STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G247	A. BUILDING 00 B. WING	12/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWELL DR 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
W 0000 Bldg. 00	This visit was for a full recertification and state licensure survey. Dates of Survey: December 11, 12, 13, 14 and 17, 2018. Facility Number: 000769 Provider Number: 15G247 AIMS Number: 100248810 These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/14/19.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review, and interview, for 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7 and #8), the Governing Body failed to exercise general policy, budget, and operating direction over the facility to ensure implementation of the agency's abuse, neglect, and mistreatment policy and procedures to protect clients from financial exploitation, and failed to develop a policy regarding the storage and use of oxygen canisters used for client #3. Findings include: 1. During observations on 12/11/18 from 4:15 PM until 7:05 PM, clients #1, #2, #3, #4, #5, #6, and #8 went about their evening routine of medications,	W 0104	1.The facility will install proper signage notifying occupants, staff, and visitors that portable canisters of oxygen are in use in the facility and that oxygen containers are stored in a secure dedicated location within the facility. The agency has developed protocol for the storage of oxygen and all employees will be trained on the new procedure. 1.The facility revised the client finance operation standard to include: **Spend Down Funds:**	02/01/2019

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

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	hygiene and mealtime tasks. Client #7 arrived to the facility after attending a funeral at 5:45 PM. Upon entering the facility at 4:15 PM, a silver colored metal cylinder (oxygen container for client #3) was observed in the front entryway hall. There were 5 smaller silver cylinders (oxygen containers for client #3) on the left side of the entryway into the facility's medication/office room. There were no signs on the front entry door or the medication/office rooms to alert individuals that oxygen was stored and in use at the facility. Client #3 was observed to use nasal cannula attached to an oxygen concentrator machine in the facility's living area. When client #3 was in the bedroom he shared with client #2, the oxygen concentrator was rolled to the bedroom and back to the living area for client #3's constant use. Client #3 used portable canisters of oxygen while in the community or traveling in the facility's van. The facility staff did not place the oxygen containers in a dedicated, secure location within the facility. The facility's undated Policy and Procedure: Medication Storage and Disposal" was reviewed on 12/13/18 at 1:00 PM. The Policy did not address the use of oxygen or its storage within the facility. Interview with the health services coordinator nurse #1 on 12/13/18 at 1:10 PM indicated the facility did not have a policy addressing the use of oxygen by its clients. 2. The governing body failed to exercise general policy, budget, and operating direction over the facility for 2 of 3 sampled clients (#2 and #3), and 4 additional clients (#4, #5, #6 and #7), to ensure the facility's neglect/abuse/mistreatment policy was implemented regarding financial exploitation by facility staff towards clients #2, #3, #4, #5, #6		- Any spend down of $100 or more is the responsibility of the area supervisor and must be spent within 5 business days. All receipts for the spend down purchases must be returned to the business manager once purchases have been completed. Any outstanding checks will be redeposited after 30 days. Spend Downs will be dispersed in the order of preference listed below ·through use of Spend Down P-cards ·through checks approved by the business manager and executive director All employees will be trained on the revised standard. Persons Responsible: Program Manager, Maintenance Manager, Business Manager, Area Supervisor, QIDP, Residential Manager, and DSPs.	

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	and #7. Please see W149. 9-3-1(a)			
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 2 of 3 sampled clients (#2, #3), and 5 additional clients (#4, #5, #6, #7 and #8), the facility failed to assure a full and complete accounting of clients' finances to avoid theft and failed to ensure the facility's policy of cashing clients' checks within 5 business days was implemented. Findings include: 1. An investigation dated July 19 to 26, 2018 conducted by Quality Assurance Manager/QAM #1 was reviewed on 12/11/18 at 11:00 AM and indicated the following: The investigation was initiated after an audit of client finances indicated the possibility of missing client funds. The following was determined after the investigation: The investigation's factual findings indicated former staff #2 and former Residential Manager/RM #2 were the only staff who had access to the safe which contained client funds. The investigation determined RM #2 had client funds in her personal possession at her residence instead of the facility's safe. The investigation determined items said to have been purchased for clients could not be accounted for.	W 0140	**W140:** The facility has revised the client financial standards to include: **Spend Down Funds:** Any spend down of $100 or more is the responsibility of the area supervisor and must be spent within 5 business days. All receipts for the spend down purchases must be returned to the business manager once purchases have been completed. Any outstanding checks will be redeposited after 30 days. Spend Downs will be dispersed in the order of preference listed below ·through use of Spend Down P-cards ·through checks approved by the business manager and executive director All employees will be trained on the revised standard.	02/01/2019

