

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/13/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(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	<p>This visit was for a focused fundamental recertification and state licensure survey.</p> <p>Survey dates: 2/10/20, 2/11/20, 2/12/20 and 2/13/20.</p> <p>Facility Number: 000709 Provider Number: 15G175 AIM Number: 100243190</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/24/20.</p>		W 0000				
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>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 (#1 and #2) and 1 additional client (#5), the facility failed to implement its policy and procedures for prohibiting abuse, neglect, exploitation, mistreatment or violation of an individual's right in regard to preventing incidents of client to client physical aggression.</p> <p>Findings include:</p> <p>On 2/11/20 at 12:19 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports was completed. The reports indicated:</p> <p>-BDDS report dated 1/19/20 indicated, "[Client #1] sat down to eat when [client #2] yelled.</p>		W 0149	<p>1.The Facility will develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>2.Program Manager will ensure the Area Supervisor and Residential Manager retrain direct care staff on the Abuse, Neglect and Exploitation Policy. Failure to follow policy will result in disciplinary action up to and including termination.</p> <p>3.The QIDP will retrain the staff on the ISP and BSP on Physical aggression, SIB (self-injurious behavior) and Property</p>		03/13/2020	

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 that other safeguards 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.

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

PRINTED: 05/19/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/13/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(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
	<p>[Client #1] got upset and sat down next to [client #5]. [Client #1] hit [client #5] and [client #2], [client #2] hit [client #1] back. Staff redirected all individuals. There were no injuries reported as a result of this incident".</p> <p>-Investigative Summary dated 1/19/20 indicated, "Interviews: Staff stated the clients were sitting down to eat. [Client #2], wanted some cheese and he yelled in a loud voice which he sometimes does. The loud sound upset [client #1] and he threw his bowl across the table and slapped [client #5] on the arm. He got up and pushed his chair over and walked away pushing some papers on the desk off to the floor ...Recommendations: Staff will monitor any occurrence of verbal and or physical aggression on consumer ABC (Antecedent-Behavior-Consequence) tracking".</p> <p>-BDDS report dated 1/19/20 indicated, "[Client #1] was upset about taking medications, he slapped staff and [client #2], (sic) [Client #2] slapped him (client #1) back. Staff stepped in between both individuals and redirected, [client #1] hit staff and they escorted him to his room to calm down". The incident of client #1's physical aggression toward client #2 occurred on 1/17/20, but was not reported until 1/19/20.</p> <p>-Investigative Summary dated 1/18/20 indicated, "Interviews: [Client #1] does not want to answer questions. He paced around the room. [Client #2] said I hit him because he hit me. [Former Staff #1], [Client #1] smacked his meds out of my hand. He hit [client #2] and [client #2] hit him. [Client #1] hit himself a few more times. He hit me again and when he went to his room he tried to trash his room ...Recommendations: If a pattern develops with [client #1] aggressing towards others when he is agitated, his BSP</p>				<p>Destruction. Including a new protocol to include a on protocol on Physical aggression, SIB (self-injurious behavior) and Property Destruction.</p> <p>Persons Responsible: Program Manager, Area Supervisor, QIDP, Residential Manager, and DSP.</p>		

