STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G167	A. BUILDING 00 B. WING	10/03/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	749 SOUTH BEARS BEND ROAD FRENCH LICK, IN 47432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a full annual recertification and state licensure survey which resulted in an Immediate Jeopardy. Dates of Survey: 9/27/17, 9/28/17, 9/29/17, 10/2/17 and 10/3/17. Facility Number: 000701 Provider Number: 15G167 AIMS Number: 100248800 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/13/17.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 3 of 3 sampled clients (#1, #2 and #3), plus 3 additional clients (#4, #5 and #6). The	W 0102	**W102:** The facility must ensure that specific governing body and management requirements are met. **Corrective Action:**	11/02/2017

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	governing body neglected to implement its written policy and procedures to prevent neglect of clients #2, #3 and #4 from client #1's physical aggression. The governing body neglected to address client #1's continued physical aggression which caused injury to clients #2 and #4. The governing body neglected to address client #2 and #4's fear of client #1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the home was maintained in a sanitary condition (#1, #2, #3, #4, #5, #6). The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility met the Condition of Participation: Client Protections for 3 of 3 sampled clients (#1, #2 and #3), plus one additional client (#4). The governing body neglected to implement its written policy and procedures to prevent neglect of clients #2, #3 and #4 from client #1's physical aggression. The governing body neglected to update client #1's BSP (Behavior Service Plan). The governing body neglected to address client #1's continued physical aggression which caused injury to clients #2 and #4. The governing body neglected to address client #2 and #4's fear of client #1.		**(Specific):** All staff at the home will be re-trained on the Operation Standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual rights. The Area Supervisor will be in the home at least three times weekly monitoring staff. **How others will be identified: (Systemic):** Observations will be implemented at the home to monitor staff at least twice weekly for the next 30 days. The Program Manager will visit the home at least once weekly and a member of HR will be in the home at least weekly. The Grievance policy and Bill of Rights will be reviewed with all clients at the home. **Measures to be put in place:** All staff at the home will be re-trained on the Operation Standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual rights. The Area Supervisor will be in the home at least three times weekly monitoring staff. **Monitoring of Corrective:** Observations will be implemented at the home to	

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	Findings include: 1. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the home was maintained in a sanitary condition for clients #1, #2, #3, #4, #5 and #6. The governing body failed to prevent neglect of clients #2, #3 and #4 from client #1's physical aggression. The governing body neglected to update client #1's BSP (Behavior Service Plan). The governing body neglected to address client #1's continued physical aggression which caused injury to clients #2 and #4. The governing body neglected to address client #2 and #4's fear of client #1. The governing body failed to complete a thorough investigation regarding client to client abuse. The governing body failed to ensure the group home had a specific QIDP (Qualified Intellectual Disabilities Professional) to monitor the clients' Individual Support Plans, Behavior Support Plans (BSP), and to head the clients' interdisciplinary teams without having other administrative duties/titles. The governing body failed to ensure staff implemented client #3's Dining Plan. Please see W104. 2. The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the		monitor staff at least twice weekly for the next 30 days. The Program Manager will visit the home at least once weekly and a member of HR will be in the home at least weekly. The Grievance policy and Bill of Rights will be reviewed with all clients at the home. **Completion date: 11.02.17**	

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	facility met the Condition of Participation: Client Protections for 3 of 3 sampled clients (#1, #2 and #3), plus one additional client (#4). The governing body neglected to implement its written policy and procedures to prevent neglect of clients #2, #3 and #4 from client #1's physical aggression. The governing body neglected to update client #1's BSP (Behavior Service Plan). The governing body neglected to address client #1's continued physical aggression which caused injury to clients #2 and #4. The governing body neglected to address client #2 and #4's fear of client #1. Please see W122. 9-3-1(a)			
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), plus 3 additional clients (#4, #5 and #6), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the home was maintained in a sanitary condition (#1, #2, #3, #4, #5 and #6). The	W 0104	**W104:** The governing body must exercise general policy, budget, and operating direction over the facility. **Corrective Action: (Specific):** The hallway bathroom will have the bathroom cabinet replaced or fixed, baseboard and caulking replaced around the toilet and cabinet area. The Site	11/02/2017

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	governing body failed to implement its written policy and procedures to prevent neglect of clients #2, #3 and #4 from client #1's physical aggression. The governing body neglected to update client #1's BSP (Behavior Support Plan). The governing body neglected to address client #1's continued physical aggression which caused injury to clients #2, and #4. The governing body neglected to address client #2 and #4's fear of client #1. The governing body failed to complete a thorough investigation regarding client to client abuse. The governing body failed to ensure the group home had a specific QIDP (Qualified Intellectual Disabilities Professional) to monitor the clients' Individual Support Plans, Behavior Support Plans (BSP), and to head the clients' interdisciplinary teams without having other administrative duties/titles. The governing body failed to ensure staff implemented client #3's Dining Plan. Findings include: 1. Observations were conducted at the group home on 9/27/17 from 4:00 PM through 6:00 PM Clients #1, #2, #3, #4, #5 and #6 were observed in the home throughout the observation period. At 4:30 PM the home's hallway bathroom (right side) was observed. The hallway bathroom had a strong smell of urine.		Supervisor will be re-trained on the timely completion of maintenance requests for items that need repaired in the home. The staff in the location will be retrained on all client dining plans. All staff in the home will be re-trained on the operation standard for reporting and investigating abuse neglect exploitation mistreatment or violation of an individual's rights. Client one received a CIH waiver and no longer resides in the home. The QIDP in the home will be retrained on ensuring that client to client investigations are complete and the quality Assurance Manager will review after they are completed. **How others will be identified: (Systemic):** The maintenance coordinator will visit the home at least monthly and complete an environmental inspection checklist and turn it into the Program Manager each month. If any areas are noted as needing repair the maintenance coordinator will schedule the repairs immediately. The Area Supervisor will visit the home at least every other week to complete and environmental inspection checklist and follow up on all repairs completed by the maintenance coordinator. The	