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	"Conclusion It is substantiated client funds were missing from the home. It is substantiated [client #4] is missing $2313.88; [client #2] $85.20; [client #6] $99.09; [client #3] $48.37; [client #5] $97.07; and [client #7] $192.69. It is substantiated [former Residential Manager #2] was the last known person to be in possession of the client funds." The "Investigation Peer Review" dated 7/27/18 which accompanied the investigation indicated the following recommendations: Former staff #2 and former Residential Manager/RM #2 be terminated from employment and their personnel files be marked as ineligible for rehire. The agency's policies (clients' Bill of Rights and Grievance Procedure) be reviewed with the clients. The clients' personal funds should be reimbursed. According to review of Residential Fund Management Services Statements for clients and interview with Quality Assurance Coordinator/QAC #1 on 12/11/18 at 11:30 AM indicated clients #2, #3, #4, #5, #6 and #7 had been reimbursed the missing money by the facility. The interview indicated former RM #2 had been terminated from employment for financial exploitation of the clients and the information had been turned over to the proper authorities. Client #2 had been reimbursed $85.20 on 8/27/18. Client #3 had been reimbursed $48.37 on 8/27/18. Client #4 had been reimbursed $2,313.88 on 9/10/18. Client #5 had been reimbursed $97.07 on 8/27/18. Client #6 had been reimbursed $99.09 on 8/27/18. Client #7 was reimbursed $197.69 on 8/17/18.		Persons Responsible: Program Manager, Business Manager, Area Supervisor, QIDP, Residential Manager, and DSP.	

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	2. Clients #2 and #8's RFMS/Residential Fund Management Services Statements for 08/01/18 through 12/06/18 were reviewed on 12/13/18 at 1:30 PM and indicated the following: Client #2 had two checks made out on 11/28/18 for $400.00 and $500.00 (totaling $900.00) for "spend down." Client #8 had two checks listed on 11/30/18 for $400.00 for "spend down" (total of $800.00). When office staff in charge of clients' funds (Client Benefits Coordinator) was interviewed at on 12/13/18 at 2:00 PM, the checks were still at the facility's administrative offices and had not been cashed. Client #2 also had two checks at the office dated 4/2618 totaling $700.00 which had not been cashed or placed back into his account. Clients #4, #5 and #6's RFMS/Residential Fund Management Services Statements for 08/01/18 through 12/07/18 were reviewed on 12/13/18 at 1:30 PM and indicated the following: Client #4 had 4 checks for $500.00 dated 9/26/18 (totaling $2,000.00) for "spend down" which were still in the administrative office and had not been cashed or placed back into his account. Client #5 had a check dated 7/11/18 in the amount of $500.00 at the administrative office which had not been cashed or placed back into his account. Client #6 had a check dated 7/11/18 in the amount of $500.00 at the administrative office which had not been cashed or placed back into his account. The Client Benefits Coordinator was interviewed on 12/13/18 at 2:00 PM. The interview indicated when a request for client money was obtained, a check was dispersed by the office in the client's name. The Residential Manager or designee was responsible to take the client to the bank to cash the check. The Procedure of obtaining receipts			

