STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G080	A. BUILDING 00 B. WING	06/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CARR ST MILAN, IN 47031

(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	This visit was for a pre-determined full annual recertification and state licensure survey. This visit included the investigation of complaint #IN00229394. Complaint #IN00229394: Substantiated, federal and state deficiencies related to the allegations are cited at: W149. Dates of Survey: 6/5/17, 6/6/17, 6/7/17 and 6/9/17. Facility Number: 000623 Provider Number: 15G080 AIMS Number: 100233870 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality review of this report completed June 21, 2017 by #09182.	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 (A, B and C) plus 3 additional clients (D, E and F), the governing body failed to exercise general	W 0104	**W104:** The governing body must exercise general policy, budget and operating direction over the facility.	06/28/2017

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

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	policy, budget and operating direction over the facility to ensure the group home maintained in good repair a van for clients. Findings include: Observations were conducted at the group home on 6/5/17 between 3:50 PM and 7:15 PM and on 6/6/17 between 6:00 AM and 7:30 AM. Clients A, B, C, D, E and F were observed in the home throughout the observation period. There was no van at the home during the observation period. House Manager (HM) #1 was interviewed on 6/5/17 at 6:30 PM. HM #1 indicated the home did not have a van right now. HM #1 indicated the physically accessible van had been in the repair shop for over 2 weeks. HM #1 indicated they did not know when they would get it back. HM #1 indicated another home picked up clients for workshop. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/6/17 at 3:30 PM. QIDP #1 indicated the home did not have a van in working order. QIDP #1 indicated the home's van had been in the shop for several weeks. QIDP #1 indicated the facility used to		**Corrective Action:** ·The Site Supervisor will ensure all consumers are taken to all appointments and scheduled outings. ·The Site Supervisor will call the Area Supervisor immediately if there is a vehicle issue that would prevent clients from attending workshop, appointments or outings in the community. ·The Site Supervisor and all staff have been trained on what to do when there are vehicle issues. **(Attachment A)** ·The Area Supervisor once notified will notify the Fleet Manager and inform them of the vehicle issue. ·The Site Supervisor along with the Area Supervisor will reach out to other locations for use of company vehicles to ensure client needs are met. ·The Site Supervisor completes a monthly vehicle check and turns in	

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	rent vans for homes but they no longer do that. QIDP #1 indicated clients were still able to attend workshop but they were not able to go on outings. HM #1 was interviewed on 6/6/17 at 3:30 PM. HM #1 indicated the repair shop had called on 6/6/17 and indicated the van was not safe to drive. HM #1 indicated they did not have a time frame for the van to be repaired. HM #1 indicated staff was not able to take clients on outings in their personal vehicles because they were not adapted to the needs of the clients. HM #1 indicated clients had not been on outings since the van had been in the shop. 9-3-1(a)		to the Fleet Manager monthly noting any concerns on/with the vehicle. **(Attachment B)** **How we will identify others:** ·The Program Manager trained all staff on what to do when there are issues with the vehicle assigned to their facility. ·The Site Supervisor will notify the Area Supervisor immediately to report vehicle issues. ·The Area Supervisor will contact the Fleet Manager immediately to report vehicle issues. ·The Fleet Manager will monitor and remain in contact with the facility where the vehicle will be serviced/repaired to ensure timely completion. **Measures to be put in place:** ·The Site Supervisor will call the Area Supervisor immediately if there is a vehicle issue that would	

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			prevent clients from attending workshop, appointments or outings in the community. ·The Site Supervisor and all staff have been trained on what to do when there are vehicle issues. **(Attachment A)** ·The Area Supervisor once notified will notify the Fleet Manager and inform them of the vehicle issue. ·The Site Supervisor along with the Area Supervisor will reach out to other locations for use of company vehicles to ensure client needs are met. ·The Site Supervisor completes a monthly vehicle check and turns in to the Fleet Manager monthly noting any concerns on/with the vehicle. **(Attachment B)** **Monitoring of Corrective Action:** ·The Site Supervisor will ensure all client needs are met such as workshop,	

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			medical appointments and outings in the community either by making arrangements with another location or using staff personal vehicles. ·The Site Supervisor will notify the Area Supervisor immediately when there are vehicle issues. ·The Area Supervisor will contact the Program Manager to report the vehicle issues and to the Fleet Manager for the monitoring of completion of service and repairs. ·Program Manager, will report to the Associate Executive Director and Executive Director all vehicle concerns or issues. **Completion Date: 6-28-17**	
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit			

