PRINTED: 06/29/2021 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-0391		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED			
		15G157	B. WI	NG		05/21/2021			
				STREET	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF I	PROVIDER OR SUPPLIER	R							
RES CA	RE COMMUNITY A	LTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130						
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
W 0000									
Bldg. 00	This visit was for th	ne investigation of complaint	W 0	000					
	#IN00349419.								
	Complaint #IN0034	19419: Substantiated, Federal							
	and State deficienci	es related to the allegation(s)							
	are cited at W149 a	nd W186.							
	Survey Dates: 5/20/	/21 and 5/21/21.							
	Facility Number: 00	00693							
	Provider Number: 1	15G157							
	AIMS Number: 100	0234510							
		also reflect state findings in							
	accordance with 46								
	#15068 on 6/10/21.	this report completed by							
W 0149	483.420(d)(1)	ENT OF CLIENTS							
Bldg. 00		levelop and implement							
Diag. 00	I	d procedures that prohibit							
		lect or abuse of the client.							
		view and interview for 1 of 5	W 0	140	The Program Manager will en	sure	06/20/2021		
		ecting clients A, B, C, D, E, F,	W 0	149	the Area Supervisor and	Juic	00/20/2021		
	_	y failed to implement its			Residential Manager retrain s	taff			
		res for prohibiting abuse,			on the Abuse, Neglect and	.an			
		n, mistreatment or violation			Exploitation Policy and				
		ghts when staffing coverage			disciplinary action will be give	n if			
	I	n 3/10/21 from 11 PM to			the policy is not followed.				
	7:30 AM on 3/11/2								
					Area Supervisor and Resident	tial			
	Findings include:				Manager will ensure that the				
	<i>5</i>				Abuse, Neglect and Exploitation	on			
	On 5/20/21 at 4:42	PM, a review of the Bureau			Policy is followed.				
		Disabilities Services (BDDS)							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

incident reports and accompanying Investigative

TITLE

Monitoring of Corrective Action:

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G157		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/21/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			3011 A	ADDRESS, CITY, STATE, ZIP CODE APACHE DR ERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	reported staff [staff 12:00 AM to 8:00 A #6] did not report to unsupervised during Investigation summ 3/12/21 indicated, "after it was reported scheduled shift, resutheir allotted amoun Conclusion: It is unintentionally negligishow for his shift on On 5/20/21 at 6:07 interviewed. The TI of staff #6 failing to on 3/11/21. The TL before. He misunde was a miscommunic shift in a second hot confirmed he was contexted me at 7 AM to was asked who the put why they left. The Ther it was ok to leave not used all of their asked how long the H were alone. The Triangle of the staff #2 left the hor shift around 11 PM,	a3/11/21 indicated, "It was #6] was scheduled to work and at the group home. [Staff this shift, which left clients this time frame". ary dated 3/11/21 through An investigation was initiated staff did not show up for a alting in clients exceeding to of alone time substantiated [staff #6] was ent by being a no call, no in 3/11/2021". PM the team leader (TL) was a was asked about the incident report to his shift reported stated, "He's worked for me restood the shifts. He said it eation. He picked up a 2nd in incident incident. The TL stated, "I had not coming in. The girls (clients) that nobody was here". The TL corevious shift staff was and the early because the girls had alone time". The TL was clients A, B, C, D, E, F, G and TL stated, "From 11 PM to as here". The TL indicated the prior to the end of her and staff #6 failed to report elients A, B, C, D, E, F, G and It of 7:30 AM.		The Program Manager, Area Supervisor and Residential Manager will ensure all incide of possible abuse, neglect an exploitation are reported to the department. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Direct Support Lead	d e QA

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	OF CORRECTION OF CORRECTION 15G157	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/21/2021			
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130					
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the incident of staff #6 failing to report to his shift reported on 3/11/21. The QIDP indicated clients A, B, C, D, E, F, G and H's Individual Support Plans were updated to clarify their alone times would need to occur prior to 8 PM. Only the Area Supervisor could approve the use of the clients' alone time after 8 PM. The QIDP stated, "HRC (Human Rights Committee) approval" had been obtained as clients A, B, C, D, E, F, H and G, all clients have 4 to 6 hours of approved alone time within their plans. The QIDP was asked what corrective actions were taken to ensure the miscommunication did not reoccur. The QIDP stated, "[Staff #6] was suspended. They did bring him back (after investigation). I believe all of the Residential Managers were retrained". The QIDP indicated the staff coverage should be maintained and the Abuse, Neglect, Exploitation, Mistreatment, or violation of an Individuals Rights (ANE) policy should be implemented at all times. On 5/21/21 at 3:26 PM the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the incident noted above and the lack of staffing coverage. The QAM indicated the period of time without staffing overage was 11 PM on 3/10/21 to 7:30 AM on 3/11/21. The QAM indicated it was determined through investigation that the use of client alone time for the benefit of staff and the lack of staff coverage during the overnight shift was a failure to implement staffing supports for clients A, B, C, D, E, F, G and H. The QAM stated, "It did not happen (staffing supports) the way we expect". The QAM indicated the ANE policy should be implemented at all times.						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G157		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 05/21/2021			
	ROVIDER OR SUPPLIER	TERNATIVES SE IN	3011 A	ADDRESS, CITY, STATE, ZIP CODE APACHE DR ERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
W 0186 Bldg. 00	10/16/20 was review indicated, "ResCare neglect, exploitation of an Individual's right This federal tag relation and the second	TAFF rovide sufficient direct ge and supervise clients in neir individual program re defined as the present lated over all shifts in a each defined residential iew and interview for 3 of 3 B and C) and 5 additional nd H), the facility failed to ports on 3/10/21 from 11 3/11/21. PM, a review of the Bureau bisabilities Services (BDDS) accompanying Investigative bleted. The reports indicated: 13/11/21 indicated, "It was #6] was scheduled to work M at the group home. [Staff b his shift, which left clients	W 0186	1. The Program Manager conduct a weekly meeting to project needs and plan covera for open shifts. All Area Supervisors in the New Albany Program, and Residential Managers will attend if availabe 2. ResCare New Albany Operation has brought in staff from out of town and, increase wages for DSPs outside of the ICF System including paid travitime bonuses, and mileage. 3. Human Resources has made filling DSP Open shifts a priority, this will continue until vacancies are filled. 4. The Area Supervisor wi	ge y ple. ed evel

