

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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	<p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>Survey Dates: October 21, 22, 23, 24 and 25, 2019</p> <p>Facility Number: 013405 Provider Number: 15G811 AIM Number: 201267570</p> <p>These deficiencies also reflect state findings in accordance with 410 IAC 16.2-5.</p> <p>Quality Review of this report completed by #15068 on 11/6/19.</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 20 of 20 clients living in the group home (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20), the facility's governing body failed to exercise operating direction over the facility by failing to ensure the facility remained in good repair.</p> <p>Findings include:</p> <p>An environmental observation was completed on 10/22/19 at 12:48 PM to 1:55 PM. The observation indicated the following:</p> <p>-The Pacer hallway laundry room had a large spackled area one foot by one foot under the window.</p>	W 0104	<p>W104 GOVERNING BODY-The governing body exercises general policy, budget, and operating direction over the facility. The facility's governing body will exercise operating direction over the facility by ensuring the facility remains in good repair. The facility has contracted with Aramark to oversee its maintenance program and to streamline work orders, inspections and timely repairs. Program Manager and Executive Director is monitoring progress and working with Aramark to ensure all</p>	11/15/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/25/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(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
	<p>-Pacer hallway shower room was missing drywall around the vent on the ceiling, the caulking was cracked around the shower floor with stained tile on the bottom of the shower. This affected clients #3, #5, #8, #9, #10, #11, #13, #17, #18 and #20.</p> <p>-Bedroom #4 (client #8), there was a urine odor throughout client #8's bedroom, the door frame entering the bedroom was broken, the spackling throughout the bedroom walls and there was toothpaste running down side of bathroom sink shared with client #18 in bedroom #3.</p> <p>-Bedroom #3 (client #18), there was a urine odor in the bathroom, toothpaste running down bathroom sink, ceiling lifting from the walls and spackling throughout the bedroom walls.</p> <p>-Bedroom #2 (client #13), the door was closed. No one answered the door.</p> <p>-Bedroom #1 (client #5), spackling throughout on walls, missing trim around the floor of bathroom, door frames separating at the top of both the bedroom door and bathroom door.</p> <p>-Common Living Area, there was spackling throughout on the walls, the window in dining room broken with fractured glass held in place by privacy adhesive film, and the ceiling had green smudges throughout. The affected clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20.</p> <p>-Bedroom #18 (client #2), there was a broken window with fractured glass held in place by privacy adhesive film, there was tape around the seal of his windows to prevent cold air drafts and spackling throughout on the walls.</p>		<p>maintenance tasks are completed at the facility timely. All Management personnel will be retrained on how to call in work orders, obtain updates and report concerns related to timeliness or thoroughness of repairs.</p> <p>Date of Completion- 11/15/2019</p> <p>Persons Responsible- Program Manager and Executive Director</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>-Colts restroom, there was a broken door handle and urine odor.</p> <p>-Bedroom #17 (clients #6 and #14), there was a missing electrical outlet cover.</p> <p>-Bedroom #16 (client #1), there was a urine odor and spackling on walls throughout the bedroom.</p> <p>-Bedroom #15 (client #15), on 10/22/19 at 1:27 PM client #15 was asked if anything in his room was broken. Client #15 stated, "Yeah, the heat". The bedroom was noticeably cooler than other areas of the residential building. The shared bathroom with client #1 had a urine odor.</p> <p>-Bedroom #14 (client #16), the door was closed. No one answered the door.</p> <p>-Bedroom #13 (client #7), there was a urine odor in shared bathroom with client #16.</p> <p>-Bedroom #12 (clients #19 and #4), there was clutter throughout the bedroom.</p> <p>-Colts bathroom and shower, there was a broken door frame, marks, scuffs and discoloration on the walls, ceiling and the seal around tub and shower.</p> <p>-Bedroom #11 (client #12), the ceiling had 2 cracks above client #12's television 8 inches by 8 inches long and marks, scuffs and discoloration on the ceiling.</p> <p>-Bedroom #10 (client #9), there was spackling on the walls throughout, green discoloration smudges on the ceiling and a urine odor in bathroom.</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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>-Bedroom #9 (client #10), the ceiling was separating from the wall upon entry into the bedroom on the right side and spackling throughout on the walls. The shared bathroom with client #20 had a sink with a broken back splash which was missing a corner of the ceramic and a cabinet door was missing. The bathroom had a urine odor and puddle of liquid on the bathroom floor.</p> <p>-Bedroom #8 (client #20), there was spackling throughout on the walls and urine odor.</p> <p>-Bedroom #7 (client #11), on 10/22/19 at 1:45 PM client #11 was asked if anything in his bedroom was broken. Client #11 indicated his television cable had exposed wiring and stated, "It still works". The shared bathroom with client #3 had a broken window with fractured glass held in place by privacy adhesive film.</p> <p>-Bedroom #6 (client #3), there was clutter throughout the bedroom.</p> <p>-The ceiling in the Pacer hallway and Colts hallway was missing drywall and had spackling. On 10/21/19 at 1:30 PM, the custodian indicated he reported issues to the Program Manager who then turned them into another company for maintenance.</p> <p>On 10/22/19 at 9:50 AM, staff #11 indicated since [name of maintenance company] has started, it is hard to figure out what has been done and what has not been done.</p> <p>On 10/22/19 at 1:01 PM, staff #13 stated when "stuff" gets broken, it doesn't get fixed in a timely manner, "for example when [client #2] breaks something and it goes without getting fixed, he</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 0149  Bldg. 00	<p>becomes proud of it."</p> <p>On 10/23/19 at 1:37 PM, the Executive Director (ED) indicated ResCare had recently contracted with [name of maintenance company] for all maintenance, lawn care, snow removal, and the [name of maintenance company] prioritizes and contacts vendors for repairs. The ED indicated she calls in anything that is main priority. The ED indicated the facility should be maintained in good repair.</p> <p>5-1.3(h) 5-1.5(a)</p> <p>483.420(d)(1) <b>STAFF TREATMENT OF CLIENTS</b> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review and interview for 4 of 20 clients living in the facility (#1, #6, #14 and #15) and two former clients (#21 and #22), the facility failed to implement its policies and procedures to prevent abuse of the clients.