

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2018
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN 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 pre-determined full recertification and state licensure survey.</p> <p>Survey dates: November 27, 28, 29, 30 and December 3, 2018.</p> <p>Facility Number: 000956 Provider Number: 15G442 AIM Number: 100244760</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9.</p> <p>Quality Review of this report completed by #15068 on 12/12/18.</p>	W 0000		
W 0157 Bldg. 00	<p>483.420(d)(4)</p> <p>STAFF TREATMENT OF CLIENTS</p> <p>If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Based on record review and interview for 1 of 8 clients (former client #1), the facility failed to develop and implement effective corrective measures to address staff's failure of notifying the nurse of a seizure, administering PRN (as needed) medications and completion of bed checks per instructions.</p> <p>Findings include:</p> <p>On 11/27/18 at 2:50 PM, former client #1's (FC #1) record was reviewed. The client record indicated the following:</p> <p>-Death Certificate dated 1/10/18, indicated FC #1's immediate cause of death to be "Cardiac Arrest Related To Cerebral Vascular Accident, Time of Death [time] and Date of Death 1/8/2018."</p>	W 0157	<p>W157: If the alleged violation is verified, appropriate corrective action must be taken.</p> <p>Corrective Action: (Specific): All staff in the location will be retrained on the medication Administration Policy. All staff will be retrained on ensuring to follow supervisor's directives. All staff in the home will be retrained on completing bed checks.</p> <p>Persons Responsible: Direct Support Professionals, Residential Manager, Area Supervisor,</p>	01/02/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2018
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN 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)
	<p>-Investigative Summary dated January 8-12, 2018 indicated, "Factual Findings: Through review of the Seizure Protocol for [FC #1] the Risk of Support includes Ataxia, slurred speech, mental confusion, motor twitching, nausea, vomiting, rashes, and liver damage.... Through review of the Seizure Protocol for [FC #1] one of the staff is to document all seizure activity and report it to the nurse.... Two witnesses stated they observed [FC #1] slurring words on Sunday, 1/7/2018.... Witnesses stated [FC #1] did require assistance getting up from the bathroom floor and throughout the day when needing to move about on Sunday (1/7/2018).... Witnesses stated the nurse and Area Supervisor were contacted on Sunday, 1/7/2018 and informed [FC #1] was having mobility issues.... Witnesses stated [former staff #1] was instructed to make an appointment for [FC #1] to see her PCP (Primary Care Physician) on Monday 1/8/2018 for her mobility issues and a possible UIT (sic).... Witnesses stated [former staff #1] instructed [staff #6] to check on [FC #1] through the night on 1/8/2018, but not to get her up because of the issues [FC #1] had on Sunday (1/7/2018) with her mobility.... Witnesses stated [FC #1] was found unresponsive on Monday 1/8/2018 at approximately 6am.... Witnesses stated [staff #6] called 911 and then performed CPR (Cardiopulmonary Resuscitation) chest compressions on [FC #1] until EMS (Emergency Medical Services) arrived.... Witnesses stated [FC #1] was pronounced deceased shortly after EMS arrived on Monday 1/8/2018.... Through review of documentation there was no seizure report filed by [former staff #2] on Sunday 1/7/2018 and the nurse was not notified of the seizure.... Per the witness statement given by [former staff #1] she did not report administering PRNs (when</p>			(X5) COMPLETION DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2018
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN 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 0249 Bldg. 00	<p>necessary) to the nurse.... Per the witness statement given by [staff #6] she did not complete all bed checks per instructions in the MAR (Medication Administration Record) on Sunday night/Monday morning January 8, 2018.... Conclusion: It is concluded that [former staff #2] [former staff #1] and staff #6 did not follow policies and procedures for care, reporting and documenting for [FC #1]. It is not conclusive that the above actions of the employees were contributing factors in the death of [FC #1]."</p> <p>On 11/29/18 at 1:59 PM, the Nurse was interviewed. The nurse was asked if staff should have notified the Nurse of PRN medication administration. The Nurse stated, "Yes". When asked what PRN medication was administered to FC #1 the Nurse stated, "Tylenol (Acetaminophen)". When asked if staff training was completed as result of FC #1's death the Nurse stated, "Not as a direct result of the death investigation." When asked if staff failed to report a change in FC #1's status in level of consciousness and seizure, the Nurse stated "Right".</p> <p>9-3-2(a)</p> <p>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, record review and interview for 1 of 3 sampled clients (#1), the</p>	W 0249		01/02/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2018
