STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442			(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2023	
	PROVIDER OR SUPPLIE	GR ALTERNATIVES SE IN	STREET 402 E' JEFFE			
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		
TAG W 0000	REGULATORY C	DR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
Bldg. 00	This visit was for a pre-determined full annual recertification and state licensure survey. This visit included the investigation of complaint #IN00407148.		W 0000			
	deficiencies relate	407148: Federal and state d to the allegation(s) are cited W122, W149, W157, W318 and				
	Survey dates: 11/2 11/30/23, 12/1/23	27/23, 11/28/23, 11/29/23, and 12/4/23.				
	Facility Number: 0 Provider Number: AIM Number: 100	15G442				
	accordance with 4	s also reflect state findings in 60 IAC 9. f this report completed by #15068				
W 0102	483.410					
Bldg. 00	The facility must governing body a requirements are Based on observat interview for 2 of facility failed to m Participation: Gov governing body fa budget, and operat prevent 1) a patter	ensure that specific and management e met. ion, record review and 2 sampled clients (A and C), the meet the Condition of terning Body. The facility's illed to exercise general policy, thing direction over the facility to an of falls resulting in injury to eattern of falls resulting in injury	W 0102	1 Due to COVID shelter place two unannounced rand daily observations began at the Facility on 12/8/2023 to ensure plans are being implemented staff. Observers will question staff on ANE and ensure documentation is completed a required. Weekday daily observations will remain in efforce of two controls.	om he re by the	
LABORATO	RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S S	SIGNATURE	TITLE	(X6) DATE	
Mark Slau	ıghter		AED		12/21/2023	

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to

Event ID: 7FKA11 Facility ID: 000956 If continuation sheet Page 1 of 74

continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED		
		15G442	B. W	ING			12/04/2023	
				CTREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			ING LN			
DES CAI		LTERNATIVES SE IN			RSONVILLE, IN 47130			
INLO CAI		ELLINATIVES SE IN		JEI I EI				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	Findings include:				for 60 days. After 60 days			
					monthly, administrative			
	1) Please refer to W104. The governing body failed to exercise general policy, budget, and				observations will be conducte			
					2 The management tean			
		over the facility to prevent 1) a			began daily update meetings	on		
	_	ilting in injury to client A and			December 1, 2023, to ensure			
	2) a pattern of falls	resulting in injury to client C.			compliance and implement			
					changes needed developing a	a plan		
		V122. The governing body			and implementation of those			
		Condition of Participation: Client			changes. Meetings will contin	nue		
	_	overning body neglected to			until conditions are lifted.			
	implement its policy and procedures to prevent 1)				3 The Program Manger v			
	a pattern of falls resulting in injury to client A and				retrain staff in the Facility on t			
	2) a pattern of falls	resulting in injury to client C.			Abuse, Neglect, and Exploitat			
					Policy and disciplinary action	will		
		V318. The governing body			be given if the policy is not			
		Condition of Participation:			followed. Area Supervisor and			
		es. The facility's health care			Direct Support Lead will ensu	re		
		nsure sufficient nursing			that the Abuse, Neglect, and			
	_	ided to address 1) client A's			Exploitation Policy is followed			
	1 -	ulting in fractures to both of her			Monitoring of ANE will be don	e by		
		Iditional medical reasons such			The Program Manager, Area			
	1	re contributing factors for the			Supervisor, and Residential			
	-	stained during the falls and, 2)			Manager to ensure all inciden	ts of		
	_	f falls with injury to ensure			possible abuse, neglect, and			
	_	an in home exercise program			exploitation are reported to the	e QA		
		while she ambulated to			department.			
	ensure her safety.				4 Observations conducte			
	TEL: C 1 14 1	1			my members of the administra			
	I his federal tag ref	ates to complaint #IN00407148.			team including managers fron			
	9-3-1(a)				Quality, Nursing and Program	ming		
	9-3-1(a)				will conduct twice daily			
					observations weekdays focus	-		
					on Adaptive Equipment, Exerc	use		
					Program, Staff Training and	. h.a		
					Medication. Any issues are to	be		
					immediately reported to the			
					Facility Team.			
					5 An IDT comprised of	_		
	ĺ.		1		paraprofessionals was held or	11	I	

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

PRINTED: 01/03/2024 FORM APPROVED OMB NO. 0938-039

, ´		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		15G442	B. W	ING		12/04/2	2023
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDENCEN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					December 1, 2023 to address client issues QIPD, Nurse and Member of Programming Management will retrain all stathe facility on updated BSPs IS and HRP as needed. 6 An IDT comprised of Paraprofessionals was held to identify fall risk and work on clientify fall risk and work on clientify fall risk and work on clientify fall risk and bed alarm a guarded assist have been add to client plan. QIDP will retrain updated plans and monitored members of the the Administrational observation Team for effectiveness. 7 The QIDP will be retrain to review falls IR and completi investigations. The Quality Assurance Team will review fainvestigations to identify trends and implement protective measuith input from the IDT. 8 The governing body will ensure all staff is retrained on ANE policy and procedures. 9 The DSL will monitor he activities and client interaction daily to ensure there is no suspected ANE/Mistreatments clients and all plans are follow an issue is noted the Program Manager, Nurse, QIDP and Alf will be immediately notified an correction will be made. 10 The Direct Support Lead Area Supervisor, Facility Nurse.	aff in SP aff in SP aient and led an on by ative ative all sasure Il oome as of red if red led ad,	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 3 of 74

STATEMENT OF DEFICIENCIES X1) PROVID		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLET			ETED	
		15G442	B. W	NG		12/04/	
				CTP FFT	ADDRESS SITE OF THE STREET	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
DECOAL		I TEDNIATIVES SE IN			/ING LN		
KES CAP	COMMUNITY A	LTERNATIVES SE IN		JEFFER	RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL			TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					and QIDP will proactively mon	itor	
					clients to ensure plan		
					implementation.		
					11 If there is suspected AN		
					all staff will immediately report		
					QA and ResCare Policy will be	е	
					followed.		
					Persons Responsible: Execut		
					Director, AED, Program Mana	ger,	
					Quality Assurance, Quality		
					Assurance Manager Director		
					Nursing, Nurse, Area Supervis	sor,	
					QIDP, DSL, and DSP.		
W 0404	400 440()(4)						
W 0104	483.410(a)(1)	DV					
Bldg. 00	GOVERNING BO						
Blug. 00		dy must exercise general					
	the facility.	d operating direction over					
	•	on, record review and	W	104	1 Due to COVID shelter i	n	12/21/2022
		sampled clients (A and C), the	w (71U 4	place two unannounced rando		12/21/2023
		led to exercise general policy,			daily observations began at th		
		ng direction over the facility to			Facility on 12/8/2023 to ensure		
		of falls resulting in injury to			plans are being implemented		
		ttern of falls resulting in injury			staff. Observers will question t	-	
	to client C.	21 tano 1000ting in injury			staff on ANE and ensure		
					documentation is completed a	s	
	Findings include:				required. Weekday daily	. -	
	<i>5</i>				observations will remain in eff	ect	
	1) Please refer to W	7149. The governing body			for 60 days. After 60 days		
	· ·	nent its policy and procedures			monthly, administrative		
		buse, Neglect, Exploitation,			observations will be conducted	d.	
		r Violation of Individual's			2 The management team		
		event 1) a pattern of falls			began daily update meetings		
		o client A and 2) a pattern of			December 1, 2023, to ensure		
	falls resulting in inj				compliance and implement		
					changes needed developing a	plan	
	2) Please refer to W	331. The governing body			and implementation of those	•	
	· ·	nursing services provided			changes. Meetings will contin	ue	

FORM CMS-2567(02-99) Previous Versions Obsolete

continued support and services to address 1)

Event ID:

7FKA11

Facility ID: 000956

until conditions are lifted.

If continuation sheet

Page 4 of 74

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

PRINTED: 01/03/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE C A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 12/04/2023		
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ION (X5) D BE COMPLETION DATE		
	2) client C's pattern	falls to ensure her safety and of falls to ensure her safety.		3 The Program Mana retrain staff in the Facility Abuse, Neglect, and Explo	on the		
	This federal tag rela	ates to complaint #IN00407148.		Policy and disciplinary act be given if the policy is no followed. Area Supervisor	t and		
	9-3-1(a)			Direct Support Lead will et that the Abuse, Neglect, a Exploitation Policy is follow Monitoring of ANE will be The Program Manager, Ar Supervisor, and Residenti Manager to ensure all incipossible abuse, neglect, a exploitation are reported to department. 4 Observations condimy members of the adminiteam including managers Quality, Nursing and Progwill conduct twice daily observations weekdays foon Adaptive Equipment, E Program, Staff Training ar Medication. Any issues an immediately reported to the Facility Team. 5 An IDT comprised of paraprofessionals was held December 1, 2023 to addictient issues QIPD, Nurse Member of Programming Management will retrain a the facility on updated BSI and HRP as needed. 6 An IDT comprised of	nsure nd wed. done by rea al dents of nd o the QA ucted istrative from ramming cusing exercise nd re to be e of d on ress and a Il staff in Ps ISP		
				Paraprofessionals was he identify fall risk and work of specific plans. The QIDP and Nurse will train staff based	on client and		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 5 of 74

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

PRINTED: 01/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	NCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED		
		15G442	B. W	ING		12/04/2023		
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOUIDEDIG N. AV ON CONTROL		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	IE .	DATE	
					these recommendations PERs	6		
					system, chair and bed alarm a	ınd		
					guarded assist have been add	led		
					to client plan. QIDP will retraii	n on		
					updated plans and monitored			
					members of the the Administra	ative		
					Observation Team for			
					effectiveness.	.		
					7 The QIDP will be retrain			
					to review falls IR and completi investigations. The Quality	iig		
					Assurance Team will review fa	,,,		
					investigations to identify trends			
					and implement protective mea			
					with input from the IDT.	louro		
					8 An IDT comprised of			
					Paraprofessionals was held to	,		
					identify fall risk and work on cl			
					specific plans. The QIDP and			
					Nurse will train staff based on			
					these recommendations.			
					9 The governing body wil			
					ensure all staff is retrained on			
					ANE policy and procedures.			
					10 The DSL will monitor ho	I		
					activities and client interaction	s		
					daily to ensure there is no			
					suspected ANE/Mistreatments	I		
					clients and all plans are follow an issue is noted the Program			
					Manager, Nurse, QIDP and Al			
					will be immediately notified an	I		
					correction will be made.	~		
					11 The Direct Support Lead	_{d.}		
					Area Supervisor, Facility Nurs			
					and QIDP will proactively mon			
					clients to ensure plan			
					implementation.			
					12 If there is suspected AN	IE		
			1		all staff will immediately report			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 6 of 74

PRINTED: 01/03/2024

PARTMENT OF HEALTH AND HU	FORM APPROVED		
NTERS FOR MEDICARE & MEDIC	AID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>	COMPLETED
	15G442	B. WING	12/04/2023

STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 402 EWING LN IFFFFRSONVILLE. IN 47130 RES CARE COMMUNITY ALTERNATIVES SE IN

RES CA	RE COMMUNITY ALTERNATIVES SE IN	JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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		
			QA and ResCare Policy will be followed. 13 The governing body will ensure all staff is retrained on ANE policy and procedures. 14 If there is suspected ANE all staff will immediately report to QA and ResCare Policy will be followed. Persons Responsible: Executive Director, AED, Program Manager, Quality Assurance, Quality Assurance Manager Director of Nursing, Nurse, Area Supervisor, QIDP, DSL, and DSP.			
W 0122 Bldg. 00	483.420(a) CLIENT PROTECTIONS The facility must ensure the rights of all clients. Therefore the facility must Based on observation, record review and interview for 2 of 2 sampled clients (A and C), the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its policy and procedures to ensure their system to prohibit and prevent abuse, neglect, and/or mistreatment was implemented to prevent 1) a pattern of falls resulting in injury to client A and 2) a pattern of falls resulting in injury to client C. Findings include: 1) Please refer to W149. The facility failed to implement its policy and procedures to implement the Abuse, Neglect, Exploitation, Mistreatment and/or Violation of Individual's Rights policy to prevent 1) a pattern of falls resulting in injury to	W 0122	1 The management team began daily update meeting on December 1, 2023 to ensure compliance and implement changes needed developing a plan and implementation of those changes. Meetings will continue until conditions are lifted. 2 The Facility will retrain staff on the Abuse, Neglect and Exploitation Policy and disciplinary action will be given if the policy is not followed. Area Supervisor and Direct Support Lead will ensure that the Abuse, Neglect and Exploitation Policy is followed. Monitoring of ANE will done by The Program Manager,	12/21/2023		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 7FKA11 Facility ID: 000956

If continuation sheet

Page 7 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u>			COMPLETED	
		15G442	B. W	B. WING		12/04/2023		
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	8			/ING LN			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	_		RSONVILLE, IN 47130			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	client A and 2) a pattern of falls resulting in injury				Area Supervisor and Resident			
	to client C.				Manager to ensure all incident	ts of		
	0) P1	4157 FDL 6 11' 6 11 1			possible abuse, neglect and			
	· ·	7157. The facility failed to			exploitation are reported to the	€ QA		
	_	measures that ensured			department.			
		and services to prevent 1) a Iting in injury to client A and			3 An IDT comprised of	, l		
	_	resulting in injury to client A and			paraprofessionals was held or December 1, 2023 to address			
	2) a patient of falls	resulting in injury to chefit C.			client issues QIPD, Nurse and			
	This federal tag rela	ates to complaint #IN00407148.			Member of Programming	u		
	I me reactar tag rett	10 Templante //11 100 10 / 1 10.			Management will retrain all sta	affin		
	9-3-2(a)				the facility on updated BSPs Is			
					and HRP as needed.			
					4 An IDT comprised of			
					Paraprofessionals was held to	,		
					identify fall risk and work on cl			
					specific plans. The QIDP and			
					Nurse will train staff based on			
					these recommendations PERs	3		
					system, chair and bed alarm a	ınd		
					guarded assist have been add			
					to client plan. QIDP will retrai			
					updated plans and monitored			
					members of the the Administra	ative		
					Observation Team for			
					effectiveness.	ad ta		
					5 The QIDP will be retrained to the completing			
					review falls IR and completing investigations. The Quality			
					Assurance Team will review fa	,, l		
					investigations to identify trend			
					and implement protective mea			
					with input from the IDT.	.54.5		
					6 An IDT comprised of			
					Paraprofessionals was held to	,		
					identify fall risk and work on cl			
					specific plans. The QIDP and			
					Nurse will train staff based on			
					these recommendations.			
					7 The governing body will			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 8 of 74

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

PRINTED: 01/03/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COM	E SURVEY PLETED 4/2023
	ROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP C VING LN RSONVILLE, IN 47130	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
				ensure all staff is retra ANE policy and proced 8 The DSL will mo activities and client into daily to ensure there is suspected ANE/Mistre clients and all plans ar an issue is noted the F Manager, Nurse, QIDF will be immediately no correction will be made 9 The Direct Suppo Area Supervisor, Facil and QIDP will proactiv clients to ensure plan implementation. 10 If there is suspect staff will immediately re and ResCare Policy w followed. 11 The governing be ensure all staff is retra ANE policy and proced 12 If there is suspect staff will immediately re and ResCare Policy w followed. 13 The Facility will e Doctors Orders are ca expeditiously as possil Persons Responsible: Director, AED, Program Quality Assurance, Qu Assurance Manager D Nursing, Nurse, Area S QIDP, DSL, and DSP.	dures. nitor home eractions is no eatments of re followed if Program P and AED tified and e. ort Lead, lity Nurse rely monitor ted ANE all report to QA rill be ody will ined on dures. ted ANE all report to QA rill be ensure the rried out as ble. Executive m Manager, uality Director of Supervisor,	
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANC The facility must	ES establish and maintain a				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 9 of 74