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	mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 1 of 3 sampled clients (A), the facility failed to implement its policy and procedures to prevent neglect of client A regarding leaving the client unattended in a vehicle. Findings include: Observations were conducted at the group home on 6/5/17 from 3:50 PM through 7:15 PM and 6/6/17 from 6:00 AM through 7:30 AM. Client A was observed throughout both the observation periods. Client A used a wheelchair PRN (as needed) and wore a gait belt. Client A had 1 person/staff assistance when ambulating. Client A was non-verbal but could make vocalizations. Bureau of Developmental Disabilities Services (BDDS) reports were reviewed on 6/6/17 at 9:00 AM. A 5/5/17 BDDS report indicated, "The facility received a report from the How's My Driving Program posted on the back of each company van. A caller called to report a staff had left a client on the van alone at the [store] parking lot in [town]. The client was screaming and crying sitting on the van. Caller called police and police responded. [Client A] is doing well and did not receive any injuries. The	W 0149	**W149:** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. **Corrective Action:** ·The Rescare Abuse and Neglect Policy states that at any time abuse or neglect is suspected staff should immediately contact the Area Supervisor, who will then notify the Program Manager. Staff will then notify the Rescare Nurse. **(Attachment C)** ·The Rescare Nurse will do an assessment of the client within 24 hours of the report. ·In the case of Client "A" staff was negligent and left Client "A" on the van unattended and was	07/03/2017

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	staff has been suspended and an investigation has been initiated." The BDDS Follow-Up Report dated 5/16/17 indicated, "Investigation completed with peer review. Investigation substantiated neglect. Staff admitted she did leave [client A] on the van while she ran into the [store]. Staff stated she only left [client A] for approximately 10 minutes. Staff reported the screaming and crying is a behavior he exhibits in all sittings (sic). [Client A] was non responsive to interview and said uh huh to all questions. [Client A] did not receive any injuries or has not displayed any negative effects from this incident. Allegation substantiated. Staff has been terminated. As preventative measures all staff will receive training on the rights of client safety and all staff to receive training that clients are never left on the van alone." The Investigative Summary (IS) was reviewed on 6/6/17 at 9:00 AM. The 5/10/17 IS indicated, "Based on witness statements the allegation of neglect is substantiated. [Staff #6] admits she ran into the [store] to get something to eat because she was feeling shaky and dizzy. [Staff #6] stated she did not have any cash and she went into [store] because she could write a check. [Staff #6] stated		suspended immediately upon receiving the report and an investigation was initiated. ·The Quality Assurance Department completed the investigation on neglect of Client "A" and determined the neglect was susbstantiated and staff was terminated. **How we will identify others:** ·All staff will report any suspected Abuse or Neglect immediately to their supervisor. ·The supervisor will contact Human Resources immediately and the alleged staff will be suspended pending an investigation. ·The Quality Assurance Department will open an investigation immediately into the allegation. ·Any client that is the victim of Abuse or Neglect will be accessed by the Rescare Nurse within 24 hours of the allegation.	

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	Friday was her day off and she came into work sick because the home needed help. [Staff #6] stated she used poor judgment but would never do anything to hurt the clients. The investigation concludes that [staff #6] did leave [client A] on the van for appropriately (sic) 10 minutes not following policy and procedure. [Client A] did not receive any injuries and the 'grunting noise' is a recent behavior that he is exhibiting in all sittings (sic)." A Police Report was reviewed on 6/6/17 at 9:15 AM. The Police Report dated 5/5/17 at 8:46 AM indicated, "Description: [Store] called and advised that there is a black van in the parking lot and there is a child screaming inside. They can not see the child but they can hear it. Lost contact with the caller. Comments: 8:53 AM Advised that the subject in the van has special needs. The driver of the vehicle came out and advised that she had to run in for just a second and didn't want to get him out in the rain." Client A's record was reviewed on 6/6/17 at 1:00 PM. Client A's 5/1/17 Physician's Orders indicated his diagnoses included, but were not limited to, severe speech impairment, neurosensory hearing loss, hyperplasia (enlargement of organ/tissue), hypertension (high blood		**Measures to be put in place:** ·All staff will report any suspected Abuse or Neglect immediately to their supervisor. ·The supervisor will contact Human Resources immediately and the alleged staff will be suspended pending an investigation. ·The Quality Assurance Department will open an investigation immediately into the allegation. ·Any client that is the victim of Abuse or Neglect will be accessed by the Rescare Nurse within 24 hours of the allegation. ·The Program Manager, Associate Executive Director and Executive Director will meet to discuss the investigation within 5 days of the allegation. ·If it is determined that the allegation is substantiated Human Resources will terminate the employment of the alleged staff. **Monitoring of Corrective Action:**	