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	for all expenditures was expected to be followed. Checks were to be cashed within 5 business days. 9-3-2(a)			
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 record review and interview for 2 of 3 sampled clients (#2 and #3), and 4 additional clients (#4, #5, #6 and #7), the facility failed to ensure the facility's neglect/abuse/mistreatment policy was implemented regarding financial exploitation by facility staff towards clients #2, #3, #4, #5, #6 and #7. Findings include: An investigation dated July 19 to 26, 2018 conducted by Quality Assurance Manager/QAM #1 was reviewed on 12/11/18 at 11:00 AM and indicated the following: The investigation was initiated after an audit of client finances indicated the possibility of missing client funds. The following was determined after the investigation: The investigation's factual findings indicated former staff #2 and former Residential Manager/RM #2 were the only staff who had access to the safe which contained client funds. The investigation determined RM #2 had client funds in her personal possession at her residence instead of the facility's safe. The investigation determined items said to have been purchased for clients could not be accounted for.	W 0149	The facility has revised the client financial standards to include: **Spend Down Funds:** - Any spend down of $100 or more is the responsibility of the area supervisor and must be spent within 5 business days. All receipts for the spend down purchases must be returned to the business manager once purchases have been completed. Any outstanding checks will be redeposited after 30 days. Spend Downs will be dispersed in the order of preference listed below ·through use of Spend Down P-cards ·through checks approved by the business manager and executive director All employees will be trained on the revised standard and disciplinary action will be given if the standard is not followed.	02/01/2019

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	"Conclusion It is substantiated client funds were missing from the home. It is substantiated [client #4 is missing $2313.88; [client #2] $85.20; [client #6] $99.09; [client #3] $48.37; [client #5] $97.07; and [client #7] $192.69. It is substantiated [former Residential Manager #2] was the last known person to be in possession of the client funds." The "Investigation Peer Review" dated 7/27/18 which accompanied the investigation indicated the following recommendations: Former staff #2 and former Residential Manager/RM #2 be terminated from employment and their personnel files be marked as ineligible for rehire. The agency's policies (clients' Bill of Rights and Grievance Procedure) be reviewed with the clients. The clients' personal funds should be reimbursed. According to review of Residential Fund Management Services Statements for clients and interview with Quality Assurance Coordinator/QAC #1 on 12/11/18 at 11:30 AM indicated clients #2, #3, #4, #5, #6 and #7 had been reimbursed the missing money by the facility. The interview indicated former RM #2 had been terminated from employment for financial exploitation of the clients and the information had been turned over to the proper authorities. Client #2 had been reimbursed $85.20 on 8/27/18. Client #3 had been reimbursed $48.37 on 8/27/18. Client #4 had been reimbursed $2,313.88 on 9/10/18. Client #5 had been reimbursed $97.07 on 8/27/18. Client #6 had been reimbursed $99.09 on 8/27/18. Client #7 was reimbursed $197.69 on 8/17/18.		Persons Responsible: Program Manager, Business Manager, Area Supervisor, QIDP, Residential Manager, and DSP.	

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	The Agency's "Operation Standard Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or Violation of an Individual's Rights" dated 3/08/2018 was reviewed on 12/13/18 at 10:00 AM and indicated the agency prohibited, reported, investigated and implemented corrective measures in regards to abuse/neglect/exploitation/mistreatment of the clients it served. The review of the agency's policy indicated, in part, the following: ..."ResCare strictly prohibits abuse, neglect, exploitation, mistreatment or violation of an Individual's rights....Program Implementation/Intervention: Failure to provide goods and/or services necessary for the individual to avoid physical harm and /or intentional failure to implement a support plan, inappropriate application of intervention, etc. which may result in jeopardy without qualified person notification/review.... Any situation involving weapons, regardless if abuse, neglect, mistreatment or violation of an Individual's rights is suspected, will be immediately investigated. All employees receive training upon hire regarding definitions/causes of different types of, how to identify, prevent, document, remedial action to be taken, timely debriefing following the incident and how to report abuse, neglect, exploitation, mistreatment or violation of an Individual's rights, as well as what to expect from an investigation. All employees receive this training upon hire and annually, thereafter. Procedures: 1. Any ResCare staff person who suspects an individual is the victim of abuse, neglect, exploitation or mistreatment of an individual should immediately notify the Program Manager,			