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/04/2023	
	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN	•	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
IAU	system that assur accounting of clie entrusted to the far Based on record resampled clients (A (D, G and H), the far complete accounting personal funds entrusted in the complete accounting personal funds indicated an ending actual cash on hand client B's financial QIDP indicated to obtain the balance AM, staff #5 indicated an ending actual cash on hand client D's financial QIDP indicated an ending actual cash on hand client D's financial QIDP indicated at the client D's financial QIDP indicated at the complete indicated at the compl	res a full and complete ints' personal funds acility on behalf of clients. View and interview for 2 of 3 and B) and 3 additional clients acility failed to ensure a full and ag of clients A, B, D, G and H's instead to the facility. 4 AM, a review of the clients' leted. The review indicated the cial ledger dated 11/2023 g balance of \$0.00. Within client is was a gift card and no cash on d Intellectual Disabilities b) indicated at 8:57 AM, client A 6.08 on her gift card and financial ledger. The total financial ledger dated 11/2023 g balance of \$9.25. Client B's d balance was \$9.25. Within pouch was a gift card. The staff #5 she needed to call and of client B's gift card. At 9:05 ated to the QIDP client B had a for her gift card. The total financial ledger dated 11/2023 g balance of \$40.00. Client D's d balance was \$40.00. Within pouch was a gift card. The for the pouch was a gift card. The for the pouch was a gift card. The total financial ledger dated 11/2023 g balance of \$40.00. Client D's d balance was \$40.00. Within for the pouch was a gift card. The	W	0140	The facility will establish and maintain a system that assures a full and complete accounting of clients' personal funds. The Facility will retrain son the standard of maintaining system of accounting for client funds entrusted to the facility. receipts for the purchases mube returned to the facility and identify which client funds we spent on. The DSL will conduce weekly reviews of the Client Financial Record's to ensure transactions have been record and account is balanced. The Program Manager will in-served the Area Supervisor, and Dires Support Lead on the use of clinance book. All employees will be trained on the revised standary and disciplinary action will be given if the standard is not followed. The Facility will ensure the abuse neglect and exploit policy is followed. A member of the Administrative team will condimonthly site reviews for all cliin facility and the administration discuss issues that arise in the facility.	staff g the nt's All ust re ct all ded e cice ect dient rd that ration uct a ents or will	12/21/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)		(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		15G442	B. WI			12/04/	
			<u> </u>				
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
					/ING LN		
RES CARE COMMUNITY ALTERNATIVES SE IN				JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
		e total amount of funds					
	unaccounted for wa	s \$34.00.					
	4) Client G's financ	ial ledger dated 11/2023			Persons Responsible: AED,		
		balance of \$0.00. Within client			Quality Assurance Manager, C	DΑ	
	_	were two gift cards and no			Coordinator/QIDP Manager,	~, `	
	_	QIDP indicated to staff #5 she			Program Manager, Area		
	needed to call and obtain the balance of client G's				Supervisor, QIDP, Direct Supp	ort	
		M, staff #5 indicated to the			Lead, and DSP.	ΜI	
	_	ance on the first gift card was			Leau, and Dor.		
		d gift card was \$10.00. The					
		ds unaccounted for was					
	\$15.00.						
	5 50 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5						
		have a 11/2023 financial ledger					
	_	nce. Within client H's financial					
	_	sh on hand and a gift card. At					
	8:47 AM, the QIDP	asked client H how much					
	money was on her g	gift card. Client H stated, "I					
	don't know". The Q	IDP asked if she thought it					
	was a \$20.00 gift ca	ard to use. Client H stated, "I					
	don't know, maybe	\$10.00". At 8:50 AM, staff #5					
	_	"[Client D's] family church					
		cards). I think it's got \$5.00 on					
		off #5 called to obtain the					
	· · · · · · · · · · · · · · · · · · ·	's gift card and stated,					
		amount of funds unaccounted					
	for was \$10.26.	amount of funds unaccounted					
	101 was \$10.20.						
	On 11/29/23 at 4.46	6 PM, the QIDP was					
		IDP was asked about					
	-						
	_	ts A, B, D, G and H's personal					
		he facility. The QIDP stated,					
	, , , , , , , , , , , , , , , , , , , ,	ledger with everything (gift					
		h. Maintained accurately and					
	accounted for".						
	9-3-2(a)						

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7FKA11 Facility ID: 000956 If continuation sheet Page 11 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15G442	B. W	ING		12/04/	2023
	ROVIDER OR SUPPLIER	LTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
TAG W 0149 Bldg. 00	Ass. 420(d)(1) STAFF TREATME The facility must d written policies and mistreatment, neg Based on observation interview for 2 of 2 facility failed to imp Exploitation, Mistre Individual's Rights p of falls resulting in it pattern of falls result Findings include: 1) Observations wer 3:37 PM to 5:13 PM to 9:17 AM. During wore a hard plastic b PM, client A prepar medications. Client the group home. Cli house. It's better tha Client A was asked plastic boot. Client A Client A then procee medications. At 9:12 AM, client foot. Client A stated backwards". Client doing when the fall was putting dishes a what caused her to I stated, "I got a little this happened often. A was asked about a April 2023 which re	LSC IDENTIFYING INFORMATION	W	149	The Facility will retrain stat the site on the Abuse, Negle and Exploitation Policy and disciplinary action will be giver the policy is not followed. Area Supervisor and Direct Support Lead will ensure that the Abus Neglect and Exploitation Policifollowed. Monitoring of ANE with done by The Program Manage Area Supervisor and Direct Support Lead to ensure all incidents of possible abuse, neglect and exploitation are reported to the QA department. The Program Manager with ensure the Area Supervisor with retrain staff on the Abuse, Neglect and Exploitation Policy and disciplinary action will be given the policy is not followed. Area Supervisor and Program Manager will ensure the Abuse, Neglect and Exploitation Policy is followed through random monitoring. Monitoring of Corrective Action: The Program Manager Area Supervisor and Resident Manager will ensure all incident of possible abuse, neglect and exploitation are reported to the department.	taff ect n if see, y is ill glect n if that	12/21/2023
	clothes on the floor'	'. The Oualified Intellectual					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15G442	B. W	ING		12/04	/2023
		L		CTD FET 4	ADDRESS CITY STATE TIP COP		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
DEC CAL		I TEDNATIVES SE IN			RSONVILLE, IN 47130		
KES CAP	NE COMMUNITY A	LTERNATIVES SE IN		JEFFER	NOUNVILLE, IN 47 100		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		sional (QIDP) stated to client A,					
		portant to keep your room			Persons Responsible: AED,		
	•	A responded by stating,			Quality Assurance Manager,	QA	
		vore the hard plastic boot			Coordinator/QIDP Manager,		
	_	e evening and morning			Program Manager, Area		
	observations.				Supervisor, QIDP, Direct Sup	port	
					Lead, and DSP.		
		0 PM, a review of the facility's					
		ies Services (BDS) reports and					
		estigation summaries was					
		riew indicated the following					
	affecting client A:						
	14) RDS incident	report dated 4/20/23 indicated,					
	l '	lient A] came to the living room					
		Staff stated [client A] appeared					
		ary movement in her right					
		and drool on her face, neck,					
		does receive a medication to					
	_	Staff informed [client A] she					
		ower so she could be taken to					
		room), so [client A] went to					
		heard a noise and went to					
		. [Client A] was sitting on the					
		. Her left ankle appeared					
		eginning to bruise. [Client A]					
		o her bed while staff went to					
	contact EMS (emer	rgency medical services). Plan					
	to Resolve: EMS as	rrived and transported [client					
	A] to the ER for ev	raluation. [Client A] was					
	evaluated and adm	itted to [name of hospital].					
	[Client A's] left anl	kle and some of her toes are					
	_	a] is scheduled to have surgery					
	on 4/21/23. Staff ha	ave been placed on leave					
		on and review to ensure plans					
	were being followed at the time of incident".						
	T 4'	1 4 1 4/20 /22 4 1					
	"	hary dated 4/20/23 through					
		"Introduction: An investigation					
	was initiated when	[client A] fell in her bedroom					I

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 13 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00		
		15G442	B. W			12/04/	/2023
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		402 EWING LN JEFFERSONVILLE, IN 47130			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	i	R LSC IDENTIFYING INFORMATION eture in (sic) her left ankle		TAG	DEFICIENCT		DATE
	which required surg						
	concerned about [cl	Staff #5] stated she was lient A] due to drooling and er questions. [Staff #5] also know [client A] as well as					
	[client A's] drooling or the fact that [clie #5]. [Staff #1] state normal for [client A] thought [client A] v attention, she would to the ER and not w needing a shower. [take [client A] to th	e was not concerned about g, twitching in her arm and leg, ent A] did not respond to [staff d all of these behaviors were a]. [Staff #1] also stated had she was in need of medical d have transported [client A] corried about [client A] Staff #1] was only going to e ER because [Staff #5] was so were unable to reach the					
	got out of bed from state she became dithe sofa, but it just! A] has no history of Risk Plan. Medicatishow [client A] is p times daily to decrea fractured ankle the Conclusion: It is su	taking a nap. [Client A] did zzy when she stood up from lasted a few seconds. [Client f falls therefore has no Fall ion Administration Records prescribed Atropine three has saliva. [Client A] sustained at required surgery to repair bstantiated [client A] was revices at the time of her fall					
		Reinstate staff. Retrain staff					
	·	nt Report dated 8/12/23 cident: Fall What happened					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11 Facility ID: 000956

If continuation sheet Page 14 of 74

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	
		15G442	B. W	ING		12/04	/2023
	PROVIDER OR SUPPLIER	R LITERNATIVES SE IN	•	402 EW	ADDRESS, CITY, STATE, ZIP COD VING LN RSONVILLE, IN 47130	<u>, </u>	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	**************************************		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE	DATE
	during the incident	? Staff walked down the					
	hallway and saw [c	lient A] in her room. When					
		o med (medication) room, other					
		on her (client A) again. She					
		ng by her bed. Staff asked					
		was on the floor. She (client A)					
		r bed and ended up on the					
		d the side of her thigh there					
	was no redness or b	oruising".					
	Investigation	agent dated 9/12/22 : 1: 4- 1					
	_	nary dated 8/12/23 indicated, ts: On 8/12/23, [client A] stated					
		she had fallen. [Client A]					
		ing out of her bed. [Client A]					
	_	nead or getting hurt. [Client A]					
		s slippery and denied tripping					
	over anything.	support and demod apping					
	o ver um jumng.						
	On 8/12/23, [staff #	#2] stated she was not with					
	_	e fell but had walked down the					
	hall to check on her	r and found her on the floor.					
	[Staff #2] stated [cl	lient A] reported she slid down					
	the bed to the floor.	. [Staff #2] stated she helped					
	[client A] up and cl	hecked her for injuries and did					
	not find any						
		ibstantiated [client A] fell due					
	to her bedroom floo	or being slippery					
	Recommendations	[Client A] will have a new rug					
		as well as gripper socks that					
		er footing when getting in and					
		ll be added to the fall risk					
	plan".	a so added to the full flox					
	1C) BDS incident report dated 11/5/23 indicated,						
	"Staff reported [client A] fell as she was walking						
		ne reported back pain. [Client					
		bed and [nurse] was					
	_	ere advised to transport to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 15 of 74

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15G442		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	e survey pleted 4/2023	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP O VING LN RSONVILLE, IN 47130	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	experienced a fall the injuries or complain Resolve: [Client A] on 11/5/2023, she was with metatarsal fract A] was given a wall orders to follow up use ice and Tylenol will be reviewed an Investigation summed 11/6/23 indicated, "was reported [client back hallway when what happened and thought she tripped there was nothing of A] denied having an 'No really, I'm ok' On 11/5/23, staff rewalking to her room [Client A] was assist contacted. Staff we urgent care in the market and the statement of the fall? On to smoke. On the 5t kitchen to get a snarsmoke 2. Was state her/him? No 6. Desire history of falls? Yes been completed in the last fall was in Augwas completed, were needed/implemente A] was transported	ported [client A] fell as she was n, and she reported back pain. sted to the bed and [nurse] was re advised to transport to norning 1. What was the client doing at the 4th she was going outside h she had gone into the ck and then go outside to ff with the client and assisting ones this consumer have a s 7. Has a fall assessment he past 3-6 months? Yes. Her ust 2023. 8. If a fall assessment				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 16 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPI	
		15G442	B. WI				/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	R		402 EW			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		_
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE	E RIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	ot and discharged with orders					
	and Tylenol as need	rthopedic doctor and use ice					
	and Tylehol as need	icu ioi pani.					
	Conclusion: [Client	t A's] had 2 falls and each time					
	_	sed correctly. The [nurse] and					
	_	Risk plan and discussed the					
	incident with [clien	t A] and the staff involved					
	Recommendations:	[Nurse] will review and revise					
		fall risk plan was revised on					
	11/5/23".	•					
		PM, client A's record was					
	reviewed. The review	ew indicated the following:					
	-Emergency Depart	tment to Hospital Admission					
		23 indicated, "Medical					
		. x-ray shows a dislocated					
	_	fracture. Chest x-ray					
	interpretation show	s no cardiomegaly					
	(enlargement of hea	art) fusion or infiltrate.					
	Metabolic panel (m	etabolism) is at baseline. There					
		fectious process. I did speak					
		pedic (treatment of bone					
		nd hospitalist. Patient (client					
	A) will be admitted	for surgical repair".					
	-Hospital Medical (Consult dated 11/5/23					
	•	for Visit: Fall, Back Pain.					
	Diagnosis: Fall, bro	oken foot, acute bilateral low					
	back pain without s	ciatica (nerve) Summary: A					
	metatarsal fracture	is a break in one of the five					
		the toes to the rest of the					
	foot".						
	-Falls Health Risk I	Plan dated 11/5/23 indicated,					
		Falls 1. Staff will assist with					
	transfers to ensure	safety 2. Staff will assist with					
		dressing in its entirety 3. Staff					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 17 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		15G442	B. W	ING		12/04/	/2023
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	•	402 EW	DDRESS, CITY, STATE, ZIP COD ING LN RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	DATE
	will provide hands	on assistance with helping					
	[client A] on the va	n 4. Staff will keep					
	environment free of	f any obstacles to prevent					
	falls".						
		6 PM, the Nurse was					
		urse was asked about client					
	_	with injuries to her feet. The					
		ent A had two falls which					
		s. The Nurse was asked about for fractured bones due to the					
	1	ad experienced. The Nurse					
		lid not have a calcium					
		one density evaluation had not					
	I	ne Nurse stated, "Yes. Need to					
	_	on that. She should have a					
	_	evaluation)". The Nurse was					
		d a diagnosis of skeletal issues					
	or Osteoporosis (de	creased bone mass). The					
	Nurse stated, "No. 7	Γhat's why I'm going to ask					
	them (Orthopedic)	to do it. She returns in 2					
		was asked about client A's					
	1 ^	cating environmental issues					
	1	her bedroom floor. The Nurse					
		environment should be free					
		client A should be supported					
	by staff to ensure he	er safety and prevent falls.					
	On 12/4/23 at 11:13	3 AM, the Director of Nursing					
		ewed. The DON was asked					
	` ′	dical history, age, the three					
		vo of which resulted in					
		ner feet and how the pattern of					
		. The DON indicated more					
		was needed and stated, "She					
		y test". The DON indicated					
		ls with injury and history of					
		raluation was needed and					
	_	s Osteoporosis". The DON					
		lical follow up was going to be					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11 Facility ID: 000956

If continuation sheet Page 18 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15G442	B. W	ING		12/04	/2023
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IIE.	DATE
	completed with clie	ent A.					
	2) Observations wer 3:37 PM to 5:13 PM to 9:17 AM. During observed to ambula and/or staff assistanthe group home, clies he no longer used a Client C ambulated dining area, the hall administration room and bathroom without During the morning routine at 7:17 AM, "Sometimes my fee but sometimes they had told the nurse o going numb. Client doctor next time". Cknew about her feet "No". At 9:09 AM, client Intellectual Disabilitia question. Client Couple short steps b verbal prompt and sheld her hand towar gain her balance. W prompting, client C group home during use of adaptive supplies while she ambulated On 11/27/23 at 2:30 Bureau of Disabilitia	re conducted on 11/27/23 from M and on 11/28/23 from 7:05 AM g observations, client C was te without adaptive supports are nearby her. Upon entering ent C indicated to the surveyor a walker while ambulating. throughout the kitchen area, lway, to the medication a, and to and from her bedroom out staff nearby her. g medication administration g client C stated to staff #1, t feel numb. Not all the time, do". Client C was asked if she are a doctor about her feet C stated, "I'm going to tell the Client C was asked if the doctor a going numb. Client C stated, C approached the Qualified ties Professional (QIDP) to ask c shuffled her feet and took a mackwards. The QIDP used a stated "[Client C] go slow" and and client C if she needed to with the exception of the QIDP's ambulated throughout the the observation without the ports and/or staff nearby d to assist her.					
		stigation summaries was					
	conducted. The revi	iew indicated the following					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11 Facility ID: 000956

