Staff called police to report the elopement. Police called back to the home stating they found him at [name] gas station that he was standing in the store drinking a soft drink and refused to get in the police vehicle and return to the group home. Staff went to the gas station and [former client H] agreed to return to the home".</p> <p>Investigation summary dated 8/6/20 indicated, "Factual findings:... 8. [Former client H] was gone from the group home and out of sight of staff for appropriately (sic) 40 minutes...".</p> <p>-BDDS report dated 5/21/20 indicated, "Today while the Nurse was completing her weekly review of the home [former client H] told her he had fell (sic). [Former client H] had pulled up his pant leg to show the Nurse his left knee stating he had fell while getting the mail but couldn't remember what day. His left knee has a 2" (inch) round abrasion that has scabbed over...".</p> <p>Investigation summary dated 5/28/20 indicated, "When the Nurse came to the home to complete a med (medication) pass observation [former client H] asked if she wanted to look at his right knee. [Former client H] stated he fell but couldn't say when or how". Was medical treatment needed as a result of the fall? "Quarter sized scabbed</p>				

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	<p>over area right knee".</p> <p>-BDDS report dated 7/2/20 indicated, "Staff had taken [former client H] to the store to purchase a soft drink. When he got out of the car the [name] distributor products had fallen over into the parking lot and [former client H] was watching the [name] distributor, talking and not paying attention to where he was walking. [Former client H] tripped over the sidewalk curb and fell forward into the side of store building. He had scratches on the top of his head and knees. He was taken to [hospital name] ER (emergency room) for evaluation. At the ER the attending physician stated there was no need for a CT (computerized imaging) scan of his head and no other test were needed. He was released from the ER with order to apply triple antibiotic ointment to injuries areas".</p> <p>Investigation summary dated 7/3/20 indicated, "... [former client H] was watching the [name] distributor, talking and not paying attention to where he was walking. He tripped over the sidewalk curb and fell forward into the side of the store building".</p> <p>-BDDS report dated 7/31/20 indicated, "[Former client H] was standing in the doorway facing the doorframe and suddenly fell to the floor. Staff immediately assisted [former client H] up from the floor and checked him for injuries. Staff found no visual injuries but [former client H] was complaining of slight pain in both of his hands. Staff assisted him to the couch where he sat down had no further issues".</p> <p>Investigation summary dated 8/5/20 indicated, "[Former client H] was standing in the doorway (front door) facing the door frame and suddenly</p>				

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	<p>fell forward out the door and onto (the) concrete porch". Was medical treatment needed as a result of the fall? "No visual injuries (sic) sat on the couch for a few minutes and stated he was fine".</p> <p>-BDDS report dated 8/18/20 indicated, "[Former client H] was in the house and saw a staff pull in the driveway for work. [Former client H] immediately ran out the front door to greet the oncoming staff. He tripped over the concrete speed bump at the end of the driveway and fell to his knees. Staff assisted him up, checked for injuries finding his right knee to be skinned. Staff applied first aid. [Former client H] did not complain of pain".</p> <p>Investigation summary dated 8/18/20 indicated, "[Former client H] was inside the house, saw the oncoming staff pull in the driveway and went outside to greet her. [Former staff #2] pulled in (and) said [former client H] running/walking fast and tripped over (the) concrete strip at (the) end of the driveway".</p> <p>-BDDS report dated 8/18/20 indicated, "[Former client H] was standing in the living room talking to staff about sitting outside on the porch smoking. Staff told [former client H] they would be right with him and before staff turned around, she heard a loud thump. Staff turned around and [former client H] was sitting on the floor in front of the doorway. Staff assisted him up, he broke his glasses during the fall but had no visual injuries. [Former client H] did not complain of any pain".</p> <p>Investigation summary dated 8/18/20 indicated, "2020: 8/18/20 - morning (2 falls same day) rushed out of house to meet on coming staff. Fell over concrete slab in driveway. 7/30/20 -</p>			