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	pressure), and heart failure. Client A has 6/19/16 HRP (High Risk Plans) for exploitation, vision deficit, fall risk and hearing loss. Qualified Intellectual Disabilities Professional (QIDP) was interviewed on 6/6/17 at 3:30 PM. QIDP #1 indicated staff did not notify the administrator of the incident. QIDP #1 indicated staff took client A to his neurology appointment as scheduled after the incident. QIDP #1 indicated the nurse was not notified to check client A for monitoring throughout the evening. QIDP #1 indicated client A was not evaluated at the hospital, emergency room/urgent care for the incident of being left in the van. QIDP #1 indicated client A was seen at the neurologist for a prescheduled check up. QIDP #1 indicated the allegation of neglect was substantiated. QIDP #1 indicated looking back they should have had client A evaluated medically for the incident and monitored throughout the evening. Quality Assurance Control Staff (QAC) was interviewed on 6/6/17 at 3:30 PM. QAC indicated staff #6 had been terminated for neglect. QAC indicated staff #6 had left client A in the van for about 10 minutes. QAC indicated staff did not report the incident to the		·All staff will report any suspected Abuse or Neglect immediately to their supervisor. ·The supervisor will contact Human Resources immediately and the alleged staff will be suspended pending an investigation. ·The Quality Assurance Department will open an investigation immediately into the allegation. ·Any client that is the victim of Abuse or Neglect will be accessed by the Rescare Nurse within 24 hours of the allegation. ·The Quality Assurance Department will complete their investigation within 5 days of the allegation and meet with the Program Manager, Associate Executive Director and Executive Director to discuss the investigation. ·If the allegation is substantiated the Human Resource Manager will terminate the alleged staff from employment. ·The safety committee will review all allegations of abuse and neglect	

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	administrator. QAC indicated when the call had come in from the "How's my driving?" line they were able to tell what van it was. QAC indicated the facility spoke to the officer and the officer said client A did not appear to be in any distress. LPN #1 was interviewed on 6/7/17 at 1:00 PM. LPN #1 indicated she had only been at the facility for a month. LPN #1 indicated client A should have been monitored throughout the evening for any unusual symptoms. The facility's policies and procedures were reviewed on 6/7/17 at 10:54 AM. The facility's policy entitled, 'Abuse, Neglect, Exploitation' dated 7/18/11 indicated the following: -"CASC (Community Alternatives South Central) staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse/neglect/exploitation shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of CASC, local state and federal guidelines....ResCare strictly prohibits abuse/neglect/exploitation/mistreatment. All employees receive training upon hire		quarterly. **Completion Date: 7-3-17**	

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	regarding definitions/causes of different types of abuse/neglect/exploitation/mistreatment, how to identify abuse/neglect/mistreatment/exploitation, and what to expect from an investigation. All employees receive this training upon hire and annually thereafter." This federal tag relates to complaint #IN00229394. 9-3-2(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 1 of 3 sampled clients (B), the facility failed to ensure staff implemented client B's dining plan. Findings include: Observations were conducted at the group home on 6/5/17 from 3:50 PM	W 0249	**W249:** The facility failed to ensure implementation of program plans. **Corrective Action:**	07/03/2017

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	through 7:15 PM. Client B was observed throughout the observation period. At 6:50 PM, client B ate a family style dinner. Client B's dinner consisted of pureed chicken and stuffing, pureed dinner roll moistened with gravy, and peas (not pureed). Client B drank tea out of a Provale (adapted) cup. Client B had a divided plate and small eating utensils. Client B's record was reviewed on 6/6/17 at 10:00 AM. Client #1's 5/11/17 Dining Plan (DP) indicated, "Aspiration Risk-Severe. Food Texture: Pureed. Foods should have a smooth, pudding-like consistency. Gelatin is blenderized to ease getting it on a spoon. Cookies and cakes are broken, soaked in liquid (milk or fruit juice) and stirred until smooth. May have mechanical soft pleasure foods: pancakes, dredged in syrup, popcorn puffs, french fries, baked fish, cake, and bananas. Provide verbal cues to clear throat and/or cough. Fluid Texture: Thin with 5 cc (cubic centimeters) Provale cup (cup allows sips of 5cc of liquid at a time to decrease aspiration risk) (if refuses cup liquids are to be pudding thick)." Client B's 5/1/17 Physicians Orders (PO) indicated, "Pureed Diet, pudding thick liquids." Client B's 4/7/17 Nutrition Assessment (NA) indicated, "Diet: Pureed, pudding thick liquids. Accepts diet texture, history		·The Nurse Manager sent to the Doctor of Client “B” to verify Client “B” dining plan orders. . (**Attachment D)** ·The Nurse Manager revised Client “B” dining plan to reflect the new orders from the doctor. . **(Attachment E)** ·All staff will be trained on new dining plan by Rescare Nurse. ·The Site Supervisor will complete mealtime active treatment observations 3 times weekly to ensure the dining plan is being followed**. (Attachment F)** ·The Area Supervisor will review all dining plans at monthly staff meetings with all staff in the home. ·The QIDP will complete 2 weekly mealtime active treatment observations to ensure dining plans are being followed. **How we will identify others:** ·Nurse will review all dining plans weekly to ensure they are accurate and current. **(Attachment G)**	

