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	11/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWALL DR 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	This visit was for a post certification revisit/PCR for the investigation of complaint #IN00199703 completed on 7/01/2016. This survey was conducted in conjunction with a pre-determined full recertification and state licensure survey. Complaint #IN00199703: Not corrected. Survey Dates: November 28, 29, and 30, 2016. Facility Number: 000769 Provider Number: 15G247 AIM Number: 100248810 These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/14/16.	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 and interview for 4 of 4 sampled clients (A, B, C, and D), and 3 additional clients, (E, F and G),	W 0104	**W104:** The governing body must exercise general policy, budget, and operating direction over the facility.	12/30/2016

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

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	facility's governing body failed to ensure the facility's physical environment was maintained in good repair. Findings include: Observations at the facility where clients A, B, C, D, E, F, and G lived were conducted on 11/28/16 from 4:00 PM until 6:30 PM and on 11/29/16 from 6:00 AM until 10:30 AM. The large bathroom had discolored and loose quarter round on the wall's baseboard around the shower area. The shower stall was missing caulking. The small bathroom's shower was discolored and had missing caulking. The chair and love seat in the living room had a strong odor. The air conditioning vent in the living room was rusted and had a strong odor. The back bedroom hallway which led to a fire exit had a 3 drawer dresser in front of the door belonging to client B. The facility had a deck on the rear of the house accessed via a door from the dining area. This was a fire exit. The deck had no light fixture. Interview with House Manager staff #1 on 11/30/16 at 10:30 AM indicated the doors leading from the back bedroom hallway and to the deck were fire exit doors accessed by the clients during		**Corrective Action: (Specific):** The large bathroom will have the quarter round, baseboard and caulking replaced around the shower area. The small bathroom shower will be re-caulked and thoroughly cleaned. The furniture in the home will be cleaned and/or replaced and the air conditioning vent in the living room will be replaced. The dresser in the back bedroom hallway will be removed and the deck will have lighting added. The Site Supervisor will be re-trained on the timely completion of maintenance requests for items that need repaired in the home. **How others will be identified: (Systemic):** The maintenance coordinator will visit the home at least weekly and complete an environmental inspection checklist and turn it into the Program Manager each week. If any areas are noted as needing repair the maintenance coordinator will schedule the repairs immediately. The Program Manager 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. **Measures to be put in place:**	

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	evacuation drills. The interview indicated the strong odor emanating from the furniture and heating vent was urine. This federal tag relates to complaint #IN00199703. This deficiency was cited on 7/01/2016. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)		The large bathroom will have the quarter round, baseboard and caulking replaced around the shower area. The small bathroom shower will be re-caulked and thoroughly cleaned. The furniture in the home will be cleaned and/or replaced and the air conditioning vent in the living room will be replaced. and the air conditioning vent in the living room will be replaced. The dresser in the back bedroom hallway will be removed and the deck will have lighting added. **Monitoring of Corrective Action:** The maintenance coordinator will visit the home at least weekly and complete an environmental inspection checklist and turn it into the Program Manager each week. If any areas are noted as needing repair the maintenance coordinator will schedule the repairs immediately. The Program Manager 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. **Completion date: 12/30/2016**	

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W 0137 Bldg. 00	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. Based on observation and interview for 1 of 4 sampled clients (A), the facility failed to ensure client A's right to retain and have access to his personal clothing. Findings include: Observation of client A's bedroom was conducted on 11/29/16 at 6:00 AM. Client A's room had two closets. One had a locked door. One closet was unlocked and contained an air freshener, a plastic hanger and one bedroom slipper. The closet had no clothing. Interview with House Manager staff #1 on 11/29/16 at 10:00 AM indicated client	W 0137	**W137:** The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. **Corrective Action: (Specific):** All staff at the home will be re-trained on client rights. Client #1 no longer lives in the home. **How others will be identified: (Systemic):** The Area Supervisor	12/30/2016

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	A's clothing was not kept in his bedroom because it would become soiled. The locked closet contained clothing that did not fit client A. Interview with Administrative staff #2 on 11/30/16 at 2:45 PM indicated client A was supposed to have clean clothing outfits in his bedroom. This deficiency was cited on 7/01/2016. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)		and the QIDP will be at the home at least weekly to ensure that all clients in the home have access to their clothing items at all times. **Measures to be put in place:** All staff at the home will be re-trained on client rights. Client #1 no longer lives in the home. **Monitoring of Corrective Action:** The Area Supervisor and the QIDP will be at the home at least weekly to ensure that all clients in the home have access to their clothing items at all times. **Completion date: 12.30.2016**	
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	W 0149	**W149:** The facility must	12/30/2016