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN 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>facility failed to implement client #1's dining protocol by not offering a healthy substitute for a refused meal.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 11/27/18 from 4:28 PM to 6:15 PM and on 11/28/18 from 6:10 AM to 8:45 AM.</p> <ul style="list-style-type: none"> -At 4:42 PM, client #1 sat under a cover in her rocker recliner in the living area with her IPad (electronic device) while other housemates consumed snacks in the dining area. No prompt to join or have a snack was provided by staff. -At 5:08 PM, client #1 received a phone call from her boyfriend. Client #1 continued to sit in her rocker recliner with her IPad and the telephone. -At 5:22 PM, client #1 continued to sit in rocker recliner with her IPad and telephone talking with her boyfriend. -At 5:28 PM, staff #2 asked client #1 to help set the table for a family style meal. Client #1 placed utensils, plates and napkins on the table while talking on the telephone. -At 5:39 PM, client #1 stated, "I am not hungry, I had a big lunch." -At 5:41 PM, client #1 left the dining area and went to her bedroom. No prompt or healthy substitute was offered to client #1 by staff #2 or staff #3. -At 6:05 PM, staff #2 stated, "[client #1] said she might order a pizza later, she has been given permission to eat at different times in her chair." -At 7:30 AM, staff #3 stated, "[client #1] likes to get up later." Staff #3 was asked if client #1 ate prior to going to bed. Staff #3 stated, "She [client #1] ate some oatmeal before going to bed." -At 7:48 AM, client #1 came out to the living area and then returned to her bedroom. 		<p>W249: Program Implementation</p> <p>Corrective Action: (Specific): All staff in the location will be retrained on the client #1's dining plan. All staff in the location will be retrained on all clients dining plans.</p> <p>Persons Responsible: Direct Support Professionals, Residential Manager, Area Supervisor, Program Manager, Nursing & Associate Executive Director.</p> <p>The residential manager will be monitoring dining plans and completing a meal observation twice weekly. The Area Supervisor will be in the location at least once weekly to complete a meal observation. The Nurse will create a dining binder for quick reference</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2018	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN 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 8:02 AM, client #1 returned to the living area with a blanket and sat in her rocker recliner. Client #1 indicated she did not want to go to work.</p> <p>-At 8:06 AM, staff #3 stated to client #1, "You have a doctor's appointment today at 12:30 PM." Staff #3 indicated it was a follow up appointment and client #1 replied, "It's my radiation doctor."</p> <p>-At 8:35 AM, staff #5 called the nurse to inform client #1 did not want to go to work due to pain in her leg. No prompt or healthy substitute was offered to client #1 by staff #3 or staff #5.</p> <p>On 11/29/18 at 10:54 AM, client #1's record was reviewed. Client #1's record indicated the following:</p> <p>-Dining protocol dated 6/1/18 indicated, "No chewing or swallowing problems. [Client #1] must be reminded about portion control and healthy choices. If [client #1] refuses to eat partial or an entire meal, offer a healthy substitute. Total meal refusals x2, notify nurse" Under the section titled "Specific Skills to Maintain / Acquire" the dining plan indicated, "The ability to eat safely as well as maintaining ideal body weight, follow the menu"</p> <p>On 11/29/18 at 11:18 AM, the Qualified Intellectual Disability Professional (QIDP) was interviewed. The QIDP was asked if client #1 should be provided equivalent substitutes if a meal is refused. The QIDP stated, "Yes, she [client #1] should be provided options." The QIDP was asked if staff should follow the dining plan. The QIDP indicated, client #1's dining protocol should be followed.</p> <p>On 11/29/18 at 2:42 PM, the Nurse was interviewed. The Nurse was asked if staff should have offered a healthy substitute when client #1 refused to eat her evening meal on 11/27/18. The</p>			<p>during meal times and will complete a meal time observation once weekly for thirty days and then monthly after the thirty days.</p> <p>Completion date: 01.02.19</p> <p>Completion date: 01.02.19</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2018