</p> <p>Findings include:</p> <p>On 10/21/19 at 1:23 PM, a review of the facility's incident/investigative reports was conducted and indicated the following:</p> <p>On 9/3/19 at 6:48 PM, client #3 grabbed client #15's foot. Staff #12 redirected client #3 however he refused to comply. Additional staff arrived and client #3 was aggressive toward staff. Client #3 was restrained used a supine (lying face upward) hold. Client #3 continued to be aggressive toward staff. The nurse was called to assess client #3 for</p>	W 0149	<p>W149 STAFF TREATMENT OF CLIENTS-The facility has developed and implemented written policies and procedures that prohibit mistreatment, neglect or abuse of the client. The facility implements its policies and procedures to prevent abuse of the clients.</p> <p>ResCare has a policy for prevention of, and reporting any allegations of abuse, neglect and mistreatment of any client. All staff are trained on the policy upon hire and annually thereafter. In addition, all staff will receive in-service training on the policy of abuse, neglect, exploitation and mistreatment. This policy is and, will continue to be reviewed for</p>	11/15/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>an as needed (PRN) medication. Client #3 was administered Haldol (PRN psychotropic medication for maladaptive behavior) at 7:30 PM. He was released from the restraint at 7:51 PM. A 9/4/19 Investigative Summary indicated, "[Staff #12] states that during a YSIS (You're Safe I'm Safe) intervention with client [#3], [staff #17] was verbally threatening and used more force during the hold than necessary." Staff #12's interview in the investigation indicated, "[Staff #17] came to assist when called (sic) [client #3] was combative and [staff #17] said, 'You don't know who you are dealing with' and pushed on [client #3]. Additional staff arrived to assist and placed [client #3] in a hold. I took [client #15] out of the area. I did not mention this to the RM (Residential Manager) at the time but later thought about it and wrote a statement which was left for the Program Manager." Staff #17 denied threatening or using excessive force during the hold. The Conclusion of the investigation indicated, "The allegation of verbal abuse is not substantiated. The client states he was not threatened and does not have any concerns working with [staff #17] or any of the other staff involved."</p> <p>On 10/21/19 at 5:19 PM, staff #12 stated staff #17 "threw [client #3] down on the floor and then put his elbow on his chest." Staff #12 stated client #3 told staff #17 he was "hurting him." Staff #12 stated she reported her concerns to the Program Manager and he "did nothing."</p> <p>On 10/22/19 at 7:42 AM, client #15 stated staff #17 "treats me like dirt." Client #15 stated staff #17 told him he was "weird." Client #15 stated "don't feel comfortable with him. Don't like him at all. Told [Qualified Intellectual Disabilities Professional #2] about him. He said to ignore him."</p>	<p>competency at every monthly all staff meeting. Staff will be trained on the requirement for reporting any allegation immediately to a supervisor. Staff will be in-serviced that NOT IMMEDIATELY reporting an allegation immediately is, in itself considered neglect. Administrative staff will ensure that front line staff understand that a verbal report must be made immediately. In addition, all staff will receive in service training on the chain of command if they feel that a direct supervisor has not taken their complain immediately seriously. This will ensure that any report of possible ANE is addressed immediately. In addition, all administrative staff will receive in-service training to ensure that competency is reached regarding policy if an administrative staff does not immediately respond, per policy, to an allegation of abuse or neglect. Trained investigators will be in-serviced on ResCare procedures for conducting a thorough investigation, including ensuring that all reportable incidents and allegations are reported to BDDS, the Executive Director and any other necessary entity, and that all necessary individuals and staff are interviewed regarding an allegation, and putting in place timely implementation of corrective</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>On 10/22/19 at 8:59 AM, former client #21 stated staff #17 "tried to get us to go off." Former client #21 stated staff #17 "instigated" the clients into having behaviors.</p> <p>On 10/22/19 at 9:03 AM, client #6 stated staff #17 "cussed a lot" and "picked on clients." Client #6 stated staff #17 "starts stuff" and "messes with people." Client #6 indicated staff #17 had an "attitude."</p> <p>On 10/22/19 at 9:35 AM, former client #22 stated he "had a few problems with [staff #17]." Client #22 stated staff #17 "yelled at us." Client #6 was interviewed on 10/22/19 at 5:44 PM. Client #6 stated, "There are some staff who treat you better than others. [Staff #17] doesn't treat you well at all." Client #6 indicated he did not like how staff #17 spoke to him. Client #6 stated, "He gets in my face a lot. He uses curse words. I don't like that." Client #6 indicated he had witnessed staff #17 be physically aggressive towards other clients. Client #6 stated, "He pushes clients out of the way if he's in a bad mood. He'll grab clients and shove them out of his way. He tells other staff that the clients are 'getting on his nerves'." Client #6 indicated he will go to his room when staff #17 is working. Client #6 stated, "I go into my room to get away from him. I'm sick of the way he treats us." Client #6 indicated other staff working see staff #17's behavior and do not intervene.</p> <p>Staff #17 was interviewed on 10/22/19 at 5:54 PM. Staff #17 indicated he had worked at the facility for two years on second shift. Staff #17 indicated he had been trained on the abuse and neglect policy. Staff #17 indicated he had not witnessed any verbal or physical aggression of staff towards clients at the facility. Staff #17 stated, "There</p>		<p>measures and actions. The Executive Director will monitor and review progress of and completion of all investigations and approve any recommended corrective actions to ensure thoroughness of the investigation and appropriate corrective measures. Staff #17 is no longer employed with ResCare. However, at the time of the complaint, it was not possible to substantiate that A/N/E had occurred. An investigation was completed into this allegation per policy. Following the completion of the investigation, staff #17 received in-service training to re-certify him on de-escalation techniques and YSIS physical intervention per policy.</p> <p>Date of Completion- 11/15/2019 Persons Responsible- All staff, Program Manager and Executive Director</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>aren't any issues here." An interview was conducted with client #15 on 10/21/19 at 1:32 PM. When asked if staff were nice to him, client #15 stated, "Some of them are." When asked who was not nice to him, client #15 stated, "[Staff #17] teases me sometimes." Client #15 indicated he couldn't always tell when staff #17 was joking. Client #15 indicated through gestures (walking in place with a hopping gait and swinging his arms in an exaggerated manner) staff #17 mocks the way some clients walk. Client #15 indicated staff #17 works on the night shift.