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

PRINTED: 05/19/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/13/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(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 0153	<p>(Behavioral Support Plan) will need to be updated. Staff are going to notate on ABC (Antecedent-Behavior-Consequence) tracking any other aggressive behaviors".</p> <p>On 2/11/20 at 2:30 PM, the Qualified Intellectual Disability Professional (QIDP) was interviewed. The QIDP was asked about client to client physical aggression. The QIDP stated, "January 18th was the last time (client #1 hit another client). We discussed more supervision and we know mornings are a terrible time (client #1 is likely to be agitated). Hitting and slapping is identified in his ISP (Individual Support Plan) and BSP (Behavior Support Plan)". The QIDP reviewed client #1's ISP and BSP and stated, "Physical aggression, SIB (self-injurious behavior) and Property Destruction are in his plans". The QIDP was asked if client to client physical aggression was defined as a form of abuse per provider protocols. The QIDP stated, "Yes". The QIDP was asked about implementation of the abuse, neglect, exploitation, mistreatment or violation of an individual's rights policy. The QIDP indicated implementation of policy had not occurred for the above mentioned incidents of client to client physical aggression.</p> <p>On 2/11/20 at 2:45 PM, the Abuse, Neglect, Exploitation, Mistreatment and or a Violation of Individual's Rights (ANE) policy dated 7/10/19 was reviewed. The ANE policy indicated, "ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights".</p> <p>9-3-2(a)</p> <p>483.420(d)(2)</p> <p>STAFF TREATMENT OF CLIENTS</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/13/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(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
Bldg. 00	<p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>Based on record review and interview for 1 of 3 incidents involving an allegation of client to client physical abuse (clients #1 and #2), the facility failed to immediately report the incident to Bureau of Developmental Disabilities Services (BDDS) in accordance with state law.</p> <p>Findings include:</p> <p>The facility's incident reports were reviewed on 2/11/20 at 12:19 PM and indicated the following:</p> <p>-BDDS report dated 1/19/20 indicated, "[Client #1] was upset about taking medications, he slapped staff and [client #2], (sic) [Client #2] slapped him (client #1) back. Staff stepped in between both individuals and redirected, [client #1] hit staff and they escorted him to his room to calm down". The incident of client #1's physical aggression toward client #2 occurred on 1/17/20, but was not reported until 1/19/20.</p> <p>-Investigative Summary dated 1/18/20 indicated, "Interviews: [Client #1] does not want to answer questions. He paced around the room. [Client #2] said I hit him because he hit me. [Former Staff #1], [Client #1] smacked his meds out of my hand. He hit [client #2] and [client #2] hit him. [Client #1] hit himself a few more times. He hit me again and when he went to his room he tried to trash his room ...Recommendations: If a pattern develops with [client #1] aggressing towards others when he is agitated, his BSP</p>			W 0153	<p>1.The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>2.The QA Manager will train the Quality Assurance Department on the BDDS Reporting Standard.</p> <p>3.The Area Supervisor will train all Facility Staff on the BDDS Reporting Standard.</p> <p>Persons Responsible: QA Manager, QA Coordinator, QIDP, Residential Manager, Area Supervisor, DSP and Program Manager.</p>		03/13/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/13/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(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 0227 Bldg. 00	<p>(Behavioral Support Plan) will need to be updated. Staff are going to notate on ABC (Antecedent-Behavior-Consequence) tracking any other aggressive behaviors".</p> <p>On 2/11/20 at 2:30 PM, the Qualified Intellectual Disability Professional (QIDP) was interviewed. The QIDP was asked about reporting procedures for client to client physical aggression. The QIDP indicated the administrator should be notified immediately of alleged abuse and stated, "January 18th was the last time (client #1 hit another client). We discussed more supervision and we know mornings are a terrible time (client #1 is likely to be agitated). Hitting and slapping is identified in his ISP (Individual Support Plan) and BSP (Behavior Support Plan)". The QIDP reviewed client #1's ISP and BSP and stated, "Physical aggression, SIB (self-injurious behavior) and Property Destruction are in his plans". The QIDP was asked if client to client physical aggression was defined as a form of abuse per provider protocols. The QIDP stated, "Yes". The QIDP was asked about reporting procedures and stated, "Should be reported within 24 hours".</p> <p>9-3-2(a)</p> <p>483.440(c)(4)</p> <p>INDIVIDUAL PROGRAM PLAN</p> <p>The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#1), and 1 additional client (#6), the facility failed to develop plans to address 1) client #1 pacing and</p>		W 0227	<p>1.The facility will ensure that the individual program plan states specific objectives necessary to meet clients' needs identified in</p>		03/13/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/13/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(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			
	<p>leaving the table during family style dining and 2) client #6's desire to explore sensory stimulation through smells and aromas.</p> <p>Findings include:</p> <p>Observations were conducted on 2/10/20 from 4:02 PM to 6:05 PM and 2/11/20 from 6:30 AM to 8:17 AM. Observations indicated the following:</p> <p>1) -At 4:17 PM, client #1 arrived home from day program.</p> <p>-At 4:28 PM, client #1 sat down at the table to eat apple sauce, graham crackers and drink some juice.</p> <p>-At 4:32 PM, client #1 walked from the dining room, to the living room back to the dining room before sitting down to finish his snack.</p> <p>-At 4:33 PM, staff #2 asked client #1 to help with laundry.</p> <p>-At 4:35 PM, client #1 walked from the living room to the kitchen area.</p> <p>-At 4:58 PM, client #1 walked around the kitchen area, to the living area, to the laundry area and back to the living area. As client #1 passed by, client #1 was asked how he was doing. Client #1 continued walking on to the living area and did not engage in conversation.</p> <p>-At 5:33 PM, client #1 was seated at the dining room table for the evening meal with his housemates. Client #1 was having chicken, mashed potatoes, carrots, bread and kool-aid and water for his drinks.</p>		<p>their comprehensive assessment.</p> <p>2.The Facility will purchase a counter height table and chair set to facilitate an option for client #1 to be used as an alternative to family style dining.</p> <p>3.The QIDP will update Client #1 ISP to include a strategy for mealtime redirection and for redirection for pacing.</p> <p>4.The QIDP will train Staff on the updated ISP for Client #1.</p> <p>5.The QIDP will meet with the Day Program Coordinator and explore sensory stimulation and aroma therapy opportunities offered by the program for Client #6.</p> <p>6.The QIDP will update Client #6 ISP to include a sensory stimulations for smells and aromas and redirection to appropriate items for sensory stimulation.</p> <p>7.The QIDP will train Staff on the updated ISP for Client #6.</p> <p>Persons Responsible: QA Manager, QA Coordinator, QIDP, Residential Manager, Area Supervisor, DSPs, and Program Manager.</p>				