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	of dysphagia." Client B's 12/12/16 Medical Consult (MC) indicated, "Pneumonia possibly related to aspiration." Client B's 12/28/16 MC indicated, "Cough, Fatigue, Aspiration." Client B's 5/11/17 High Risk Plan indicated, "Aspiration and choking risk." Client B's record indicated he had a history of aspiration illness and his pureed diet, dining protocol should be followed to address the risk of illness. LPN #1 was interviewed on 6/7/17 at 1:00 PM. LPN #1 indicated she was new to the home. LPN #1 indicated she was unsure if client B's peas should have been pureed. LPN #1 indicated client B's plan was not clear. LPN #1 stated the dining plan was "confusing." LPN #1 indicated client B's plan should be revised. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/6/17 at 3:30 PM. QIDP #1 indicated she was unsure if client B's peas should have been pureed. QIDP #1 indicated he could have 8 to 9 pleasure foods which did not have to be pureed. QIDP #1 indicated peas were not on the list of foods he could have in mechanical soft texture. QIDP #1 indicated dining plans should be followed as written. 9-3-4(a)		·Site Supervisor will complete 3 mealtime active treatment observations per week to ensure dining plans are being followed. ·The QIDP will complete 2 weekly mealtime active treatment observations to ensure dining plans are being followed. ·The Area Supervisor will review all dining plans at monthly staff meetings with all staff in the home. **Measures to be put in place:** ·Nurse will review all dining plans weekly to ensure they are accurate and current. **(Attachment G)** ·The Nurse weekly check will be sent to the Area Supervisor, Nurse Manager and Program Manager for review. ·Site Supervisor will complete 3 mealtime active treatment observations per week to ensure dining plans are being followed. ·The QIDP will complete 2 weekly mealtime active treatment observations to	

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			ensure dining plans are being followed. ·The Area Supervisor will review all dining plans at monthly staff meetings with all staff in the home. **Monitoring of Corrective Action:** ·The Nurse weekly check will be sent to the Area Supervisor, Nurse Manager and Program Manager for review. ·The Active Treatment Monitoring will be sent to the Program Manager for review. ·The Program Manager will review all Individual Support Plans and Behavior Support Plans and Dining Plans to ensure plans meet all needs of the individuals served. ·The QIDP will review all plans with IDT quarterly and annually. ·Program Manager will complete quarterly book	

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			reviews to ensure all plans are accurate, current and in place. **Completion Date: 7-3-17**	
W 0322 Bldg. 00	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 3 sampled clients (B), the facility failed to ensure client B received a physical on an annual basis. Findings include: Client B's record was reviewed on 6/6/17 at 10:00 AM. Client B's Annual Physical was dated 5/3/16. Client B's record did not have a more recent annual physical. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/6/17 at 3:30 PM. QIDP #1 indicated client B should have an annual physical once per year. 9-3-6(a)	W 0322	**W322:** The facility must provide or obtain preventative and general medical care. **Corrective Action:** ·The Nurse completes a weekly checklist to ensure all appointments are up to date. **(Attachment G)** ·The Nurse will send weekly checklist to the Area Supervisor, Program Manager and Nurse Manager for monitoring. ·Site Supervisor will schedule all appointments as needed according to clients needs.	07/03/2017

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			·Annual Physical was completed for Client “B” on 6/27/2017. **(Attachment H)** ·All Staff trained on vehicle issues for client appointments. (**Attachment A)** **How we will identify others:** ·Site Supervisor will schedule all needed appointments timely. ·Nurse will complete the weekly checklist to ensure all appointments have been completed or are scheduled timely. ·Program Manager will complete quarterly book reviews to ensure all medical appointments are scheduled as needed. **Measures to be put in place:** ·Site Supervisor will schedule all needed appointments timely. ·Nurse will complete the weekly checklist to ensure all appointments have been completed or are scheduled timely.	

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			·Program Manager will complete quarterly book reviews to ensure all medical appointments are scheduled as needed. ·The Nurse completes a weekly checklist to ensure all appointments are up to date. **(Attachment G)** ·The Nurse will send weekly checklist to the Area Supervisor, Program Manager and Nurse Manager for monitoring. ·Site Supervisor will schedule all appointments as needed according to client's needs. **Monitoring of Corrective Action:** ·The Nurse will send her weekly checklist to the Area Supervisor, Program Manager and Nurse Manager for review and monitoring. ·The Site Supervisor will report to the Nurse and Area Supervisors any issues or concerns with scheduling or completing all	