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	and then complete an Incident Report. The Program Manager will then notify the Executive Director immediately. 2. The Program Manager, or designee, will report the suspected abuse, neglect, exploitation, mistreatment or violations of Individual's rights with 24 hours of the initial report to the appropriate contacts... 3. Any person who is suspected of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights toward an individual will be immediately suspended until the allegation can be fully investigated... 4. The Program Manager will assign an investigative team. A full investigation will be conducted by investigators who have received training from Labor Relations Association and ResCare's internal procedures on investigations. ResCare will not allow for nepotism during the conducting, directing, reviewing or other managerial activity of an investigation into an allegation of abuse, neglect, exploitation or mistreatment, by prohibiting friends and relatives of an alleged perpetrator from engaging in these managerial activities. One of the investigators will complete a detailed investigative case summary based on witness statements and other evidence collected. The report will be maintained in a confidential, secured file at the office. The investigation file will include the following components: a clear statement indicating why the investigation/review is being conducted along with the nature of the allegations/event (e.g., allegation of neglect, etc.), a clear statement of the event or alleged event in a time-line format including what, where, and when the event happened or is alleged to have happened,			

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	Identification by name and title of all involved parties or alleged involved parties including any victim(s) or alleged victim(s), all staff assigned to the victim(s) or alleged victim(s) at the time of the incident, all alleged perpetrators, when indicated; and all actual or potential witnesses to the event or alleged event, signed and dated statements from all involved parties, including all actual and potential witnesses to the event or alleged event, a statement describing all record and other document review associated with the event or alleged event, copies of all records and other documents reviewed that provide evidence supporting the finding of the investigation or review, if there are any discrepancies/conflicts between the evidence gathered, the discrepancy is resolved and/or explained, a determination if rights have been violated, if services and/or care were not provided or were not appropriately provided, if agency policies and/or procedures were not followed, and/or if any federal or state regulations were not followed, a clear statement of substantiation or non-substantiation of any allegation that includes a description/summary of the evidence that result in the finding, a definitive description of all corrective actions developed and implemented and/or to be implemented as a result of the investigation or review, including completion dates for each corrective action, the signature, name and title of the person completing the investigation and the date the investigation was completed. 5. An investigative peer review committee chosen by the Executive Director will meet to discuss the outcome of the investigation and to ensure that a thorough investigation has been completed. Members of the committee must include at least one of the investigators, the Executive Director or designee, Program Manager, QA representative			

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	and a Human Resources representative." 9-3-2(a)			
W 0381 Bldg. 00	483.460(l)(1) DRUG STORAGE AND RECORDKEEPING The facility must store drugs under proper conditions of security. Based on observation, record review and interview, 4 of 4 sampled clients (clients #1, #2, #3, and #4) and 4 additional clients (clients #5, #6, #7 and #8), the facility to ensure clients' medications were kept in a secure location. Findings include: 1. During observations on 12/11/18 at from 4:15 PM until 7:05 PM, clients #1, #2, #3, #4, #5, #6, and #8 went about their evening routine of medications, hygiene and mealtime tasks. Client #7 arrived to the facility after attending a funeral at 5:45 PM. At 4:33 PM, GHS (Group Home Staff) #1 went into the open medication room to prepare for the clients' afternoon medications. Staff #1 could not find the medication keys. Staff #1 called staff #3, and the Area Supervisor regarding the keys. Supervisory staff alerted maintenance personnel to come to the facility and assist in getting the medication cabinets open so medications could be administered. The clients' medications were stored in two hard plastic modular cabinets in the facility's office. The controlled medications were stored in a large red plastic tackle box inside one of the large plastic cabinets. Staff #2 pried off the plastic doors to the cabinets housing the clients' medications. The clients' medications were accessible as was the red tackle box containing clients' controlled medications. At 5:01 PM, staff #2 administered clients' medications. At 5:07 PM, staff #2 and staff	W 0381	The facility has installed secured cabinets to ensure client medications are stored in a secured location. The facility will provide a durable metal lock box to provide secure storage for controlled substances which will also be secured by a secondary lock. The facility will provide a secured and dedicated refrigerator in a locked area for medication requiring refrigeration. Persons Responsible: Program Manager, Maintenance Manager, Area Supervisor, QIDP, Residential Manager, and DSP.	02/01/2019