If continuation sheet Page 19 of 74

CENTERS FOI	NTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2023					
		130442	D. WING		12/04/2023				
	PROVIDER OR SUPPLIE	R JLTERNATIVES SE IN	402 EV	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	CTION (X5)				
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE COMPLETION				
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE				
	affecting client C:								
	"It was reported [cl and pans when she reported she lost he abrasion on [client reported no pain. S Resolve: Staff will will contact the nur Investigation summ "Description of inc walking to put pots It is substantiated [fell while putting a a scrape that requir Recommendations:	nary dated 7/24/23 indicated, ident: [Client C] fell as she was and pans away Conclusion: client C] lost her balance and way the pots and pans causing							
	2B) BDS incident i	report dated 8/6/23 indicated, "It							
		t C] was getting a cup from the							
		aid she tripped over her feet							
		: Staff completed skin and a ¾ inch red mark on her							
		reported no pain. Plan to							
		inded [client C] to slow down							
	while walking. Star	ff will continue to report all							
	falls".								
	"Description of inc kitchen and fell tur area to table. She g check her for injuri She pulled her pant	nary dated 8/5/23 indicated, ident: [Client C] was in the ning around to go from sink ot up and staff came over to es. [Client C] said she was fine. I leg up and there was a small is always moving quickly. Staff							
		to slow down. [Client C]							

FORM CMS-2567(02-99) Previous Versions Obsolete

doesn't take this seriously... Conclusion: [Client C]

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 20 of 74

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G442	B. W	/ING		12/04	/2023
NAME OF T	ADOLUDED OF CURRY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	S.		402 EW			
	RE COMMUNITY A	LTERNATIVES SE IN	ı	JEFFEF	RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		s moving too fast. She slipped					
		nmendations: Staff will continue					
		to slow down. Anti-Slip socks or her. Staff will be trained to					
	-	ic) socks or shoes at all times".					
	remind her to ear (s	ic) socks of shoes at all times.					
	2C) BDS incident re	eport dated 9/8/23 indicated, "It					
		t C] went outside to sit on the					
		ne to leave for day program.					
	-	ng her bags down when she					
		I fell to the ground. [Client C]					
	sustained a 1-inch a	nd a ½ inch abrasion on her					
	right knee and a 2-i	nch knot just below her right					
	kneecap. Nurse was	s contacted and [client C] was					
	-	ospital for evaluation. Plan to					
	-	completed with normal result.					
		ased with discharge paperwork					
	-	of right knee, and Abrasion.					
		sed to take Tylenol or					
		Rest, ice, and elevate as					
	-	ion clean and dry and covered					
	as needed until heal	ed".					
	Investigation summ	ary dated 9/7/23 indicated,					
	-	dent: [Client C] took her lunch					
	box and other items	to the front porch to wait to					
	leave for work. Who	en she set them down, she lost					
	her balance and fell	to her knees. She had a					
	scratch on her right	knee and some swelling. The					
		needed to be sent out to					
		e was sent to Urgent Care					
		C] had a fall outside due to					
		The ground (cement) on the					
	_	en. Recommendations: The					
		to evaluate the amount of					
		arrying to ensure she is not					
	carrying too much".	•					
		1 . 10/0/02					
	-	ary dated 9/8/23 indicated,					
	"Description of inci	dent: [Client C] was taking a					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 21 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUP				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPI	LETED
		15G442	B. W	ING		12/04	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	S.		402 EW			
	RE COMMUNITY A	LTERNATIVES SE IN	ı	JEFFEF	RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!)		DATE
		all. She said the floor was ed her up and assessed her					
		requested further monitoring					
		ary care physician) for any					
	-	Conclusion: [Client C] had a					
		resent. The floor was slippery.					
	-	Nonslip decals will be					
		s work request to put in a					
	•	bathroom shower. [Client C]					
	-	check for a UTI (urinary tract					
		medical issue to determine if it					
	is making her feel d	lizzy".					
	2D) BDS incident r	eport dated 9/21/23 indicated,					
	"It was reported [cli	ient C] was talking to staff					
		walk away and fell to her					
		[Client C] scraped a scab on					
	-	vious incident and it began to					
		first aid. Plan to Resolve:					
		risk plan that was being					
		ad a recent fall assessment					
	_	imary care physician) ordered					
		py) which is in the process of					
	being scheduled".						
	Investigation summ	ary dated 9/20/23 indicated,					
	"Description of inci	dent: [Client C] came from the					
	dining room to tell	staff another client was eating					
	loud. She spoke to t	the staff and turned around					
	quickly to return to	the table, and she fell on the					
	floor hitting both kr	nees. There were no new					
	injuries but a scab f	rom a past fall broke open and					
		her knee cleaned and a					
	-	on: It is substantiated [client					
	_	ll risk plan not being					
		priately. [Client C] fell because					
		ove too quickly, and staff					1
	failed to remind her						
		The staff will be retrained on					
	notifying AS (Area	Supervisor) /Nurse/QIDP					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 22 of 74

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPI	LETED
		15G442	B. W	ING _		12/04	/2023
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R		1	ING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
	I COMMONT				TOO. TVILLE, IIT TI TOO		•
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	` `	ual Disabilities Professional)					
		cident. Staff will be retrained to					
	remind [client C] to slow down when she is walking quickly".						
	2E) BDS incident report dated 9/26/23 indicated,						
		ient C] was attempting to open					
		and lost her balance and fell					
		Completed skin assessment					
		njuries. Staff did find a 3 ½					
		nt C's] right mid back that					
	<u> </u>	ing. [Client C] told staff she					
	had sustained the b	ruise after her last fall No					
	injuries were visible	e on [client C's] back at the time					
	of that fall. Plan to	Resolve: Staff will continue to					
	report all falls. [Cli-	ent C] has a fall risk plan in					
	place that was being	g followed at the time of the					
		had a recent fall assessment					
	completed".						
	_	nary dated 9/26/23 indicated,					
	_	ident: [Client C] had fallen					
		e van. [Staff #4] had caught					
	_	g down to the ground. When					
		ecked her for injury. She had a					
	_	ise that was yellow/green/blue.					
		e got it the last time she fell in					
	` ′	She said she hit the shower					
		onclusion: [Client C] had an from a fall on 9.8.23. [Client C]					
	1	ime for bruises to show up.					
		HRC (Human Rights					
		al) was requested as well, as					
		to supervise [client C's]					
		precautions. Staff will be					
	trained".	F					
	2F) BDS incident re	eport dated 10/17/23 indicated,					
		ient C] was going to get a					
		could start her laundry. Staff					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 23 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		15G442	B. W	ING		_ 12/04/2023	
NAME OF F	PROVIDER OR SUPPLIEF		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	-	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROP		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		wait until staff finished					
		cations to [client C's]					
		vas a box in the floor that					
		I to move with her foot. [Client and fell to the floor. Staff					
	_	rom the floor and completed					
		-					
	skin assessment. [Client C] sustained a ½ inch abrasion on each elbow. The abrasions did not						
		se was contacted. Plan to					
		remind [client C] not to attempt					
		e floor with her foot".					
	_						
	Investigation summary dated 10/16/23 through						
	10/17/23 indicated, "Introduction: [Client C]						
		od to do laundry. Staff asked					
	_	C] did not wait and tried to					
] med (medication) box out of					
		lost her balance from pushing					
		x out of the way. She fell to					
		d small scrapes on both her					
		was notified, and first aid was					
	given						
	Factual Findings:	11. Were there any					
		ors that contributed to the fall?					
	-	ent C's] way once she tried to					
		e when asked not to. 12. Do					
		be made to prevent future					
		asking [client C] to wait, have					
		her to not impulsively fall due					
	_	Conclusion: Staff will be					
	_	at C] to sit down if they are					
	update the risk plan	or something. The [nurse] will					
	update the risk plan						
		Staff will be trained to ask					
		n if they are asking her to wait					
	_	[nurse] will update the risk					
	1 ~	f asking [client C] to sit down if					
	they are asking her	to wait for something".					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11 Facility ID: 000956

If continuation sheet Page 24 of 74

		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED	
		15G442	B. W	B. WING			12/04/2023	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
DECOAL		I TEDNIATIVES SE INI		402 EW	'ING LN RSONVILLE, IN 47130			
	TE COMMUNITY A	LTERNATIVES SE IN		<u> </u>	NOUNVILLE, IIN 47 100		1	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DET TO LEAVE 17		DATE	
	2G) BDS incident r	eport dated 11/13/23 indicated,						
	l '	ff was assisting [client C] with						
	_	noticed a 3-inch bruise on						
	[client C's] right hip	o/lower back. When staff asked						
	[client C] how she s	sustained the bruise, [client C]						
	reported she got the	bruise the last time she fell.						
	_	lient C] fell on 11/3/23 landing						
	_	ere no visible injuries at the						
	time of the fall".							
	The cause of the bri	uise was determined to be from						
	a fall in the shower on 11/3/23, and therefore no							
	investigation was conducted and/or available for							
	review.							
	In addition, internal	incident reports indicated						
	client A fell on the	following dates without injury:						
	5/10/23, 7/21/23, 8/	25/23 and 9/8/23.						
	On 11/28/23 at 5:01	PM, client C's guardian was						
		ardian was asked about client						
	_	and her program plan to reduce						
	the risk of falling w	rith injury. Client C's guardian						
	stated, "I would like	e to see the use of a cane for						
	1	ere is not a way to use it						
		rder". Client C's guardian						
		ed a cane with client C during						
		ited, "I just feel more						
	I	with her (ambulating). Also,						
		bulating, let's look at doing						
	_	lient C's guardian was asked if						
		ssessed by Physical Therapy.					1	
	_	, "I think she has. That was ength and got rid of the walker.						
		her, you can tell these little						
	1	It's minor, but it could help".						
	umigo (cane) neip. i	it s minor, out it could help.						
	On 11/29/23 at 1:03	3 PM, a review of client C's						
		ed. The review indicated the						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11 Facility ID: 000956

If continuation sheet Page 25 of 74

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

PRINTED: 01/03/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		A. BUILDING B. WING	00	COMPLETED 12/04/2023	
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	402 E\	ADDRESS, CITY, STATE, ZIP COD WING LN ERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	-Fall Health Risk Pl "Problem: Fall risks [client C] with amb safety. 2) Staff will appropriate shoes, to non-skid shoes. 3) Sof any obstacles to p notify nurse of any report 12) Staff w shower chair and th needed remaining in in case assistance is will monitor and ass -Medical Consult da [Client C] Reason start of care visit/ini Orders: Plan to see activity, therapeutic neuromuscular retra balance, and endura and improve safety/ and ADLs (adult da On 11/29/23 at 3:26 interviewed. The Nu pattern of falls with of client C's prograf falls with injury. Th participated in home weekly. The Nurse complete Physical Trepeated falls, be di referred for more Pl was asked if the vis documented the stat progress. The Nurse				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 26 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			ETED	
		15G442	B. W	'ING		12/04	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L		402 EW			
	RE COMMUNITY A	LTERNATIVES SE IN	1	JEFFEF	RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		g the therapy with client C. The					
	-	erapist documentation of was requested at that time.					
	chem C's progress v	was requested at that time.					
	On 11/29/23 at 3:48	3 PM, the Nurse provided two					
		rapy consult forms for review.					
	The review indicate						
		O					
	-Physical Therapy (PT) Consult dated 11/13/23					
	indicated, "Patient of	c/o (complaint) R (right) knee					
	pain Results Pat	tient reported 0/10 (no pain)					
	at rest, but increased	d with activity Standing					
	Home Exercise Program: Complete 2-3 (times) /						
		each. 1) Marching in place. 2)					
		l / Toe raises. 4) Hip abduction					
		raight). 5) Hip Extension (kick					
		6) Hamstring curls ('butt' kicks					
	/ donkey kicks). 7)	Sitting and Standing".					
	DI ' 1771 (S 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 2, 1, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2, 2,					
		Consult dated 11/22/23					
		for visit: Physical Therapy trength with 30 sit to stand					
		it still requires hands on					
		7) Orders: Plan to recertify					
	for additional PT vi	•					
	101 additional 1 VI						
	On 11/29/23 at 3:54	PM, the Nurse was asked					
		Therapy consults indicating an					
	•	nd client C requiring assistance					
		ety. The Nurse indicated more					
	follow up was need	ed to review and revise client					
	C's program plans a	and train staff. The Nurse					
	indicated staff shou	ld be within arm's reach of					
		o provide support and					
	_	nt falls and promote client C's					
	safety while she am	bulated.					
	0 10/4/20 110 -						
		6 AM, the Qualified Intellectual					
		ional (QIDP) was interviewed.					
	I ne QIDP was aske	ed about client C's Standing					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 27 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DA	TE SURVEY MPLETED 04/2023		
	PROVIDER OR SUPPLIEI	₹ LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION OULD BE PPROPRIATE	(X5) COMPLETION	
TAG	Home Exercise Prowas unaware of a Phome exercise programy have got some but I don't know an On 12/4/23 at 11:11 (DON) was intervious about the PT recombome exercise programing for client of communication issues "I'm not aware of a program. That wou strength". The DON would be complete home exercise programsistance for safety implemented as part At 11:40 AM, the I follow up to the recabout client C's start QIDP indicated the not know". The DO guessing". On 12/4/23 at 12:24 Manager (QAM) wasked about clients injuries, further meindicated, and how Exploitation, Mistri Individual's Rights implemented. The On 11/30/23 at 10:	gram. The QIDP indicated she 'T recommendation for an in gram. The QIDP stated, "[Nurse] thing started up with the staff, ything about that". B AM, the Director of Nursing ewed. The DON was asked amendations of a standing in gram and hands on assistance C's safety. The DON indicated a ue had occurred and stated, standing home exercise Id help her balance and N indicated more follow up d to ensure the standing in gram and the hands on y during ambulation would be et of client C's program plans. DON and QIDP provided further quest of the nurse's knowledge anding exercise program. The en urse had responded "I did DN stated, "That's what I was 4 PM, the Quality of Assurance has interviewed. The QAM was A and C's pattern of falls with dical supports and services the Abuse, Neglect, eatment and/or a Violation of (ANE) policy should be QAM stated, "At all times, by 18 AM, a review of the 11/10/23 anducted. The review indicated	TAG			DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

the following: "ResCare staff actively advocate for

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 28 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2023		
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		
TAG W 0157 Bldg. 00	the rights and safety strictly prohibits ab mistreatment, or vid rights". This federal tag related 9-3-2(a) 483.420(d)(4) STAFF TREATMENT If the alleged violated corrective action in Based on observation interview for 2 of 2 facility failed to devensured sufficient sufficient A and 2) a part to client A and 2) a part to client C. Findings include: 1) Observations we 3:37 PM to 5:13 PM to 9:17 AM. During wore a hard plastic PM, client A preparamedications. Client the group home. Client A was asked plastic boot. Client	LISC IDENTIFYING INFORMATION of all individuals ResCare use, neglect, exploitation, olation of an Individual's utes to complaint #IN00407148.	W 0157	The facility will ensure the results of all investigations must be reported to the administrated designated representative or to other officials in accordance we state law within five working do for the incident. The Quality Assurance Department will ensure all investigations are completed in accordance with the policies of ResCare, local, state and feder guidelines. The Quality Assurance Department will be retrained by the Associate Executive Direct on the local, state and federal guidelines for investigations of ANE. The Facility will retrain ston the Abuse, Neglect and	e 12/21/2023 st or or o ith ays	
	foot. Client A stated backwards". Client	A was asked how she hurt her I, "I was in the kitchen and fell A was asked what she was occurred. Client A stated, "I		Exploitation Policy and disciplinary action will be giver the policy is not followed. Area Supervisor and Residential Manager will ensure that the Abuse, Neglect and Exploitation		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 29 of 74

