STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G193	A. BUILDING 00 B. WING	09/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	13711 BENNETTSVILLE RD MEMPHIS, IN 47143

(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 the investigation of complaint #IN00238821. Complaint #IN00238821: Substantiated, federal and state deficiencies related to the allegations are cited at: W149 and W186. Dates of Survey: 8/29/17, 8/30/17 and 9/1/17. Facility Number: 000723 Provider Number: 15G193 AIMS Number: 100234760 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/18/17.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.			

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

Any defiencystatement 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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	Based on record review and interview for 1 of 4 sampled clients (A), the facility failed to implement its written policy and procedures to prevent neglect of client A regarding supervision by leaving client A home alone. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 8/30/17 at 1:30 PM. The review indicated the following: BDDS report dated 8/23/17 indicated, "SC (Service Coordinator) [name] received a phone call from guardian/step mom, [name]. She stated that on 8/22/17, [client A] asked staff on Duty, HM (House Manager) #1, if he could lay down and take a nap. [HM #1] told him he could. When [client A] woke up, he could not find any staff in the house. [SC] asked if there were other clients in the home at the time, [guardian] reported there were not, that [client A] was home alone. [Guardian] stated that when the second shift staff came in he asked [client A] if he told his mom and dad that he was there alone and [client A] reported to this staff [staff #2] 'yes' he had called his mom and told her. [Client A] reported to his mom that when he told [staff #2] this	W 0149	**W149:** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. **Corrective Action: (Specific):** All staff working at the home will be re-trained on the Operation Standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual's rights. **How others will be identified: (Systemic):** All staff will be retrained on ensuring they do room checks before leaving the home each time. The Area supervisor will be in the home at least weekly to ensure policies are being followed. **Measures to be put in place:** All staff working at the home will be re-trained on the Operation Standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual's rights. **Monitoring of Corrective Action:** All staff will be retrained on ensuring they do room checks before leaving the home each time. The Area supervisor will be in the home at least weekly to ensure policies are being followed.	10/01/2017

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	[staff #2] yelled 'Well, F---' SC asked mom if [client A] was okay and she stated yes but he was afraid he was in trouble for telling and he doesn't like it in the home and wants to move soon." BDDS Follow-Up Report dated 8/23/17 indicated, "It was reported that before leaving his shift [HM #1] informed [staff #3], a second shift staff person, that [client A] was in his bed napping." BDDS Follow-Up Report dated 8/30/17 indicated, "[Staff #3] will be terminated for leaving [client A] alone. In addition, all staff will receive an in service on checking all bedrooms and bathrooms prior to leaving the home to ensure no client is ever left behind. [Client A] will also receive a review of the Bill of Rights and Grievance procedure." Investigative Summary dated 8/29/17 indicated, "The allegation that staff left [client A] home alone is substantiated." Peer Review of Investigation dated 8/29/17 indicated, "[Staff #3] will be terminated." Client A was interviewed on 8/29/17 at 4:50 PM. Client A indicated he was taking a nap and when he woke up no one was in the home. Client A indicated			

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	he looked outside and there was one car but the van was gone. Client A indicated he called his parents. Client A indicated he then texted the home manager. Client A indicated he was scared when he realized he was home by himself. Client A indicated he did not know how long he had been home alone because he was sleeping. Client A indicated after he texted the house manager someone came after about 10 minutes. Client A's Guardian was interviewed on 9/1/17 at 9:08 AM. The guardian indicated client A had called her and said he was left alone. The guardian indicated staff #3 was having problems in her personal life. The guardian indicated staff would tell client A not to tell his parents when things happen. The guardian stated she "was unhappy with the facility" and client A should not be left at home alone. House Manager (HM) #1 was interviewed on 8/30/17 at 8:00 AM. HM #1 indicated he had told staff #3 before he left (the house) client A was in his bed asleep. HM #1 indicated he later was notified by client A there were no staff in the home. HM #1 indicated he got someone there as soon as he found out client A was alone Program Manager (PM) #1 was			

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	interviewed on 8/30/17 at 12:30 PM. PM #1 indicated client A had been left alone in the home. PM #1 indicated staff #3 had indicated to her she did not realize client A was in the home. PM #1 indicated clients should not be left in the home alone. PM #1 indicated staff #3 had been terminated. The facility's policy and procedures were reviewed on 8/30/17 at 9:19 AM. The facility's Abuse, Neglect, Exploitation Policy and Procedure revised date of 1/9/15 indicated the following: -"Community Alternatives South East staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and/or exploitation shall be reported and thoroughly investigated. Community Alternatives South East strictly prohibits abuse, neglect and/or exploitation." -"The Clinical Supervisor will assign an investigative team and a thorough investigation will be completed within 5 business days of the report of the incident. Once the investigation has been completed, the investigation will be given to the Executive Director or designee for review." -"F. Abuse- Exploitation. 1. An act that			

