

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

PRINTED: 06/15/2021

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP CODE 154 CHAD DR VERSAILLES, IN 47042		
(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 a pre-determined full 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 #IN00351051.</p> <p>Survey dates: 5/11/21, 5/12/21, 5/13/21 and 5/14/21.</p> <p>Facility Number: 000775 Provider Number: 15G255 AIMS Number: 100248960</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #15068 on 5/27/21.</p>	W 0000		
W 0231 Bldg. 00	<p>483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. Based on observation, record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A's Behavior Support Plan (BSP) defined his refusal to use his medical bed as an aspect of his targeted behaviors.</p> <p>Findings include:</p> <p>Observation was completed on 5/12/21 from 6:19 AM to 9:26 AM. At 6:23 AM, staff #5 was asked how the night had gone. Staff #5 shook her</p>	W 0231	<p>W231: The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance.</p> <p>Corrective Action:</p> <ul style="list-style-type: none"> • IDT team held meeting to discuss implementation of changes to client (A) plans. <p>(Attachment A)</p>	06/13/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 05/14/2021
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP CODE 154 CHAD DR VERSAILLES, IN 47042		
(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>head no and stated, "[Client A] was up most of the night. He's not in a good mood today". At 6:36 AM, client A came out to the living room seated in his wheelchair for the morning breakfast. At 6:34 AM, staff #5 was asked to describe client A's behavior during the night. Staff #5 stated, "[Client A] was trying to throw himself out of the bed. That, and hitting the walls". Staff #5 then stated to staff #6, "We're going to have to check his hands for bruising today". Staff #5 was asked why client A was so upset during the night. Staff #5 stated, "I have no idea why. I couldn't tell you".</p> <p>At 6:45 AM, client A began eating his morning meal of cold cereal, an English muffin and drinking his coffee. Client A continued to eat until finished at 7:15 AM. At 7:17 AM, client A returned from the dining room to the living room. Client A was asked how he was doing. Client A stated, "Pretty good". Client A was asked how his night had gone. Client A stated, "Pretty good, pretty good" and then changed the subject by asking different questions of the surveyor.</p> <p>At 7:23 AM, staff #5 was asked how long she had worked with client A. Staff #5 stated, "I've worked here 2 to 3 weeks". Staff #5 was asked how often client A had nights with behavior of not wanting to sleep in his bed. Staff #5 stated, "[Client A's] behavior is not normally like last night. I work here Tuesday through Saturday. He (client A) says he doesn't want to be in bed. Insomnia is listed in his book (plan). I assume that's apart of it".</p> <p>At 7:32 AM, staff #5 assisted client A with putting his coat on so he could go outside on the back porch to smoke. Staff #5 assisted client A outside with staff #6 so he could smoke until 7:41 AM.</p>		<ul style="list-style-type: none"> · All staff trained on changes to client (A) plans and programming. (Attachment B) · QIDP updated client (A) active treatment plan to reflect a later bedtime. (Attachment C) · Client (A) mattress was replaced to see if the new mattress would help with his sleeping and reduce behaviors. (Attachment D) · Maintenance order was completed to place foam padding around the wall in the area of Client (A) bed to prevent injuries. (Attachment E) · QIDP updated the behavior tracking documentation to include strategies for refusing to stay in bed. (Attachment F) · Area Supervisor completes weekly checks to monitor all issues or concern in the facility. (Attachment G) · Area Supervisor as well as the QIDP will conduct monthly house meetings with all staff to review plans and any concerns. · Site Supervisor will conduct observations during the night shift 2 times weekly to monitor and assist staff as needed for no less than 30 days. (Attachment H) · Area Supervisor will conduct observations during the night shift 1 time weekly to monitor and assist staff as needed for no less than 30 days. (Attachment H) 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP CODE 154 CHAD DR VERSAILLES, IN 47042		
(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>At 7:46 AM, staff #6 was asked about client A's ambulation and adaptive support needs using his walker. Staff #6 stated, "No, he used to before he went to Rehab". Staff #6 indicated client A had returned from Rehab with new adaptive equipment such as a wheelchair and a pressure ulcer on his Coccyx. Staff #6 stated, "The doctor has him being in bed 18 to 20 hours a day. You can't keep someone in bed that long. Talk about bad behaviors". Staff #6 was asked if this had anything to do with client A's behavior during the night. Staff #6 shook her head yes and stated, "Probably". At 8:00 AM, the Home Manager entered the home and into client A's bedroom. The Home Manager was asked about client A's use of his bed. The Home Manager indicated client A did not like his bed and stated, "It's a custom bed. He's afraid of missing something (wants to be in the living room)".</p> <p>At 8:06 AM, client A's bed had an air flow mattress, yellow padded alarm and rails on the side.