01/03/2024 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/04/2023 15G442 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 402 EWING LN RES CARE COMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE was putting dishes away". Client A was asked Policy is followed. Monitoring of what caused her to lose her balance. Client A ANE will done by The Program stated, "I got a little dizzy". Client A was asked if Manager, Area Supervisor and this happened often. Client A stated, "No". Client Residential Manager to ensure all A was asked about a previous fall that occurred in incidents of possible abuse. April 2023 which resulted in an injury and how it neglect and exploitation are occurred. Client A stated, "I fell on my floor. I had reported to the QA department. clothes on the floor". The Qualified Intellectual The QIPD will review all Disabilities Professional (QIDP) stated to client A, Clients in the facility's BSPs and "That's why it's important to keep your room ensure reactive procedures are cleaned up". Client A responded by stating, accurate and remain up to date. "Yeah". Client A wore the hard plastic boot The Area Supervisor will throughout both the evening and morning retrain all staff in the facility on observations. completing behavior tracking data on a daily basis On 11/27/23 at 2:30 PM, a review of the facility's The Area Supervisor will Bureau of Disabilities Services (BDS) reports and retrain all staff in the facility on accompanying investigation summaries was notifying the QIDP if behavioral conducted. The review indicated the following tracking is unavailable in Task affecting client A: Master Pro based on goals being timed out. 1A) BDS incident report dated 4/20/23 indicated, The QAM will retrain the "It was reported [client A] came to the living room QIDP on review Behavior Tracking after taking a nap. Staff stated [client A] appeared Data monthly at a minimum. to have an involuntary movement in her right The QIDP Review all clients hand and right leg and drool on her face, neck, in the facility BSPs to ensure and and shirt. [Client A] does receive a medication to reactive procedures are accurate address the issue. Staff informed [client A] she The QAM will retrain QIPD on needed to take a shower so she could be taken to completing investigation within 5 the ER (emergency room), so [client A] went to Business Days and ensuring her bedroom. Staff heard a noise and went to corrective measures are developed check on [client A]. [Client A] was sitting on the and implemented to prevent floor due to falling. Her left ankle appeared recurrence, and reactive measures swollen and was beginning to bruise. [Client A] are in place. was able to move to her bed while staff went to A member of the contact EMS (emergency medical services). Plan Administrative team will conduct a to Resolve: EMS arrived and transported [client monthly site reviews for all clients A] to the ER for evaluation. [Client A] was in facility and the administrator will evaluated and admitted to [name of hospital]. hold a weekly ICF meeting to [Client A's] left ankle and some of her toes are discuss issues that arise in the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 30 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			LETED
		15G442	B. W	ING		12/04	/2023
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	R					
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	402 EWING LN JEFFERSONVILLE, IN 47130				
	I COMMONT A	E.E.G.C.IVEO OL IIV					•
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		a] is scheduled to have surgery			facility.		
		ave been placed on leave			B B		
	pending investigation and review to ensure plans were being followed at the time of incident".				Persons Responsible: AED,		
	were being followe	a at the time of incident".			Quality Assurance Manager, (λA	
	Investigation summ	nary dated 4/20/23 through			Coordinator/QIDP Manager,		
		'Introduction: An investigation			Program Manager, Area Supervisor, QIDP, Direct Sup	oort	
	was initiated when [client A] fell in her bedroom and sustained a fracture in (sic) her left ankle which required surgery				Lead, and DSP.	JUIL	
					Loau, and DOF.		
	- I I I I I I I I I I I I I I I I I I I	<i>→</i>					1
	Factual Findings: [Staff #5] stated she was concerned about [client A] due to drooling and not responding to her questions. [Staff #5] also						1
		know [client A] as well as					1
	[staff #1] does.						
		e was not concerned about					
		g, twitching in her arm and leg,					
	_	ent A] did not respond to [staff					
		ed all of these behaviors were					
	_	A]. [Staff #1] also stated had she					1
		was in need of medical					
		d have transported [client A]					
		vorried about [client A]					
		[Staff #1] was only going to					
		e ER because [Staff #5] was so					1
		were unable to reach the					
	nurse for advice.						
	[Client All stated ab	a was faaling fina when she					
		te was feeling fine when she taking a nap. [Client A] did					
	1 -	zzy when she stood up from					
		lasted a few seconds. [Client					
	1	-					
	A] has no history of falls therefore has no Fall Risk Plan. Medication Administration Records show [client A] is prescribed Atropine three						
	_	ease saliva. [Client A] sustained					
	I	at required surgery to repair					
		and sargery to repair					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 31 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2023		
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	Conclusion: It is substantiated [client A] was receiving quality services at the time of her fall					
	Recommendations: Reinstate staff. Retrain staff on 911 protocol".					
	1B) Internal Incident Report dated 8/12/23 indicated, "Type Incident: Fall What happened during the incident? Staff walked down the hallway and saw [client A] in her room. When staff walked back to med (medication) room, other staff went to check on her (client A) again. She (client A) was sitting by her bed. Staff asked [client A] why she was on the floor. She (client A) said she slid off her bed and ended up on the floor. Staff checked the side of her thigh there was no redness or bruising". Investigation summary dated 8/12/23 indicated,					
	"Witness Statements: On 8/12/23, [client A] stated 'Yes' when asked if she had fallen. [Client A] stated she was getting out of her bed. [Client A] denied hitting her head or getting hurt. [Client A] stated the floor was slippery and denied tripping over anything.					
	On 8/12/23, [staff #2] stated she was not with [client A] when she fell but had walked down the hall to check on her and found her on the floor. [Staff #2] stated [client A] reported she slid down the bed to the floor. [Staff #2] stated she helped [client A] up and checked her for injuries and did not find any					
	Conclusion: It is substantiated [client A] fell due to her bedroom floor being slippery					
	Recommendations: [Client A] will have a new rug with floor grippers as well as gripper socks that will help her get her footing when getting in and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 32 of 74

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	00	COMPLETED	
		15G442			12/04/2023	
NAME OF P	PROVIDER OR SUPPLIE			ADDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		/ING LN RSONVILLE, IN 47130		
				I	275	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
1710		ll be added to the fall risk	IMG		DATE	
	plan".					
	1					
	1C) BDS incident report dated 11/5/23 indicated,					
	"Staff reported [clic	ent A] fell as she was walking				
		ne reported back pain. [Client				
	_	bed and [nurse] was				
		ere advised to transport to				
	_	norning. [Client A] also				
	experienced a fall the day prior, 11/4/2023, with no					
	injuries or complaints noted at the time. Plan to Resolve: [Client A] was transported to urgent care					
	on 11/5/2023, she was assessed and diagnosed					
	with metatarsal fracture of the right foot. [Client					
		king boot and discharged with				
		with orthopedic doctor and				
	-	l as needed for pain. Risk plans				
	-	nd updated as needed".				
	_	nary dated 11/4/23 through				
	· ·	"Introduction: On 11/4/23, it				
		t A] was walking down the				
		she fell Staff asked [client A]				
		[client A] reported she l over her feet. Staff reported				
		on the floor to trip over. [Client				
	_	ny pain or discomfort stating,				
	'No really, I'm ok'					
	J, 3 1.					
	On 11/5/23, staff re	eported [client A] fell as she was				
	walking to her roor	n, and she reported back pain.				
		sted to the bed and [nurse] was				
		ere advised to transport to				
	urgent care in the n	norning				
	Factual Findings	. 1. What was the client doing				
	prior to the fall? On the 4th she was going outside					
	_	th she had gone into the				
		ick and then go outside to				

FORM CMS-2567(02-99) Previous Versions Obsolete

smoke... 2. Was staff with the client and assisting

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 33 of 74

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	G	00	COMPLETED	
		15G442	B. WING			12/04	/2023
			STDE	ET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ING LN		
RES CAF		LTERNATIVES SE IN			RSONVILLE, IN 47130		
	T. COMMONTA	ETERMATIVES SE IIV	, I "	'			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	X	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	_	DEFICIENCY)		DATE
		oes this consumer have a					
	history of falls? Yes 7. Has a fall assessment						
	_	the past 3-6 months? Yes. Her					
	_	ust 2023. 8. If a fall assessment					
	was completed, we	ed? No new changes [Client					
	_	to urgent care, assessed and					
		atarsal fracture of right foot,					
	_	ot and discharged with orders					
	_	rthopedic doctor and use ice					
	and Tylenol as need	-					
	and Tylenor as needed for pain.						
	Conclusion: [Client A's] had 2 falls and each time						
	_	sed correctly. The [nurse] and					
	QIDP reviewed the	Risk plan and discussed the					
	incident with [clien	t A] and the staff involved					
		[Nurse] will review and revise					
	-	fall risk plan was revised on					
	11/5/23".						
	0 11/00/00 11.50	D16 11					
		PM, client A's record was					
	reviewed. The revie	ew indicated the following:					
	Emarganay Danart	tment to Hospital Admission					
		23 indicated, "Medical					
		. x-ray shows a dislocated					
	_	fracture. Chest x-ray					
	interpretation show						
	•	art) fusion or infiltrate.					
	` •	netabolism) is at baseline. There					
		fectious process. I did speak					
		pedic (treatment of bone					
		nd hospitalist. Patient (client					1
		for surgical repair".					
	-Hospital Medical (Consult dated 11/5/23					
	indicated, "Reason	for Visit: Fall, Back Pain.					
	_	ken foot, acute bilateral low					
	back pain without s	back pain without sciatica (nerve) Summary: A					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11 Facility ID: 000956

If continuation sheet Page 34 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		15G442	B. W	'ING		12/04/	/2023
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	•	402 EW	DDRESS, CITY, STATE, ZIP COD ING LN RSONVILLE, IN 47130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DROVIDERIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	.TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE	DATE
	metatarsal fracture	is a break in one of the five					
	bones that connect t	the toes to the rest of the					
	foot".						
	-Falls Health Risk I "Problem: Risk of I transfers to ensure shygiene, toileting, dwill provide hands of [client A] on the varient environment free of falls". On 11/29/23 at 3:26 interviewed. The Ni A's pattern of falls of Nurse indicated client A had indicated client A had indicated client A had deficiency, but a bobeen completed. The follow up, I'll check bone density eval (casked if client A had or Osteoporosis (de Nurse stated, "No. Tathem (Orthopedic) to the state of the s	Plan dated 11/5/23 indicated, Falls 1. Staff will assist with safety 2. Staff will assist with dressing in its entirety 3. Staff on assistance with helping n 4. Staff will keep f any obstacles to prevent 6 PM, the Nurse was urse was asked about client with injuries to her feet. The ent A had two falls which s. The Nurse was asked about for fractured bones due to the ad experienced. The Nurse tid not have a calcium one density evaluation had not the Nurse stated, "Yes. Need to a on that. She should have a evaluation)". The Nurse was d a diagnosis of skeletal issues creased bone mass). The That's why I'm going to ask to do it. She returns in 2					
		was asked about client A's					
	-	cating environmental issues					
		her bedroom floor. The Nurse					
		environment should be free					
		client A should be supported					
	by staff to ensure he	er safety and prevent falls.					
	(DON) was intervie about client A's med	3 AM, the Director of Nursing ewed. The DON was asked dical history, age, the three					
	incidents of falls, tv	vo of which resulted in					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11 Facility ID: 000956

If continuation sheet Page 35 of 74

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			0	MB NO. 0938-039		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DAT	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COM	COMPLETED		
		15G442	B. WING			4/2023		
		100112				.,_020		
NAME OF E	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP	COD			
NAME OF F	NO VIDER OR SUFFLIER		402 EV	VING LN				
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	JEFFE	RSONVILLE, IN 47130				
(VA) ID	CIDALADV	OT A TEMPLIT OF DEFLOYENCE		1		(7/5)		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5)		
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE		COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
		ner feet and how the pattern of						
		. The DON indicated more						
	_	was needed and stated, "She						
	needs a bone densit	y test". The DON indicated						
	due to client A's fal	ls with injury and history of						
	smoking, further ev	aluation was needed and						
	stated, "I bet she ha	s Osteoporosis". The DON						
		lical follow up was going to be						
	completed with clie							
	2) Observations we	re conducted on 11/27/23 from						
	l '	A and on 11/28/23 from 7:05 AM						
		g observations, client C was						
		te without adaptive supports						
		ice nearby her. Upon entering						
		ent C indicated to the surveyor						
	_	a walker while ambulating.						
		throughout the kitchen area,						
	_	lway, to the medication						
	administration roon	n, and to and from her bedroom						
	and bathroom withou	out staff nearby her.						
	During the morning	medication administration						
	routine at 7:17 AM,	, client C stated to staff #1,						
	"Sometimes my fee	t feel numb. Not all the time,						
	I	do". Client C was asked if she						
	I	r a doctor about her feet						
		C stated, "I'm going to tell the						
		Client C was asked if the doctor						
		going numb. Client C stated,						
	"No".	o						
	110.							
	At 0:00 AM aliant	C approached the Qualified						
		ties Professional (QIDP) to ask						
	_	Shuffled her feet and took a						
		ackwards. The QIDP used a						
	verbal prompt and stated "[Client C] go slow" and							
		rd client C if she needed to						
	gain her balance. W	ith the exception of the QIDP's						

FORM CMS-2567(02-99) Previous Versions Obsolete

prompting, client C ambulated throughout the

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 36 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		15G442	B. W	'ING		12/04	/2023
NAME OF D	PROVIDER OR SUPPLIER	·	•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
				402 EW			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		the observation without the ports and/or staff nearby					
	while she ambulated	•					
	On 11/27/23 at 2:30 PM, a review of the facility's						
		ies Services (BDS) reports and					
		stigation summaries was					
		iew indicated the following					
	affecting client C:						
	2A) BDS incident report dated 7/10/23 indicated, "It was reported [client C] was putting away pots and pans when she fell to the floor. [Client C]						
	•	r balance. Staff found a 1-inch					
	_	C's] right knee, [client C]					
		taff applied first aid. Plan to					
	will contact the nur	continue to report all falls. Staff					
	will contact the nur	se for all falls.					
	Investigation summ	ary dated 7/24/23 indicated,					
	"Description of inci	ident: [Client C] fell as she was					
		and pans away Conclusion:					
	-	client C] lost her balance and					
	a scrape that require	way the pots and pans causing					
		Staff need to remind [client C]					
		a calm pace to prevent losing					
	her balance".						
	a D) DDG :	. 1 . 10/6/22 : ** - 1 **-					
		eport dated 8/6/23 indicated, "It					
		t C] was getting a cup from the aid she tripped over her feet					
		. Staff completed skin					
		nd a ¾ inch red mark on her					
		reported no pain. Plan to					
		nded [client C] to slow down					
		f will continue to report all					
	falls".						
	Investigation	nome data d 9/5/32 in 4:4-4					
	investigation summ	nary dated 8/5/23 indicated,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 37 of 74

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA				X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPI	
		15G442	B. W	ING		12/04	/2023
NAME OF F	PROVIDER OR SUPPLIER		-		ADDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		402 EW JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOWIDED'S BLANCE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE)TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NIE.	DATE
	"Description of inci	dent: [Client C] was in the					
	kitchen and fell turr	ning around to go from sink					
	_	ot up and staff came over to					
	1	es. [Client C] said she was fine.					
		leg up and there was a small					
		is always moving quickly. Staff					
		to slow down. [Client C]					
		iously Conclusion: [Client C]					
		s moving too fast. She slipped					
		nmendations: Staff will continue					
	to remind [client C] to slow down. Anti-Slip socks						
	will be purchased for her. Staff will be trained to						
	remind her to ear (sic) socks or shoes at all times". 2C) BDS incident report dated 9/8/23 indicated, "It						
		t C] went outside to sit on the					
		ne to leave for day program.					
	1 ~	ng her bags down when she					
		I fell to the ground. [Client C]					
	sustained a 1-inch a	and a ½ inch abrasion on her					
	right knee and a 2-i	nch knot just below her right					
	kneecap. Nurse was	s contacted and [client C] was					
	_	ospital for evaluation. Plan to					
	1	completed with normal result.					
		ased with discharge paperwork					
		of right knee, and Abrasion.					
		sed to take Tylenol or					
		Rest, ice, and elevate as					
	1 -	ion clean and dry and covered					
	as needed until heal	led".					
	Investigation summ	ary dated 9/7/23 indicated,					
	_	ident: [Client C] took her lunch					
		to the front porch to wait to					
		en she set them down, she lost					
		to her knees. She had a					
		knee and some swelling. The					
	_	needed to be sent out to					
		e was sent to Urgent Care					
		C] had a fall outside due to					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11 Facility ID: 000956