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	deprives and individual of real or personal property by fraudulent or illegal means." -"E. Neglect- Emotional/Physical. 1. Failure to provide goods and/or services necessary for the individual to avoid physical harm. 2. Failure to provide the support necessary to an individual's psychological and social well being. 3. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment." -"F. Neglect- Program Intervention. 1. Failure to provide goods and/or services necessary for the individual to avoid physical harm." This federal tag relates to complaint #IN00238821. 9-3-2(a)			
W 0186	483.430(d)(1-2) DIRECT CARE STAFF			

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Bldg. 00	The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 of 4 sampled clients (A), the facility failed to provide sufficient staffing resulting in client A being left alone. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 8/30/17 at 1:30 PM. The review indicated the following: BDDS report dated 8/23/17 indicated, "SC (Service Coordinator) [name] received a phone call from guardian/step mom, [name]. She stated that on 8/22/17, [client A] asked staff on Duty, HM (House Manager) #1, if he could lay down and take a nap. [HM #1] told him he could. When [client A] woke up, he could not find any staff in the house. [SC] asked if there were other clients in the home at the time, [guardian] reported there were not, that [client A] was home alone. [Guardian] stated that when the second shift staff came in he asked [client	W 0186	**W186:** The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. **Corrective Action: (Specific):** The Residential Manager will be re-trained on ensuring that staffing ratios are consistent with the scheduled hours for the home. **How others will be identified: (Systemic):** The Area Supervisor will review the schedule for the home with the Residential Manager at least three times weekly for the next 30 days then at least weekly thereafter to ensure that staffing ratios are consistent with the scheduled hours for the home and verifying that all shifts have staff scheduled. **Measures to be put in place:** The Residential Manager will be re-trained on ensuring that staffing ratios are consistent with the scheduled hours for the home.	10/01/2017

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	A] if he told his mom and dad that he was there alone and [client A] reported to this staff [staff #2] 'yes' he had called his mom and told her. [Client A] reported to his mom that when he told [staff #2] this [staff #2] yelled 'Well, F---'. SC asked mom if [client A] was okay and she stated yes but he was afraid he was in trouble for telling and he doesn't like it in the home and wants to move soon." BDDS Follow-Up Report dated 8/23/17 indicated, "It was reported that before leaving his shift [HM #1] informed [staff #3], a second shift staff person, that [client A] was in his bed napping." BDDS Follow-Up Report dated 8/30/17 indicated, "[Staff #3] will be terminated for leaving [client A] alone. In addition, all staff will receive an in service on checking all bedrooms and bathrooms prior to leaving the home to ensure no client is ever left behind. [Client A] will also receive a review of the Bill of Rights and Grievance procedure." Investigative Summary dated 8/29/17 indicated, "The allegation that staff left [client A] home alone is substantiated." Peer Review of Investigation dated 8/29/17 indicated, "[Staff #3] will be terminated."		**Monitoring of Corrective Action :)** The Area Supervisor will review the schedule for the home with the Residential Manager at least three times weekly for the next 30 days then at least weekly thereafter to ensure that staffing ratios are consistent with the scheduled hours for the home and verifying that all shifts have staff scheduled. **Completion date: 10/01/17**	

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	Client A was interviewed on 8/29/17 at 4:50 PM. Client A indicated he was taking a nap and when he woke up no one was in the home. Client A indicated he looked outside and there was one car but the van was gone. Client A indicated he called his parents. Client A indicated he then texted the home manager. Client A indicated he was scared when he realized he was home by himself. Client A indicated he did not know how long he had been home alone because he was sleeping. Client A indicated after he texted the house manager someone came after about 10 minutes. Client A's Guardian was interviewed on 9/1/17 at 9:08 AM. The guardian indicated client A had called her and said he was left alone. The guardian indicated staff #3 was having problems in her personal life. The guardian indicated staff would tell client A not to tell his parents when things happen. The guardian indicated she was "unhappy with the facility" and client A should not be left at home alone. House Manager (HM) #1 was interviewed on 8/30/17 at 8:00 AM. HM #1 indicated he had told staff #3 before he left (the house) client A was in his bed asleep. HM #1 indicated he later was			

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	notified by client A there were no staff in the home. HM #1 indicated he got someone there as soon as he found out client A was alone. Program Manager (PM) #1 was interviewed on 8/30/17 at 12:30 PM. PM #1 indicated client A had been left alone in the home. PM #1 indicated staff #3 had indicated to her she did not realize client A was in the home. PM #1 indicated clients should not be left in the home alone. PM #1 indicated staff #3 had been terminated. This federal tag relates to complaint #IN00238821. 9-3-3(a)			