</p> <p>At 8:19 AM, staff #4 was asked about client A's use of his bed, his return from Rehab with pressure ulcers and the adaptive equipment supports needs of client A. Staff #4 stated, "That (client A's return from Rehab) was horrible. He was so thin. He lost like 40 pounds and come home with pressure sores". Staff #4 described client A returned home with 3 pressure ulcers and stated, "One on each heel and the one on his coccyx". Staff #4 was asked the size of ulcer client A returned with on his coccyx. Staff #4 stated, "I would say baseball size...". Staff #4 indicated client A received wound care treatment and had improved by stating, "He's come a long way". Staff #4 was asked about client A's use of</p>		<p>QIDP will conduct observations during the night shift 1 time weekly for no less than 30 days to monitor and assist staff as needed. (Attachment H)</p> <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> QIDP will send all meeting notes, updated plans to the Program Manager for review. Area Supervisor will send completed weekly checks to the Program Manager. QIDP will conduct IDT meetings with all team members quarterly and as needed. The QIDP will review all program plans quarterly and as needed and will also be noted when completing consumer monthly summaries. Area Supervisor, Site Supervisor and QIDP will report back to the team their findings during observations. Area Supervisor will send monthly house meeting inservice to the Program Manager for review. <p>Completion Date: 6/13/21</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 154 CHAD DR VERSAILLES, IN 47042		
(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>his bed. Staff #4 stated, "He doesn't like that bed. He will hit the wall, try to throw himself on the floor. He's been having diarrhea bad". Staff #4 was asked if client A's dislike for sleeping in his bed was a nightly occurrence. Staff #4 shook her head yes and stated, "He wants to be in the living room. He usually sits in his wheelchair. It's difficult to get him in his chair (recliner)". Staff #4 indicated client A would attempt to steal foods and stated, "He's sneaky [client A] for a reason". Staff #4 was asked if a plan was in place to address client A's not wanting to use his bed. Staff #4 stated, "I don't think so. We all may handle it differently. He throws his biggest fit when he's close to getting something or he's had it". Staff #4 was asked if her primary shift was night shift when client A would be using his bed for sleeping. Staff #4 stated, "Yes, until April. I had to drop the amount of hours I could work. I work Sunday night and Monday night twelve hours and Wednesday I do shopping". Staff #4 was asked why client A did not like his bed. Staff #4 stated, "I think the reason he hates that bed is because he can't get up".</p> <p>On 5/12/21 at 1:37 PM, client A's record was reviewed. The record indicated the following:</p> <p>-Individual Support Plan (ISP) Addendum dated 3/29/21 indicated, "Purpose of Meeting: Change in adaptive equipment ... How changes to current plan will be implemented... High Risk plans updated to include ... add hospital bed/half rails with low pressure mattress when lying down, Roho cushion when sitting in wheelchair or in chairs ...".</p> <p>-BSP dated 3/2/21 indicated, "Anxiousness, defined as: Difficulty staying on task/changing the subject, excessive worrying, feelings of</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 154 CHAD DR VERSAILLES, IN 47042		
(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>uneasiness, poor socialization skills, afraid, scared. (display of anxiousness mainly revolves around his decline in physical health).</p> <p>Non-Compliance, defined as: Unwillingness to follow simple directions, requests, or prompts from staff such as completing chores, cleaning room, completing hygiene, transfers, etc.</p> <p>Agitation is defined as: Becoming verbally upset, argumentative, crying, yelling. May tell others 'shut up' or 'be quiet', may spit (typically at the ground), may hit staff, throw objects, and pound fist on tables/walls cabinets when he is prompted to do something he does not want to.</p> <p>Non-Truthful Statements is defined as: Telling other's events that did not happen or telling other's events that did happen but out of context.</p> <p>Insomnia, defined as: Inability to fall asleep or to stay asleep".</p> <p>Client A's targeted behaviors did not define client A's not wanting to use his bed with adaptive supports or a preference of being in the living room and how client A's behavior would appear or be displayed as by client A. Through interview, some staffing supports referred to the behavior of client A not wanting to use his bed as an aspect of Insomnia and others described a preference for being in the living room as non-compliance.</p> <p>On 5/12/21 at 2:42 PM, the Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed. The QIDPD was asked how client A's behavior for not wanting to use his bed was defined and tracked according to his behavior plan. The QIDPD indicated the team was aware of a recent fall in the month of March and had put a bed alarm in place at that time. The QIDPD indicated she was not aware of client A's dislike for his bed and stated, "I don't know</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G255	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 154 CHAD DR VERSAILLES, IN 47042		
(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>anything about him trying to throw himself out of bed". The QIDPD indicated client A's behavior plan needed further review.</p> <p>On 5/12/21 at 2:45 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked how client A's behavior for not wanting to use his bed was defined and tracked according to his behavior plan. The QIDP stated, "I understand what you're saying. I know how we're going to start this. We need to look at the behavior plan and define agitation and Insomnia from there". The QIDPD indicated the behavior plan needed further review.</p> <p>9-3-4(a)</p>				