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

PRINTED: 05/19/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/13/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(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			
	<p>-At 5:40 PM, client #1 used a fork with his left hand to eat a bite of mashed potatoes. Client #1 used both hands to hold the bread and take a bite.</p> <p>-At 5:42 PM, client #1 stood and took his plate to the counter by the sink. Staff #3 helped client #1 place his plate on the counter so it would not fall. Client #1 then began to pace from the living area, to the kitchen and dining area.</p> <p>-At 5:46 PM, staff #1 asked client #1 to come sit down at the table to finish eating his apple sauce. Client #1 brought the bowl of apple sauce over and placed his bowl of apple sauce on the counter.</p> <p>-At 5:48 PM, client #1 returned to the counter and took a bite of his apple sauce. Client #1 then began to pace from the kitchen area through the dining area into the living area and back.</p> <p>-At 5:50 PM, staff #1 was asked if client #1 would sit at the table to eat his meal family style with his housemates. Staff #1 stated, "He will, but when he's done he just wants to walk around and go by and get a bite". Staff #1 was asked if client #1 had a plan to address his pacing or a mealtime objective. Staff #1 stated, "No, I didn't think about that, but it would be good though".</p> <p>-At 5:55 PM, client #2 had finished eating his evening meal and brought his plate over to the counter. As client #2 pushed his plates onto the counter his dining ware came into contact with client #1's bowl of apple sauce. The Qualified Intellectual Disability Professional (QIDP) noticed client #2's dining ware coming into contact with client #1's bowl of apple sauce which remained and separated client #1's bowl of</p>						

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

PRINTED: 05/19/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/13/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(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		
	<p>apple sauce from client #2's dining ware.</p> <p>-At 5:57 PM, the QIDP was asked if client #1 had a plan to address pacing and not sitting at the table during family style dining. The QIDP stated, "No, no dining goal" and indicated a mealtime objective could be added to client #1's plan.</p> <p>Morning observation of client #1's breakfast:</p> <p>-At 6:38 AM, staff #1 helped client #1 use a microwave to prepare some scrambled eggs for the morning meal. Client #1 then began to pace from the kitchen to the living room.</p> <p>-At 6:42 AM, client #1 came back to the kitchen and greeted the Area Supervisor as she had just entered the home.</p> <p>-At 6:45 AM, client #1 stopped pacing and stood behind staff #1 and watched as she checked the eggs, stirred them and placed them back into the microwave for more heating.</p> <p>-At 6:48 AM, client #6 began dishing up and serving himself some scrambled eggs. Staff #1 asked client #1 to come sit down and client #1 stated, "ought oh" and then walked into the laundry room.</p> <p>-At 6:53 AM, staff #1 asked client #1 if he needed to use the bathroom and then to come sit down at the table. Client #1 went to the table and pushed his chair in under the table and began pacing from the kitchen to the living area. Client #1's plate had scrambled eggs and an English muffin plated at his location at the dining room table.</p> <p>-At 6:56 AM, client #7 finished eating and took</p>						