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	interview for 8 of 22 reportable incidents/investigations reviewed, affecting 4 of 4 of sampled clients, (A, B, C and D), and 3 additional clients (E, F and G), the facility failed to ensure its policies and procedures which prohibited neglect (failure to implement programming) and abuse (peer to peer aggression) of clients were implemented. Findings include: The facility's incident reports, BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 11/28/16 at 1:00 PM and on 11/30/16 at 1:24 PM and indicated the following: 1. An investigation dated 8/02-04/16 indicated facility staff hid food from client A in an effort to control his food seeking behavior. The hiding of food was substantiated. 2. A BDDS report dated 11/05/16 indicated client A wanted more snack food and attacked staff three times, tearing staff's clothing. Staff employed YSIS (You're Safe, I'm Safe/restraint technique for managing behavior). The staff called 911 for assistance. 3. A BDDS report dated 9/24/16		develop and implement written procedures that prohibit mistreatment, neglect or 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 A received a CIH waiver and no longer resides in the home. **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 Program 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. **Measures to be put in place:** All staff in the home will be re-trained on the operation standard for reporting and investigating	

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	indicated on 9/24/16 at 4:30 PM, client A wanted more food after dinner. He attacked client C causing bleeding to his arm (he was on a blood thinning medication). Client A "cornered" (threatened) client F. Client A physically attacked staff, ripping off her blouse and causing injury. Staff called 911 and client A was transported to a hospital for treatment. EMS (Emergency Medical Services) personnel treated client F's injuries to his arm. Staff treated staff's injuries. 4. A BDDS report indicated on 9/23/16 at 8:00 PM, client A attacked staff and threatened his housemates (clients B, C, D, E, F, and G). Housemates went to their bedrooms and 911 was called. Client A went to a local hospital and was released after doctors began haloperidol (antipsychotic) 2 milligrams three times daily for behavior. 5. A BDDS report dated 9/23/16 indicated client A scratched client E. 6. A BDDS report dated 9/10/16 indicated client A went into the kitchen to pour out his kool aid and client F tried to stop him. Staff got between the clients. Client A grabbed client F's arm leaving 3 scratches.		abuse neglect exploitation mistreatment or violation of an individual's rights. Client A received a CIH waiver and no longer resides in the home. **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 Program 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. **Completion date: 12/30/2016**	

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	7. A BDDS report dated 7/20/16 indicated an incident on 7/19/16 at 12:00 PM wherein client A tried to take client E's lunch and it fell onto the floor. Client E hit client A with the palm of his hand. 8. A BDDS report dated 6/19/16 indicated an incident on 6/18/16 at 7:00 AM. The report indicated client G was having a "Behavior" and client A reached out and grabbed his arm as he was walking by. Client G received two 1 inch scratches to his left forearm. Observations at the facility where clients A, B, C, D, E, F, and G lived were conducted on 11/28/16 from 4:00 PM until 6:30 PM, on 11/29/16 from 6:00 AM until 10:30 AM, and 11/30/16 from 11:15 AM until 12:00 PM. Client A was home with clients E and C on 11/29/16 with House Manager #1 while staff #3 took the other clients to workshop (7:45 AM to 9:00 AM). On 11/30/16, clients A and C were at home with HM #1 at 11:15 AM. Staff #2 had taken clients to work at 8:00 AM, then had taken client F to a medical appointment and back to workshop. Staff #2 returned to the facility at 11:35 AM. During these observation periods, client A was not on a true one on one staffing ratio.			

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	Interview with House Manager staff #1 on 11/28/16 at 4:45 PM indicated client A was a one on one (one staff to one client ratio) due to his physically aggressive behaviors toward peers and staff. Client A was to be in staff's line of sight when he was awake unless he was in his bedroom. Confidential interview #1 indicated client A "targeted" client C physically. During a recent incident, client C had held up his cane as a barrier when client A came toward him in a threatening manner as client C sat with his feet elevated so he was unable to move quickly. Confidential interview #2 indicated there was not always second staff when staff had to take client A on appointments in the community. When clients were taken to workshop, that left client A in the facility with 1 or 2 other clients and one staff. Review of client A's record on 11/30/16 at 2:25 PM indicated an Interdisciplinary Team Meeting/IDT dated 11/07/16. The IDT indicated a one on one staffing ratio (one staff for client A) would be implemented with client A: "The team is meeting today to discuss the safety of him (client A) and the housemates (clients B, C, D, E, F, and G). The			