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	Staff #1 was interviewed on 9/27/17 at 4:45 PM. Staff #1 indicated the hallway bathroom smelled like urine. Staff #1 indicated the bathroom was clean but the urine had soaked into the wood grain on the cabinet. Staff #1 indicated sometimes the smell of urine was more prominent. Staff #1 indicated she thought the cabinet needed to be removed. Staff #2 was interviewed on 9/27/17 at 5:00 PM. Staff #2 indicated the hallway bathroom smelled of urine. Staff #2 indicated he felt it was soaked into the floor or cabinet. Staff #3 was interviewed on 9/28/17 at 5:00 AM. Staff #3 indicated he thought the hallway bathroom smelled of urine. Area Supervisor (AS) #1 was interviewed on 10/2/17 at 12:45 PM. AS #1 indicated she did not notice the hallway bathroom smelling of urine. AS #1 indicated it was possible. AS #1 stated some of the clients would "not hit" the toilet when they urinated. AS #1 indicated the facility would look into replacing the cabinet in the bathroom. 2. The governing body failed to implement its written policy and procedures to prevent neglect of clients		nurse will conduct at least on meal observation at least weekly to ensure dining plans are being followed. **Measures to be put in place:** The hallway bathroom will have the bathroom cabinet replaced or fixed, baseboard and caulking replaced around the toilet and cabinet area. The Site Supervisor will be re-trained on the timely completion of maintenance requests for items that need repaired in the home. The staff in the location will be retrained on all client dining plans. All staff in the home will be re-trained on the operation standard for reporting and investigating abuse neglect exploitation mistreatment or violation of an individual's rights. Client one received a CIH waiver and no longer resides in the home. The QIDP in the home will be retrained on ensuring that client to client investigations are complete and the quality Assurance Manager will review after they are completed. **Monitoring of Corrective Action:** The maintenance coordinator will visit the home at least monthly and complete an environmental inspection checklist and turn it into the Program Manager each month. If	

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	#2, #3 and #4 from client #1's physical aggression. The governing body neglected to update client #1's BSP (Behavior Support Plan). The governing body neglected to implement a plan to address client #1's continued physical aggression which caused injury to clients #2 and #4. The governing body neglected to address client #2 and #4's fear of client #1. Please see W149. 3. The governing body failed to complete a thorough investigation for 3 of 3 sampled clients (#1, #2 and #3), regarding client to client abuse. Please see W154. 4. The governing body failed to ensure the group home had a specific QIDP (Qualified Intellectual Disabilities Professional) for 3 of 3 sampled clients (#1, #2 and #3), to monitor the clients' Individual Support Plans, Behavior Support Plans (BSP), and to head the clients' interdisciplinary teams without having other administrative duties/titles. Please see W159. 5. The governing body failed to ensure staff implemented client #3's Dining Plan. Please see W249. 9-3-1(a)		any areas are noted as needing repair the maintenance coordinator will schedule the repairs immediately. The Area Supervisor will visit the home at least every other week to complete and environmental inspection checklist and follow up on all repairs completed by the maintenance coordinator. The nurse will conduct at least on meal observation at least weekly to ensure dining plans are being followed. **Completion date: 11.02.17**	

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W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, interview and record review, the facility failed to meet the Condition of Participation: Client Protections for 3 of 3 sampled clients (#1, #2 and #3) plus 1 additional client (#4). The facility neglected to implement its written policy and procedures to prevent neglect of clients #2, #3 and #4 from client #1's physical aggression. The facility neglected to have a behavior clinician to address client #1's continued physical aggression. The facility neglected to address client #1's continued physical aggression which caused injury to clients #2 and #4. The facility neglected to address client #2 and #4's fear of client #1. This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 9/28/17 at 12:56 PM. The Immediate Jeopardy began on 9/27/17 when client #1 continued to pose a safety risk to other clients in the home by fracturing client #2's nose. Client #2 was sent to the Emergency Room and client #1 was incarcerated. The Executive Director and Program Manager were notified of the Immediate Jeopardy on 9/28/17 at 12:56	W 0122	**W122:** The facility must ensure that specific client protections requirements are met. **Corrective Action: (Specific):** The staff will be retrained on the operation standards for reporting and investigating abuse, neglect, exploration, mistreatment or violation of an individual's rights. **How others will be identified: (Systemic):** Client A was moved from the Orange County Jail. The ResCare Team worked with the local BDDS team to ensure the safety of the client and worked with the prosecutor of Orange County to ensure that Client A was removed from the Clark County Jail. **Measures to be put in place:** The staff will be retrained on the operation standards for reporting and investigating abuse, neglect, exploration, mistreatment or violation of an	11/02/2017

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	PM. The facility submitted a Plan of Correction (POC) for the removal of the Immediate Jeopardy (IJ) on 9/29/17 at 12:09 PM. The facility's revised POC for removal indicated the following: "1. All clients in the home have had individual meetings with management staff on 9/28/17. 2. During these individual meetings the following was discussed: a. Review with each individual the situation that occurred last evening. b. Reassured each individual that the client (client #1) who had the behavioral outburst would not be returning to this home. c. Discussed any questions or concerns related to this incident or any other incident with each individual. d. Reviewed the Client Bill of Rights and Client Grievance with each individual. 3. Each individual stated they were reassured by these measures and the assurance that the client in question would not be returning to the home and they feel safe in their home. 4. Mental health counseling will be offered and provided to each individual if requested. 5. The client in question is currently incarcerated, a member of ResCare management team is at the court hearing		individual's rights. . **Monitoring of Corrective Action:)** Client A was moved from the Orange County Jail. The ResCare Team worked with the local BDDS team to ensure the safety of the client and worked with the prosecutor of Orange County to ensure that Client A was removed from the Clark County Jail. **Completion date: 11.02.17**	

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	to answer any questions and is working with the prosecutor and court appointed attorney to have him released. 6. The client in question has a CIH (Community Integrated Habilitation) waiver and a meeting was held 9/28/17 with the BDDS district manager to discuss waiver placement options. 7. The client in question will not be returned to this house upon release and will be supported at an alternate location until his CIH waiver is activated." The Immediate Jeopardy which began on 9/28/17 was removed on 10/2/17 at 1:12 PM when the facility put a plan of correction into place to remove the immediacy of the situation. The non-compliance remains at condition level until permanent placement for client #1 is arranged. Observations were conducted at the group home on 9/29/17 from 12:00 PM through 1:00 PM. Client #1 was still incarcerated during the observation period. Observations were conducted on 10/2/17 from 7:45 AM through 9:15 AM. Client #1 was not observed to be in the home during the observation period. On 10/2/17 at 7:45 AM clients #2, #3, and #4 indicated they felt safe in the home.			