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	<p>standing in the front doorway and suddenly fell. Fell asleep. No injuries. 7/2/20 - fell while walking into store, scratches head and knees - ER (emergency room). 5/21/20 - fell on sidewalk R (right) knee quarter size scratch. Recommendation: Seeking neurology review".</p> <p>2) On 1/19/21 at 2:08 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and Investigative Summaries was completed. The reports indicated:</p> <p>-BDDS report dated 5/17/20 indicated, "last night during staff's hourly bed check staff found [client A] on his bedroom floor laying (sic) beside his bed with his comforter around him... [Client A] stated he fell when he started to get up to use the bathroom. [Client A] is assessed as a fall risk and has a fall plan".</p> <p>Investigation summary dated 5/17/20 indicated, "... staff was completing a routine hourly bed check at 12:45 AM she walked into [client A's] room, saw he wasn't in his bed nor was his comforter. (Staff) walked around bed he was laying (sic) on the floor (left side of his bed). He was laying (sic) on his left side".</p> <p>-BDDS report dated 8/13/20 indicated, "[Client A] was in his bedroom looking for a CD. He fell to his knees beside the bed. Staff heard the noise (sic) went to his bedroom and assisted him off the floor and to a chair. Staff checked him for injuries finding his right knee to have red marks. [Client A] stated he had no pain".</p> <p>Investigation summary dated 8/12/20 indicated, "[Client A] fell in his bedroom". Was medical treatment needed as a result of the fall? "No,</p>				

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	<p>staff assisted him to chair, saw no visual injuries, he stated he had no pain".</p> <p>-BDDS report dated 9/6/20 indicated, "Staff had walked back (sic) the hallway to complete a bed check and [client A] was standing in the bathroom holding onto the tank of the toilet and had urinated and defecated on the floor. Staff asked [client A] to let go of the toilet and let her help him to the shower chair to get a shower. [Client A] continued to stand holding the tank of the toilet and would not move. Staff attempted to help [client A] move toward the shower chair and he slid down to the floor. Staff was unable to get him up from the floor and called 911 for assistance. EMS (emergency medical services) responded and got [client A] up from the floor and sat him in the shower chair. Staff checked him for injuries and found bruises developing on both arms".</p> <p>Investigation summary dated 9/6/20 indicated, "(At) 4:30 AM [client A] got out of bed and went to restroom. [Staff #3] heard his walker on (the) floor and went to check on him. She found him leaning over the toilet (stomach almost touching the toilet seat). He was stiff and afraid to move. She couldn't get him straightened back up, she had him slide to (the) floor but then couldn't get him off the floor (and) called 911 for assistance".</p> <p>3) On 1/19/21 at 2:08 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and Investigative Summaries was completed. The reports indicated:</p> <p>-BDDS report dated 4/10/20 indicated, "[Client B] was sleeping in bed. He got up to go to the</p>			

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	<p>restroom, got his foot tangled in the comforter and fell forward. He fell to the floor on his stomach. Staff assisted him up and took him to the bathroom. Staff checked for injuries and found a small scratch on his chin/neck. [Client B] had urinated on self and staff cleaned him and assisted him to change his pajamas. Staff assisted him back to bed. [Client B] got up for the restroom a few times after the fall without any issues.</p> <p>Investigation summary dated 4/13/20 indicated, "Briefly describe the incident and sustained injury from the fall: [Client B] was asleep in bed. Staff had just completed a bed check and walked back into the office, Staff heard a noise, went back in [client B's] room and he was laying (sic) on the floor with his foot caught in the comforter... Do any changes need to be made to prevent future occurrences? He has a fall plan, bed rails, walker and a goal to sit up in bed a few minutes to gain bearings before standing".</p> <p>-BDDS report dated 6/18/20 indicated, "This morning staff heard a noise went to check and found [client B] laying (sic) on the floor with both legs in one leg of his pants. Staff assisted him up and saw no visual injuries".</p> <p>Investigation summary dated 6/23/20 indicated, "... [former staff #1] walked into [client B's] bedroom he was sitting in between bed and chair leaning on 02 (oxygen) tank with both legs in one pant leg of pants".</p> <p>-BDDS report dated 8/17/20 indicated, "[Client B] was walking into the house from the front porch. Another client was walking toward the door to go outside. [Client B] started to hurry to get through the door first and tripped over the</p>				

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	<p>threshold of the door and fell onto his knees. Staff assisted him up, checked him for injuries and saw no visual injuries".</p> <p>Investigation summary dated 8/21/20 indicated, "The clients were getting ready to leave for the day program... [client B] was on the porch, [client D] was walking toward the door and [client B] came hurrying through the door tripped, walker flew, and he went to his knees. (The) nurse helped him up and asked if he was trying to beat [client D] through the door and [client B] grinned".</p> <p>On 1/20/21 at 12:31 PM, the Program Manager (PM) was interviewed. The PM was asked about the implementation of the Abuse, Neglect, Exploitation (ANE) policy concerning former client H's elopements. The PM indicated elopement was considered an aspect of neglect with the provider policy and stated, "That (elopement by former client H), did happen". The PM was asked about the number of incidents where former client H, client A and client B had incidents that resulted in falls. The PM indicated the incidents of client A and client B's falls had occurred and both clients had fall risk plans. The PM was asked if the ANE policy should be implemented to prevent a pattern of elopement and falls and stated, "Yes, absolutely".</p> <p>On 1/20/21 at 3:04 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the implementation of the ANE policy concerning former client H's elopements. The QIDP stated, "Those (former client H's elopements) did occur". The QIDP indicated the police purchasing former client H drinks and or cigarettes during the elopements did not help the situation. The</p>			