</p> <p>An interview was conducted with client #1 on 10/21/19 at 1:40 PM. When asked if staff were nice to him, client #1 stated, "Yeah, except [staff #17]. Client #1 stated staff #17 had put him in a "choke hold twice." When asked if he was having a behavior at the time and was being restrained, client #1 indicated he had been sleeping at the time and was not having a behavior. While describing the incident, client #1 put his arm over his shoulder and stated he had been "choked" and threw himself on the bed. Client #1 stated, "He put me in a choke hold and threw me down." When asked if staff #17 had told him to "Shut up," client #1 stated, "Yeah." When asked if staff had seen these incidents take place, client #1 stated, "Yeah." When asked if he had told anyone, client #1 stated he had told staff #1, #19, and #21. When asked if he had told his Residential Manager (RM), client #1 stated, "Yeah. I told [RM #5]." When asked if RM #5 filled out an IR (Incident Report), client #1 stated, "No." Upon further questioning, client #1 indicated he (client #1) had filled out an IR.</p> <p>An interview was conducted with client #14 on 10/21/19 at 2:02 PM. When asked if he likes living in the facility, client #14 stated, "Oh, yeah! The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>food is really good!" When asked if he gets along with everyone, client #14 indicated he did. Client #14 stated, "[Staff #17] is sometimes in a bad mood." When asked if he had seen staff #17 touch anyone or tell them to "shut up", client #14 stated "No, but I've heard about it. [A previous client] told me when I first moved here."</p> <p>On 10/23/19 at 1:18 PM, the Executive Director (ED) indicated when the surveyor reported the clients' and staff's concerns to her, she suspended staff #17. The ED indicated the facility was conducting an investigation of the incident. The ED indicated the facility should prevent abuse of the clients. The ED indicated the facility should ensure the clients were treated with respect. The ED indicated she was going to discuss with the clients living on the unit reporting their issues and concerns with how they were treated with her or other administrative staff. The ED indicated the facility had a policy and procedure prohibiting abuse of the clients.</p> <p>On 10/24/19 at 3:02 PM, a review of the 11/14/18 Abuse, Neglect and Exploitation policy indicated the following: "ResCare does not tolerate abuse, neglect, or exploitation of any persons served.... ResCare will: Ensure all persons served are treated with dignity and respect. Ensure that all persons served are free from abuse, neglect, or exploitation. Establish a protocol for reporting all incidents of abuse, neglect and exploitation to the ResCare Critical Incident Database. Ensure all incidents of abuse, neglect, and exploitation are reported to the appropriate authority as defined by state and local regulations...."</p> <p>5-1.2(24)(l)</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 0210  Bldg. 00	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN</p> <p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>Based on record review and interview for 3 of 5 clients in the sample (#2, #5 and #8) who moved into the facility since 10/21/18, the facility failed to ensure the clients' comprehensive functional assessments (CFA) were completed within 30 days of admission to the facility.</p> <p>Findings include:</p> <p>1) On 10/22/19 at 2:00 PM, a review of client #8's record was reviewed. Client #8 was admitted into the facility on 6/10/19. There was no documentation the CFA was completed.</p> <p>On 10/23/19 at 12:55 PM, Qualified Intellectual Disabilities Professional (QIDP) #1 indicated a CFA was to be completed within the first 30 days of admission.</p> <p>On 10/23/19 at 12:59 PM, QIDP #2 indicated the CFA was to be completed within 30 days of admission and then annually.</p> <p>2) Client #2's record was reviewed on 10/22/19 at 11:55 AM. Client #2's record did not indicate documentation of a CFA (Comprehensive Functional Assessment). Client #2 was admitted to the facility on 9/7/19.</p> <p>3) Client #5's record was reviewed on 10/22/19 at 12:05 PM. Client #5's record did not indicate documentation of a CFA (Comprehensive Functional Assessment). Client #5 was admitted to the facility on 1/28/19.</p>	W 0210	<p>W210 INDIVIDUAL PROGRAM PLAN-Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. The facility will ensure the clients' comprehensive functional assessments (CFA) are completed within 30 days of admission to the facility.</p> <p>All client needs will be assessed, at least annually, and noted on the client's Comprehensive Functional Assessment. Clients who are deemed unable to exercise their rights as citizens, including the rights to file complaint and to due process will be assisted in obtaining a health care representative or legal guardian. The Program Manager and QIDP will monitor ongoing progress of each individual and will note such on the monthly, quarterly and annual reviews, which are also reviewed by the individual's team.</p> <p>Person's Responsible- QIDPs and Program Manager</p> <p>Date of Completion- 11/15/2019</p>	11/15/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 0227  Bldg. 00	<p>On 10/23/19 at 12:50 PM Qualified Intellectual Disability Professional #1 (QIDP) was interviewed. The QIDP #1 was asked if a current CFA could be provided for review. QIDP #1 indicated a current CFA was needed for client #5 and stated, "He (client #5) does not have one (CFA)". QIDP #1 indicated a CFA should be completed within 30 days from admission and annually thereafter.</p> <p>5-2(e)</p> <p>483.440(c)(4) INDIVIDUAL PROGRAM PLAN 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. Based on observation, record review and interview for 2 of 8 clients in the sample (#1 and #5), the facility failed to ensure client #5 had a plan to assess him for pain and client #1 had a plan to put on his shoes correctly.</p> <p>Findings include:1) An observation was completed on 10/21/19 from 4:32 PM to 6:26 PM. The observation indicated the following:</p> <p>-At 4:32 PM, client #5 was lying on the hallway floor in front of his bedroom. Client #5 was making verbalizations. Staff #9 was prompting client #5 to go outside for a walk.</p> <p>-At 4:43 PM, client #5 left the residential building and was lying on the hallway floor in front of the arts and crafts room making verbalizations. Staff #9 was prompting client #5 to stand up and walk with her.</p> <p>-At 4:45 PM staff #9 prompted client #5 to get up</p>	W 0227	<p>W227 INDIVIDUAL PROGRAM PLAN- The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment. The facility will ensure client #5 has a plan to assess him for pain and client #1 has a plan to put on his shoes correctly. A plan has been put in place to assist client #1 in reporting issues of pain. Any time client #1 is having behavioral issues or displays any behaviors that seem out of the ordinary, staff will ask him if he is in pain. If he replies that he is in pain, nursing will assess. Client #1's plan has been modified approved by his guardian and the Human Rights Committee to add this as a training goal; to</p>	11/15/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>from the hallway floor in front of the arts and crafts room and walk with her.</p> <p>-At 4:49 PM, client #5 was on the ground between the residential building and activities building. Client #5 kicked and made verbalizations. Residential Manager (RM) #6 came outside and assisted staff #9 with prompting client #5 up from the ground.</p> <p>-At 4:54 PM, RM #6 and staff #9 assisted client #5 back inside the residential building.</p> <p>-At 4:56 PM, client #5 laid on the floor near one of the common living area's sofas. RM #6 asked client #5 if he wanted a banana. Client #5 made verbalizations. RM #6 asked client #5 if he wanted to go back outside.