

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

PRINTED: 01/03/2019

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G749		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 11/27/2018	
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP COD 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
(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.</p> <p>Survey dates: November 19, 20, 21, 26 and 27, 2018.</p> <p>Facility Number: 011595 Provider Number: 15G749 AIM Number: 200905630</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/6/18.</p>		W 0000				
W 0248 Bldg. 00	<p>483.440(c)(7) INDIVIDUAL PROGRAM PLAN</p> <p>A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. Based on interview and record review for 1 of 2 clients in the sample (#1), the facility failed to ensure client #1's work site had a current Individual Support Plan (ISP) and Behavior Support Plan (BSP).</p> <p>Findings include:</p> <p>On 11/20/18 observation was conducted at client #1's workshop from 9:00 AM to 10:20 AM. At 9:41 AM, client #1 took a break during which the current ISP and BSP were requested for review. Workshop staff #1 searched for the plans on a desk and stated, "his [client #1] regular supervisor is off this week, but should have it here in a</p>		W 0248	<p>Corrective Action: QIDP and behavior clinician will ensure all relevant staff, including staff of other agencies who work with the clients are adequately trained on the ISPs and BSPs. QIDP and behavior clinician will ensure all plans are up to date and made available to all relevant staff, including staff of other agencies who work with the clients.</p> <p>Persons responsible: QIDP, behavior clinician, area supervisors, program managers,</p>		12/27/2018	

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 other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 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.

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

PRINTED: 01/03/2019
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G749		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 11/27/2018	
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP COD 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
(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 0362 Bldg. 00	<p>program book." Workshop staff #1 indicated the client records could not be located, but the Industrial Manager (IM) would have electronic copies that could be reviewed. At 9:56 AM, after the IM searched on his computer he stated, "we do not have a current ISP, it's dated December 2016 and I'm not able to locate a BSP." The IM indicated he would get with the Qualified Intellectual Disability Professional (QIDP) to obtain current copies of the ISP and BSP. No plans were available for record review.</p> <p>On 11/20/18 at 10:05 AM the Area Supervisor (AS) was interviewed. The AS was asked if the workshop should have current copies of client #1's ISP and BSP. The AS stated, "Yes, I would think so." The AS indicated she would get with the QIDP to obtain and provide current copies of client #1's plans to the workshop.</p> <p>On 11/20/18 at 3:00 PM, the Quality Manager (QM) was interviewed. The QM indicated the workshop should have current copies of client #1's plans.</p> <p>On 11/26/18 at 10:22 AM the QIDP was interviewed. The QIDP indicated client #1's ISP and BSP were up to date. The QIDP stated, "Normally I print the plans off and staff deliver the plans when they take [client #1] to work. Apparently that may not have happened." The QIDP stated, "staff stay with [client #1] while at work, but it would be a good idea for them (workshop) to know about his [client #1's] plans."</p> <p>9-3-4(a)</p> <p>483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the</p>				associate executive director		

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

PRINTED: 01/03/2019
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G749		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 11/27/2018	
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA				STREET ADDRESS, CITY, STATE, ZIP COD 16613 SIMA GRAY RD HENRYVILLE, IN 47126			
(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>interdisciplinary team must review the drug regimen of each client at least quarterly. Based on interview and record review for 1 of 2 clients in the sample (#1), the facility failed to ensure client #1's drug regimen was reviewed quarterly by a pharmacist.</p> <p>Findings include:</p> <p>On 11/20/18 at 11:25 AM, client #1's record was reviewed. The form titled "Chronological Record of Drug Regimen Review" was last completed on 1/30/18. No April 2018 or August 2018 quarterly drug regimen pharmacist reviews were available for record review.</p> <p>On 11/20/18 at 11:57 AM, the Area Supervisor (AS) was interviewed. The AS indicated the pharmacist recently was at the home in October 2018. The AS indicated she would follow up with the nurse. At 12:05 PM, the AS indicated an October consult could be provided, but she and the nurse believed the previous drug regimen was reviewed by a former pharmacist. The April 2018 and August 2018 quarterly reviews were not available for record review.</p> <p>On 11/26/18 at 10:22 AM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the April 2018 and August 2018 quarterly drug regimen reviews and stated, "I've not seen those either. They (pharmacist) come about every 3 or 4 months. They switched gears and sent someone else, but yes those should be available."</p> <p>9-3-6(a)</p>			W 0362	<p>Corrective action: Nurse will provide oversight to ensure quarterly reviews of client drug regimens by a pharmacist are completed as required. Director of nursing will develop a protocol for the oversight of quarterly pharmacy reviews. Director of nursing will monitor to ensure nursing documentation indicates quarterly pharmacy reviews are completed as required.</p> <p>Person responsible: Nurse, director of nursing, residential manager, area supervisor, program manager, associate executive director</p>		12/27/2018