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	<p>QIDP was asked about the number of incidents where former client H, client A and client B had incidents of falls. The QIDP indicated the incidents for falls had occurred. The QIDP indicated both client A and client B had fall risk plans and used walkers as adaptive devices to assist in their ambulation. The QIDP indicated client A had issues with his feet getting tangled up in his bedding and had a personal safety goal to address why supervision was need. The QIDP indicated client B had experienced falls from rushing and ambulating too quickly. The QIDP indicated client B had a fall risk plan which addressed staff monitoring his ambulation and the use of his walker. The QIDP was asked about the implementation of the ANE policy to prevent a pattern of elopement and falls and stated, "The ANE policy should be implemented at all times, I understand".</p> <p>On 1/20/21 at 2:53 PM, the Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights policy dated 7/10/19 was reviewed. The policy indicated, "ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare, local, state and federal guidelines ... ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights".</p> <p>9-3-2(a)</p>				

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W 0474  Bldg. 00	<p>483.480(b)(2)(iii) <b>MEAL SERVICES</b></p> <p>Food must be served in a form consistent with the developmental level of the client. Based on observation, record review and interview for 1 of 3 sampled clients (B), the facility failed to ensure client B received the correct diet consistency of pureed broccoli per his dining plan.</p> <p>Findings include:</p> <p>An observation was conducted at the facility on 1/19/21 at 3:22 PM to 6:30 PM. The observation indicated the following:</p> <p>-At 4:11 PM, the Qualified Intellectual Disabilities Professional Designee (QIDPD) entered the home. Client B used his rolling walker and returned to the living room from the medication administration room to continue watching television.</p> <p>-At 5:39 PM, the QIDPD assisted client B by use of hand over hand assistance to serve his pureed hamburger, macaroni salad and when she got to the bowl of broccoli stated to the Home Manager at 5:41 PM, "Is this pureed?". The Home Manager stated, "Yes" and then indicated to client B to make sure he kept his head up while he ate his evening meal.</p> <p>-At 5:57 PM, client B cleared his throat. Staff #4 stated to client B, "You ok? Take a drink".</p> <p>-At 6:00 PM, the QIDP and the QIDPD were asked about the dining supports of client B. The QIDPD indicated a new swallow study was completed the previous week and was pending on client B's Primary Care Physician signature for</p>	W 0474	<p><b>W474:</b> Food must be served in a form consistent with the developmental level of the client.</p> <p><b>Corrective Action:</b></p> <ul style="list-style-type: none"> <li>·All staff trained on pureed texture. (<b>Attachment H</b>)</li> <li>·All staff trained on food preparations annually and as needed.</li> <li>·Client (B) has an OT evaluation on 2/25/21.</li> <li>·Client (B) guardian declined the doctors recommendations for client (B) to have a feeding tube placed. (<b>Attachment I</b>)</li> <li>·Nurse completes weekly review in the facility to ensure all medical needs are addressed. (<b>Attachment J</b>)</li> <li>·Nurse will update all dining and high risk plans annually and as needed.</li> <li>·QIDP will update Individual Program Plan annually and as needed and will include all adaptive equipment, high risk issues and dining plans.</li> <li>·Mealtime observations will be completed by Rescare Management daily for no less than 30 days and then 3 times weekly for an additional 30 days. (<b>Attachment F</b>)</li> </ul>	02/21/2021