</p> <p>-At 4:57 PM, RM #6 brought a banana over and asked client #5 if he wanted it. Client #5 did not take the banana and staff #9 asked if he wanted to sit on the sofa with her.</p> <p>-At 5:00 PM, staff #6 was asked if she understood what client #5 was verbalizing. Staff #6 indicated client #5 made gestures, smiled and would exhibit self-injurious behavior. Staff #6 indicated client #5's behavior was believed to be discomfort from stomach pain and stated, "It (behavior) comes from stomach pain." Staff #6 was asked if a nurse assessed client #5 during a behavior believed to be related to stomach pain. Staff #6 stated, "Yes, I guess if you ask and got to it (client 5's stomach area) he'll say if it does."</p> <p>-At 5:06 PM, staff #6 went with client #5 into his bedroom. Client #5 laid on his mattress.</p> <p>-At 5:13 PM, staff #6 asked client #5 if he wanted</p>		<p>report pain. Staff have been trained on this new goal. A plan has been put in place to assist Client #5 to wear his shoes properly. The plan has been approved by his guardian and the Huma Rights Committee. Staff will assist him by verbal prompts to wear his shoes appropriately. All clients needs will be assessed, at least annually, and noted on the client's Comprehensive Functional Assessment. Client's who are deemed unable to exercise their rights as citizens, including the rights to file complaint and to due process will be assisted in obtaining a health care representative or legal guardian. The Program Manager, Nurse Manager and QIDP will monitor ongoing progress of each individual and will note such on the monthly, quarterly and annual reviews, which are also reviewed by the individual's team.</p> <p>Person Responsible- All staff, Nursing Staff, QIDPs and Program Manager</p> <p>Date of Completion- 11/15/2019</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>to go outside.</p> <p>-At 5:16 PM, client #5 laid down on the floor of the common living area.</p> <p>-At 5:18 PM, client #5 laid on the floor with a tissue in his hand making a verbalization.</p> <p>-At 5:22 PM, client #5 laid on the floor of the common living area making verbalization. Staff #6 leaned over and spoke with client #5 as he laid on the floor. It was unclear what staff #6 was saying to client #5.</p> <p>-At 5:25 PM, staff #6 prompted housemates around client #5 as he laid on the floor of common living area.</p> <p>-At 5:26 PM, client #5 went from the floor of the common living area to the medication administration room to receive eye drops.</p> <p>On 10/22/19 at 12:05 PM, client #5's record was reviewed and indicated the following:</p> <p>-Individual Support Plan (ISP) dated 3/1/19 indicated, "[Client #5] requires constant supervision and has a limited sense of danger that precludes functioning without supervision. Behavioral observations suggest that [Client #5] is extremely delayed in motor skills, cognitive processing ability, language ability and self-direction and control abilities needed to effectively interact with his environment. Significant impulsivity and extremely poor social skills and very immature understanding of social rules and norms. [Client #5] currently lacks the skills for self-care, requires set up and prompting for all ADLs (adult daily living skills) shaving, brushing teeth, cleaning himself after BM,</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>bathing, dressing, and domestic skills laundry meal prep (preparation), cutting his food."</p> <p>-There was no plan to conduct a pain assessment was found in client #5's record.</p> <p>On 10/21/19 at 5:34 PM, Licensed Practical Nurse (LPN) #1 was interviewed. LPN #1 was asked how client #5 communicated his wants and needs. LPN #1 indicated client #5 used signs and gestures and would rub his stomach when in pain and stated, "He can't communicate, but you hear him fart and smell it." LPN #1 was asked if client #5's lying on the floor making verbalizations was believed to be a medical issue or behavioral issue. LPN #1 stated, "behavior." LPN #1 was asked how she would know if client #5 was in pain. LPN #1 stated, "We really don't know. Sometimes he will say headache." LPN #1 was asked if an assessment for nonverbal clients was used. LPN #1 indicated client #5 did not have a pain assessment for review.</p> <p>On 10/23/19 at 1:14 PM, the Regional Nurse Manager (RNM) #1 was interviewed. The RNM #1 was asked if client #5 had a plan to assess for pain when he was lying on the floor making verbalizations. The RNM #1 indicated a plan for a pain assessment was not available for review and stated, "I agree with you. I'll see that we train staff on pain versus behavior. It should be individualized. We need to know behavior versus pain of stomach from gas."2) Observations were completed on 10/22/19 from 7:00 AM to 8:50 AM. At 7:25 AM, client #1 was at the nurses' station with staff #19 and Licensed Practical Nurse (LPN) #1 to receive his morning medications. Client #1 sat down in the chair in the nursing station and stated, "My toes hurt (on his right foot)." LPN #1 removed client #1's shoes and stated, "They hurt</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 <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/25/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(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
	<p>because you're not putting your shoe on right. The tongue of the shoe is wedged up by your toes." Client #1's toes were red. Staff #19 stated, "You need to put your shoes on right and your toes won't hurt."</p> <p>Staff #19 was interviewed on 10/22/19 at 7:25 AM. Staff #19 stated, "[Client #1] does not put his shoes on correctly. He doesn't pull the tongue of his shoes up. The tongue gets pushed down and hurts his toes." Staff #19 indicated he had told client #1 to pull on the tongue of his shoes when he put them on. Staff #19 stated, "I think he needs help putting them on correctly." Staff #19 indicated client #1 did not have a goal to assist him in putting on his shoes properly.</p> <p>Client #1's record was reviewed on 10/22/19 at 12:23 PM. Client #1's record indicated the following:</p> <p>Client #1's Health Risk Plan (HRP) for Diabetes dated 5/2019 indicated, "Staff will monitor [client #1's] feet for open areas during ADL (Activities of Daily Living) care... Nurse will assure all staff receive training regarding... foot care...".</p> <p>Client #1's Diabetes Control Plan (DCP) dated 4/9/19 indicated, "... Foot care is very important as wounds or cuts can be very dangerous for any diabetic client...".</p> <p>Client #1's Individual Support Plan (ISP) dated 4/9/19 indicated client #1 had goals in the area of medication administration, oral hygiene skills, money management, personal hygiene skills, meal preparation, safety skills, adaptive equipment use, dietary skills, healthy living skills, exercise skills, and emotional regulation. Client #1's ISP did not indicate a goal for putting on his shoes.</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 0249  Bldg. 00	<p>Licensed Practical Nurse (LPN) #1 was interviewed on 10/22/19 at 7:25 AM. LPN #1 indicated client #1 is a diabetic. LPN #1 indicated client #1 does not wear his shoes properly. LPN #1 stated, "Diabetics have difficulty with circulation." LPN #1 indicated client #1 needed to wear his shoes correctly because of his medical condition.</p> <p>5-2(e)(1)</p> <p>483.440(d)(1) PROGRAM IMPLEMENTATION</p> <p>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.