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	housemates have stated they are scared of him and the team has decided to place him on a one to one to ensure the safety of him and all housemates. The one to one will be during all waking hours and the staff (one to one) will remain within line of sight of him (client A)...." The agency's Operational Standard "Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or Violation of an Individual's Rights" revision date of 1/2016 was reviewed on 11/28/16 at 3:00 PM. The review indicated the agency prohibited staff neglect/abuse/exploitation of clients. The policy indicated all allegations would be investigated and addressed. The Operation's Standard included, in part, the following: "[The agency] strictly prohibits abuse, neglect exploitation, mistreatment, or violation of an Individual's rights. These include and are defined as any of the following:...hitting...the infliction of physical pain...verbal abuse including screaming, swearing, name-calling, belittling, damaging an individual's self-respect or dignity...Medical treatment or care...." This federal tag relates to complaint #IN00199703.			

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	This deficiency was cited on 7/01/2016. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on record review and interview for 2 of 4 sampled clients, (A and C), the facility failed to add methodology to address client A's refusals for medical appointments (desensitization programming) and client C's heart/lung issues. Findings include: Client A's record was reviewed on 11/29/16 at 9:25 AM and 1:30 PM. Client A had not been to the dentist since 2/4/15. He had been to the ENT (Ear, Nose, and Throat) physician 3/18/15 and was supposed to return in one year. There was no evidence of a hearing assessment in his record. An appointment was scheduled for a hearing evaluation on 12/15/16. The client's record contained an ISP/Individual Support Plan dated 8/25/16 and a BSP/Behavior Support	W 0240	**W240:** The individual program plan must describe relevant interventions to support the individual towards independence. **Corrective Action: (Specific):** Client A received a CIH waiver and no longer resides in the home. The nurse will be re-trained on ensuring that all clients are up to date on all medical appointments. The QIDP will be re-trained on ensuring that clients who are refusing to attend medical appointments have plans developed with methodologies and desentization techniques to assist them toward independence. The nurse will be re-trained on the development and implementation of risk plans for related diagnosis for all clients. Client C will have a risk plan developed for the oxygen use, Coumadin therapy and heart/respiratory issues if it is still required.	12/30/2016

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	Plan dated 1/25/16. The client's record had no methodology which addressed being compliant with medical appointments. Interview with House Manager staff #1 on 11/29/16 at 11:30 AM indicated client A was resistive to going into offices for medical appointments. The client had gone to the gastroenterologist's office but would not remain in the office. He left the office and tried to get into the locked facility van, then got into his mother's car and refused to get out. His mother had transported him to the appointment and House Manager #1 had driven the facility van to the appointment. Client C's record was reviewed on 11/29/16 at 9:50 AM. The record review indicated client C had been hospitalized with pneumonia on 10/20/16. Client C had been treated on 8/10/16 for signs/symptoms of a stroke in the hospital. Client C had also been treated for cardiac problems in the hospital on 8/13/16. The client's record indicated his diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), acute CHF/congestive heart failure, and chronic atrial fibrillation with rapid ventricular response (irregular heartbeat). The client was receiving a blood thinning drug,		**How others will be identified: (Systemic):** The Nursing Manager will review all client medical files at least monthly to ensure that all clients are up to date on all medical appointments and have risk plans in place to address all medical diagnosis and needs. All client plans will be reviewed at least quarterly by the team. **Measures to be put in place: Corrective Action: (Specific):** Client A received a CIH waiver and no longer resides in the home. The nurse will be re-trained on ensuring that all clients are up to date on all medical appointments. The QIDP will be re-trained on ensuring that clients who are refusing to attend medical appointments have plans developed with methodologies and desentization techniques to assist them toward independence. The nurse will be re-trained on the development and implementation of risk plans for related diagnosis for all clients. Client C will have a risk plan developed for the oxygen use, Coumadin therapy and heart/respiratory issues if it is still required. **Monitoring of Corrective Action:** The Nursing Manager will review all client medical files at least monthly to ensure that all clients are up to date on all	