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Area Supervisor (AS) #1 was interviewed on 10/2/17 at 9:15 AM. AS #1 indicated client #1 had been moved to another location in a supported living home. AS #1 indicated all the clients were happy and felt safe. AS #1 indicated all clients had meetings and were offered emotional support.

Findings include:

1. The governing body failed to implement its written policy and procedures to prevent neglect of clients #2, #3 and #4 from client #1's physical aggression. The governing body neglected to update client #1's BSP (Behavior Support Plan). The governing body neglected to address client #1's continued physical aggression which caused injury to clients #2 and #4. The governing body neglected to address client #2 and #4's fear of client #1. Please see W149.

2. The governing body failed to complete a thorough investigation regarding client to client abuse for clients #1, #2, and #3. Please see W154.

9-3-2(a)

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W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.			
	Based on observation, record review and interview for 3 of 3 sampled clients (#1, #2 and #3), plus 3 additional clients (#4, #5 and #6), the facility neglected to	W 0149	**W149:** The facility must develop and implement written procedures that prohibit mistreatment, neglect or	11/02/2017

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	implement its written policy and procedures to prevent neglect of clients #2, #3 and #4 from client #1's physical aggression. The facility neglected to update client #1's BSP (Behavior Support Plan). The facility neglected to address client #1's continued physical aggression which caused injury to clients #2 and #4. The facility neglected to address client #2 and #4's fear of client #1. Findings include: Observations were conducted on 9/27/17 from 4:00 PM through 6:00 PM. Clients #1, #2, #3, #4, #5 and #6 were observed in the home throughout the observation period. At 4:00 PM clients #2 and #4 were outside smoking with staff #1 and staff #2. There were no staff inside of the home with the other clients. At 4:30 PM client #1 was observed playing his video game in his bedroom. Client #1 stayed in his bedroom until dinner time at 5:30 PM. All clients ate dinner together. Staff #1 and staff #2 stood in the kitchen and observed the dinner meal. Client #1 was not observed to be in line of sight or 1:1 (one staff to one client) at any time during the observation period. Observations were conducted on 9/28/17 from 5:45 AM through 8:00 AM. At 5:45 AM Client #4 (non-verbal), grabbed his		abuse of the client. **Corrective Action:** **(Specific):** All staff in the home will be re-trained on the operation standard for reporting and investigating abuse neglect exploitation mistreatment or violation of an individual's rights. Client one received a CIH waiver and no longer resides in the home. Client#4 Glasses has been replaced. Client #2 has followed up with the ENT and no other follow up is needed. The QIDP will be retrained on ensuring that there are IDT meeting held for all incident reports. The Quality Assurance Coordinators and QIDP Manager are partnering with other senior administrative staff to assure ongoing training is in place to maintain competency. Additionally, the governing body has committed to enlisting the services of outside Masters level behavioral clinicians when the interdisciplinary team has assessed that clients' aggressive behavior is exacerbated by complicated comorbid psychiatric condition(s). In addition to the administrative monitoring	

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	own face, then took his glasses off to show surveyor. Client #4's glasses were broken on the side and bent. At 6:00 AM client #2 came into the medication room. Client #2 was observed to have a swollen nose with a red cut across the top of it. Bureau of Developmental Disabilities Services (BDDS)/IR (Incident Reports) reports were reviewed on 9/28/17 at 9:30 AM. BDDS report dated 11/7/16 indicated, "[Client #1] had just returned home from work and asked staff to take him to [fast food restaurant]. Staff encouraged him to eat dinner at the group home that was already being made. [Client #1] instantly became upset, threw a chair and hit [client #3] and [client #5]. Staff directed consumers to their room and out of harm and verbally redirected [client #1] until he was calm. After [client #1] had calmed down everyone was checked for injury and none were (sic) noted." BDDS report dated 11/23/16 indicated, "[Client #2] went into the office to ask for a cigar. [Client #1] told [client #2] that staff was in the bathroom. [Client #2] hit [client #1] in the face while walking out. [Client #1] then hit [client #2] in the back. Staff immediately stepped in between the individuals and		described below, the governing body has implemented expanded, detailed quality assurance audits that will occur no less than twice monthly at all ResCare facilities. These audits will focus on safety and consistent regulatory compliance. **How others will be identified: (Systemic):** Quality Assurance will review all incidents daily to ensure that incidents of peer to peer aggression are addressed and have preventative measures put in place. The QA Manager will meet with QA at least weekly to ensure that all incidents of peer to peer aggression are addressed and have preventative measures implemented. The QIDP lead will meet with the QIDP weekly for the next thirty days to ensure all incidents are meeting to have IDT meetings. **Measures to be put in place:** All staff in the home will be re-trained on the operation standard for reporting and investigating abuse neglect exploitation	

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	directed both to separate. Both were checked for injury and none were (sic) noted." BDDS report dated 12/15/16 indicated, "For unknown reason [client #3] opened [client #1's] bedroom door while he was inside and flashed him the middle finger. [Client #1] became upset and ran out his door and followed [client #3] into the living room. [Client #1] pushed [client #3] down to the ground and staff intervened. [Client #1] was verbally redirected from the room. [Client #3] was assisted up and checked for injury, none were (sic) noted. Staff spoke with [client #1] one to one and notified the team of the information. Shortly after the initial incident staff were (sic) passing medication and [client #1] came into the office, pushed past staff and grabbed all his medication. [Client #1] stated he did not need his medication and he was going to throw it away. Staff called 911 to come speak with [client #1] and assist in getting his medication back. Police arrived and spoke to [client #1]. [Client #1] returned his medication and continued his night time routine as regular without any additional concerns the remainder of the evening. The team was notified of the information. Grievance and bill of rights were reviewed with all individuals in the		mistreatment or violation of an individual's rights. Client one received a CIH waiver and no longer resides in the home. Client #4 glasses have been replaced. Client #2 has followed up with the ENT and no other follow up is needed. The QIDP will be retrained on ensuring that there are IDT meeting held for all incident reports The Quality Assurance Coordinators and QIDP Manager are partnering with other senior administrative staff to assure ongoing training is in place to maintain competency. Additionally, the governing body has committed to enlisting the services of outside Masters level behavioral clinicians when the interdisciplinary team has assessed that clients' aggressive behavior is exacerbated by complicated comorbid psychiatric condition(s). In addition to the administrative monitoring described below, the governing body has implemented expanded, detailed quality assurance audits that will occur no less than twice monthly at all ResCare facilities. These audits will focus on safety and consistent regulatory	