</p> <p>Based on observation, record review, and interview for 7 of 8 sampled clients (#1, #2, #3, #5, #6, #7 and #8), the facility failed to ensure the staff implemented the clients' program plans.</p> <p>Findings include:</p> <p>On 10/21/19 from 4:31 PM to 6:26 PM, an observation was conducted at the facility. At 1:32 PM, client #7 approached the surveyor and began talking. Client #7 was not engaged in any formal activities and followed the surveyor into the hallway and down to the end of the hall. Client #7 waited outside clients #15 and #1's room while the surveyor visited with the clients. At 1:38 PM, client #1 was lying in his bed. Client #1 stated, "I was taking a nap." At 4:16 PM, client #5 was lying on the floor of the common area. Staff #11 stood</p>	W 0249	<p>W249 Program Implementation. The facility ensures that clients receive continuous active treatment based upon what is approved in their program plans as well as informal opportunities for active treatment.</p> <p>All staff will be in-serviced on individual program plans, including but not limited to, specific goals and objectives as written and approved in their Individual Support Plan. All staff will complete a competency based assessment to</p>	11/15/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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>over him and told him to stand up. Client #5 continued to lay on the floor. At 4:31 PM, client #8 approached the surveyor and followed the surveyor down the hallway. At 4:43 PM, client #8 was in his bedroom walking around. At 4:45 PM, client #8 exited his bedroom and walked to the lounge area, entered the kitchen, came out of the kitchen, walked around and stood in front of the couch. At 4:49 PM, client #8 stood in front of the kitchen door, entered the kitchen and got gloves and returned to the lounge area and stood. At 4:52 PM, client #8 approached the surveyor stating "quit pushing me," staff #5 redirected and assisted client #8 with putting gloves on, until client #8 jerked his hand away. At 4:56 PM, client #5 laid down on the lounge area floor. Residential Manager (RM) #6 offered client #5 a banana to assist in getting client #5 up from the floor. Client #5 then turned and put his feet up on the couch. At 4:59 PM, client #8 entered the kitchen, stood and then walked back out of the kitchen. At 5:02 PM, client #8 walked down the Colts hallway, shut a door, and walked back to the lounge area and into the kitchen. At 5:20 PM, client #8 walked to his bedroom and changed his shirt. At 5:26 PM, client #8 entered the kitchen and then came back to the lounge area. Client #5 got up from laying on the floor. At 5:27 PM, client #8 went back into the kitchen and then returned to the lounge area. At 5:29 PM, client #8 turned toward clients #6 and #13 and verbally aggressed toward them. Staff #9 approached client #8 and redirected. At 5:31 PM, client #8 entered the nurse's station. At 5:31 PM, client #13 came to the lounge area with a mask and fake knife approaching other clients in an aggressive manner. At 5:33 PM, client #8 entered the kitchen and RM #6 escorted client #8 back to the lounge area and prompted him to have a seat. At 5:35 PM, client #8 stood in the doorway to the kitchen. At 5:36 PM, client #5 sat at his place at</p>	<p>ensure that staff understand the need, frequency and implementation of each goal.</p> <p>All staff will be in-serviced on active treatment. This will include all administrative staff who are responsible for over-seeing implementation of active treatment. Included in active treatment training will be ensuring implementation of specific goals and objects in the individual program plan, as well as training all staff and supervisors on ensuring opportunities for natural learning opportunities that might exist in the daily environment of all individuals, not included in the individual program plan.</p> <p>The facility employs two QIDP's to ensure that individual program plans, staff training, and active treatment are occurring. The Executive Director will directly train all Q's as well as the Program Manager on how to implement active treatment and ensure that it is occurring in real time on the residential hall. The Executive Director will develop a schedule and checklist to ensure that active treatment observations are occurring by QIDP's and the Program Manager, on the floor, on all shifts, at least 7 days per week, for 30 days. If progress is seen towards staff understanding of goal implementation, then the</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>the dining room table. Client #20 sat at his place at the dining room table. At 5:37 PM, client #8 swatted at staff #9. At 5:39 PM, client #8 was talking to LPN #1 and then entered the kitchen. At 5:41 PM, client #8 yelled at staff #5. At 5:50 PM, client #8 attempted to enter the nurses station and then entered and exited the kitchen. At 6:01 PM, client #8 sat down and ate supper. At 6:12 PM, client #8 got a second serving of broccoli. At 6:15 PM, client #8 got up from the dining room table and stood talking with staff #9. At 6:16 PM, client #8 entered the kitchen, grabbed food off the counter and from the floor and ate it. At 6:24 PM, staff #9 and Executive Director talked with client #8 and prompted him to go to his room. At 6:25 PM, client #8 stood in front of his bedroom door.</p> <p>During the evening observation, clients #1, #2 and #6 wandered around speaking with their peers, staff and visitors. Clients #1, #2 and #6 were not prompted to engage in their active treatment schedules. Clients #1, #2 and #6 were not prompted to engage in their program plan training objectives. During the observation, client #3 was in his bed asleep. Staff did not prompt him to get out of bed and engage in his program plan training objectives.</p> <p>On 10/22/19 from 7:04 AM to 8:49 AM, an observation was conducted at the facility. At 7:08 AM, client #8 stood in the hallway at his bedroom door. From 7:11 AM to 7:18 AM, client #8 was in his bedroom. From 7:15 AM to 8:49 AM, client #4 sat at a dining room table writing jokes. From 7:18 AM to 7:30 AM, client #8 stood outside his bedroom in the hallway. At 7:31 AM, client #8 walked to the lounge area without shoes on. Staff prompted client #8 to put shoes on. At 7:38 AM, client #8 stood in the hallway by his bedroom</p>		<p>frequency of observations may be reduced to 5 times per week for 30 days subsequent to this. Pending successful demonstration of active treatment active treatment observations will be reduced to the standard of 3 times per week..</p> <p>The facility endeavors to ensure that all individuals, when ready, go to day service outside of the facility. For individuals who are not stabilized enough to go to an outside day service, the facility will ensure that these people receive a consistent schedule list of day service activities, that will cover the bulk of their day. Refusals to day service will be documented in their behavior support plans and addressed in order to ensure appropriate implementation of day service planning. This will include that all individuals not working Monday through Friday from 9 am to 2:30 pm will have schedules filled with individual activities, if not participating in day service, at the facility during those hours. The Executive Director will review individual specific active treatment plans for each person that does not attend outside day service, to ensure appropriateness of this plan as well as consistent participation and implementation of such.