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

PRINTED: 05/19/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/13/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(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			
	<p>his plate to the sink. Staff #1 asked client #1 to come sit and if he was going to eat his breakfast. The Area Supervisor asked client #1 to come sit beside her at the table as encouragement to come eat. Client #1 continued to pace from the kitchen to living area to the laundry area and back.</p> <p>-At 7:02 AM, client #2 took a drink of his coffee when client #1 returned to the dining area. Staff #4 stated "Hi" to client #1. Client #1 left the dining area and went into the laundry area.</p> <p>-At 7:06 AM, client #1 stopped pacing and watched staff #1 assisting client #4 with his blending his morning breakfast in a blender. Client #1 then began to pace from the living area to the laundry area and back.</p> <p>-At 7:09 AM, client #1 turned on the water at the kitchen sink and rinsed his hands.</p> <p>-At 7:10 AM, client #1 went to the table and picked up his plate and took it over to the counter.</p> <p>-At 7:14 AM, staff #1 asked client #1 if he wanted jelly on his toast. Client #1 rushed over to the table and laid his chair down on the floor. Staff #1 prompted client #1 to pick up his dining room chair and reposition it correctly to the dining room table. Client #1 picked his dining room chair up and slid it under the table.</p> <p>-At 7:22 AM, client #1 paced from the laundry room to the living room and back to the kitchen.</p> <p>-At 7:33 AM, staff #1 asked staff #4 to make sure client #6 brushed his teeth after taking his morning medications. Staff #1 then asked client #1 to come to the medication room for his</p>						

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

PRINTED: 05/19/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/13/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(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
	<p>morning medicines. Client #1 hit his chest and staff #1 stated, "Oh, don't hit yourself honey". Client #1 then went to the medication room for his morning medicines.</p> <p>-At 7:35 AM, client #1 returned to the kitchen from the medication room and began to pace from the kitchen to the living room saying "ought oh".</p> <p>-At 7:36 AM, client #1 sat down in a chair in the dining room for a couple seconds and then got up and began to pace from the living area to the laundry area.</p> <p>-At 7:38 AM, client #1 stopped pacing through the dining area and opened a drawer on a desk, shut it and then paced into the living area.</p> <p>-At 7:41 AM, client #1 went into client #4's bedroom and stopped to watch client #4 and the Area Supervisor work on a puzzle.</p> <p>-At 7:48 AM, clients #5 and #6 were seated in the living room with staff #4. Client #1 paced from the living area to the laundry area.</p> <p>-At 7:50 AM, client #1 continued his pacing from the living area to the laundry area and stated, "Hey".</p> <p>-At 8:02 AM, the Area Supervisor asked client #1 if he wanted to eat breakfast and client #1 stated, "Coat". Client #1 continued to pace.</p> <p>-At 8:03 AM, staff #1 asked client #1 if he wanted to eat breakfast. Client #1 continued to pace.</p> <p>-At 8:06 AM, client #1 paced with a jacket over his shoulder.</p>						

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

PRINTED: 05/19/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/13/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(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		
	<p>-At 8:07 AM, client #1 leaned over his plate on the counter and took a bite of his English muffin. The Area Supervisor poured client #1 some juice from the refrigerator into a cup. Client #1 drank some of his juice and then began to pace from the laundry area to the living area to the kitchen.</p> <p>-At 8:08 AM, the Area Supervisor stated to staff #1, "He (client #1) ate 2 bites of his toast".</p> <p>-At 8:10 AM, client #1 took another bite of English muffin. The Area Supervisor poured more juice into client #1's cup and stated, 'Here is more juice for [client #1]".</p> <p>-At 8:11 AM, the Area Supervisor stated to staff #1, "He ate 3 bites of his toast". Staff #1 then asked the Area Supervisor if she would drive client #1 to day programming and stated, "He will not ride with me. He'll go in a car". Staff #1 indicated client #1 did not like to ride on a van and stated, "He slapped me and slapped himself". Staff #1 indicated client #1 would not get upset and would ride in a car without behavioral issues.</p> <p>-At 8:15 AM, client #1 and the Area Supervisor got into the Area Supervisor's vehicle to transport client #1 to day programming.</p> <p>-At 8:17 AM, the Area Supervisor and client #1 left the home to go to day program.</p> <p>2)-At 5:04 PM, client #6 stood in the bathroom with the door partially open and his pants down. Client #6 walked to the cabinet in the bathroom, poured shampoo on his hand and smelled it. Client #6 then walked back to the toilet and wiped himself and placed toilet paper in the in toilet and smelled his hand again off and on again</p>						