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	home. An immediate protective plan was put in place to have [client #1] as a 1:1 (one staff to one client) during waking hours and within 5 feet of staff to prevent further incidents. Staff were also instructed to remain in between him and any other individual while in common areas of the home and 15 minute checks are being implemented." BDDS report dated 9/16/17 indicated, "[Client #1] became upset when he was unable to get to work due to flooding conditions on the roads in town. He became physically aggressive with staff and police were called for assistance. When police arrived at the home [client #1] continued verbal aggression towards officers and was handcuffed and placed in the back of the police car. After about 30 minutes [client #1] calmed down and was released. He was given a warning a police left the home. [Client #1] remained calm the rest of the evening and there were no additional concerns." BDDS report dated 9/16/17 indicated, "[Client #1] became upset because he wanted to go out but [client #3] didn't want to. [Client #1] then pushed [client #4]. Staff redirected [client #4] and [client #1] to separate rooms. [Client #1] walked down the road remaining within line of sight to calm down."		compliance. **Monitoring of Corrective Action:** Quality Assurance will review all incidents daily to ensure that incidents of peer to peer aggression are addressed and have preventative measures put in place. The QA Manager will meet with QA at least weekly to ensure that all incidents of peer to peer aggression are addressed and have preventative measures implemented. The QIDP lead will meet with the QIDP weekly for the next thirty days to ensure all incidents are meeting to have IDT meetings. **Completion date: 11.02.17**	

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	BDDS report dated 9/27/17 indicated, "[Client #1] was upset with [client #2] because of an earlier incident (between client #2 and client #3) and staff verbally prompted him to calm down as he was threatening to hurt [client #2]. Staff asked [client #1] to go to his room and staff remained in the hallway until [client #1] was safely in his bedroom. Staff then went to complete paperwork and heard [client #2] screaming. Staff ran to the hallway and [client #2] and [client #1] were coming out of [client #2's] bedroom and [client #2] was bleeding from an unknown area on his face. Staff cleaned up the area and called the nurse. The nurse then instructed staff to call 911 and have [client #2] taken to the Emergency Room. [Client #2] called 911 and when they arrived [client #2] informed the police he wanted to file charges against [client #1]. Police took [client #1] into custody and he is now incarcerated with an anticipated court appearance to occur on 9/28/17 in the late afternoon. In addition, [client #1] has received a waiver to move to supported living and the facility is actively pursuing housing options for him. At the time the waiver was initially given [client #1] refused to sign it which delayed action toward other residential options; however he has since completed the necessary paperwork with			

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	BDDS. Upon release from jail the facility will continue to work with BDDS and [client #1] to find a waiver setting for him. [Client #2] was transported via EMS (Emergency Medical Services) to [Hospital] with instructions to follow up with an ENT (Ear, Nose and Throat) as soon as possible (for fractured nose). He was also instructed to use an ice pack on his nose for no more than 15-20 minutes at a time every 1-2 hours for the first 24-48 hours then use as needed for pain. He was also instructed to take OTC (Over the counter) pain medication as needed. [Client #2] and staff were also given instruction paperwork on other symptoms to watch for and directions on what to do in the event any of those symptoms develop. The team will meet to discuss the incident and what changes are needed to ensure client safety and prevent future client to client incidents. In addition [Doctor] was contacted on 9/28/17 and stated he preferred to see clients in 5-7 days to allow swelling to go down and ENT appointment has been scheduled for 10/5/17." Client #1's record was reviewed on 9/28/17 at 7:30 AM. Client #1's Behavior Support Plan (BSP) dated 6/26/16 (reviewed 9/28/17 at 7:30 AM) indicated the following: "Physical Aggression: Staff will prompt [client #1] to stop the			

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	behavior. Staff will ensure the safety of all individuals in the home. Redirect [client #1] to a quiet area of the home or out onto the porch. Talk with [client #1] to try and determine why he was upset. Discuss ways to deal with his frustrations. If talking with [client #1] does not calm him down and he continues to escalate or is harming himself or others staff will use YSIS (You're Safe I'm Safe) as needed to protect all individuals. Anytime there is an incident of physical aggression, [client #1] will be placed on 15 minute checks for 24 hours during sleeping hours." Client #1's BSP did not include a 1:1 staff or line of sight supervision. IDT (Interdisciplinary Team) Notes were reviewed on 9/28/17 at 7:30 AM. IDT notes dated 2/9/17 indicated, "Team met to discuss the client to client (aggression) between [client #1] and [client #4]. There was a previous meeting where it was decided that [client #1] would sit by the window on the van due to him jumping out of the van. [Client #1] knows this, he gets upset sometimes because of this. Maybe bring 2 staff for transportation, both AM and PM. [Client #1] will be fine one moment and then agitated the next. Different transportation for client that [client #1] does not like."			