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	Coumadin and oxygen when in bed. The record contained health risk plans dated 11/04/16 but no health risk plans/methodology for the oxygen, Coumadin therapy or his heart/respiratory issues. Interview with LPN #1 on 11/30/16 at 2:25 PM indicated a health risk plan for hypertension. The interview indicated client C was still not released by his physician to return to work and portable oxygen was being pursued. The interview indicated the risk plans would be updated. This federal tag relates to complaint #IN00199703. This deficiency was cited on 7/01/2016. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)		medical appointments and have risk plans in place to address all medical diagnosis and needs. All client plans will be reviewed at least quarterly by the team. **Completion date: 12/30/2016**	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for	W 0331	**W331:** The facility must provide clients with nursing services in	12/30/2016

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RES CARE COMMUNITY ALTERNATIVES SE IN	2401 CORNWALL DR JEFFERSONVILLE, IN 47130

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	2 of 4 sampled clients, (A and C), the facility's nursing services failed to add methodology to address client A's refusals for medical appointments (desensitization programming) and client C's heart/lung issues. Findings include: Client A's record was reviewed on 11/29/16 at 9:25 AM and 1:30 PM. Client A had not been to the dentist since 2/4/15. He had been to the ENT (Ear, Nose, and Throat) physician 3/18/15 and was supposed to return in one year. There was no evidence of a hearing assessment in his record. An appointment was scheduled for a hearing evaluation on 12/15/16. The client's record contained an ISP/Individual Support Plan dated 8/25/16 and a BSP/Behavior Support Plan dated 1/25/16. The client's record had no methodology which addressed being compliant with medical appointments. Interview with House Manager staff #1 on 11/29/16 at 11:30 AM indicated client A was resistive to going into offices for medical appointments. The client had gone to the gastroenterologist's office but would not remain in the office. He left the office and tried to get into the locked facility van, then got into his mother's car		accordance with their needs. **Corrective Action: (Specific):** Client A received a CIH waiver and no longer resides in the home. The nurse will be re-trained on ensuring that all clients are up to date on all medical appointments. The QIDP will be re-trained on ensuring that clients who are refusing to attend medical appointments have plans developed with methodologies and desentization techniques to assist them toward independence. The nurse will be re-trained on the development and implementation of risk plans for related diagnosis for all clients. Client C will have a risk plan developed for the oxygen use, Coumadin therapy and heart/respiratory issues if it is still required. **How others will be identified: (Systemic):** The Nursing Manager will review all client medical files at least monthly to ensure that all clients are up to date on all medical appointments and have risk plans in place to address all medical diagnosis and needs. All client plans will be reviewed at least quarterly by the team. **Measures to be put in place: Corrective Action: (Specific):** Client A received a CIH waiver and no longer resides in the home. The nurse will be	

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	11/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	and refused to get out. His mother had transported him to the appointment and House Manager #1 had driven the facility van to the appointment. Client C's record was reviewed on 11/29/16 at 9:50 AM. The record review indicated client C had been hospitalized with pneumonia on 10/20/16. Client C had been treated on 8/10/16 for signs/symptoms of a stroke in the hospital. Client C had also been treated for cardiac problems in the hospital on 8/13/16. The client's record indicated his diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease), acute CHF/congestive heart failure, and chronic atrial fibrillation with rapid ventricular response (irregular heartbeat). The client was receiving a blood thinning drug, Coumadin and oxygen when in bed. The record contained health risk plans dated 11/04/16 but no health risk plans/methodology for the oxygen, Coumadin therapy or his heart/respiratory issues. Interview with LPN #1 on 11/30/16 at 2:25 PM indicated a health risk plan for hypertension. The interview indicated client C was still not released by his physician to return to work and portable oxygen was being pursued. The interview		re-trained on ensuring that all clients are up to date on all medical appointments. The QIDP will be re-trained on ensuring that clients who are refusing to attend medical appointments have plans developed with methodologies and desentization techniques to assist them toward independence. The nurse will be re-trained on the development and implementation of risk plans for related diagnosis for all clients. Client C will have a risk plan developed for the oxygen use, Coumadin therapy and heart/respiratory issues if it is still required. **Monitoring of Corrective Action:** The Nursing Manager will review all client medical files at least monthly to ensure that all clients are up to date on all medical appointments and have risk plans in place to address all medical diagnosis and needs. All client plans will be reviewed at least quarterly by the team. **Completion date: 12/30/2016**	

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	indicated the risk plans would be updated. This federal tag relates to complaint #IN00199703. This deficiency was cited on 7/01/2016. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			