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			needed appointments. ·Program Manager will send completed book reviews to the Associate Executive Director for review. **Completion Date: 7-3-17**	
W 0327 Bldg. 00	483.460(a)(3)(iv) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes tuberculosis control, appropriate to the facility's population, and in accordance with the recommendations of the American College of Chest Physicians or the section on diseases of the chest of the American Academy of Pediatrics, or both.			
	Based on record review and interview for 2 of 3 sampled clients (A and C), the facility failed to ensure clients A and C received annual TB (Tuberculosis) testing, x-ray or symptom screenings. Findings include: Client A's record was reviewed on 6/6/17 at 1:00 PM. Client A's Mantoux (TB) Test Sheet indicated Client A had a previous positive TB reading. Client A's	W 0327	**W327:** The facility must provide clients with nursing services in accordance with their needs. **Corrective Action:** ·The Nurse completes a weekly checklist to ensure all medical is up to date and completed.	07/03/2017

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	last symptom screening/chest x-ray was 4/13/16. Client C's record was reviewed on 6/6/17 at 11:48 AM. Client C's Mantoux (TB) Test Sheet indicated Client C had a negative TB test on 4/7/16. LPN (Licensed Practical Nurse) #1 was interviewed on 6/7/17 at 1:25 PM. LPN #1 indicated clients A and C should have annual TB testing, x-rays or symptom screenings. LPN #1 indicated she had just taken over the home so she was unsure if their TB testing was up to date. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/6/17 at 3:30 PM. QIDP #1 indicated clients A and C should have received annual TB (Tuberculosis) testing, x-rays or symptom screenings. 9-3-6(a)		**(Attachment G)** ·The Nurse will send weekly checklist to the Area Supervisor, Program Manager and Nurse Manager for monitoring. ·Site Supervisor will schedule all appointments as needed according to client's needs. ·Program Manager will complete quarterly book reviews to ensure all medical appointments are scheduled as needed. ·The Nurse Manager will complete the Nurse Checklist at one home per month per Nurse. **How we will identify others:** ·Nurse will complete weekly checklist. ·Site Supervisor will ensure all medical appointments are scheduled and completed within the timeframe annually as ordered.	

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			·Program Manager will complete quarterly book reviews to ensure all medical has been completed or scheduled. ·The Nurse Manager will complete the Nurse Checklist at one home per month per Nurse. **Measures to be put in place:** ·Site Supervisor will ensure all clients appointments are scheduled and completed. ·Site Supervisor will notify the Area Supervisor if there are any issues or concerns with any medical appointments. ·The Nurse will complete weekly checks in the home to ensure all needed appointments are scheduled and or completed. ·Program Manager will complete quarterly book reviews to ensure all	

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			medical has been scheduled or completed. ·The Nurse Manager will complete the Nurse Checklist at one home per month per Nurse. **Monitoring of Corrective Action:** ·The Nurse will send the completed weekly checklist to the Area Supervisor, Program Manager and Nurse Manager for review. ·The Site Supervisor will contact the Area Supervisor and the Nurse for any issues or concerns with scheduling or completing medical appointments. ·The Program Manager will send completed book reviews to the Associate Executive Director for review. ·The Nurse Manager will complete the Nurse Checklist at one home per month per Nurse.	

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			Completion Date: 7-3-17	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 2 of 3 sampled clients (A and B), the facility's nursing services failed to aggressively monitor and track client B's diet plan to ensure he received the proper diet, and failed to ensure a plan for proper placement of client A's gait belt. Findings include: 1. Observations were conducted at the group home on 6/5/17 from 3:50 PM through 7:15 PM. Client B was observed throughout the observation period. At 6:50 PM, client B ate a family style dinner. Client B's dinner consisted of pureed chicken and stuffing, pureed dinner roll moistened with gravy, and peas (not pureed). Client B drank tea out of a Provale (adaptive) cup. Client B had a divided plate and small eating utensils. Client B's record was reviewed on 6/6/17 at 10:00 AM. Client B's 5/11/17 Dining	W 0331	**W331:** The facility must provide clients with nursing services in accordance with their needs. **Corrective Action:** ·The Nurse Manager sent to the Doctor of Client "B" to verify Client "B" dining plan orders. . (**Attachment D)** ·The Nurse Manager revised Client "B" dining plan to reflect the new orders from the doctor. . **(Attachment E)** ·All staff will be trained on new dining plan by Rescare Nurse. ·The Site Supervisor will complete mealtime active treatment observations 3	07/03/2017