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	<p>the order and approval. The QIDPD stated, "It (diet consistency) came out last week. [Client B] will be on nectar thick liquids. We have to get guardian approval and train staff". Staff #4 then stated, "The dietician said you can't aspirate on water. We do 5 cc (cubic centimeter) of nectar thick at a time". Staff #4 was asked how he measured client B's thickened drinks to ensure it was only 5 cc's. Staff #4 stated, "It's a tablespoon at a time". Client B then cleared his throat.</p> <p>-At 6:09 PM, the QIDPD took client B's serving bowl of broccoli away and said to the Home Manager, "It's supposed to be pureed". The Home Manager stated, "We could try to chop it more or put it in the blender". The QIDP stated, "I'm afraid he will choke on that (broccoli)".</p> <p>-At 6:13 PM, staff #4 was asked if had received information to compare food items to for chopped versus pureed consistency. Staff #4 stated, "No. We usually use broth for his meat, milk or water". Staff #4 was asked if client B's broccoli had been chopped. Staff #4 stated, "Yeah, but it was put in the blender". Staff #4 was asked if water had been added. Staff #4 stated, "Yeah, a little". Then the Home Manager asked staff #4, "Do you guys have a reference to go by to determine pureed consistency"? Staff #4 stated, "No, like a chart to refer to? No".</p> <p>On 1/20/21 at 12:59 PM, client B's record was reviewed. The record indicated the following:</p> <p>-Individual Support Plan (ISP) dated 5/8/20 indicated, "[Client B] had a swallow study on 10/3/19 (sic). Recommendations all foods pureed, liquids to be nectar thick given at 5 cc's at a time. PCP has signed off on the recommendations. Continue use of small coated</p>			<p><b>Monitoring of Corrective Action:</b></p> <ul style="list-style-type: none"> <li>·Nurse will update all dining and high risk plans as needed and annually and send to the Nurse Manager for review.</li> <li>·Nurse weekly review is sent to all Rescare Management for review and to ensure completion.</li> <li>·QIDP will review Individual Program Plans quarterly and update as needed.</li> <li>·Nurse will report to IDT team results of OT evaluation and update plans accordingly.</li> <li>·The QIDP will update the Individual Program Plan as needed to include the swallow study results.</li> <li>·Mealtime observations will be sent to the Program Manager for monitoring and to ensure completion.</li> </ul> <p><b>Completion Date:</b> 2-21-21</p>	

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	<p>spoon and divided plate. Encourage [client B] to eat slowly, alternating small bites with small sips. PCP (Primary Care Physician) ordered the recommended diet. History of swallow evaluation, a barium swallow study was completed in 2015 and a feeding tube was recommended at that time, [guardian] did not want the feeding tubes as food is one of his few enjoyments in life. She understands that [client B] is at risk for aspiration, she wants [client B] to remain on his current diet."</p> <p>-Dining Plan dated 5/9/20 indicated, "FOOD TEXTURE: Pureed 1. Foods should have a smooth, pudding-like consistency. 2. Gelatin is blenderized (sic) to ease getting it on a spoon. 3. Cookies and cakes are broken, soaked in liquid (milk or fruit juice) and stirred until smooth. 4. Thickening agents: a. Breadcrumbs are the usual pureed food thickening agent used in food preparation, b. Dry cereal is available at table side for thickening pureed food, c. Commercial thickeners and gels are agents for thickening fluids (fluids are evaluated separately from foods)".</p> <p>On 1/20/21 at 12:23 PM, the QIDP was interviewed. The QIDP was asked about client B's pureed consistency of his broccoli served. The QIDP stated, "They (staff) said they blended it for 10 minutes". The QIDP indicated client B's broccoli was not of pureed consistency.</p> <p>On 1/20/21 at 12:33 PM, the Program Manager (PM) was interviewed. The PM was shown a picture of client B's prepared broccoli served and then stated, "That's chopped, not pureed. I don't doubt their effort, but we have to prepare it (broccoli) the right way".</p>			

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W 0475  Bldg. 00	<p>On 1/20/21 at 12:33 PM, the Nurse was interviewed. The Nurse was shown a picture of client B's broccoli prepared and asked how staff are trained on preparing diet consistencies. The Nurse stated, "They do it (training) at time of hire and annually thereafter. Both of these staff would have done it (training) just once". The Nurse was asked if client B received a pureed diet consistency for his broccoli and stated, "It was not pureed". The Nurse was asked to clarify the information around client B's recent swallow study. The Nurse stated, "He (client B) went to Speech on 10/8/20 for a swallow study. They said no and recommended a Barium Swallow Evaluation. The PCP (Primary Care Physician) said no, the next step would be a feeding tube. The guardian does not want a feeding tube. We went back to Speech on 12/11/20 and they said pureed diet, nectar thick liquids, and a Frazier water protocol (regular water up to the first bite of foods)". The Nurse indicated staff should assist client B with preparing his food items to the pureed diet consistency and follow client B's dining protocol.</p> <p>9-3-8(a)</p> <p>483.480(b)(2)(iv) MEAL SERVICES</p> <p>Food must be served with appropriate utensils.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A was supported during meals to use appropriate dining utensils.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 1/19/21 from 3:22 PM to 6:30 PM and 1/20/21</p>	W 0475	<p><b>W475:</b> Food must be served in a form consistent with the developmental level of the client.</p> <p><b>Corrective Action:</b></p> <ul style="list-style-type: none"> <li>Client (A) has an OT evaluation scheduled for <b>2/25/21</b>.</li> <li>Nurse completes weekly review</li> </ul>	02/21/2021