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	IDT notes dated 2/23/17 indicated, "Met to discuss [client #1] leaving his community job once off work on the 22nd even though there was a staff there to pick him up in their private vehicle. The HM (House Manager) was called and arrived and followed him with staff. He went across the bridge that is now a dead end and by the time staff were able to drive detour he was out of site (sic) for 40 minutes before found sitting under the bridge. AS (Area Supervisor) arrived as he had been found and he then took off on foot and walked to the other side of town to a new restaurant, ordered a to go meal. He then walked to [store] and purchased items that are not according to his physician orders. At one point when he was being monitored at [store] he became shaky. He did allow AS to test his blood sugar. It was 62. He finally agreed to get in the van to go home after staff attempted to take [client #1] to be checked for medical due to out of site for 40 minutes and he refused. AS also attempted to get him to go and he continued to refuse medical treatment. AS followed and remained at the group home for 3 hours to observe and be support for any behaviors that may occur once he arrived home and ate his carry out meal he was fine. [Client #1] did curse and got up and went to his room when a housemate he does not care for			

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	arrived back to the home. [Client #1] also refused his medications three shifts in a row except for his insulin." IDT notes dated 2/28/17 indicated, "The team met today to discuss with [client #1] other living options due to the facility serving him notice, not able to meet his needs. [Client #1] repeatedly stated he wants to stay at (current home). [Client #1] stated he will do his best to do better. Each time BDDS SC (Service Coordinator) stated SL (supported Living) really is not an option at this point due to his past behaviors with taking to (sic) much insulin, not taking medication (etc). [Client #1] said if he can't stay here then he wants to get an apartment of his own. BDDS SC discussed with him if he does not cooperate with choosing another placement he is at risk and she would need to get APS (Adult Protective Services) involved and get an emergency guardian for him." IDT notes dated 6/9/17 indicated, "The team met for Psych review. [Client #1] refused to come today. He started having behaviors on the van and staff had to pull over and call the police." There was no BDDS report for this incident. There were no IDT meetings held to			

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	address client #1's physical aggression. There were no IDT meetings to discuss if other housemates felt safe around client #1. Hospital Consultation (HC) was reviewed on 9/28/17 at 11:30 AM. HC dated 12/15/16 for client #4 indicated, "The patient (client #4) presents with rib-trunk pain and the resident was assaulted by another resident (client #1) last night. He landed against a table with direct blow to right elbow and right ribs he is c/o (complaining of) left hand pain as well. The attendant with the patient reports he did witness the incident. He was also hit directly in the left jaw and the dentist reported broken teeth on his dentures of left side when at the dental appointment. The onset was 15 hours ago. The course/duration of symptoms is constant. The pt is developmentally challenged unable to communicate verbally other than moaning/grunts moan and point to areas that hurt when asked. The degree of pain is unable to assess he does not appear to have any sights of pain....." HC dated 9/27/17 was reviewed on 9/28/17 at 11:30 AM for client #2. HC indicated a diagnosis of "Nose Fracture". Client #1 was interviewed on 9/27/17 at			

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	5:00 PM. Client #1 indicated he has a job at a pizza restaurant. Client #1 indicated he made money at his job and could buy things he liked. Client #1 indicated he liked living in the home. Client #1 indicated he liked his other roommates and staff. Client #2 was interviewed on 9/27/17 at 6:15 PM. Client #2 stated client #1 jumped on him last week. Client #2 indicated his shoulder and hip are still bruised. Client #2 stated client #1 "Scares the living Jesus out of me." Client #2 was interviewed on 9/28/17 at 6:15 AM. Client #2 indicated client #1 "beat the tar" out of him. Client #2 stated client #1 came into his room and jumped on him in while he was on his bed. Client #2 stated client #1 "broke" his nose. Client #2 indicated when the police came he told them he wanted to press charges. Client #2 stated he wanted client #1 "outta here." Client #4 was interviewed on 9/27/17 at 6:00 PM. Client #4 indicated client #1 has pushed him before. Client #4 indicated they (other clients) can't go on outings because client #1 won't go. Client #4 stated client #1 calls him "R-----" and "Fat A--". Client #4 indicated he likes to live here and he likes staff, but he doesn't			

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	feel safe with client #1. Staff #1 was interviewed on 9/27/17 at 4:45 PM. Staff #1 indicated all the other clients (clients #2, #3, #4, #5 and #6) were afraid of client #1. Staff #1 indicated client #1 pushed client #2 into the kitchen table and knocked him down. Staff #1 stated they have had to go over the bill of rights "so many" times with all the clients because of client #1. Staff #1 stated the other clients are "terrified of [client #1]." Staff #1 indicated she has filled out numerous IR reports for client #1's physical aggression. Staff #1 indicated she faxed the IR reports to the office. Staff #1 indicated there were no IR's in the home. Staff #3 was interviewed on 9/28/17 at 6:00 AM. Staff #3 indicated client #1 had fractured client #2's nose on 9/27/17. Staff #3 stated the clients are "terrified" of client #1. Staff #3 indicated he didn't think it was right for client #1 to be able to do whatever he wanted and the other clients did not understand why they couldn't. Staff #3 indicated client #1 displays physical aggression on a regular basis. House Manager (HM) #1 was interviewed on 9/28/17 at 5:45 AM. House Manager (HM) #1 stated it had			

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	"been a mess at the home" the previous night. HM #1 indicated client #2 had hit client #3 in the face over some bologna. HM #1 indicated client #1 heard the commotion and came out of his room. Client #1 then followed client #2 into his bedroom. HM #1 indicated staff began to hear client #2 yelling for help and client #2 came running into the hall with blood covering his face and client #1 pursuing him. HM #1 indicated the police were called. HM #1 indicated client #1 remains in jail and client #2 was taken to the Emergency room and was treated for a fractured nose. HM #1 indicated she felt bad for the clients in the home because of client #1. HM #1 stated the clients were "scared and uncomfortable" in their own home. HM #1 indicated client #1 was not a good fit for the home. HM #1 indicated client #1 was at a higher functioning level than the other clients. HM #1 indicated the other clients in the home were mostly older and client #1 was younger. HM #1 indicated client #1's BSP had not been revised or updated to include 1 to 1 supervision. HM #1 indicated client #1's BC and QIDP were the same person. HM #1 indicated the BC/QIDP did not come to the home on a regular basis. Quality Assurance Manager (QAM) #1 was interviewed on 9/28/17 at 11:25 AM.			