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	Plan (DP) indicated, "Aspiration Risk-Severe. Food Texture: Pureed. Foods should have a smooth, pudding-like consistency. Gelatin is blenderized to ease getting it on a spoon. Cookies and cakes are broken, soaked in liquid (milk or fruit juice) and stirred until smooth. May have mechanical soft pleasure foods: pancakes, dredged in syrup, popcorn puffs, french fries, baked fish, cake, and bananas. Provide verbal cues to clear throat and/or cough. Fluid Texture: Thin with 5 cc (cubic centimeters) Provale cup (cup allowing only 5cc's of liquid at a time) (if refuses cup liquids are to be pudding thick)." Client B's 5/1/17 Physicians Orders (PO) indicated, "Pureed Diet, pudding thick liquids." Client B's 4/7/17 Nutrition Assessment (NA) indicated, "Diet: Pureed, pudding thick liquids. Accepts diet texture, history of dysphagia." Client B's 12/12/16 Medical Consult (MC) indicated, "Pneumonia possibly related to aspiration." Client B's 12/28/16 MC indicated, "Cough, Fatigue, Aspiration." Client B's 5/11/17 High Risk Plan indicated, "Aspiration and choking risk." LPN #1 was interviewed on 6/7/17 at 1:00 PM. LPN #1 indicated she was new to the home. LPN #1 indicated she was unsure if client B's peas should have been pureed. LPN #1 indicated client B's plan		times weekly to ensure the dining plan is being followed**. (Attachment F)** ·The Area Supervisor will review all dining plans at monthly staff meetings with all staff in the home. ·The QIDP will complete 2 weekly mealtime active treatment observations to ensure dining plans are being followed. ·Nurse requested new orders from Client “A” PCP to confirm what position is approved to wear his gait belt due to a hernia. **(Attachment I)** ·Nurse revised Client “A” high risk plan to include the approved position he can wear his gait belt due to having a hernia**. (Attachment J)** ·Nurse will train all staff on the revised high risk plan for Client “A.” **How we will identify**	

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	was not clear. LPN #1 indicated the dining plan was "confusing." LPN #1 indicated client B's dining plan should be revised. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/6/17 at 3:30 PM. QIDP indicated she was unsure if client B's peas should have been pureed. QIDP #1 indicated he could have 8 to 9 pleasure foods which did not have to be pureed. QIDP #1 indicated peas were not on the list of foods he could have mechanical soft texture. QIDP #1 indicated dining plans should be followed as written. 2. Observations were conducted at the group home on 6/5/17 from 3:50 PM through 7:15 PM and on 6/6/17 from 6:00 AM through 7:30 AM. Client A was observed throughout both observation periods. Client A wore a gait belt. Client A's gait belt was placed directly over his breast bone and underneath of his armpits for the duration of both observations. Client A's record was reviewed on 6/6/17 at 1:00 PM. Client A had 6/19/16 HRP (High Risk Plans) for fall risk. Client A's fall risk plan does not include how his gait belt should be placed. Staff #2 was interviewed on 6/6/17 at		**others:** ·The Site Supervisor will complete mealtime active treatment observations 3 times weekly to ensure the dining plan is being followed**. (Attachment F)** ·The Area Supervisor will review all dining plans at monthly staff meetings with all staff in the home. ·The QIDP will complete 2 weekly mealtime active treatment observations to ensure dining plans are being followed. ·Nurse requested new orders from Client “A” PCP to confirm what position is approved to wear his gait belt due to a hernia. **(Attachment I)** ·Nurse revised Client “A” high risk plan to include the approved position he can wear his gait belt due to having a hernia**.** **(Attachment J)** ·Nurse will train all staff on the revised high risk plan for Client “A.”	

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	6:30 AM. Staff #2 indicated she believed client A's gait belt was placed in the correct location. House Manager (HM) #1 was interviewed on 6/6/17 at 3:00 PM. HM #1 indicated she did not know where client A's gait belt should be placed. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/6/17 at 3:30 PM. QIDP #1 indicated his plan does not include how his gait belt should be placed. LPN #1 was interviewed on 6/7/17 at 1:00 PM. LPN #1 indicated the physical therapist put his gait belt there so she thought it was ok. LPN #1 indicated she thought the proper placement was below the waist. LPN #1 indicated there was no protocol for how to wear the gait belt. 9-3-6(a)		**Measures to be put in place:** ·The Site Supervisor will complete mealtime active treatment monitoring 3 times weekly to ensure staff are following current dining plans. ·The Area Supervisor will review all dining plans at monthly staff meetings. ·The QIDP will complete 2 weekly mealtime active treatment observations to ensure dining plans are being followed. ·The Nurse will complete weekly checks in the home to ensure all dining plans are current. ·The Nurse will address any medical needs with all clients medical doctors and update plans according to the orders received. ·The Nurse Manager will complete the Nurse Checklist at one home per month per Nurse. ·Program Manager will complete quarterly book reviews.	

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			Monitoring of Corrective Action: ·All active treatment monitoring will be sent to the Program Manager for review. ·Nurse weekly checks will be sent to the Area Supervisor, Program Manager and Nurse Manager for monitoring and review. ·Program Manager will send quarterly book reviews to the Associate Executive Director for review. ·All High Risk plans are sent from the Nurse to the Nurse Manager for review, once approved staff are trained and plans put in place. ·The Nurse Manager will complete the Nurse Checklist at one home per month per Nurse. ·Program Manager will complete quarterly book reviews and send to the Associate Executive Director for review.	

