

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G159	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 05/11/2021
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP CODE 1337 E SOUTHVIEW LN PAOLI, IN 47454		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (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	<p>This visit was for a predetermined full recertification and state licensure survey. This visit included the Covid-19 focused infection control survey.</p> <p>Survey Dates: 5/7/21, 5/10/21 and 5/11/21</p> <p>Facility Number: 000695 Provider Number: 15G159 AIM Number: 100243150</p> <p>This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/24/21.</p>	W 0000			
W 0104 Bldg. 00	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on observation and interview for 7 of 7 clients living in the group home (#1, #2, #3, #4, #5, #6 and #7), the facility's governing body failed to exercise operating direction over the facility by failing to ensure the home remained in good repair.</p> <p>Findings include:</p> <p>On 5/10/21 from 5:59 AM to 8:26 AM, an observation was conducted at the group home. At 6:20 AM, dishes were sitting in a dish drainer next to the kitchen sink. At 7:06 AM, staff #1 filled a large pot with water and began heating the water on the stove. This affected clients #1, #2, #3, #4, #5, #6 and #7.</p>	W 0104	<p>ISSUE: The facility's governing body failed to exercise operating direction over the facility by failing to ensure the home remained in good repair. The dishwasher was not in working order.</p> <p>PLAN OF CORRECTION: Program Manager called in a work order to Aramark on 5/16/2021. The replacement dishwasher was delivered and installed on May 18, 2021.</p> <p>PERSONS RESPONSIBLE: Program Manager</p>	06/01/2021	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

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

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FORM APPROVED
OMB NO. 0938-039

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	<p>On 5/10/21 at 6:22 AM, the RM (Resident Manager) stated, "The dishwasher does not work and has not in forever." The RM indicated a work order had been completed for the dishwasher.</p> <p>On 5/10/21 at 7:06 AM, staff #1 indicated the dishwasher was broken. Staff #1 stated, "We boil water to wash the kettles in and use paper plates for the clients to eat from since the dishwasher is broken."</p> <p>On 5/10/21 at 4:29 PM the DSL (Direct Support Lead) indicated the dishwasher had been broken for 5 months. The DSL stated, "We need a new dishwasher."</p> <p>On 5/11/21 at 11:52 AM, the QIDP (Qualified Intellectual Disabilities Professional) stated, "I was not aware the dishwasher was not operating." The QIDP indicated the dishwasher should be operational. The QIDP stated, "The dishwasher should be operational for sanitary conditions, especially due to COVID."</p> <p>9-3-1(a)</p>		DATE TO BE COMPLETED: This was completed on 5/18/2021.	