If continuation sheet Page 38 of 74

<u> </u>		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		15G442	B. W	'ING		12/04/	2023
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	-	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDEDIS DI ANI CE CODDECTIONI		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	\\\L	DATE
		The ground (cement) on the					
	-	en. Recommendations: The					
		to evaluate the amount of					
		arrying to ensure she is not					
	carrying too much".	•					
	Investigation summary dated 9/8/23 indicated,						
	-	ident: [Client C] was taking a					
	-	all. She said the floor was					
		ed her up and assessed her					
	injuries. The nurse	requested further monitoring					
	-	ary care physician) for any					
	underlying issues Conclusion: [Client C] had a						
		resent. The floor was slippery.					
		Nonslip decals will be					
	-	s work request to put in a bathroom shower. [Client C]					
	-	check for a UTI (urinary tract					
		nedical issue to determine if it					
	is making her feel d						
	8	,					
	2D) BDS incident r	eport dated 9/21/23 indicated,					
		ient C] was talking to staff					
		walk away and fell to her					
		[Client C] scraped a scab on					
	-	vious incident and it began to					
		first aid. Plan to Resolve: risk plan that was being					
		ad a recent fall assessment					
		imary care physician) ordered					
		py) which is in the process of					
	being scheduled".	() / provide of					
	_	ary dated 9/20/23 indicated,					
		dent: [Client C] came from the					
		staff another client was eating					
	-	the staff and turned around					
		the table, and she fell on the					
		nees. There were no new					
	injuries but a scab f	rom a past fall broke open and	Ī				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11 Facility ID: 000956

If continuation sheet Page 39 of 74

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	E CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G	00	COMPL	LETED
		15G442	B. WING			12/04	/2023
			QTD	EET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			ING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
	Г						ı
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	i	DEFICIENCY)		DATE
	1 2	her knee cleaned and a					
	~	ion: It is substantiated [client					
	_	ill risk plan not being					
	implemented appropriately. [Client C] fell because she was trying to move too quickly, and staff						
	failed to remind her						
	Recommendations: The staff will be retrained on notifying AS (Area Supervisor) /Nurse/QIDP						
	1	ual Disabilities Professional)					
	` `	cident. Staff will be retrained to					
	remind [client C] to slow down when she is						
	walking quickly".						
	2E) BDS incident report dated 9/26/23 indicated,						
	"It was reported [cl	ient C] was attempting to open					
	the door on the van	and lost her balance and fell					
	to the ground. Staff	completed skin assessment					
	and found no new is	njuries. Staff did find a 3 ½					
	_	nt C's] right mid back that					
		ing. [Client C] told staff she					
		ruise after her last fall No					
	1 -	e on [client C's] back at the time					
		Resolve: Staff will continue to					
		ent C] has a fall risk plan in					
		g followed at the time of the					
		had a recent fall assessment					
	completed".						
	Investigation assure	nome datad 0/26/22 in disasted					
	_	nary dated 9/26/23 indicated, ident: [Client C] had fallen					
	_	e van. [Staff #4] had caught					
		g down to the ground. When					
	_	cked her for injury. She had a					
		ise that was yellow/green/blue.					
	_	e got it the last time she fell in					
		She said she hit the shower					
	` ′	onclusion: [Client C] had an					
		from a fall on 9.8.23. [Client C]					
		ime for bruises to show up.					
	_	HRC (Human Rights					
	ī				1		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11 Facility ID: 000956

If continuation sheet Page 40 of 74

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G442	A. BUILDING B. WING	00	COMPLETED 12/04/2023
NAME OF T	PROVIDER OR SUPPLIEI	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
		LTERNATIVES SE IN		/ING LN RSONVILLE, IN 47130	
	T			NOONVILLE, IIN 47 130	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG		al) was requested as well, as	TAG		DATE
		to supervise [client C's]			
	showers for safety precautions. Staff will be				
	trained".				
	2F) BDS incident report dated 10/17/23 indicated, "It was reported [client C] was going to get a				
		could start her laundry. Staff			
		wait until staff finished			
	_	cations to [client C's]			
	housemate. There was a box in the floor that [client C] attempted to move with her foot. [Client C] lost her balance and fell to the floor. Staff assisted [client C] from the floor and completed				
		Client C] sustained a ½ inch			
	abrasion on each el	bow. The abrasions did not			
		se was contacted. Plan to			
		remind [client C] not to attempt			
	moving items on th	e floor with her foot".			
	Investigation summ	nary dated 10/16/23 through			
		"Introduction: [Client C]			
		od to do laundry. Staff asked			
	_	C] did not wait and tried to			
	_] med (medication) box out of lost her balance from pushing			
	, , ,	ox out of the way. She fell to			
		d small scrapes on both her			
		was notified, and first aid was			
	given				
	Factual Findings:	11. Were there any			
	_	ors that contributed to the fall?			
	The box was in [cli	ent C's] way once she tried to			
		e when asked not to. 12. Do			
		o be made to prevent future			
		asking [client C] to wait, have			
		her to not impulsively fall due Conclusion: Staff will be			

FORM CMS-2567(02-99) Previous Versions Obsolete

trained to ask [client C] to sit down if they are

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 41 of 74

OF CORRECTION	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		00	(X3) DATE SURVEY	
	IDENTIFICATION NUMBER 15G442	A. BUILDING B. WING	00	COMPLETED 12/04/2023	
		402 EW	/ING LN		
SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
_					
[client C] to sit dow for something. The plan to include staff	on if they are asking her to wait [nurse] will update the risk fasking [client C] to sit down if				
"It was reported state a shower when she [client C's] right hip [client C] how she s reported she got the Plan to Resolve: [C.	ff was assisting [client C] with noticed a 3-inch bruise on b/lower back. When staff asked sustained the bruise, [client C] bruise the last time she fell. lient C] fell on 11/3/23 landing				
a fall in the shower	on 11/3/23, and therefore no				
client A fell on the	following dates without injury:				
interviewed. The gu C's pattern of falls a the risk of falling w stated, "I would like walking. I'm told th without a doctor's o indicated he had use a home visit and sta comfortable usually	ardian was asked about client and her program plan to reduce ith injury. Client C's guardian e to see the use of a cane for ere is not a way to use it rder". Client C's guardian ed a cane with client C during ated, "I just feel more with her (ambulating). Also,				
	SUMMARY: (EACH DEFICIEN REGULATORY OR asking her to wait for update the risk plans Recommendations: [client C] to sit down for something. The plan to include staff they are asking her 2G) BDS incident rown "It was reported state a shower when she [client C] how she is reported she got the Plan to Resolve: [Con her hip. There we time of the fall". The cause of the broad a fall in the shower investigation was converted. In addition, internal client A fell on the staff of falling we stated, "I would like walking. I'm told the without a doctor's of indicated he had use a home visit and stacomfortable usually while she's still ambility of the site of still and the staff of the site of the staff of the staff of the staff of the site of the staff o	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION asking her to wait for something. The [nurse] will update the risk plan Recommendations: Staff will be trained to ask [client C] to sit down if they are asking her to wait for something. The [nurse] will update the risk plan to include staff asking [client C] to sit down if they are asking her to wait for something". 2G) BDS incident report dated 11/13/23 indicated, "It was reported staff was assisting [client C] with a shower when she noticed a 3-inch bruise on [client C's] right hip/lower back. When staff asked [client C] how she sustained the bruise, [client C] reported she got the bruise the last time she fell. Plan to Resolve: [Client C] fell on 11/3/23 landing on her hip. There were no visible injuries at the time of the fall". The cause of the bruise was determined to be from a fall in the shower on 11/3/23, and therefore no investigation was conducted and/or available for	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION asking her to wait for something. The [nurse] will update the risk plan Recommendations: Staff will be trained to ask [client C] to sit down if they are asking her to wait for something. The [nurse] will update the risk plan to include staff asking [client C] to sit down if they are asking her to wait for something". 2G) BDS incident report dated 11/13/23 indicated, "It was reported staff was assisting [client C] with a shower when she noticed a 3-inch bruise on [client C's] right hip/lower back. When staff asked [client C] how she sustained the bruise, [client C] reported she got the bruise the last time she fell. Plan to Resolve: [Client C] fell on 11/3/23 landing on her hip. There were no visible injuries at the time of the fall". The cause of the bruise was determined to be from a fall in the shower on 11/3/23, and therefore no investigation was conducted and/or available for review. In addition, internal incident reports indicated client A fell on the following dates without injury: 5/10/23, 7/21/23, 8/25/23 and 9/8/23. On 11/28/23 at 5:01 PM, client C's guardian was interviewed. The guardian was asked about client C's pattern of falls and her program plan to reduce the risk of falling with injury. Client C's guardian stated, "I would like to see the use of a cane for walking. I'm told there is not a way to use it without a doctor's order". Client C's guardian indicated he had used a cane with client C during a home visit and stated, "I just feel more comfortable usually with her (ambulating). Also, while she's still ambulating, let's look at doing	RE COMMUNITY ALTERNATIVES SE IN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION asking her to wait for something. The [nurse] will update the risk plan Recommendations: Staff will be trained to ask [client C] to sit down if they are asking her to wait for something. The [nurse] will update the risk plan to include staff asking [client C] to sit down if they are asking her to wait for something". 2G) BDS incident report dated 11/13/23 indicated, "It was reported staff was assisting [client C] with a shower when she noticed a 3-inch bruise on [client C]s right hip/lower back. When staff asked [client C] how she sustained the bruise, [client C] reported she got the bruise the last time she fell. Plan to Resolve: [Client C] fell on 11/3/23 landing on her hip. There were no visible injuries at the time of the fall". The cause of the bruise was determined to be from a fall in the shower on 11/3/23, and therefore no investigation was conducted and/or available for review. In addition, internal incident reports indicated client A fell on the following dates without injury: 5/10/23, 7/21/23, 8/25/23 and 9/8/23. On 11/28/23 at 5:01 PM, client C's guardian sinterviewed. The guardian was asked about client C's pattern of falls and her program plan to reduce the risk of falling with injury. Client C's guardian stated, "I would like to see the use of a came for walking. I'm told there is not a way to use it without a doctor's order". Client C's guardian indicated he had used a came with client C during a home visit and stated, "I just feel more comfortable usually with her (ambulating). Also, while she's still ambulating, let's look at doing	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 42 of 74

		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G442	B. W	'ING		12/04	/2023
NAME OF P	DOMDED OF CURPLIES			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF			402 EW			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		R LSC IDENTIFYING INFORMATION ssessed by Physical Therapy.		TAG			DATE
		, "I think she has. That was					
	_	ength and got rid of the walker.					
	-	her, you can tell these little					
	things (cane) help. It's minor, but it could help". On 11/29/23 at 1:03 PM, a review of client C's						
		ed. The review indicated the					
	following:						
	-Fall Health Risk P	lan dated 10/13/23 indicated,					
	"Problem: Fall risks	s Approach: 1) Staff will assist					
	[client C] with amb	ulation as necessary to ensure					
	• /	ensure [client C] wears					
		ennis shoes, soled shoes or					
	· ·	Staff will keep environment free					
		prevent falls. 4) Staff will					
		falls and complete incident ill ensure that [client C] uses a					
	-	at staff are assisting as					
		n close proximity of bathroom					
		needed/requested. 13) Staff					
		sist as needed with showers".					
	-Medical Consult d	ated 9/30/23 indicated, "Name:					
		for Visit: Physical Therapy					
		itial evaluation Consult					
		1 wk (week) 7 for therapeutic					
		exercise, gait training,					
		nining to improve strength,					
	· ·	ance to reduce the risk of falls					
		independence with mobility					
	and ADLs (adult da	my nving skills)".					
		6 PM, the Nurse was					
		urse was asked about client C's					
	*	injury and the implementation					
		m plans to reduce the risk of					
		ne Nurse indicated client C					
	participated in hom	e Physical Therapy services					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 43 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		15G442	B. W	/ING		12/04	/2023
NAME OF F			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	C.		402 EW	ING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION indicated client C would	+	TAG	DEFICIENC!)		DATE
	1						
	complete Physical Therapy services due to repeated falls, be discharged, and would be						
	1 -	hysical Therapy. The Nurse					
		iting Physical Therapist					
		tus of client C's therapy and					
		e indicated the Physical					
	Therapist usually ha	ad a folder and would					
	document regarding	g the therapy with client C. The					
	outside Physical Th	erapist documentation of					
	client C's progress was requested at that time.						
	On 11/29/23 at 3:48 PM, the Nurse provided two						
	· ·	rapy consult forms for review.					
	The review indicate	ed the following:					
	-Physical Therapy (PT) Consult dated 11/13/23					
		c/o (complaint) R (right) knee					
		tient reported 0/10 (no pain)					
	1 ~	d with activity Standing					
		gram: Complete 2-3 (times) /					
	day for 10-15 reps of	each. 1) Marching in place. 2)					
	Mini squats. 3) Hee	l / Toe raises. 4) Hip abduction					
	l ·	raight). 5) Hip Extension (kick					
		6) Hamstring curls ('butt' kicks					
	/ donkey kicks). 7)	Sitting and Standing".					
	Dlaygian The	Compult dated 11/22/22					
	1	Consult dated 11/22/23 for visit: Physical Therapy					
		trength with 30 sit to stand					
		it still requires hands on					
		y) Orders: Plan to recertify					
	for additional PT vi	•					
	On 11/29/23 at 3:54	PM, the Nurse was asked					
	about the Physical T	Therapy consults indicating an					
		nd client C requiring assistance					
	_	ety. The Nurse indicated more					
	_	ed to review and revise client					
	C's program plans a	and train staff. The Nurse					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 44 of 74

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	, ,		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD B. WING	ING	00	COMPL 12/04/	
		15G442				12/04/	
NAME OF I	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			ING LN RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION Id be within arm's reach of	TA	AG	DEFICIENCY		DATE
		o provide support and					
		nt falls and promote client C's					
	safety while she am	-					
		6 AM, the Qualified Intellectual					
	Disabilities Professional (QIDP) was interviewed.						
		ed about client C's Standing gram. The QIDP indicated she					
		T recommendation for an in					
	home exercise program. The QIDP stated, "[Nurse] may have got something started up with the staff, but I don't know anything about that".						
		3 AM, the Director of Nursing					
		ewed. The DON was asked					
		mendations of a standing in					
		ram and hands on assistance C's safety. The DON indicated a					
	_	ie had occurred and stated,					
		standing home exercise					
		ld help her balance and					
		N indicated more follow up					
	would be completed	d to ensure the standing in					
		ram and the hands on					
		during ambulation would be					
	implemented as par	t of client C's program plans.					
	At 11:40 AM the Γ	OON and QIDP provided further					
		uest of the nurse's knowledge					
		nding exercise program. The					
		nurse had responded "I did					
	not know". The DO	N stated, "That's what I was					
	guessing".						
	On 12/4/23 at 12·24	PM, the Quality of Assurance					
		as interviewed. The QAM was					
		A and C's pattern of fall with					
		ical supports and services					
		ective measures to prevent					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 45 of 74

PRINTED: 01/03/2024

	T OF HEALTH AND HU					RM APPROVED B NO. 0938-039	
	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CO A. BUILDING B. WING	CONSTRUCTION (X3) DATE SURVEY 00 COMPLETED 12/04/2023		ETED	
	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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	
W 0252 Bldg. 00	to retrain the Qs (Q question does the p look into the histor implemented". This federal tag rel 9-3-2(a) 483.440(e)(1) PROGRAM DOC Data relative to a criteria specified i plan objectives m measurable terms Based on observati interview for 1 add failed to ensure clicher Behavioral Supconsistently and ac Findings include: Observations were 3:37 PM to 5:13 PM to 9:17 AM. During isolated herself to be heard with the door agitated. Upon enteindicated client H visit on the story in the property of the plant o	ccomplishment of the n client individual program ust be documented in s. on, record review and itional client (H), the facility ent H's target behaviors from port Plan were documented	W 0252	The facility will develop a maintain a recordkeeping system that documents the client's head care, active treatment, social information, and protection of client's rights. The Area Supervisor will retrain all staff in the facility on completing behavior tracking on a daily basis. Behavior data tracking sheets have been updated to include client target behavior. QIDP has trained all staff in the facility on updated behavior data tracking sheets	em alth the data The e	12/21/2023	

FORM CMS-2567(02-99) Previous Versions Obsolete

4:23 PM, client H went to the bathroom to

Client H isolated herself to her bedroom.

complete her evening shower. At 4:37 PM, client

H was returning to her bedroom and was asked if

she was feeling a little better. Client H stated, "A

little" and continued to walk toward her bedroom.