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	<p>from 6:28 AM to 8:13 AM. The observations indicated the following:</p> <p>-At 5:37 PM, client A was seated at the dining room table and then went to the kitchen cabinet to get utensils. Client A had 2 regular forks, a regular spoon and a coated spoon next his plate.</p> <p>-At 5:49 PM, client A used one his regular forks to eat a bite of his chopped hamburger. Client A used the coated spoon to eat his macaroni salad and broccoli.</p> <p>-At 5:53 PM, the Home Manager was asked if client A should eat with a regular spoon or coated spoon. The Home Manager stated, "Coated spoon". Staff #4 then stated, "The coated. I've been watching him. He must have grabbed that (regular spoon) from somewhere".</p> <p>-At 5:56 PM, staff #4 verbally prompted client A to put the regular spoon down and to use the coated spoon to eat his Jell-O.</p> <p>-At 5:57 PM, client A ate more of his Jell-O by using the coated spoon until he had finished eating.</p> <p>Morning observation on 1/20/21:</p> <p>-At 7:19 AM, client A had a bowl of oatmeal, chopped biscuits and a cup of coffee. Client A had a coated spoon he used to eat his oatmeal.</p> <p>-At 7:27 AM, staff #4 was asked about client A's chopped biscuit. Staff #4 stated, "I'm doing that because [client A] gets his breads chopped".</p> <p>-At 7:28 AM, client A continued to use the coated spoon to eat the remainder of his oatmeal.</p>		<p>in the facility to ensure all medical needs are addressed.</p> <p><b>(Attachment J)</b></p> <ul style="list-style-type: none"> <li>·Nurse will update all dining and high risk plans annually and as needed.</li> <li>·QIDP will update Individual Program Plan annually and as needed and will include all adaptive equipment, high risk issues and dining plans.</li> <li>·Mealtime observations will be completed by Rescare Management daily for no less than 30 days and then 3 times weekly for an additional 30 days.</li> </ul> <p><b>(Attachment F)</b></p> <p><b>Monitoring of Corrective Action:</b></p> <ul style="list-style-type: none"> <li>·Nurse will update all dining and high risk plans as needed and annually and send to the Nurse Manager for review.</li> <li>·Nurse weekly review is sent to all Rescare Management for review and to ensure completion.</li> <li>·QIDP will review Individual Program Plans quarterly and update as needed.</li> <li>·Nurse will report to IDT team results of the OT evaluation and update plans accordingly.</li> <li>·The QIDP will update the Individual Program Plan as needed to include the OT recommendations.</li> <li>·Mealtime observations will be sent to the Program Manager for monitoring and to ensure</li> </ul>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 01/22/2021	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL			STREET ADDRESS, CITY, STATE, ZIP CODE  725 CARR ST MILAN, IN 47031		
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	<p>On 1/20/21 at 1:48 PM, client A's record was reviewed. The record indicated the following:</p> <p>-Individual Support Plan (ISP) dated 6/15/20 indicated, "Adaptive Utensils: Sm (small) coated spoon".</p> <p>-Dining Plan dated 6/15/20 indicated, "EATING: [Client A] is able to feed himself for meals and snacks. [Client A] is edentulous and may wear dentures as he chooses. [Client A] uses a small coated spoon for all meals and snacks...".</p> <p>On 1/20/21 at 12:23 PM, the QIDP was interviewed. The QIDP was asked about client A's dining supports for the use of a regular fork to eat chopped hamburger and a coated spoon for macaroni salad, broccoli, Jell-O and oatmeal. The QIDP indicated client A's dining plan did identify the use of a coated spoon but did not identify the use of a regular fork. The QIDP indicated further review with the interdisciplinary team was needed to identify the appropriate dining supports for client A.</p> <p>On 1/20/21 at 12:33 PM, the Nurse was interviewed. The Nurse was asked about client A's dining supports for the use of a regular fork to eat chopped hamburger and a coated spoon for macaroni salad, broccoli, Jell-O and oatmeal. The Nurse stated, "The dining plan says to use a coated spoon. The regular utensils came because he got them. I was looking for a consult. In his swallow evaluation it doesn't give a reason why. Yeah, I think he needs an evaluation. I don't see a reason why he couldn't use one (regular fork)".</p> <p>9-3-8(a)</p>			completion.  <b>Completion Date: 2-21-21</b>	