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	QAM #1 indicated he had given the surveyor all the BDDS reports he had for the home. Program Manager (PM) #1 was interviewed on 9/28/17 at 10:45 PM. PM #1 indicated client #1's BSP had not been revised to include 1 to 1 supervision. PM #1 indicated the QIDP was in the process of revising the BSP. PM #1 indicated client #1 did not have a BC. PM #1 indicated client #1's QIDP served as his BC. PM #1 indicated she could not say if clients were scared only client #1 was not a good fit for the home. PM #1 indicated the facility had served client #1 notice they could no longer serve him in early spring. PM #1 indicated they have not been successful in finding a placement for client #1. PM #1 indicated client #1 remained in jail at this time. PM #1 indicated she would call in late afternoon to see if he would be seen by the judge on 9/28/17. Area Supervisor (AS) #1 was interviewed on 9/29/17 at 3:00 PM. AS #1 indicated she was unaware of client #1 ever being 1:1. AS #1 indicated when client #1 has physical aggression staff try to verbally redirect him. AS #1 indicated client #1 will be sent to his room. AS #1 indicated to make clients feel safe staff should always be in the common area of the			

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	home. AS #1 indicated the home had not increased staffing due to the severity of the injuries. AS #1 indicated client #1 spends most of his time in his room so he doesn't really interfere with any other client. AS #1 indicated none of the IR's are kept in the home. AS #1 indicated she has no knowledge of where IR's would be. AS #1 indicated injuries should be reported in the BDDS report. The facility's policy and procedures were reviewed on 9/28/17 at 9:19 AM. The facility's Abuse, Neglect, Exploitation Policy and Procedure revised date of 1/9/15 indicated the following: -"Community Alternatives South East staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and/or exploitation shall be reported and thoroughly investigated. Community Alternatives South East strictly prohibits abuse, neglect and/or exploitation." -"The Clinical Supervisor will assign an investigative team and a thorough investigation will be completed within 5 business days of the report of the incident. Once the investigation has been completed, the investigation will be given to the Executive Director or designee for review."			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

-"F. Abuse- Exploitation. 1. An act that deprives and individual of real or personal property by fraudulent or illegal means."

-"E. Neglect- Emotional/Physical. 1. Failure to provide goods and/or services necessary for the individual to avoid physical harm. 2. Failure to provide the support necessary to an individual's psychological and social well being. 3. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment."

-"F. Neglect- Program Intervention. 1. Failure to provide goods and/or services necessary for the individual to avoid physical harm."

9-3-2(a)

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	15G167	A. BUILDING 00 B. WING	10/03/2017

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W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), for 6 allegations of abuse, neglect or mistreatment reviewed, the facility failed to complete a thorough investigation regarding client to client abuse. Findings include: Bureau of Developmental Disabilities Services (BDDS)/IR (Incident Reports) reports were reviewed on 9/28/17 at 9:30 AM. BDDS report dated 11/7/16 indicated, "[Client #1] had just returned home from work and asked staff to take him to [fast food restaurant]. Staff encouraged him to eat dinner at the group home that was already being made. [Client #1] instantly became upset, threw a chair and hit [client #3] and [client #5]. Staff directed consumers to their room and out of harm and verbally redirected [client #1] until he was calm. After [client #1] had calmed	W 0154	**W154:** The facility must evidence that all alleged violations are thoroughly investigated. **Corrective Action:** **(Specific):** The Quality Assurance manager will be retrained on the operation standards for reporting and investigating abuse, neglect, exploration, mistreatment or violation of an individual's rights and the completion of an investigation for alleged violations. **How others will be identified: (Systemic):** The Program Manager will meet with the Quality Assurance Manager at least weekly to ensure that all alleged violations are thoroughly investigated. **Measures to be put in place:** The Quality Assurance manager will be retrained on	11/02/2017

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	down everyone was checked for injury and none were (sic) noted." Client to Client Investigation dated 11/7/16 did not include interviews. Client to client investigation did not include finding of fact or determination. Client to client investigation was completed by a staff working in the home. Investigations were not completed by a member of administration trained to do investigations. BDDS report dated 11/23/16 indicated, "[Client #2] went into the office to ask for a cigar. [Client #1] told [client #2] that staff was in the bathroom. [Client #2] hit [client #1] in the face while walking out. [Client #1] then hit [client #2] in the back. Staff immediately stepped in between the individuals and directed both to separate. Both were checked for injury and none were (sic) noted." Client to Client Investigation dated 11/23/16 did not include interviews. Client to client investigation did not include finding of fact or determination. Client to client investigation was completed by a staff working in the home. Investigations were not completed by a member of administration trained to do investigations.		the operation standards for reporting and investigating abuse, neglect, exploration, mistreatment or violation of an individual's rights and the completion of an investigation for alleged violations. **Monitoring of Corrective Action:** The Program Manager will meet with the Quality Assurance Manager at least weekly to ensure that all alleged violations are thoroughly investigated. **Completion date: 11.02.17**	

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	BDDS report dated 12/15/16 indicated, "For unknown reason [client #3] opened [client #1's] bedroom door while he was inside and flashed him the middle finger. [Client #1] became upset ran out his door and followed [client #3] into the living room. [Client #1] pushed [client #3] down to the ground and staff intervened. [Client #1] was verbally redirected from the room. [Client #3] was assisted up and checked for injury, none were (sic) noted. Staff spoke with [client #1] one to one and notified the team of the information. Shortly after the initial incident staff were (sic) passing medication and [client #1] came into the office, pushed past staff and grabbed all his medication. [Client #1] stated he did not need his medication and he was going to throw it away. Staff called 911 to come speak with [client #1] and assist in getting his medication back. Police arrived and spoke to [client #1]. [Client #1] returned his medication and continued his night time routine as regular without any additional concerns the remainder of the evening. The team was notified of the information. Grievance and bill of rights were reviewed with all individuals in the home. An immediate protective plan was put in place to have [client #1] as a 1:1 (one staff to one client) during waking hours and within 5 feet of staff to prevent			

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	further incidents. Staff were also instructed to remain in between him and any other individual while in common areas of the home and 15 minute checks are being implemented." Client to Client Investigation dated 12/15/16 did not include interviews. Client to client investigation did not include finding of fact or determination. Client to client investigation was completed by a staff working in the home. Investigations were not completed by a member of administration trained to do investigations. BDDS report dated 9/16/17 indicated, "[Client #1] became upset when he was unable to get to work due to flooding conditions on the roads in town. He became physically aggressive with staff and police were called for assistance. When police arrived at the home [client #1] continued verbal aggression towards officers and was handcuffed and placed in the back of the police car. After about 30 minutes [client #1] calmed down and was released. He was given a warning a police left the home. [Client #1] remained calm the rest of the evening and there were no additional concerns." There was no investigation for this incident.			