At 7:39 AM, client H was heard to vocalize in a

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

The Area Supervisor will

The QAM will retrain the

The QAM will retrain the

retrain all staff in the facility on

QIDP on review behavior data

QIDP on reviewing behavior

monthly at a minimum.

notifying the QIDP of trends.

Page 46 of 74

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G442	B. W	ING		12/04/	/2023
				STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	₹			/ING LN		
RES CAE	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
INLO OAI	VE OCIVIIVIOIVITITA	ETERMATIVEO DE IIV		JEI I EI	TOOMVILLE, IIV 47 100		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		alified Intellectual Disabilities			tracking during IDTs		
	` `) frustration over using the			The QAM will retrain QI		
	-	ardian concerning money.			on Behavior Tracking data ent	-	
	Client H remained t	to herself within her bedroom.			and review behavior tracking of		
	4.011.435	1			The QIDP will verify beh		
	At 8:11 AM, again client H was heard in her				tracking end dates in Task Ma		
		ally loud and being repetitive in			Pro and verify goal tracking re		
	-	finances. The QIDP was asked			current if data is not current Q		
		eing vocally loud in her			will notify the Area Supervision		
		her concern was regarding			and Program Manager who wi		
	finances. The QIDP stated, "Her dad stopped				in-service DSL and DSPs in th	ne	
	providing \$40.00 a week with her \$50.00. She was getting \$90.00 a week. She had called her dad				facility.		
					A member of the	4 -	
	-	ot taking her calls. That			Administrative team will condu		
		0) just started, but the verbal			monthly site reviews for all clie		
		e) for a longtime. Her dad says			in facility and the administrato	r Will	
	-	r mind on something			hold a weekly ICF meeting to		
		Autism (neurological and			discuss issues that arise in the	9	
	-	rder). Her dad and I have			facility.		
		g in her plan, if you can					
		cal touch or say 'pause' with			Barrage Barrage into AFD		
	-	apist wants to try a week of no			Persons Responsible: AED,	. .	
	-	s too much. I said let's get s. We've had issues with theft			Quality Assurance Manager, (λH	
		indicated client H's program			Coordinator/QIDP Manager,		
		anged where her guardian			Program Manager, Area	a a rt	
	*	nanged where her guardian additional \$40.00 a week to the			Supervisor, QIDP, Direct Supp	אטרנ	
	~	eived. The reduction in money			Lead, and DSP.		
		•					
		's obsessive compulsiveness					
		ion. The QIDP indicated due in client H's past, her					
		supplementing with the					
	-	o prevent client H from being					
		after a trial of this, the					
	_	am was concerned about the					
		m was concerned about the money of \$90.00 a week					
		reasing client H's maladaptive					
		obsessive and more aggressive					
	_	oosessive and more aggressive					
	regarding money.						
ı	i		1		I		1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 47 of 74

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/04/2023	
	PROVIDER OR SUPPLIER	R LTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP COD VING LN RSONVILLE, IN 47130		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	On 11/29/23 at 12:0	27 PM, a focused review of as conducted. The review wing:	TAG	DEFICIENCE	DATE	
	-Behavioral Support Plan dated 5/17/23 indicated, "Target Behaviors and Goals:					
		may display actions of her g able to sit still or repeating er				
		all have 3 or fewer episodes of three consecutive months				
		olating self: [Client H] may withdrawal (sic) crself from others, and isolate herself to her om				
		all have 5 or fewer episodes of or three consecutive months				
	louder than what is any time she yells,	Anytime [client H] speaks necessary for the situation, curses, threatens, or has any sts. [Client H] may also repeat er				
		ill have 5 or fewer occurrences of month for three consecutive				
	[client H] repeats h	mpulsive disorder): Anytime erself over and over again (i.e. st-food restaurant, [store])				
		ill display 5 or less occurrences for twelve (12) consecutive				
	Stealing: Taking th	nings that do not belong to her				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11 Facility ID: 000956

If continuation sheet Page 48 of 74

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COMI	e survey Pleted 4/2023
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COI VING LN)	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
TAG	without permission.		IAG			DATE
		Il have 3 or fewer episodes of onsecutive months				
	H], or outing discus	Any discussion with [client sision or shopping activity will on. Such conversations				
	Goal: [Client H] will have 0 or fewer occurrences of money aggression per month for three consecutive months					
	H's] Structured A-E (Antecedent-Behav Collection Sheet ac	ior-Consequence) Data ross all shifts. Instruction to fill are provided on the data				
	-No Behavior Track	ring was available for review.				
	interviewed. The Q target behavior trac months. The QIDP could be provided f The QIDP stated, "' you were there (obs did not have the bel	DPM, the QIDP was IDP was asked for client H's king data for the past three indicated no behavior tracking for review except for 11/4/23. That was sent the day after the tracking in the group home). It haviors that occurred (during them to track. We'll have to IDP.				
	client H's 11/4/23 b	04 AM, a focused review of ehavior tracking sheet was iew indicated the following:				
		Non-compliance Verbal cal Aggression Other".				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 49 of 74

CENTERS FOR MEDICARE & MEDICAID SERVICES	EPARTMENT OF HEALTH AND HUMAN SERVICES	
	ENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			COMPL	ETED	
		15G442	B. WI	NG		12/04/	2023
	RE COMMUNITY AI	LTERNATIVES SE IN	•	402 EW	ADDRESS, CITY, STATE, ZIP COD VING LN RSONVILLE, IN 47130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE 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 APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	check mark for an e 11/4/23. No other be H was available for provided for 11/202 observed behaviors tone in language or	behavior tracking sheet had one pisode of verbal aggression on ehavior tracking data for client review. The behavior tracking 3 did not include client H's of isolating, repetitive loud her concerns expressed in uch as calling her guardian e \$40.00 withheld.					
W 0318	483.460 HEALTH CARE S	ERVICES					1
Bldg. 00	The facility must ecare services requibased on observation interview for 2 of 2 facility failed to menaticipation: Health health care services nursing services we client A's pattern of both of her feet to ereasons such as bon factors for the level the falls and, 2) clie injury to ensure imprexercise program and ambulated to ensure Findings include: Please refer to W33 services failed to encontinued support a client A's pattern of both of her feet to estate the care to expense the	insure that specific health airements are met. on, record review and sampled clients (A and C), the et the Condition of the Care Services. The facility's failed to ensure sufficient re provided to address 1) falls resulting in fractures to insure no additional medical e density were contributing of injuries sustained during int C's pattern of falls with obtained assistance while she	WO	318	The facility will provide or of preventive and general medicacare of each client in the Facility's Nurse will schedule and follow up to ensure continusupport and services are provito address client A's pattern of falls resulting in fractures to be of her feet to ensure no addition medical reasons such as bone density were contributing factor for the level of injuries sustained during the falls and, 2) client of pattern of falls with injury to ensure implementation of an inhome exercise program and stassistance while she ambulate to ensure her safety. The Director of Nursing has retrained the Nurse on reviewi Doctor consults and implement recommendations of doctor orders.	all ty e ued ded bth onal e ed taff ed and	12/21/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11 Facility ID: 000956

If continuation sheet

Page 50 of 74

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G442	B. Wl	ING	_	12/04/	/2023
NAME OF B			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF			402 EW	VING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFE	RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		of injuries sustained during			·The Director of Nursing will		
		ent C's pattern of falls with			in-service the facility nurse on		
		plementation of an in home			scheduling, continued support		
	ambulated to ensure	nd staff assistance while she			providing sustained services for	or all	
	amburated to ensure	e ner safety.			clients in the facility. Appointment for Clients care	_	
	This federal tag rela	ates to complaint #IN00407148.			will be scheduled by the nurse		
	Tins rederar tag rea	ites to complaint #1110040 / 140.			·Staff will be retrained on	•	
	9-3-6(a)				ensuring the clients make it to		
	<i>x</i> = v()				their scheduled appointments.	The	
					staff in the Facility will be retra		
					on the client appointment		
					procedure.		
					A member of the		
					Administrative team will condu	ict a	
					monthly site reviews for all clie	ents	
					in facility and the administrator	r will	
					hold a weekly ICF meeting to		
					discuss issues that arise in the)	
					facility.		
					Persons Responsible:		
					Executive Director, AED, Prog	ram	
					Manager, Quality Assurance,		
					Quality Assurance Manager		
					Director of Nursing, Nurse, Are Supervisor, QIDP, DSL, and D		
					Supervisor, QIDP, DSL, and D	юг.	
W 0322	483.460(a)(3)	4050					
DI4 00	PHYSICIAN SER						
Bldg. 00		provide or obtain preventive					
	and general medi	cal care. view and interview for 1 of 3	337.0	222	The facility will provide an all	atain	12/21/2022
		the facility failed to ensure	I w c)322	The facility will provide or ol preventive and general medica		12/21/2023
	client B received a				care of each client in the Facili		

FORM CMS-2567(02-99) Previous Versions Obsolete

Findings include:

Event ID:

7FKA11

Facility ID: 000956

56

·facility's Nurse will schedule

and follow up to ensure continued support and services are provided

If continuation sheet Page 5

Page 51 of 74

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442 NAME OF PROVIDER OR SUPPLIER IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 12/04/2023 STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER	
NAME OF PROVIDER OR SUPPLIER	
1.4= = 1.11.4 = 1.	
RES CARE COMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CEACH CORRECTIVE ACTION SHOULD BE COMPLETION	N
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	
On 11/29/23 at 2:45 PM, a review of client B's to address client A's pattern of	
record was conducted. The review indicated the falls resulting in fractures to both	
following: of her feet to ensure no additional	
medical reasons such as bone	
-Individual Support Plan (ISP) dated 10/16/23 density were contributing factors	
indicated, "Name: [Client B] Date of Birth: [over for the level of injuries sustained	
40 years of age]". during the falls and, 2) client C's	
pattern of falls with injury to	
-A current medical consult for the completion of a ensure implementation of an in	
mammogram for client B was not available for home exercise program and staff	
review. assistance while she ambulated	
to ensure her safety.	
-Medical Consult Form dated 6/1/22 indicated, • The Director of Nursing will	
"Reason for Visit: Annual Physical Orders: in-service the facility nurse on	
Schedule mammogram". scheduling, continued support and	
providing sustained services for all	
On 11/29/23 at 3:26 PM, the Nurse was clients in the facility.	
interviewed. The Nurse was asked if client B had a Appointment for Clients care	
current medical consult for the completion of a will be scheduled by the nurse.	
mammogram and/or when client B had last Staff will be retrained on	
completed a mammogram. The Nurse indicated no ensuring the clients make it to	
documentation of a mammogram for client B could their scheduled appointments. The	
be provided for review. The Nurse indicated client staff in the Facility will be retrained	
B's primary care physician had made a on the client appointment	
recommendation to schedule a mammogram at her procedure.	
previous annual physical on 6/1/22 but the need A member of the	
for a mammogram had not been identified at her Administrative team will conduct a	
most current annual physical on 11/15/23. The monthly site reviews for all clients	
Nurse indicated more follow up to ensure client B in facility and the administrator will	
received supports and services concerning the hold a weekly ICF meeting to	
need for a mammogram was required. discuss issues that arise in the	
facility.	
9-3-6(a)	
Persons Responsible: Executive	
Director, AED, Program Manager,	
Quality Assurance, Quality Assurance Manager Director of	
Nursing, Nurse, Area Supervisor,	
QIDP, DSL, and DSP.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 12/04/2023 15G442 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 402 EWING LN RES CARE COMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE W 0331 483.460(c) NURSING SERVICES Bldg. 00 The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review and Observations conducted W 0331 12/21/2023 interview for 2 of 3 sampled clients (A and C), the my members of the administrative facility's nursing services failed to ensure team including managers from continued support and services to address 1) Quality, Nursing and Programming client A's pattern of falls resulting in fractures to will conduct twice daily both of her feet to ensure no additional medical observations weekdays focusing reasons such as bone density were contributing on Adaptive Equipment, Exercise factors for the level of injuries sustained during Program, Staff Training and the falls and, 2) client C's pattern of falls with Medication. Any issues are to be injury to ensure implementation of an in home immediately reported to the exercise program and staff assistance while she Facility Team. ambulated to ensure her safety. An IDT comprised of paraprofessionals was held on Findings include: December 1, 2023 to address client issues QIPD, Nurse and a 1) Observations were conducted on 11/27/23 from Member of Programming 3:37 PM to 5:13 PM and on 11/28/23 from 7:05 AM Management will retrain all staff in to 9:17 AM. During these observations, client A the facility on updated BSPs ISP wore a hard plastic boot on her right foot. At 4:03 and HRP as needed. PM, client A prepared to take her afternoon A bone density was medications. Client A was asked if liked living at completed for Client A in June the group home. Client A stated, "I do. I love this 2023. Once Client A is released house. It's better than [previous home]. Yes, I do". from Orthopedics the physician Client A was asked about the use of her hard will order a follow up bone density. plastic boot. Client A stated, "It's healing up". A Bone density for Client C has Client A then proceeded to take her afternoon been requested. The Facility will medications. ensure follow is complete. An IDT comprised of At 9:12 AM, client A was asked how she hurt her Paraprofessionals was held to foot. Client A stated, "I was in the kitchen and fell identify fall risk and work on client backwards". Client A was asked what she was specific plans. The QIDP and doing when the fall occurred. Client A stated, "I Nurse will train staff based on was putting dishes away". Client A was asked these recommendations. what caused her to lose her balance. Client A stated, "I got a little dizzy". Client A was asked if Persons Responsible: Program this happened often. Client A stated, "No". Client Manager, Quality Assurance, Area

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15G442	B. Wl	ING		12/04/	2023
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
				402 EW			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		a previous fall that occurred in	+	TAG	Supervisor, Director of Nursing	~	DATE
		esulted in an injury and how it			Nurse, Behavior Clinician, QIE	•	
	_	stated, "I fell on my floor. I had			Residential Manager, and DSI		
		". The Qualified Intellectual			r toolaontaar Managor, ana 201	•	
		ional (QIDP) stated to client A,					
		portant to keep your room					
	cleaned up". Client	A responded by stating,					
	"Yeah". Client A w	ore the hard plastic boot					
	_	e evening and morning					
	observations.						
	0 11/27/22 : 2.24	O.D.A					
		O PM, a review of the facility's					
		ies Services (BDS) reports and estigation summaries was					
		iew indicated the following					
	affecting client A:	lew indicated the following					
	affecting enem A.						
	1A) BDS incident r	report dated 4/20/23 indicated,					
	1	ient A] came to the living room					
	after taking a nap. S	Staff stated [client A] appeared					
	to have an involunt	ary movement in her right					
	hand and right leg a	and drool on her face, neck,					
	and shirt. [Client A] does receive a medication to					
		taff informed [client A] she					
		ower so she could be taken to					
		room), so [client A] went to					
		heard a noise and went to					
		. [Client A] was sitting on the					
	_	Her left ankle appeared					
		eginning to bruise. [Client A]					
		o her bed while staff went to					
		gency medical services). Plan rrived and transported [client					
		aluation. [Client A] was					
	_	tted to [name of hospital].					
		the and some of her toes are					
	l -] is scheduled to have surgery					
	_	ave been placed on leave					
		on and review to ensure plans					
		d at the time of incident".					
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 54 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		15G442	B. WING		12/04/2023
		<u> </u>	CTREE	Γ ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	R			
DECCAE		LTEDNIATIVES SE IN		WING LN	
RES CAR	RE COMMUNITY A	LTERNATIVES SE IN	JEFF	ERSONVILLE, IN 47130	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION (X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Investigation summ	nary dated 4/20/23 through			
	4/26/23 indicated, "	'Introduction: An investigation			
	was initiated when	[client A] fell in her bedroom			
	and sustained a frac	cture in (sic) her left ankle			
	which required surg	gery			
		Staff #5] stated she was			
	_	lient A] due to drooling and			
		er questions. [Staff #5] also			
		know [client A] as well as			
	[staff #1] does.				
		e was not concerned about			
		g, twitching in her arm and leg,			
	_	ent A] did not respond to [staff			
		ed all of these behaviors were			
	_	A]. [Staff #1] also stated had she			
		was in need of medical			
		d have transported [client A]			
		vorried about [client A]			
		[Staff #1] was only going to			
		ne ER because [Staff #5] was so			
	· ·	were unable to reach the			
	nurse for advice.				
	[Client Aller t 1 1	as year feeling for 1			
		ne was feeling fine when she			
		taking a nap. [Client A] did			
		zzy when she stood up from lasted a few seconds. [Client			
		f falls therefore has no Fall			
		ion Administration Records			
		orescribed Atropine three			
	_	ease saliva. [Client A] sustained			
	1	at required surgery to repair			
	a maciumou amkie in	at required surgery to repair			
	Conclusion: It is an	bstantiated [client A] was			
		ervices at the time of her fall			
	receiving quanty se	rices at the time of her fall			
	Recommendations:	Reinstate staff. Retrain staff			
	Accommendations.	remstate starr. Rettalli starr	I		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11 Facility ID: 000956