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	#3 pulled open the red tackle box which housed client #6's clonazepam (a controlled medication) and they were able to get the medication card out of the box without unlocking the box. Staff #2 administered client #6's medication, clonazepam and a cream to his left arm. Client #5's medication was administered by staff #2 at 5:10 PM. QIDP/Qualified Intellectual Disability Professional #1 found the medication keys on top of the plastic modular medication cabinets on 12/11/18 at 5:15 PM. Maintenance staff put the doors back onto the plastic modular cabinets at 5:30 PM on 12/11/18. 2. During morning observations at the facility on 12/12/18 at 7:25 AM, client #5 had a nutritional supplement drink at breakfast time. Client #7 had aloe juice on 12/12/18 at 7:30 AM. Client #7's unlabeled aloe juice and client #5's nutritional supplement drink were stored in the refrigerator accessible to all clients living in the facility. There was no locked container for medications in the facility's refrigerator. There was no refrigerator in the medication room. QIDP #1 was interviewed on 12/11/18 at 5:45 PM and indicated medications should be stored in a secure location. Program Director #1 was interviewed on 12/12/18 at 1:15 PM and indicated new metal cabinets were being ordered for the facility's medication and treatment storage. Interview with the health services coordinator nurse #1 on 12/13/18 at 1:00 PM indicated the facility had a policy addressing storage of clients' medications. Client #5's 12/18 MAR (Medication			

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RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWELL DR 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
	Administration Record) was reviewed on 12/13/18 at 2:10 PM and indicated the following physician's order "Boost Liqd (liquid) give one Boost twice daily." Client #7's 12/18 MAR (Medication Administration Record) was reviewed on 12/13/18 at 2:00 PM and indicated "Aloe Vera Organic Juice Drink 1 (one) Ounce Twice Daily." The facility's undated Policy and Procedure: Medication Storage and Disposal" was reviewed on 12/13/18 at 1:00 PM. The Policy indicated: "1. Each home will have a locked cabinet/room for the purpose of medication storage.... 5. Each home should have a 'locked' box for medications requiring refrigeration or a refrigerator in the locked medication storage area. Controlled substances must be double locked...." 9-3-6(a)			
W 0383 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Only authorized persons may have access to the keys to the drug storage area. Based on observation and interview for 4 of 4 sampled clients (clients #1, #2, #3, and #4), and 4 additional clients (clients #5, #6, #7 and #8), the facility to ensure the keys to clients' medications and treatments were housed in a secure location so they could not be misplaced or used by unauthorized individuals. Findings include: During observations on 12/11/18 from 4:15 PM until 7:05 PM, clients #1, #2, #3, #4, #5, #6, and #8	W 0383	The facility will ensure all staff is trained on the standard that keys to the medication cabinets are to be physically handed off to the next person coming on for their shift. Keys are not to be laid down anywhere and should remain in the possession of the staff currently on shift. Persons Responsible: Program Manager, Area Supervisor, QIDP, Residential Manager, and DSP.	02/01/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G247	A. BUILDING 00 B. WING	12/17/2018

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	went about their evening routine of medications, hygiene and mealtime tasks. Client #7 arrived to the facility after attending a funeral at 5:45 PM. At 4:33 PM, GHS (Group Home Staff) #1 went into the open medication room to prepare for the clients' afternoon medications. Staff #1 could not find the medication keys. Staff #1 indicated the medication keys were normally left on the bulletin board above the desk in the medication room. Staff #1 searched the room and could not find the keys. Staff #1 called staff #3, and the Area Supervisor regarding the keys. Supervisory staff alerted maintenance personnel to come to the facility and assist in getting the medication cabinets open so medications could be administered. QIDP/Qualified Intellectual Disability Professional #1 found the medication keys on top of the plastic modular medication cabinets on 12/11/18 at 5:15 PM. QIDP #1 was interviewed on 12/11/18 at 5:45 PM and indicated the facility's medication keys should be stored in a secure location. 9-3-6(a)			