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			Completion Date: 7-3-17	
W 0356 Bldg. 00	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. Based on record review and interview for 1 of 3 sampled clients (C), the facility failed to ensure client C had a recommended follow up dental examination. Findings include: Client C's records were reviewed on 6/6/17 at 11:48 AM. Client C's record indicated his most recent dental exam was conducted on 4/14/16. The dental exam indicated client C was to return in 6 months on 10/12/16 at 10:40 AM. There was no evidence in client C's record indicating he had a dental exam since 4/14/16. Client C's 4/14/16 Treatment	W 0356	**W356:** The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. **Corrective Action:** ·Site Supervisor was inserviced that any medical bill not covered by insurance will be paid by Rescare.	07/03/2017

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	Plan with billing had a handwritten note indicating, "Insurance only pays 1 time in 12 months." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/6/17 at 3:30 PM. QIDP #1 indicated the facility had been having trouble getting Medicaid to pay for the visit. QIDP #1 indicated if client C's insurance would not pay for the visit the facility should cover the cost. QIDP #1 indicated all recommended follow-ups should be completed. 9-3-6(a)		·Site Supervisor or Nurse will schedule all needed appointments regardless of insurance payments. ·The Site Supervisor will notify the Nurse and Area Supervisor of any issues with medical appointments. ·The Nurse will contact the Nurse Manager and all bills that are not covered by insurance will be paid by Rescare. **How we will identify others:** ·The Site Supervisor will ensure all medical appointments including follow ups are scheduled and completed per doctor's orders. ·The Site Supervisor will notify the Area Supervisor and the Nurse for any issues with medical payments. ·The Nurse will contact the Nurse Manager regarding any medical bills not covered by insurance and Rescare will pay the bills.	

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			Measures to be put in place: ·Site Supervisor was inserviced that any medical bill not covered by insurance will be paid by Rescare. ·Site Supervisor or Nurse will schedule all needed appointments regardless of insurance payments. ·The Site Supervisor will notify the Nurse and Area Supervisor of any issues with medical appointments. ·The Nurse will contact the Nurse Manager and all bills that are not covered by insurance will be paid by Rescare. **Monitoring of Corrective Action:** ·The Nurse Manager will complete one Nurse Checklist per month per Nurse to ensure completion of all medical appointments regardless of insurance payment. ·Nurse will send a	

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			completed weekly check to Area Supervisor and Program Manager for review. ·Rescare will cover all medical expenses not covered by insurance. Bills will be sent to the Office Coordinator for payment. **Completion Date: 7-3-17**	
W 0362 Bldg. 00	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. Based on interview and record review for 3 of 3 sampled clients (A, B and C), the facility failed to obtain quarterly pharmacy reviews. Findings include: Client A's record was reviewed on 6/6/17 at 1:00 PM. Client A's 5/1/17 physician's orders indicated the client received routine medications for his health. Client A's record indicated no pharmacy reviews had been completed since 11/14/16. Client B's record was reviewed on 6/6/17	W 0362	**W362:** A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. **Corrective Action:** ·The Nurse Manager updated the Nurse weekly check to include the Nurse checking the pharmacy reviews each week to	07/03/2017

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	15G080	A. BUILDING 00 B. WING	06/09/2017

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	at 10:00 AM. Client B's 5/1/17 physician's orders indicated the client received routine medications for his health. Client B's record indicated no pharmacy reviews had been completed since 11/14/16. Client C's record was reviewed on 6/6/17 at 10:00 AM. Client C's 5/1/17 physician's orders indicated the client received routine medications for his health. Client C's record indicated no pharmacy reviews had been completed since 11/14/16. Interview with LPN #1 on 6/7/16 at 1:25 PM indicated she had recently taken over the nursing duties of the group home. LPN #1 indicated she would check to see when the pharmacy reviews were done. LPN #1 indicated she was unsure if the pharmacy reviews were completed or not. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/6/17 at 3:30 PM. QIDP #1 indicated pharmacy reviews should be done quarterly. QIDP #1 indicated pharmacy reviews should be in the clients medical books. QIDP #1 could not locate the pharmacy reviews in client A, B or C's medical books. 9-3-6(a)		ensure they are current and up to date. **(Attachment G)** ·The Nurse Manager will complete one Nurse checklist per Nurse per home each month to monitor the completion and presence of pharmacy reviews. ·Pharmacy reviews were reviewed and signed on February 27th 2017 but had not been placed in the home at the time of survey. **(Attachment K)** **How we will identify others:** ·The Nurse will complete the weekly check and send to the Nurse Manager and Program Manager upon completion. ·All client files will be audited monthly to ensure pharmacy reviews are present by the Site Supervisor. **Measures to be put in**	