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN 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 0323 Bldg. 00	<p>Nurse stated, "Yes, healthy substitutes should be offered. [Client #1] should have had a boost with her oatmeal."</p> <p>9-3-4(a)</p> <p>483.460(a)(3)(i) PHYSICIAN SERVICES</p> <p>The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing.</p> <p>Based on interview and record review for 2 of 3 clients in the sample (#1 and #3), the facility failed to ensure clients #1 and #3 had annual hearing and vision examinations.</p> <p>Findings include:</p> <p>On 11/29/18 at 10:54 AM, client #1's record was reviewed.</p> <p>-An eye doctor order and progress note dated 8/31/17 indicated, "Ocular health normal.... return visit 1 year."</p> <p>- No record was available for Audiology (hearing) screening.</p> <p>On 11/29/18 at 9:25 AM, client #3 record was reviewed.</p> <p>-An eye doctor order and progress note dated 9/14/17 indicated, "Ocular health normalreturn visit 1 year."</p> <p>-A doctor order and progress note dated 10/4/17 indicated, "Follow up in one year for hearing."</p> <p>On 11/29/18 at 10:40 AM, the Qualified Intellectual Disability Professional (QIDP) was interviewed. The QIDP was asked if client #1 and client #3 had follow up appointments for hearing and vision screening. The QIDP reviewed a desk top calendar</p>	W 0323	<p>W323: The facility must provide or obtain annual physical examinations of each client at a minimum includes an evaluation of vision and hearing.</p> <p>Corrective Action: (Specific): Client #1 has a hearing follow up scheduled and client #3 has an eye appointment scheduled as well.</p> <p>Persons Responsible: Direct Support Professionals, Residential Manager, Area Supervisor, Program Manager, Nursing, Director of nursing & Associate Executive Director</p> <p>Completion date: 01.02.19</p>	01/02/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2018
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN 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 0331 Bldg. 00	<p>and indicated client #1 had appointments scheduled in September, but had a lot of other medical appointments during that time and client #3 had transferred from another home. The QIDP indicated further review would be needed to determine if appointments were maintained and if consults forms could be provided. No documentation of current annual hearing or vision consults for client #1 and client #3 was provided for review.</p> <p>On 11/29/18 at 2:42 PM, the Nurse was interviewed. The Nurse was asked if staff should be taking client #1 and client #3 to hearing and vision appointments. The Nurse stated, "staff should be taking all the ladies to follow ups and should not miss regular scheduled appointments."</p> <p>9-3-6(a)</p> <p>483.460(c)</p> <p>NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility's nursing services failed to include the use of boost (supplement) per physician's orders in client #1's dining protocol.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 11/27/18 from 4:28 PM to 6:15 PM and on 11/28/18 from 6:10 AM to 8:45 AM.</p> <p>-At 4:42 PM, client #1 sat under a cover in her rocker recliner in the living area with her IPad (electronic device) while other housemates consumed snacks in the dining area. No prompt to</p>	W 0331	<p>W249: Program Implementation</p> <p>Corrective Action: (Specific): All staff in the location will be retrained on the client #1's dining plan. All staff in the location will be retrained on all clients dining plans.</p> <p>Persons Responsible: Direct Support Professionals, Residential Manager, Area Supervisor, Program Manager, Nursing &</p>	01/02/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2018	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN 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>join or have a snack was provided by staff.</p> <p>-At 5:08 PM, client #1 received a phone call from her boyfriend. Client #1 continued to sit in her rocker recliner with her IPad and the telephone.</p> <p>-At 5:22 PM, client #1 continued to sit in rocker recliner with her IPad and telephone talking with her boyfriend.</p> <p>-At 5:28 PM, staff #2 asked client #1 to help set the table for a family style meal. Client #1 placed utensils, plates, napkins on the table while talking with her boyfriend on the telephone.</p> <p>-At 5:39 PM, client #1 stated, "I am not hungry, I had a big lunch."</p> <p>-At 5:41 PM, client #1 left the dining area and went to her bedroom. No prompt or healthy substitute was offered by staff #2 or staff #3.</p> <p>-At 6:05 PM, staff #2 stated, "[client #1] said she might order a pizza later, she has been given permission to eat at different times in her chair." Client #1 did not eat during observations.</p> <p>-At 7:30 AM, staff #3 stated, "[client #1] likes to get up later." Staff #3 was asked if client #1 ate prior to going to bed. Staff #3 stated, "she ate some oatmeal before going to bed."</p> <p>-At 7:48 AM, client #1 came out to the living area and then returned to her bedroom.