If continuation sheet Page 55 of 74

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	e survey pleted 4/2023
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP COE VING LN RSONVILLE, IN 47130)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	1B) Internal Incider indicated, "Type Induring the incident? hallway and saw [cl staff walked back to staff went to check (client A) was sittin [client A] why she was aid she slid off her floor. Staff checked was no redness or b Investigation summ "Witness Statement 'Yes' when asked if stated she was gettin denied hitting her histated the floor was over anything. On 8/12/23, [staff # [client A] when she hall to check on her [Staff #2] stated [client A] up and ch not find any Conclusion: It is sult to her bedroom floor Recommendations: with floor grippers a will help her get her out of bed. This will plan".	ary dated 8/12/23 indicated, ss: On 8/12/23, [client A] stated she had fallen. [Client A] ng out of her bed. [Client A] ead or getting hurt. [Client A] slippery and denied tripping 2] stated she was not with fell but had walked down the and found her on the floor. Lent A] reported she slid down [Staff #2] stated she helped ecked her for injuries and did obstantiated [client A] fell due				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 56 of 74

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/04/2023
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP COD VING LN RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	"Staff reported [clie to her room, and shall was assisted to be contacted. Staff were urgent care in the mexperienced a fall the injuries or complair Resolve: [Client A] on 11/5/2023, she with metatarsal fraction A] was given a wall orders to follow upuse ice and Tylenol will be reviewed and Investigation summusity 11/6/23 indicated, "was reported [client back hallway when what happened and thought she tripped there was nothing of A] denied having an 'No really, I'm ok' On 11/5/23, staff rewalking to her room [Client A] was assist contacted. Staff were urgent care in the mean staff of the fall? On to smoke. On the 5t kitchen to get a snassmoke 2. Was staff her/him? No 6. De history of falls? Yes been completed in the staff were completed in the staff was assisted 2. Was staff her/him? No 6. De history of falls? Yes been completed in the staff was assisted 2. Was staff her/him? No 6. De history of falls? Yes been completed in the staff was assisted 2. Was staff her/him? No 6. De history of falls? Yes been completed in the staff was assisted 2. Was staff her/him? No 6. De history of falls? Yes been completed in the staff was assisted 2. Was staff her/him? No 6. De history of falls? Yes been completed in the staff was assisted 2. Was staff her/him? No 6. De history of falls? Yes been completed in the staff was assisted 2. Was staff her/him? No 6. De history of falls? Yes been completed in the staff was assisted 2. Was staff her/him? No 6. De history of falls? Yes been completed in the staff was assisted 2. Was staff her/him? No 6. De history of falls? Yes been completed in the staff was assisted 2. Was staff her/him? No 6. De history of falls? Yes been completed in the staff was assisted 2. Was staff her/him? No 6. De history of falls? Yes been completed in the staff was assisted 2. Was staff her/him? Yes been completed in the staff was assisted 2. Was staff her/him? Yes been completed in the staff was assisted 2. Was staff her/h	ent A] fell as she was walking the reported back pain. [Client weed and [nurse] was the advised to transport to the torning. [Client A] also the day prior, 11/4/2023, with no the transported to urgent care was assessed and diagnosed the true of the right foot. [Client king boot and discharged with with orthopedic doctor and as needed for pain. Risk plans diagnosed dupdated as needed". ary dated 11/4/23 through Introduction: On 11/4/23, it is A] was walking down the she fell Staff asked [client A] [client A] reported she over her feet. Staff reported in the floor to trip over. [Client the pain or discomfort stating, ported [client A] fell as she was an, and she reported back pain. Sted to the bed and [nurse] was the advised to transport to	TAG	DEFICIENCY)	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 57 of 74

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMI	E SURVEY PLETED 4/2023
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP COD VING LN RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION e any changes	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	needed/implemente A] was transported diagnosed with met given a walking boo	d? No new changes [Client to urgent care, assessed and atarsal fracture of right foot, of and discharged with orders thopedic doctor and use ice				
	the risk plan was us QIDP reviewed the incident with [clien	A's] had 2 falls and each time ed correctly. The [nurse] and Risk plan and discussed the tA] and the staff involved				
	Recommendations: [Nurse] will review and revise fall risk plan The fall risk plan was revised on 11/5/23".					
	reviewed. The revie	PM, client A's record was we indicated the following:				
	Consult dated 4/19/ Decision Making: trimalleolar (ankle) interpretation shows (enlargement of hea Metabolic panel (m is no evidence of in to the on-call orthop fracture) surgeon ar	23 indicated, "Medical x-ray shows a dislocated fracture. Chest x-ray				
	indicated, "Reason Diagnosis: Fall, broback pain without smetatarsal fracture	Consult dated 11/5/23 for Visit: Fall, Back Pain. ken foot, acute bilateral low ciatica (nerve) Summary: A is a break in one of the five the toes to the rest of the				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 58 of 74

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		15G442	B. W	WING 12			12/04/2023	
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	8		402 EW				
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130			
1120 0711	·			l ozi i zi				
(X4) ID		STATEMENT OF DEFICIENCIE		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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		Plan dated 11/5/23 indicated,						
		Falls 1. Staff will assist with						
		safety 2. Staff will assist with						
		dressing in its entirety 3. Staff						
		on assistance with helping						
		n 4. Staff will keep						
		f any obstacles to prevent						
	falls".							
	On 11/29/23 at 3:26	6 PM, the Nurse was						
		urse was asked about client						
		with injuries to her feet. The						
	_	ent A had two falls which						
	resulted in fractures	s. The Nurse was asked about						
	the level of injuries	for fractured bones due to the						
	1	ad experienced. The Nurse						
		id not have a calcium						
	deficiency, but a bo	one density evaluation had not						
	· ·	ie Nurse stated, "Yes. Need to						
	follow up, I'll check	on that. She should have a						
	bone density eval (e	evaluation)". The Nurse was						
	asked if client A ha	d a diagnosis of skeletal issues						
	or Osteoporosis (de	creased bone mass). The						
	Nurse stated, "No."	That's why I'm going to ask						
	them (Orthopedic)	to do it. She returns in 2						
	weeks". The Nurse	was asked about client A's						
	pattern of falls indi	cating environmental issues						
	such as clothing on	her bedroom floor. The Nurse						
	indicated client A's	environment should be free						
	from obstacles and	client A should be supported						
	by staff to ensure he	er safety and prevent falls.						
		3 AM, the Director of Nursing						
		ewed. The DON was asked						
		dical history, age, the three						
		vo of which resulted in						
		ner feet and how the pattern of						
		. The DON indicated more						
	_	was needed and stated, "She						
	needs a bone densit	y test". The DON indicated						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 59 of 74

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

PRINTED: 01/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI		00	COMPL	
		15G442	B. WING	-		12/04/	2023
NAME OF F	PROVIDER OR SUPPLIER	- {			DDRESS, CITY, STATE, ZIP COD		
DEC CAE		LTERNATIVES SE IN			ING LN RSONVILLE, IN 47130		
	RE COMMUNITY A	LIERNATIVES SE IN		JEFFER	RSOINVILLE, IIN 47 130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		EFIX ΓAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
mo		ls with injury and history of	1	MG			DATE
		raluation was needed and					
	stated, "I bet she has Osteoporosis". The DON indicated more medical follow up was going to be completed with client A. 2) Observations were conducted on 11/27/23 from 3:37 PM to 5:13 PM and on 11/28/23 from 7:05 AM						
		g observations, client C was					
	_	te without adaptive supports					
		nce nearby her. Upon entering					
		ent C indicated to the surveyor					
		a walker while ambulating.					
		throughout the kitchen area, lway, to the medication					
	_	n, and to and from her bedroom					
	and bathroom withou						
		g medication administration					
		ct feel numb. Not all the time,					
	I	do". Client C was asked if she					
	I -	or a doctor about her feet					
		C stated, "I'm going to tell the					
		Client C was asked if the doctor					
		t going numb. Client C stated,					
	"No".						
	At 9:09 AM, client	C approached the Qualified					
		ities Professional (QIDP) to ask					
		Shuffled her feet and took a					
	couple short steps b	ackwards. The QIDP used a					
		stated "[Client C] go slow" and					
		rd client C if she needed to					
	1 -	7ith the exception of the QIDP's					
		ambulated throughout the the observation without the					
		ports and/or staff nearby					
	while she ambulate	•					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 60 of 74

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15G442	B. WI	NG		12/04	/2023
NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
DEC CAI		LTERNATIVES SE IN			'ING LN RSONVILLE, IN 47130		
	TE COMMUNITY A	LIERNATIVES SE IN		L	ROUNVILLE, IN 47 130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		0 PM, a review of the facility's					
		ies Services (BDS) reports and					
		estigation summaries was					
	affecting client C:	iew indicated the following					
	arreeding chefit C.						
		report dated 7/10/23 indicated,					
		ient C] was putting away pots					
	and pans when she fell to the floor. [Client C] reported she lost her balance. Staff found a 1-inch						
	abrasion on [client C's] right knee, [client C]						
	reported no pain. S	taff applied first aid. Plan to					
	Resolve: Staff will continue to report all falls. Staff						
	will contact the nurse for all falls".						
	Investigation summ	nary dated 7/24/23 indicated,					
	_	ident: [Client C] fell as she was					
		and pans away Conclusion:					
		client C] lost her balance and way the pots and pans causing					
	a scrape that requir						
		Staff need to remind [client C]					
		t a calm pace to prevent losing					
	her balance".						
	2B) BDS incident r	report dated 8/6/23 indicated, "It					
	1	t C] was getting a cup from the					
		aid she tripped over her feet					
		Staff completed skin					
		and a ¾ inch red mark on her] reported no pain. Plan to					
	_	inded [client C] to slow down					
		ff will continue to report all					
	falls".						
	Investigation summ	nary dated 8/5/23 indicated,					
	_	ident: [Client C] was in the					
	_	ning around to go from sink					
	_	ot up and staff came over to					
	check her for injuri	es. [Client C] said she was fine.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 61 of 74

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ´		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	G	00	COMPL	
		15G442	B. WING			12/04/	/2023
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	402	EW	ADDRESS, CITY, STATE, ZIP COD VING LN RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID				(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFI	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.16	DATE
	She pulled her pant	leg up and there was a small					
	red area. [Client C]	is always moving quickly. Staff					
	repeatedly tells her	to slow down. [Client C]					
	doesn't take this ser	iously Conclusion: [Client C]					
		s moving too fast. She slipped					
		nmendations: Staff will continue					
		to slow down. Anti-Slip socks					
	_	or her. Staff will be trained to					
	remind her to ear (s	ic) socks or shoes at all times".					
	2C) BDS incident r	eport dated 9/8/23 indicated, "It					
	was reported [client	t C] went outside to sit on the					
	patio until it was tir	ne to leave for day program.					
	[Client C] was setti	ng her bags down when she					
	lost her balance and	I fell to the ground. [Client C]					
	sustained a 1-inch a	and a ½ inch abrasion on her					
	right knee and a 2-i	nch knot just below her right					
	kneecap. Nurse was	s contacted and [client C] was					
	transported to the h	ospital for evaluation. Plan to					
	1	completed with normal result.					
		ased with discharge paperwork					
	_	of right knee, and Abrasion.					
	1	sed to take Tylenol or					
		Rest, ice, and elevate as					
		ion clean and dry and covered					
	as needed until heal	ed".					
	Investigation	ary dated 9/7/23 indicated,					
		ident: [Client C] took her lunch					
		to the front porch to wait to					
		en she set them down, she lost					
		to her knees. She had a					
		knee and some swelling. The					
	I -	needed to be sent out to					
		e was sent to Urgent Care					
		C] had a fall outside due to					
	_	The ground (cement) on the					
	, , ,	en. Recommendations: The					
	_	to evaluate the amount of					
		arrying to ensure she is not					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 62 of 74

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPI	
		15G442	B. W	ING		12/04	/2023
NAME OF D	DOWNER OF CURRINE		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIER			402 EW			
RES CAF	RE COMMUNITY AI	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	carrying too much".						
	Investigation summ	ary dated 9/8/23 indicated,					
	"Description of incident: [Client C] was taking a						
	shower and had a fa	all. She said the floor was					
	slippery. Staff helpe	ed her up and assessed her					
		requested further monitoring					
		ary care physician) for any					
		Conclusion: [Client C] had a					
	_	resent. The floor was slippery.					
		Nonslip decals will be					
	-	s work request to put in a					
	-	bathroom shower. [Client C] check for a UTI (urinary tract					
		nedical issue to determine if it					
	is making her feel d						
	is making her feet d	iizzy .					
	2D) BDS incident re	eport dated 9/21/23 indicated,					
		ient C] was talking to staff					
	when she turned to	walk away and fell to her					
	knees on the floor.	[Client C] scraped a scab on					
	her knee from a pre	vious incident and it began to					
		first aid. Plan to Resolve:					
		risk plan that was being					
		ad a recent fall assessment					
		imary care physician) ordered					
		py) which is in the process of					
	being scheduled".						
	Investigation summ	ary dated 9/20/23 indicated,					
	-	dent: [Client C] came from the					
	_	staff another client was eating					
	_	he staff and turned around					
	quickly to return to	the table, and she fell on the					
		nees. There were no new					
	injuries but a scab f	rom a past fall broke open and					
		her knee cleaned and a					
	-	on: It is substantiated [client					
	_	ll risk plan not being					
	implemented approp	priately. [Client C] fell because					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 63 of 74

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		15G442	B. W	ING		12/04	/2023
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIEF	<		402 EW	/ING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nove too quickly, and staff					
	failed to remind her to slow down. Recommendations: The staff will be retrained on						
		Supervisor) /Nurse/QIDP					
		ual Disabilities Professional)					
	` `	cident. Staff will be retrained to					
		slow down when she is					
	walking quickly".	, slow down when she is					
	2E) BDS incident r	eport dated 9/26/23 indicated,					
		ient C] was attempting to open					
	_	and lost her balance and fell					
	to the ground. Staff	completed skin assessment					
	and found no new i	njuries. Staff did find a 3 ½					
	inch bruise on [clie	nt C's] right mid back that					
	appeared to be heal	ing. [Client C] told staff she					
	had sustained the bi	ruise after her last fall No					
	injuries were visible	e on [client C's] back at the time					
	of that fall. Plan to	Resolve: Staff will continue to					
	report all falls. [Cli-	ent C] has a fall risk plan in					
	l -	g followed at the time of the					
		had a recent fall assessment					
	completed".						
	I	1-4-10/26/22 11 11					
	_	nary dated 9/26/23 indicated,					
		ident: [Client C] had fallen e van. [Staff #4] had caught					
		2 2					
		g down to the ground. When seked her for injury. She had a					
		ise that was yellow/green/blue.					
	1	e got it the last time she fell in					1
	l = =	She said she hit the shower					
		onclusion: [Client C] had an					
		from a fall on 9.8.23. [Client C]					
	1 , ,	ime for bruises to show up.					
	_	HRC (Human Rights					
		al) was requested as well, as					
		to supervise [client C's]					
		precautions. Staff will be					
	trained"						1