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			place: ·The Nurse will complete the weekly check to ensure all medical needs are being met and all pharmacy reviews are present and current. ·The Nurse will submit the weekly check to the Nurse Manager and Program Manager upon completion. ·The Nurse Manager will complete one Nurse Checklist per month per Nurse to ensure completion and presence of all pharmacy reviews. **Monitoring of Corrective Action:** ·The Nurse Manager will complete one Nurse Checklist per month per Nurse to ensure completion of the quarterly nursing reports. ·The Nurse Manager will report to the AED, Human Resources and the Executive Director for any issues concerning the Pharmacist completing the	

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			quarterly reviews for each home. **Completion Date: 7-3-17**	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 3 of 3 sampled clients (A, B, and C) plus 3 additional clients (D, E and F), the facility failed to conduct evacuation drills quarterly for the morning and evening shift of personnel. Findings include: The facility's evacuation drill record was reviewed on 6/6/17 9:00 AM. The review indicated the facility failed to conduct evacuation drills for clients A, B, C, D, E and F for the morning (6:00 AM to 2:00 PM) and evening (2:00 PM to 10:00 PM) shifts during the first quarter, January, February, March (2017), and during the morning shift for the second quarter, April, May and June (2017).	W 0440	**W440: The facility must hold evacuation drills at least quarterly for each shift of personnel.** **Corrective Action:** ·A review of the Emergency Drill Procedures and schedule of drills has been conducted with staff. All individuals are to evacuate the home if/when the fire alarm goes off, no matter what the reason. ·All staff in-serviced on completion of evacuation drills per schedule to	07/03/2017

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	Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/6/17 at 3:30 PM. QIDP #1 indicated the group home should conduct evacuation drills one time per quarter per shift of personnel. 9-3-7(a)		ensure drills are complete quarterly for each shift of personnel. **(Attachment L)** **How we will identify others:** ·Site Supervisor will review and monitor Emergency Drill Procedure in the home and report any issues to the Area Supervisor and Program Manager immediately. **Measure to be put in place:** ·Site Supervisor will review and monitor Emergency Drill Procedure in the home and report any issues to the Program Manager immediately. ·Program Manager will meet with QA department monthly to ensure all drills are completed per schedule. ·Program Manager will follow up with corrective actions to staff who fail to	

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			complete all scheduled drills each month. **Monitoring of Corrective Action:** ·Site Supervisor will review and monitor Emergency Drill Procedure in the home and report any issues to the Area Supervisor and Program Manager immediately. ·Program Manager will meet with QA department monthly to ensure all drills are completed per schedule. ·Program Manager will follow up with corrective actions to a staff who fails to complete all scheduled goals each month. ·Safety Committee will meet quarterly and discuss any issues/trends with emergency procedures. **Completion Date: 7-3-17**	

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W 9999 Bldg. 00	STATE FINDINGS: The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met. 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:	W 9999	**W9999: The facility failed to ensure written documentation of an annual PPD, x-ray or system checklist for staff #5.** **Corrective Action:** ·In review of the documentation that was provided during the survey of the home the forms did indicate that staff #5 was incompliance and had obtained a chest x-ray (page 4 of the documentation) on 6/26/14 which according to Rescare policy is good for 3 years. Staff #5 is no longer employed with us but would have been due on 6/26/17 for a new x-ray**.** **(Attachment M)** ·Human Resources department monitors completion of all annual	07/03/2017

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	Based on record review and interview for 1 of 3 employee files reviewed, the facility failed to ensure written documentation of an annual PPD, x-ray or symptom checklist was completed for staff #5. Findings include: Staff #5's employee file was reviewed on 6/6/17 at 2:00 PM. Staff #5's TB testing form was dated 9/16/15. The review did not indicate documentation of an annual PPD, x-ray or symptom checklist since 9/16/15. Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/6/17 at 3:30 PM. QIDP #1 indicated staff should have a PPD, x-ray or symptom checklist done annually. 9-3-3(e)		testing. ·Annual TB testing is done in September for all employees. ·All new hires are administered a TB test during orientation training. **How we will identify others:** ·Nurse will provide TB test to all new hires. ·All staff will receive TB test in September. ·Human Resources will monitor all files to ensure completion of TB test administered. **Measure to be put in place:** ·Nurse will provide TB test to all new hires. ·All staff will receive TB test in September. ·All staff who test positive for any reason will be required to obtain a chest x-ray immediately and every 3 years thereafter.	

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			·Human Resources will monitor all files to ensure completion of TB test administered. **Monitoring of Corrective Action:** ·Nurse Manager will schedule all annual TB testing annually. ·Human Resources will monitor and file all TB tests. ·Human Resource personnel will suspend all staff who do not receive their annual TB test annually and or chest x-ray every 3 years until the tests are completed. **Completion Date: 6-28-17**	