</p> <p>Active treatment observations will</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PART II PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>door. At 8:36 AM, client #8 was in his bed sleeping. At 8:45 AM, client #8 hollered from his bedroom, staff went and checked on him.</p> <p>During the morning observation, clients #1, #2 and #6 wandered around speaking with their peers, staff and visitors. Clients #1, #2 and #6 were not prompted to engage in their program plan training objectives.</p> <p>On 10/22/19 at 12:37 PM, a review of client #1's record was conducted. Client #1's 4/9/19 Individualized Support Plan (ISP) indicated his goals included:</p> <ul style="list-style-type: none"> <li>-Will check his blood sugar</li> <li>-Will brush his teeth with his electric toothbrush</li> <li>-Will set the table</li> <li>-Will plan a route for his personal shopping outing</li> <li>-Will make correct change when purchasing items</li> <li>-Will bathe</li> <li>-Will wear his glasses</li> <li>-Will wear his ankle brace</li> <li>-Will consume a serving a protein at each meal</li> <li>-Will be compliant with dietary plan while eating outing off campus</li> <li>-Will have the option of doing 30 minutes physical activity with his 1:1 during second shift or going to the gym to participate in an activity during evening life skills</li> <li>-Will use a skill of his choice to regulate his emotions</li> </ul> <p>Client #2's record was reviewed on 10/22/19 at 11:55 AM. Client #2's 10/14/19 ISP indicated his goals included:</p> <ul style="list-style-type: none"> <li>-Will take his meds</li> <li>-Will brush his teeth twice daily with tooth brush and staff assistance</li> <li>-Will place his dirty clothes in his laundry basket</li> </ul>		<p>be reviewed by the Executive Director, each day, to ensure that appropriate observations comments, on the spot re-training and understanding of individual program plans are demonstrated. By 1/1/2020 the Executive Director will meet with the Regional Director to determine if reduction in frequency of administrative monitoring can occur.</p> <p>Persons Responsible: Executive Director, Program Manager, QIDP</p> <p>Date of completion: 11/15/2019</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<ul style="list-style-type: none"> <li>-Will bathe</li> <li>-Will participate with staff in training session learning about appropriate ways to cope with anxiety and/or stress</li> <li>-Will tell staff when he needs help. This is the first step in reporting Abuse/Neglect/Exploitation</li> <li>-Will set the table</li> </ul> <p>On 10/22/19 at 12:18 PM, a review of client #3's record was conducted. Client #3's 12/1/18 ISP indicated his goals included:</p> <ul style="list-style-type: none"> <li>-Will brush his teeth</li> <li>-Will take his medications no later than 10:00 a.m.</li> <li>-Will do his laundry at a laundromat on his scheduled day</li> <li>-Will clean his room</li> <li>-Will identify 2 items that he can purchase with his weekly spending money</li> <li>-Will bathe</li> <li>-Will have the option of doing physical exercise, going for a walk, participating in physical activity via the X-Box, or going to the gym to play a sport during exercise time</li> <li>-Will cut his food to bite-sized pieces</li> <li>-Will use an electric razor to shave</li> <li>-Will attend day program daily (per his schedule).</li> </ul> <p>Client #5's record was reviewed on 10/22/19 at 12:05 PM. Client #5's 3/1/19 ISP indicated his goals included:</p> <ul style="list-style-type: none"> <li>-Will take his meds</li> <li>-Will clean his gums correctly</li> <li>-Will place his dirty clothes in his laundry basket</li> <li>-Will listen to his staff read his safety protocol to prevent falls</li> <li>-Will bathe</li> <li>-Will participate with staff in training session learning about appropriate ways to cope with anxiety and/or stress</li> <li>-Will sign "help" when he needs assistance. This</li> </ul>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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>is the first step in reporting Abuse/Neglect/Exploitation/Mistreatment</p> <ul style="list-style-type: none"> <li>-Will use keys words in American Sign Language</li> <li>-Will attend medical appointments</li> </ul> <p>On 10/23/19 at 9:20 AM, a review of client #6's record was conducted. Client #6's 6/13/19 ISP indicated his goals included:</p> <ul style="list-style-type: none"> <li>-Will report to the nursing station for 8am medication pass when nurse notifies him medication is ready</li> <li>-Will begin keeping a ledger with staff assistance for purchases during his weekly outing</li> <li>-Will help prepare a complete meal of choice using safe cooking techniques</li> <li>-Will initiate being physically active daily for 30 minutes</li> <li>-Will tell staff 2 positive things in his life</li> <li>-Will do something productive during his 2-way radio time</li> <li>-Will be compliant with dietary plan following his fluid restriction on/off campus</li> </ul> <p>On 10/22/19 at 11:37 AM, a review of client #7's record was conducted. Client #7's 2/26/19 ISP indicated his goals included:</p> <ul style="list-style-type: none"> <li>-Will identify his Clozaril daily when shown two cards</li> <li>-Will wash his hands prior to meals</li> <li>-Will use his water pick</li> <li>-Will wear his singlet under his clothing when outside of his room or shower due to exposing his genital and to prevent him from eating feces</li> <li>-Will brush his teeth in an up and down motion</li> <li>-Will prepare a side dish for supper</li> <li>-Will clean his room</li> <li>-Will learn to tell time by a digital clock</li> <li>-Will learn the days of the week by moving the arrow on his weekly chart to the current day of the week</li> </ul>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/25/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(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
	<ul style="list-style-type: none"> <li>-Will make a list of items he would like to purchase for his personal shopping trip weekly according to his weekly budget</li> <li>-Will bathe</li> <li>-Will state the importance of using his water pick daily. Client #7 will state the dangerous health risks of obtaining infections.</li> <li>-Will clean his glasses</li> <li>-Will put his socks on properly, so the heel is in the right place</li> <li>-Will recite different coping alternatives (ABC's, 123's, etc.)</li> <li>-Will wear his shoe inserts</li> <li>-Will identify personal space</li> <li>-Will state how his noise canceling headphones helps calm him down when there is loud noises</li> </ul> <p>On 10/22/19 at 2:00 PM, a review of client #8's record was reviewed. Client #8's 7/11/19 ISP indicated his goals included:</p> <ul style="list-style-type: none"> <li>-Will take his meds</li> <li>-Will brush in an up and down motion</li> <li>-Will place his dirty clothes in his laundry basket</li> <li>-Will bathe daily</li> <li>-Will participate with staff in training session learning about appropriate ways to cope with anxiety and/or stress</li> <li>-Will tell staff when he needs help. This is the first step in reporting Abuse/Neglect/Exploitation</li> <li>-Will set the table</li> <li>-Will identify personal space</li> </ul> <p>Confidential interview (CI) #1 indicated she normally was in the movie room or in the library with clients. CI #1 indicated client #5 was constantly wanting to be up and moving when awake. CI #1 indicated there was no set schedule for client #5, due to some days he will sleep all day and other days he was up moving all day. CI #1 indicated client #5 ate when he wanted. CI #1</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 <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/25/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(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 0250 Bldg. 00	<p>indicated client #5 was learning to interact with his peers. CI #1 stated the facility was usually pretty easy and "laid back". CI #1 indicated dinner was usually at 5:00 PM, but can be delayed when clients want to help.