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BDDS report dated 9/16/17 indicated, "[Client #1] became upset because he wanted to go out but [client #3] didn't want to. [Client #1] then pushed [client #3]. Staff redirected [client #3] and [client #1] to separate rooms. [Client #1] walked down the road remaining within line of sight to calm down."

Client to Client Investigation dated 9/16/17 did not include interviews. Client to client investigation did not include finding of fact or determination. Client to client investigation was completed by a staff working in the home. Investigations were not completed by a member of administration trained to do investigations.

BDDS report dated 9/27/17 indicated, "[Client #1] was upset with [client #2] because of an earlier incident (between client #2 and client #3) and staff verbally prompted him to calm down as he was threatening to hurt [client #2]. Staff asked [client #1] to go to his room and staff remained in the hallway until [client #1] was safely in his bedroom. Staff then went to complete paperwork and heard [client #2] screaming. Staff ran to the hallway and [client #2] and [client #1] were coming out of [client #2's] bedroom and [client #2] was bleeding from an

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	unknown area on his face. Staff cleaned up the area and called the nurse. The nurse then instructed staff to call 911 and have [client #2] taken to the Emergency Room. [Client #2] called 911 and when they arrived [client #2] informed the police he wanted to file charges against [client #1]. Police took [client #1] into custody and he is now incarcerated with an anticipated court appearance to occur on 9/28/17 in the late afternoon. In addition, [client #1] has received a waiver to move to supported living and the facility is actively pursuing housing options for him. At the time the waiver was initially given [client #1] refused to sign it which delayed action toward other residential options; however he has since completed the necessary paperwork with BDDS. Upon release from jail the facility will continue to work with BDDS and [client #1] to find a waiver setting for him. [Client #2] was transported via EMS (Emergency Medical Services) to [Hospital] with instructions to follow up with an ENT (Ear, Nose and Throat) as soon as possible (for fractured nose). He was also instructed to use an ice pack on his nose for no more than 15-20 minutes at a time every 1-2 hours for the first 24-48 hours then use as needed for pain. He was also instructed to take OTC (Over the counter) pain medication as needed. [Client #2] and staff were also			

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	given instruction paperwork on other symptoms to watch for and directions on what to do in the event any of those symptoms develop. The team will meet to discuss the incident and what changes are needed to ensure client safety and prevent future client to client incidents. In addition [Doctor] was contacted on 9/28/17 and stated he preferred to see clients in 5-7 days to allow swelling to go down and ENT appointment has been scheduled for 10/5/17." Client to Client Investigation dated 9/27/17 did not include interviews. Client to client investigation did not include finding of fact or determination. Client to client investigation was completed by a staff working in the home. Investigations were not completed by a member of administration trained to do investigations. Area Supervisor (AS) was interviewed on 10/2/17 at 12:45 PM. AS #1 indicated all allegations of abuse, neglect or mistreatment should be thoroughly investigated within 5 business days. AS #1 indicated all client to client investigations, falls and choking investigations were completed by staff working in the home. AS #1 indicated she did not know why a complete investigation was not conducted for client			

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	to client abuse. AS #1 indicated staff in the home doing the client to client investigations was the policy. 9-3-2(a)			
W 0159 Bldg. 00	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. Based on observation, record review and interview for 3 of 3 clients living in the group home (#1, #2 and #3), the facility failed to ensure the group home had a specific QIDP (Qualified Intellectual Disabilities Professional) to monitor the clients' Individual Support Plans, Behavior Support Plans (BSP), and to head the clients' interdisciplinary teams without having other administrative duties/titles. Findings include: On 9/28/17 at 9:30 AM, a review of the Qualified Mental Retardation Professional form for the survey indicated the QIDP was the same staff as the Behavior Clinician (BC) for clients #1, #2 and #3.	W 0159	**W159:** QIDP: each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional. **Corrective Action:** **(Specific):** The QIDP will be retrained on ensuring that there are IDT meeting held for all incident reports. The Quality Assurance Coordinators and QIDP Manager are partnering with other senior administrative staff to assure ongoing training is in place to maintain competency. Additionally, the governing body has committed to enlisting the services of outside Masters level behavioral clinicians when the interdisciplinary	11/02/2017

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	Client #1's record was reviewed on 9/28/17 at 7:30 AM. Client #1's 6/29/16 BSP was written by the QIDP. Client #2's record was reviewed on 10/2/17 at 8:11 AM. Client #2's 10/31/16 BSP was written by the QIDP Client #3's record was reviewed on 10/2/17 at 10:42 AM. Client #3's 8/9/17 BSP was written by the QIDP. Qualified Intellectual Disabilities Professional Manager (QIDPM) #1 was interviewed on 9/28/17 at 1:00 PM. QIDPM #1 indicated the home did not have a BC. QIDPM #1 indicated the QIDP was responsible for writing clients BSP's. QIDPM #1 stated she was "uncomfortable with QIDP's writing the BSP due to the fact they were not qualified." QIDPM #1 indicated she was not aware the QIDP could not serve as a BC as well. QIDPM #1 indicated the Program Manager told them group homes did not need a BC. 9-3-3(a)		team has assessed that clients' aggressive behavior is exacerbated by complicated comorbid psychiatric condition(s). In addition to the administrative monitoring described below, the governing body has implemented expanded, detailed quality assurance audits that will occur no less than twice monthly at all ResCare facilities. These audits will focus on safety and consistent regulatory compliance. **How others will be identified: (Systemic):** In addition to the administrative monitoring described below, the governing body has implemented expanded, detailed quality assurance audits that will occur no less than twice monthly at all ResCare facilities. These audits will focus on safety and consistent regulatory compliance. **Measures to be put in place:** The QIDP will be retrained on ensuring that there are IDT meeting held for all incident	