</p> <p>-At 8:02 AM, client #1 returned to the living area with a blanket and sat in her rocker recliner. Client #1 indicated she did not want to go to work.</p> <p>-At 8:06 AM, staff #3 stated to client #1, "you have a doctor's appointment today at 12:30 PM." Staff #3 indicated it was a follow up appointment and client #1 stated, "It's my radiation doctor."</p> <p>-At 8:35 AM, staff #5 called the nurse to inform her client #1 did not want to go to work due to pain in her leg. No prompt or healthy substitute was offered by staff #3 or staff #5. Client #1 did not eat during observations.</p>			<p>Associate Executive Director. The residential manager will be monitoring dining plans and completing a meal observation twice weekly. The Area Supervisor will be in the location at least once weekly to complete a meal observation. The Nurse will create a dining binder for quick reference during meal times and will complete a meal time observation once weekly for thirty days and then monthly after the thirty days.</p> <p>Completion date: 01.02.19</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2018	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN 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>On 11/29/18 at 10:54 AM, client #1's record was reviewed. Client #1's record indicated the following:</p> <ul style="list-style-type: none"> -Dining protocol dated 6/1/18 indicated, "No chewing or swallowing problems. [Client #1] must be reminded about portion control and healthy choices. If [client #1] refuses to eat partial or an entire meal, offer a healthy substitute. Total meal refusals x2, notify nurse" Under the section titled "Specific Skills to Maintain / Acquire" the dining plan indicated, "The ability to eat safely as well as maintaining ideal body weight, follow the menu" -Doctor order and progress note dated 7/17/18 for client #1 indicated, "Dx (diagnosis) Fatigue....Need at least 2 cans of boost with main meal" -Doctor order and progress note dated 8/22/18 for client #1 indicated, "20lb weight loss since JuneOffer boost if less than 50% of a meal is consumed". <p>On 11/29/18 at 11:18 AM, the Qualified Intellectual Disability Professional (QIDP) was interviewed. The QIDP was asked if client #1 should be provided equivalent substitutes if a meal is refused. The QIDP stated, "Yes, she [client #1] should be provided options." The QIDP was asked if staff should follow physician orders. The QIDP indicated client #1's physician orders should be followed.</p> <p>On 11/29/18 at 2:42 PM, the Nurse was interviewed. The Nurse was asked if staff should have offered a healthy substitute when client #1 refused to eat her evening meal on 11/27/18. The Nurse stated, "Yes, healthy substitutes should be offered. [Client #1] should have had a boost with her oatmeal."</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2018
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN 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 0348 Bldg. 00	<p>9-3-6(a)</p> <p>483.460(e)(1) DENTAL SERVICES</p> <p>The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement.</p> <p>Based on interview and record review for 2 of 3 clients in the sample (#2 and #3), the facility failed to ensure clients #2 and #3 had dental examinations as recommended.</p> <p>Findings include:</p> <p>On 11/29/18 at 10:12 AM, client #2's record was reviewed. A dental order and progress note dated 3/28/18 indicated, "exam and cleaning.... dental orders: return in 6 mos (months)."</p> <p>On 11/29/18 at 9:25 AM, client #3's record was reviewed. A dental order and progress note dated 3/28/18 indicated, "cleaning and oral exam... return visit: 6 mos (months)."</p> <p>On 11/29/18 at 10:39 AM, the Qualified Intellectual Disability Professional (QIDP) was interviewed. The QIDP indicated client #2 and client #3 missed September dental appointments and were rescheduled for [date].</p> <p>On 11/29/18 at 2:42 PM, the Nurse was interviewed. The Nurse was asked if staff should be taking client #2 and client #3 to dental appointments. The Nurse stated, "staff should be taking all the ladies to follow ups and should not miss regular scheduled appointments."</p>	W 0348	<p>W338: The facility must provide or make arrangements for the comprehensive diagnostic and treatment services for each client from qualified personnel.</p> <p>Corrective Action: (Specific): All staff in the location will be retrained on ensuring the clients make it to their scheduled appointments. The staff in the location will be retrained on the client appointment procedure.</p> <p>Persons Responsible: Direct Support Professionals, Residential Manager, Area Supervisor, Program Manager, Nursing, Director of nursing & Associate Executive Director</p> <p>Completion date: 01.02.19</p>	01/02/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/03/2018
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN 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
	9-3-6(a)			