</p> <p>On 10/23/19 at 9:36 AM, QIDP #2 and Behavior Clinician (BC) #1 were interviewed. QIDP #2 was asked how active treatment scheduling had been defined based on individualized scheduling. QIDP #2 stated, "Not very well for the most part". BC #1 stated, "We have the guys doing work days and for the others it's activities here. [Client #5] has road trips. It's not like [client #5] would go to cooking class". QIDP #2 stated, "I think the ISP (Individual Support Plan) goals says one or two times a week. It (activity schedule) may not even say that. It's just when they want to (take trips)". QIDP #2 indicated a Life Skills program had been initiated by a former employee. QIDP #2 was asked if the client activity schedules for clients not working Monday through Friday from 9:00 AM to 2:30 PM schedules should be filled in with individualized activities. QIDP #2 stated, "In general, it probably should be".</p> <p>On 10/23/19 at 12:05 PM, QIDP #1 indicated the clients' program plans should be implemented as written.</p> <p>5-2(e)</p> <p><b>483.440(d)(2)</b> <b>PROGRAM IMPLEMENTATION</b> The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>Based on observation, record review, and interview for 8 of 8 sampled clients (#1, #2, #3, #4,</p>	W 0250	W250 PROGRAM IMPLEMENTATION- The facility	11/15/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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>#5, #6, #7 and #8), the facility failed to ensure the clients had individualized active treatment schedules for staff to implement.</p> <p>Findings include:</p> <p>On 10/21/19 from 4:31 PM to 6:26 PM, an observation was conducted at the facility. At 4:31 PM, client #8 approached the surveyor and followed the surveyor down the hallway. At 4:43 PM, client #8 was in his bedroom walking around. At 4:45 PM, client #8 exited his bedroom and walked to the lounge area, entered the kitchen, came out of the kitchen, walked around and stood in front of the couch. At 4:49 PM, client #8 stood in front of the kitchen door, entered the kitchen and got gloves and returned to the lounge area and stood. At 4:52 PM, client #8 approached the surveyor stating "quit pushing me," staff #5 redirected and assisted client #8 with putting gloves on, until client #8 jerked his hand away.</p> <p>At 4:56 PM, client #5 laid down on the lounge area floor. Residential Manager (RM) #6 offered client #5 a banana to assist in getting client #5 up from the floor. Client #5 then turned and put his feet up on the couch. At 4:59 PM, client #8 entered the kitchen, stood and then walked back out of the kitchen. At 5:02 PM, client #8 walked down the Colts hallway, shut a door, and walked back to the lounge area and into the kitchen. At 5:20 PM, client #8 walked to his bedroom and changed his shirt. At 5:26 PM, client #8 entered the kitchen and then came back to the lounge area. Client #5 got up from laying on the floor. At 5:27 PM, client #8 went back into the kitchen and then returned to the lounge area. At 5:29 PM, client #8 turned toward clients #6 and #13 and verbally aggressed toward them. Staff #9 approached client #8 and redirected. At 5:31 PM, client #8 entered the nurse's station. At 5:31 PM, client #13 came to the</p>		<p>must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. The facility ensures the clients have individualized active treatment schedules for staff to implement.</p> <p>Individual Active treatment schedules have been implemented for all clients. Schedules will be monitored ongoing for each individual and will be noted on the monthly, quarterly and annual reviews, which are also reviewed by the individual's team. the QIDPs and Program Manager.</p> <p>All staff will be in-serviced on individual program plans, including but not limited to, specific goals and objectives as written and approved in their Individual Support Plan. All staff will complete a competency based assessment to ensure that staff understand the need, frequency and implementation of each goal.</p> <p>All staff will be in-serviced on active treatment. This will include all administrative staff who are responsible for over-seeing implementation of active treatment. Included in active treatment training will be ensuring implementation of specific goals</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>lounge area with a mask and fake knife approaching other clients in an aggressive manner. At 5:33 PM, client #8 entered the kitchen and RM #6 escorted client #8 back to the lounge area and prompted him to have a seat. At 5:35 PM, client #8 stood in the doorway to the kitchen. At 5:36 PM, client #5 sat at his place at the dining room table. Client #20 sat at his place at the dining room table. At 5:37 PM, client #8 swatted at staff #9. At 5:39 PM, client #8 was talking to LPN #1 and then entered the kitchen. At 5:41 PM, client #8 yelled at staff #5. At 5:50 PM, client #8 attempted to enter the nurses station and then entered and exited the kitchen. At 6:01 PM, client #8 sat down and ate supper. At 6:12 PM, client #8 got a second serving of broccoli. At 6:15 PM, client #8 got up from the dining room table and stood talking with staff #9. At 6:16 PM, client #8 entered the kitchen, grabbed food off the counter and from the floor and ate it. At 6:24 PM, staff #9 and Executive Director talked with client #8 and prompted him to go to his room. At 6:25 PM, client #8 stood in front of his bedroom door.</p> <p>During the evening observation, clients #1, #2 and #6 wandered around speaking with their peers, staff and visitors. Clients #1, #2 and #6 were not prompted to engage in their active treatment schedules. Client #4 sat at a dining room table telling and writing jokes to his peers, staff and visitors. Client #4 was not prompted to engage in his active treatment schedule. During the observation, client #3 was in his bed asleep. Staff did not prompt him to follow his active treatment schedule.</p> <p>On 10/22/19 from 7:04 AM to 8:49 AM, an observation was conducted at the facility. At 7:08 AM, client #8 stood in the hallway at his bedroom door. From 7:11 AM to 7:18 AM, client #8 was in</p>		<p>and objects in the individual program plan, as well as training all staff and supervisors on ensuring opportunities for natural learning opportunities that might exist in the daily environment of all individuals, not included in the individual program plan.</p> <p>The facility employs two QIDP's to ensure that individual program plans, staff training, and active treatment are occurring. The Executive Director will directly train all Q's as well as the Program Manager on how to implement active treatment and ensure that it is occurring in real time on the residential hall. The Executive Director will develop a schedule and checklist to ensure that active treatment observations are occurring by QIDP's and the Program Manager, on the floor, on all shifts, at least 7 days per week, for 30 days. If progress is seen towards staff understanding of goal implementation, then the frequency of observations may be reduced to 5 times per week for 30 days subsequent to this. Pending successful demonstration of active treatment active treatment observations will be reduced to the standard of 3 times per week. .