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í		DNSTRUCTION	(X3) DATE		
		B. W	JILDING INC	00	COMPL		
15G157		B. W.	ing		05/21/	2021	
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				3011 AF	PACHE DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					coordinate with ICF Residentia	al	
	_	ary dated 3/11/21 through			Managers to ensure shift		
		An investigation was initiated			coverage. The unfilled shift wi		
	_	I staff did not show up for a			reported to the Program Mana	-	
	their allotted amour	ulting in clients exceeding			5. A weekly report is being		
					provided to the hiring manage		
		substantiated [staff #6] was ent by being a no call, no			that will identify open positions and forecast staff gains and	•	
	show for his shift or	•			losses.		
	Show for his shift of				6. The Program Manager	will	
	On 5/20/21 at 6:07	PM the team leader (TL) was			in-service the Area Supervisor		
		L was asked about the incident			Residential Manager, and DSI	•	
	of staff #6 failing to	report to his shift. The TL			on ResCare Shift Coverage		
	stated, "He's worked	-			procedure, and Shift Coverage	9	
	misunderstood the s	shifts. He said it was a			Form.		
	miscommunication.	He picked up a 2nd shift in a					
	second house". The	TL stated, "I had not			Persons Responsible: Progra	m	
		oming in. The girls (clients)			Manager, Human Resource,		
		that nobody was here". The TL			Quality Assurance, Area		
		previous shift staff was and			Supervisor, Behavior Clinician		
		ΓL stated, "[Staff #2]. I told			QIDP, Residential Manager, a	nd	
		ve early because the girls had			DSP.		
		alone time". The TL was					
		ents A, B, C, D, E, F, G and H					
		affing supports. The TL M to 7:30 AM no staff was					
	· ·	ated staff #2 left the home					
		her shift around 11 PM, and					
	1 ~	oort to his shift leaving					
		E, F, G and H alone from 11					
	PM to 7:30 AM.						
	On 5/20/21 at 6:21						
		ties Professional (QIDP) was					
	,	IDP was asked about the					
		failing to report to his shift					
	1 -	. The QIDP indicated clients					
		and H's Individual Support					
	_	to clarify their alone times					
	would need to occur	r prior to 8 PM. Only the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE : COMPL		
		15G157	B. W		<u>00</u>	05/21/	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
RES CAF	RES CARE COMMUNITY ALTERNATIVES SE IN			JEFFER	RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	clients' alone time a "HRC (Human Righ been obtained as cli G, all clients have 4 time within their pla corrective actions we miscommunication stated, "[Staff #6] we him back (after inversed the staff c and the Abuse, Neg Mistreatment, or vio Rights (ANE) policy all times. On 5/21/21 at 11:15 reviewed. The recommends that she while participating is to her current diagn issues. [Client A] re leisure time activities has reviewed the condetermined that at the needs and training retransfer some skills settings is in need of active treatment ser. On 5/21/21 at 11:35 reviewed. The recommends that at the needs and training retransfer some skills settings is in need of active treatment ser. On 5/21/21 at 11:35 reviewed. The recommends that support "The interdisciplina"	plation of an Individuals y should be implemented at AM, client A's record was ad indicated the following: Plan dated 3/17/21 indicated, he interdisciplinary team to client A) have supervision in community activities, due to sis for health and safety equires some structure for the interdisciplinary team to mprehensive assessments and the inite time, due to the level of the equired and her inability to to other environments or for continued placement and					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G157		A. BU	A. BUILDING 00 COMPLETED B. WING 05/21/2021			ETED	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				3011 AF	DDRESS, CITY, STATE, ZIP CODE PACHE DR RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	requires some struct activities. The intercreviewed the compredetermined that at the needs and training retransfer some skills settings is in need of active treatment service. On 5/21/21 at 11:43 reviewed. The recording the interdisciplinar (client C) have supercommunity activities afe pedestrian skills structure for leisure has assessed that she skills to remain alon for up to 3 hours also others are transported have daily appointment team has reviewed the assessments and det to the level of needs inability to transfer senvironments or setting placement and active. On 5/21/21 at 3:26 If Manager (QAM) wasked about the incircof staffing coverage period of time without PM on 3/10/21 to 7: QAM indicated it we will active the set of the senting the properties of the senting the	and safety issues. [Client B] ture for leisure time disciplinary team has ehensive assessments and his time, due to the level of equired and her inability to to other environments or f continued placement and vices". AM, client C's record was d indicated the following: Plan dated 3/17/21 indicated, rry team recommends that she rvision while participating in s, as she has not acquired s. [Client C] requires time activities The team e is capable and has safety he at her residence in the day one during the day while and to work or while peers hents. The interdisciplinary he comprehensive ermined that at this time, due and training required and her					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 3011 APACHE DR JEFFERSONVILLE, IN 47130					
(X4) ID PREFIX TAG	4) ID SUMMARY STATEMENT OF DEFICIENCIES EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	

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