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 64 of 74

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

PRINTED: 01/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPI 12/04,	LETED	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP CO VING LN RSONVILLE, IN 47130	D .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	"It was reported [cl laundry pod so she asked [client C] to administering medi housemate. There we [client C] attempted C] lost her balance assisted [client C] find skin assessment. [Client C] abrasion on each elbreak the skin. Nur Resolve: Staff will moving items on the Investigation summed 10/17/23 indicated, wanted a laundry pher to wait. [Client move [housemate's the way. [Client C] the other client's bear bottom. She had elbows. The nurse we given Factual Findings: environmental factor. The box was in [client come into the office any changes need to occurrences? When her sit down to help to her quick actions trained to ask [client asking her to wait fundate the risk plant]	eport dated 10/17/23 indicated, ient C] was going to get a could start her laundry. Staff wait until staff finished cations to [client C's] was a box in the floor that I to move with her foot. [Client and fell to the floor. Staff from the floor and completed client C] sustained a ½ inch bow. The abrasions did not se was contacted. Plan to remind [client C] not to attempt e floor with her foot". Harry dated 10/16/23 through "Introduction: [Client C] od to do laundry. Staff asked C] did not wait and tried to [med (medication) box out of lost her balance from pushing x out of the way. She fell to dismall scrapes on both her was notified, and first aid was 11. Were there any ors that contributed to the fall? ent C's] way once she tried to be when asked not to. 12. Do to be made to prevent future asking [client C] to wait, have to her to not impulsively fall due in Conclusion: Staff will be at C] to sit down if they are for something. The [nurse] will impulsively fall the for something.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 65 of 74

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			0	MB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMI	PLETED
		15G442	B. WING	·	12/0	4/2023
			CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2		ING LN		
DEC CAI		I TEDNIATIVES SE INI				
KES CAI	RE COMMUNITY A	LTERNATIVES SE IN	JEFFER	RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	[client C] to sit dow	n if they are asking her to wait				
	for something. The	[nurse] will update the risk				
	plan to include staff	f asking [client C] to sit down if				
	they are asking her	to wait for something".				
	· ·	eport dated 11/13/23 indicated,				
	1	ff was assisting [client C] with				
		noticed a 3-inch bruise on				
		o/lower back. When staff asked				
	I	sustained the bruise, [client C]				
		bruise the last time she fell.				
	Plan to Resolve: [Client C] fell on 11/3/23 landing on her hip. There were no visible injuries at the					
	time of the fall".					
	l					
		uise was determined to be from				
		on 11/3/23, and therefore no				
	1 -	onducted and/or available for				
	review.					
	T 11'					
		l incident reports indicated				
		following dates without injury:				
	5/10/23, 7/21/23, 8/	725/23 and 9/8/23.				
	On 11/29/22 at 5:01	PM, client C's guardian was				
		ardian was asked about client				
	_					
	_	and her program plan to reduce rith injury. Client C's guardian				
	_	e to see the use of a cane for				
	· ·	ere is not a way to use it				
	_	order". Client C's guardian				
		ed a cane with client C during				
		ated, "I just feel more				
		with her (ambulating). Also,				
	-	oulating, let's look at doing				
		_				
		lient C's guardian was asked if				
		ssessed by Physical Therapy.				
		l, "I think she has. That was				
	now she gained stre	ength and got rid of the walker.	I			

FORM CMS-2567(02-99) Previous Versions Obsolete

When you are with her, you can tell these little

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 66 of 74

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/04/2023
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY A		402 EV	ADDRESS, CITY, STATE, ZIP COD VING LN RSONVILLE, IN 47130	
PREFIX (EACH DEFICIEN TAG REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION (It's minor, but it could help".	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) D BE COMPLETION DATE
On 11/29/23 at 1:03	B PM, a review of client C's ed. The review indicated the			
"Problem: Fall risks [client C] with amb safety. 2) Staff will appropriate shoes, t non-skid shoes. 3) Sof any obstacles to notify nurse of any report 12) Staff w shower chair and th needed remaining it in case assistance is will monitor and as -Medical Consult d. [Client C] Reason start of care visit/in Orders: Plan to see activity, therapeutic neuromuscular retrabalance, and endura and improve safety, and ADLs (adult da On 11/29/23 at 3:26 interviewed. The N pattern of falls with of client C's prograf falls with injury. The participated in hom weekly. The Nurse complete Physical Trepeated falls, be di	lan dated 10/13/23 indicated, s Approach: 1) Staff will assist ulation as necessary to ensure ensure [client C] wears ennis shoes, soled shoes or Staff will keep environment free prevent falls. 4) Staff will falls and complete incident ill ensure that [client C] uses a at staff are assisting as a close proximity of bathroom eneded/requested. 13) Staff sist as needed with showers". Lated 9/30/23 indicated, "Name: for Visit: Physical Therapy itial evaluation Consult 1 wk (week) 7 for therapeutic exercise, gait training, thing to improve strength, ance to reduce the risk of falls (independence with mobility illy living skills)". Let PM, the Nurse was urse was asked about client C's injury and the implementation in plans to reduce the risk of the Nurse indicated client C en Physical Therapy services indicated client C would Cherapy services due to scharged, and would be hysical Therapy. The Nurse			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 67 of 74

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/04/2023		
	F PROVIDER OR SUPPLIEI	₹ LTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP COD VING LN RSONVILLE, IN 47130		•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	LD BE COMPLETION	
PREFIX TAG	was asked if the vision documented the star progress. The Nurs Therapist usually his document regarding outside Physical The client C's progress. On 11/29/23 at 3:44 recent Physical The The review indicated. Physical Therapy indicated, "Patient pain Results Parat rest, but increase Home Exercise Produy for 10-15 reps. Mini squats. 3) Heck (side kicks - legs straight). If donkey kicks (side kicks - legs straight). If donkey kic	R LSC IDENTIFYING INFORMATION siting Physical Therapist tus of client C's therapy and e indicated the Physical ad a folder and would g the therapy with client C. The herapist documentation of was requested at that time. 8 PM, the Nurse provided two herapy consult forms for review. He the following: (PT) Consult dated 11/13/23 He therapy consult forms for review. He the following: (PT) Consult dated 11/13/23 He therapy consult forms for review. He the following: (PT) Consult dated 11/13/23 He therapy consult forms for review. He the following: (PT) Consult dated 11/13/23 He therapy complete 2-3 (times) / He therapy forms for review. He therapy consults in place. 2) He following: (PT) Consult dated 11/13/23 He therapy forms for review. He therapy forms for review for stands for review and revise client for the forms for stands for stands for the forms for stands for sta	PREFIX TAG			-
	safety while she an	nt falls and promote client C's abulated.				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 68 of 74

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

PRINTED: 01/03/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE C A. BUILDING B. WING	OO OO	COMI	E SURVEY PLETED 4/2023
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	402 E'	TADDRESS, CITY, STATE, ZIP O WING LN ERSONVILLE, IN 47130	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
	Disabilities Profess The QIDP was asked Home Exercise Profess was unaware of a Phome exercise programy have got some but I don't know any On 12/4/23 at 11:13 (DON) was intervied about the PT recomposed for client Communication issued in the program. That would be completed home exercise programs. That would be completed home exercise programs assistance for safety implemented as part At 11:40 AM, the Effollow up to the required program indicated the not know. The DOG guessing.	AM, the Qualified Intellectual ional (QIDP) was interviewed. In about client C's Standing gram. The QIDP indicated she Torecommendation for an information are are the properties of the propert				
W 0352	483.460(f)(2) COMPREHENSIV	'E DENTAL DIAGNOSTIC				
Bldg. 00	SERVICE Comprehensive d	ental diagnostic services kamination and diagnosis				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 69 of 74

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 12/04/2023)
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP COD VING LN RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	(X5) MPLETION DATE
	performed at least Based on record rev sampled clients (B) client B had an annual Findings include: On 11/29/23 at 2:45 record was conduct following: -A current dental correview. The most review. The most rewas dated 5/25/22. On 11/29/23 at 3:26 interviewed. The Nucleon dental consult for clienter clienter consult for clienter clie		W 0352	The Facility will ensure of client's will receive education attraining in the maintenance of health. The Nurse will be retrained by the Director of Nursing on ensuring clients receive annual dental diagnostic service. Staff will be retrained by Area Supervisor on ensuring appointments are attended as scheduled. The QIDP will retrain all in the facility on updated ISP. A member of the Administrative team will condumonthly site reviews for all clie in facility and the administrato hold a weekly ICF meeting to discuss issues that arise in the facility. Persons Responsible: AED, Nurse, DON, Quality Assurant Manager, QA Coordinator/QID Manager, Program Manager, Supervisor, QIDP, Direct Supplead, and DSP.	each and oral ed the client staff	/21/2023
W 0448	483.470(i)(2)(iv) EVACUATION DF	RILLS				
Bldg. 00	The facility must in evacuation drills, in Based on record rev	nvestigate all problems with ncluding accidents. view and interview for 3 of 3 B and C) and 5 additional	W 0448	All staff at the Facility wi		/21/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

clients (D, E, F, G and H), the facility failed to

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

be re-trained on conducting fire

Page 70 of 74

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G442	B. W	ING		12/04/	/2023
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			/ING LN		
DEC CVE		LTERNATIVES SE IN			RSONVILLE, IN 47130		
NES CAP	NE COMMONTT A	LIERNATIVES SE IN		JEFFER	NSONVILLE, IN 47 130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		drills were documented with			drills quarterly on all shifts. Th		
		nd/or issues and concerns to			Residential Manager will revie		
	prevent future reocc	currence.			drills to ensure all required dril		
					area conducted. The Progran	า	
	Findings include:				Manager will train the Area		
					Supervisor and the Area		
		PM, a review of the group			Supervisor will train all facility		
		rills was conducted. The			staff.		
		ation drills included the			2 The Area Supervisor will	l visit	
		clients A, B, C, D, E, F, G and			the home at least monthly to		
	Н:				ensure the drills are in the hor	ne	
	11/6/20 110 00 70				and up to date.		
		M, duration 10 minutes. No			3 Staff will be in serviced by	ру	
		rns were documented.			the Program Manager on		
		M, duration 10 minutes. No			conducting evacuation drills, d	lata	
		rns were documented.			collection, and determine if a	_	
		A, duration 10 minutes. No			solution to reduce the length of		
		rns were documented.			duration for evacuation drills a	IS	
		, duration 15 minutes. No issues			needed.		
	and/or concerns we				4 The Direct Support Lead		
		A, duration 17 minutes. No			submit monthly drills to the QA		
		rns were documented.			Department upon completion.		
		, duration 10 minutes. No issues			QA Department will notify the		
	and/or concerns we				Manager and Program manag	jer it	
		A, duration 30 minutes. No rns were documented.			the facility has not performed		
		, duration 15 minutes. No issues			monthly drills as required.		
	and/or concerns we				5 The Area supervisor will		
		I, duration 15 minutes. No			ensure drills are completed as	•	
		rns were documented.			required. 6 The program manager w	/ill	
		M, duration 15 minutes. No			conduct random monthly	/ III	
		rns were documented.			inspections to ensure drills are	د	
		M, duration 14 minutes. No			being completed as required.	•	
		rns were documented.			7 A member of the		
	155405 and of conce				Administrative team will condu	ıct a	
	On 11/29/23 at 4·46	5 PM, the Qualified Intellectual			monthly site reviews for all clie		
		ional (QIDP) was interviewed.			in facility and the administrato		
		ed about the duration of the			hold a weekly ICF meeting to	. ******	
	*	e evacuation indicating no			discuss issues that arise in the	ے	
		rns and if there were			facility.	•	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 71 of 74

PRINTED: 01/03/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G442	B. W	ING		12/04/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			/ING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFE	RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	o address the duration of the					
		d/or lack of documented			Persons Responsible: Progra	am	
		rns. The QIDP stated, "I'm			Manager, Area Supervisor,		
		h person to see how long it			Residential Manager, DSP		
	· ·	vas asked if there was					
	_	lans to reduce the duration					
		mentation for issues and/or					
		acuation drills. The QIDP					
		not have a documented plan to The QIDP indicated further					
		ed to review the process for					
		uation drills, data collection,					
		solution to reduce the length of					
		tion drills was needed.					
	duration for evacua	mon arms was needed.					
	9-3-7(a)						
W 9999							
Bldg. 00							
	State Findings		W	999	The AED will in-service	the	12/21/2023
					Human Resource Manager or		
		munity Residential Facilities for			ensuring employment practice		
		opmental Disabilities Rule was			assure that no staff person wo		
	not met.				be employed where there is: (
	460 14 610 2 26 1/2	\ D			conviction of a crime substant	•	
	460 IAC 9-3-2(c)(3) Resident Protections			related to a dependent popula		
	(a) The #: 14' 1	anovidon aball done			or any violent crime. The prov	ıaer	
	` ′	provider shall demonstrate that ctices assure that no staff			shall obtain, as a minimum, a	ard o	
		opployed where there is: (3)			bureau of motor vehicles reco criminal history check as	ıu, a	
		ne substantially related to a			authorized in IC 5-2-5-5 [IC 5-	2.5	
		on or any violent crime. The			was repealed by P.L.2-2003,	2-0	
		n, as a minimum, a bureau of			Section 102, effective July 1,		
	1 ~	ord, a criminal history check as			2003. See IC 10-13-3-27.], an	ıd	
		2-5-5 [IC 5-2-5 was repealed by			three (3) references are on file		
		1 102, effective July 1, 2003. See			The HR Manager will re		
		d three (3) references. Mere			all staff in the facility personne		
	_	lovment dates by previous			to ensure that no staff person		

FORM CMS-2567(02-99) Previous Versions Obsolete

employers shall not constitute a reference in

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet Page 72 of 74

would be employed where there is:

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 12/04/2023 15G442 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 402 EWING LN RES CARE COMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE compliance with this section. (3) conviction of a crime substantially related to a This State Rule is not met as evidenced by: dependent population or any violent crime. The provider shall Based on record review and interview for 1 of 3 obtain, as a minimum, a bureau of (staff #3) personnel files reviewed, the facility motor vehicles record, a criminal failed to ensure staff #3's employee file was history check as authorized in IC maintained with 1) three reference checks 5-2-5-5 [IC 5-2-5 was repealed by completed prior to employment and 2) a bureau of P.L.2-2003, Section 102, effective motor vehicle record. July 1, 2003. See IC 10-13-3-27.], and three (3) references are on Findings include: file. The Human Resources On 11/28/23 at 1:11 PM, a review of the facility's department will complete a full employee files was conducted. Staff #3's audit of all staff in the Facility no employee file did not contain documentation the later than December 21.2023. facility conducted 1) all three reference checks The Human Resources and 2) a bureau of motor vehicle record available Department will complete a full for review. Staff #3's employee filed indicated a audit of all ICF staff employed by hire date of 9/18/23 affecting clients A, B, C, D, E, the provider no later than March F, G and H. 30. 2024. A random sample of 10% of On 11/29/23 at 12:27 PM, the Human Resource all staff files will be conducted Manager (HRM) was interviewed. The HRM was monthly to ensure 100% review is asked about the missing reference checks and completed annually. bureau of motor vehicle record for staff #3's employee file. The HRM stated, "You're right, the Persons Responsible: AED, background was not (including the bureau of Human Resource Manager, motor vehicle). We've requested it. It does not Human Resource Assistant. take long. I don't know how that happened". The Human Resource HRM indicated a list of contact names for staff #3's three references had been obtained and stated, "We can contact them". The HRM was asked about the hiring process and review of information to ensure employees were not working with the clients prior to the completion of the employee's background checks. The HRM indicated a checklist was used to

FORM CMS-2567(02-99) Previous Versions Obsolete

ensure all required areas were obtained, reviewed,

Event ID:

7FKA11

Facility ID: 000956

If continuation sheet

Page 73 of 74

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

PRINTED: 01/03/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/04/2023	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DAT	
	and maintained in the employee files. The HRM indicated the human resource office had two coordinators (HRC #1 and HRC #2) assisting to maintain employee files who were newer employees to these responsibilities. The HRM indicated staff #3's employee file did not have this checklist and stated who the coordinators were and her instructions to them, "[HRC #1] and [HRC #2]. I told [HRC #1] we needed to go through every file. We'll make sure [HRC #2] uses the checklist".					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7FKA11 Facility ID: 000956 If continuation sheet Page 74 of 74