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

PRINTED: 05/19/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/13/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(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			
	<p>while standing.</p> <p>-At 5:06 PM, client #6 walked back to the cabinet in the bathroom with his pants down and got some lotion (Aquaphor Healing Ointment) and placed it on his hand and in his hair and stood in the bathroom and smelled his hand.</p> <p>-At 5:07 PM, client #6 pulled his pants up and stood in the bathroom smelling his hand.</p> <p>-At 5:08 PM, client #6 pulled his pants down and sat on the toilet and smelled his hand.</p> <p>-At 5:09 PM, client #6 flushed the toilet and stood up pulling his pants up and then smelled his hand as he walked from the bathroom to the living room.</p> <p>-At 5:11 PM, staff #1 was asked what the type of lotion was in the cabinet and told that client #6 had rubbed some on his hands and in his hair. Staff #1 indicated it was a lotion used for client #5's dry skin. Staff #1 asked staff #2 to help client #6 get a wash cloth and clean up.</p> <p>-At 5:12 PM, client #6 went back to the bathroom with staff #2 to clean up.</p> <p>-At 5:13 PM, staff #1 stated, "He never gets into things really. She (staff #2) is going to help him clean up". Staff #1 was asked why the healing lotion was in the bathroom. Staff #1 stated, "It's in there for [client #5's] feet, he has dry feet".</p> <p>-At 5:15 PM, staff #2 closed the door to the bathroom and helped client #6 with a shower and cleaning up the lotion out of his hair.</p> <p>On 2/11/20 at 1:41 PM, client #1's record was</p>						

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

PRINTED: 05/19/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/13/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(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	
	<p>reviewed. The record indicated the following:</p> <p>-Individual Support Plan (ISP) dated 7/15/19 indicated, "Priority Objectives: 1. Medication Skills, 2. Pedestrian safety skills, 3. Understanding Money Skills, 4. Oral Hygiene Skills, 5. ADL (adult daily living) living Skills". Client #1's ISP did not indicate a mealtime strategy or redirection required for his pacing.</p> <p>On 2/11/20 at 1:32 PM, client #6's record was reviewed. The client record indicated the following:</p> <p>- Individual Support Plan (ISP) dated 4/19/19 indicated, "Priority Objectives: 1. Medication Skills, 2. Pedestrian safety skills, 3. Understanding Money Skills, 4. Oral Hygiene Skills, 5. ADL (adult daily living) living Skills". Client #6's ISP did not indicate sensory stimulation for smells and aromas or redirection to appropriate items for sensory stimulation.</p> <p>On 2/11/20 at 2:30 PM, the Qualified Intellectual Disability Professional (QIDP) was interviewed. The QIDP was asked about strategies for client #1's pacing during mealtimes and client #6's sensory stimulation from smelling shampoo and lotion. The QIDP indicated discussion with staff at the home had occurred about client #1's pacing and client #6's sensory stimulation. The QIDP was asked if plans were in place to address client #1's pacing and client #6's sensory stimulation. The QIDP stated, "No". The QIDP was asked if plans were needed and stated, "Yes, I think it does need to be a part of his dining (plan). We've talked about a pub style table so he can be a part of the dining". The QIDP was asked what she meant by a pub style table. The QIDP defined it as a small table to set</p>						

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

PRINTED: 05/19/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G175		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 02/13/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP CODE 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(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
	up higher. The QIDP was asked about discussion with staff for client #6's sensory stimulation with shampoo and lotion and stated, "We talked about different sensory items. We don't have a plan, but need to review this area more". 9-3-4(a)						