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			reports. The Quality Assurance Coordinators and QIDP Manager are partnering with other senior administrative staff to assure ongoing training is in place to maintain competency. Additionally, the governing body has committed to enlisting the services of outside Masters level behavioral clinicians when the interdisciplinary team has assessed that clients' aggressive behavior is exacerbated by complicated comorbid psychiatric condition(s). In addition to the administrative monitoring described below, the governing body has implemented expanded, detailed quality assurance audits that will occur no less than twice monthly at all ResCare facilities. These audits will focus on safety and consistent regulatory compliance. **Monitoring of Corrective Action:** In addition to the administrative monitoring described below, the governing body has implemented expanded, detailed quality assurance audits that will occur no less	

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			than twice monthly at all ResCare facilities. These audits will focus on safety and consistent regulatory compliance. **Completion date: 11.02.17**	
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.			
	Based on observation, interview and record review for 1 of 3 sampled clients (#3), the facility failed to ensure staff implemented client #3's Dining Plan. Findings include: Observations were conducted at the group home on 9/28/17 from 5:45 AM through 8:00 AM. At 7:15 AM client #3 had a family style breakfast at the kitchen table. Client #3's breakfast included cereal and toast with butter and jelly. House Manager (HM) #1 sat beside client #3 while he ate his breakfast. At 7:20 AM client #3 folded his toast (like a sandwich), and ate it whole. Client #3's toast was not cut into pieces.	W 0249	**W249 :** Program Implementation **Corrective Action: (Specific):** All staff working at the home will be re-trained on the Operation Standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual's rights. **How others will be identified: (Systemic):** All staff at the home will be re-trained on all individuals BSP's to ensure full understanding. The QIDP will be at the home at least twice weekly to conduct observations, ensure that all individual program plans are implemented as written and that changes are made based in	11/02/2017

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	Client #3's 8/18/17 High Risk Plan (HRP) was reviewed on 10/2/17 at 10:43 AM. Client #3's HRP indicated he had a Potential for Choking as well as a Dining Plan. Client #3's dining plan indicated, "All foods need to be cut into 1 inch bite sized pieces, sandwiches into 16 pieces." Client #3's potential for choking indicated, "Will have zero episodes of chocking (sic) through 9/2018. Staff will encourage [client #3] to sit with good posture and prompt client to eat with a slower rate of consumption." Client #3's 9/18/17 dietary assessment indicated, "All foods need to be cut into 1 inch bite sized pieces, sandwiches into 16 pieces." Staff #1 was interviewed on 9/27/17 at 4:45 PM. Staff #1 indicated client #3 was the only client in the home with a dining plan. Staff #1 indicated client #3 had to have his food cut into bite size pieces. Area Supervisor (AS) #1 was interviewed on 10/2/17 at 12:30 PM. AS #1 indicated client #3's Dining Plan should be followed at all times. AS #1 indicated client #1's food should be cut into 1 inch pieces and sandwiches into 16 pieces. AS #1 indicated client #3's toast should have been cut up. AS #1 indicated client #1 should not eat his toast whole.		individual need. **Measures to be put in place:** All staff working at the home will be re-trained on the Operation Standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual's rights. **Monitoring of Corrective Action :)** All staff at the home will be re-trained on all individuals BSP's to ensure full understanding. The QIDP will be at the home at least twice weekly to conduct observations, ensure that all individual program plans are implemented as written and that changes are made based in individual need. **Completion date: 11.02.17**	

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	9-3-4(a)			
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel.			
	Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3) plus 3 additional clients (#4, #5 and #6), the facility failed to conduct evacuation drills quarterly for the day, evening and overnight shift of personnel. Findings include: The facility's evacuation drill records were reviewed on 9/28/17 at 7:30 AM. The review indicated the facility failed to conduct evacuation drills for clients #1, #2, #3, #4, #5 and #6 for the overnight shift (10PM-6AM) during the first quarter (January, February, March 2017), second quarter (April, May, June 2017), and the fourth quarter (October, November, December 2016). The facility failed to conduct evacuation drills for the evening hours (2 PM-10 PM) during during the first quarter quarter (January, February, March 2017), second quarter (April, May, June 2017), third quarter (July, August, September 2017) and the fourth quarter (October, November, December 2016). The facility failed to	W 0440	**W440:** The facility must hold evacuation drills at least quarterly for each shift of personnel. **Corrective Action:** **(Specific):** The Residential Manager will be re-trained on ensuring that evacuation drills are completed at least quarterly for each shift of personnel. **How others will be identified: (Systemic**): All evacuation drills are sent to QA who monitors and tracks to ensure that evacuation drills are completed at least quarterly for all shifts of personnel. If QA notes that a drill has not been completed the home is contacted prior to the deadline to ensure that it is completed timely. **Measures to be put in place:** The staff will be retrained on the drill policy and drill schedule. The residential manager will be in serviced to	11/02/2017

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RES CARE COMMUNITY ALTERNATIVES SE IN	749 SOUTH BEARS BEND ROAD FRENCH LICK, IN 47432

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	conduct evacuation drills for the morning shift (6 AM-2PM) during during the first quarter (January, February, March 2017), second quarter (April, May, June 2017), third quarter (July, August, September 2017) and the fourth quarter (October, November, December 2016). Staff #3 was interviewed on 9/28/17 at 7:30 AM. Staff #3 indicated they only had one drill in the home for the overnight shift in September. Staff #3 indicated they do not keep the drills in a book, they are faxed into the office. Staff #3 indicated they have an evacuation drill schedule posted to follow in the office/medical room. Staff #3 indicated the drills were to be done once per quarter per shift. Area Supervisor (AS) #1 was interviewed on 10/2/17 at 12:45 PM. AS #1 indicated evacuation drills were to be done once per quarter per shift. Additional evacuation drills were requested from the Program Manager on 9/29/17 at 10:05 AM. Additional drills were not provided. 9-3-7(a)		ensure that the drills are being completed. **Monitoring of Corrective Action :)** All evacuation drills are sent to QA who monitors and tracks to ensure that evacuation drills are completed at least quarterly for all shifts of personnel. If QA notes that a drill has not been completed the home is contacted prior to the deadline to ensure that it is completed timely. **Completion date: 11.02.17**	