</p> <p>The facility endeavors to ensure that all individuals, when ready, go to day service outside of the</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 bedroom. From 7:15 AM to 8:49 AM, client #4 sat at a dining room table writing jokes. From 7:18 AM to 7:30 AM, client #8 stood outside his bedroom in the hallway. At 7:31 AM, client #8 walked to the lounge area without shoes on. Staff prompted client #8 to put shoes on. At 7:38 AM, client #8 stood in the hallway by his bedroom door. At 8:36 AM, client #8 was in his bed sleeping. At 8:45 AM, client #8 hollered from his bedroom, staff went and checked on him.</p> <p>During the morning observation, clients #1, #2 and #6 wandered around speaking with their peers, staff and visitors. Clients #1, #2 and #6 were not prompted to engage in their active treatment schedules. Client #4 sat at a dining room table telling and writing jokes to his peers, staff and visitors. Client #4 was not prompted to engage in his active treatment schedule.</p> <p>On 10/22/19 at 12:37 PM, a review of client #1's undated Activities of Daily Living Schedule had the following activities planned:</p> <ul style="list-style-type: none"> <li>-6:00 - 7:00: Sleep (daily)</li> <li>-7:00 - 8:00: AM Hygiene and breakfast (daily)</li> <li>-8:00 - 9:00: Morning meds and chores (daily)</li> <li>-9:00 - 12:00: Day programming (Monday thru Friday)</li> <li>-12:00 - 12:30: Lunch - Noon Meds</li> <li>-12:30 - 2:30: Day programming (Monday thru Friday)</li> <li>-2:30 - 3:00: Incentive/token and afternoon snack (Monday thru Friday)</li> <li>-3:00 - 4:00: Big Ball Volleyball (Monday thru Friday)</li> <li>-4:00 - 5:00: Meal prep and dinner (daily)</li> <li>-5:00 - 6:00: Clean up/goals (daily except Thursdays)</li> <li>-6:00 - 7:00: Rec Time (daily except Thursdays).</li> </ul>		<p>facility. For individuals who are not stabilized enough to go to an outside day service, the facility will ensure that these people receive a consistent schedule list of day service activities, that will cover the bulk of their day. Refusals to day service will be documented in their behavior support plans and addressed in order to ensure appropriate implementation of day service planning. This will include that all individuals not working Monday through Friday from 9am to 2:30 pm will have schedules filled with individual activities, if not participating in day service, at the facility during those hours. The Executive Director will review individual specific active treatment plans for each person that does not attend outside day service, to ensure appropriateness of this plan as well as consistent participation and implementation of such.</p> <p>Active treatment observations will be reviewed by the Executive Director, each day, to ensure that appropriate observations comments, on the spot re-training and understanding of individual program plans are demonstrated. By 1/1/2020 the Executive Director will meet with the Regional Director to determine if reduction in frequency of administrative monitoring can occur.</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 10/22/19 at 11:55 AM, a review of client #2's undated Activities of Daily Living Schedule had the following activities planned:</p> <ul style="list-style-type: none"> <li>-6:00 - 7:00: Sleep (daily)</li> <li>-7:00 - 8:00: AM Hygiene and breakfast (daily)</li> <li>-8:00 - 9:00: Morning meds and chores (daily)</li> <li>-9:00 - 12:00: Day programming (Monday thru Friday)</li> <li>-12:00 - 12:30: Lunch - Noon Meds</li> <li>-12:30 - 2:30: Day programming (Monday thru Friday)</li> <li>-2:30 - 3:00: Incentive/token and afternoon snack (Monday thru Friday)</li> <li>-3:00 - 4:00: Big Ball Volleyball (Monday thru Friday)</li> <li>-4:00 - 5:00: Meal prep and dinner (daily)</li> <li>-5:00 - 6:00: Clean up/goals (daily except Thursdays)</li> <li>-6:00 - 7:00: Rec Time (daily except Thursdays).</li> </ul> <p>On 10/22/19 at 12:18 PM, a review of client #3's undated Activities of Daily Living Schedule had the following activities planned:</p> <ul style="list-style-type: none"> <li>-6:00 - 7:00: Sleep (daily)</li> <li>-7:00 - 8:00: AM Hygiene and breakfast (daily)</li> <li>-8:00 - 9:00: Morning meds and chores (daily)</li> <li>-9:00 - 12:00: Day programming (Monday thru Friday)</li> <li>-12:00 - 12:30: Lunch - Noon Meds</li> <li>-12:30 - 2:30: Day programming (Monday thru Friday)</li> <li>-2:30 - 3:00: Incentive/token and afternoon snack (Monday thru Friday)</li> <li>-3:00 - 4:00: Big Ball Volleyball (Monday thru Friday)</li> <li>-4:00 - 5:00: Meal prep and dinner (daily)</li> <li>-5:00 - 6:00: Clean up/goals (daily except Thursdays)</li> <li>-6:00 - 7:00: Rec Time (daily except Thursdays).</li> </ul>		<p>Persons Responsible: Executive Director, Program Manager, QIDP</p> <p>Date of completion: 11/15/2019</p> <p>Person's Responsible- QIDPs and Program Manager</p> <p>Date of Completion- 11/15/2019</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 10/22/19 at 11:58 AM, a review of client #4's undated Activities of Daily Living Schedule had the following activities planned:</p> <ul style="list-style-type: none"> <li>-6:00 - 7:00: Sleep (daily)</li> <li>-7:00 - 8:00: AM Hygiene and breakfast (daily)</li> <li>-8:00 - 9:00: Morning meds and chores (daily)</li> <li>-9:00 - 12:00: Day programming (Monday thru Friday)</li> <li>-12:00 - 12:30: Lunch - Noon Meds</li> <li>-12:30 - 2:30: Day programming (Monday thru Friday)</li> <li>-2:30 - 3:00: Incentive/token and afternoon snack (Monday thru Friday)</li> <li>-3:00 - 4:00: Big Ball Volleyball (Monday thru Friday)</li> <li>-4:00 - 5:00: Meal prep and dinner (daily)</li> <li>-5:00 - 6:00: Clean up/goals (daily except Thursdays)</li> <li>-6:00 - 7:00: Rec Time (daily except Thursdays).</li> </ul> <p>On 10/22/19 at 12:05 PM, a review of client #5's undated Activities of Daily Living Schedule had the following activities planned:</p> <ul style="list-style-type: none"> <li>-6:00 - 7:00: Sleep (daily)</li> <li>-7:00 - 8:00: AM Hygiene and breakfast (daily)</li> <li>-8:00 - 9:00: Morning meds and chores (daily)</li> <li>-9:00 - 12:00: Day programming (Monday thru Friday)</li> <li>-12:00 - 12:30: Lunch - Noon Meds</li> <li>-12:30 - 2:30: Day programming (Monday thru Friday)</li> <li>-2:30 - 3:00: Incentive/token and afternoon snack (Monday thru Friday)</li> <li>-3:00 - 4:00: Big Ball Volleyball (Monday thru Friday)</li> <li>-4:00 - 5:00: Meal prep and dinner (daily)</li> <li>-5:00 - 6:00: Clean up/goals (daily except Thursdays)</li> <li>-6:00 - 7:00: Rec Time (daily except Thursdays).</li> </ul>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 10/23/19 at 9:20 AM, a review of client #6's undated Activities of Daily Living Schedule had the following activities planned:</p> <ul style="list-style-type: none"> <li>-6:00 - 7:00: Sleep (daily)</li> <li>-7:00 - 8:00: AM Hygiene and breakfast (daily)</li> <li>-8:00 - 9:00: Morning meds and chores (daily)</li> <li>-9:00 - 12:00: Day programming (Monday thru Friday)</li> <li>-12:00 - 12:30: Lunch - Noon Meds</li> <li>-12:30 - 2:30: Day programming (Monday thru Friday)</li> <li>-2:30 - 3:00: Incentive/token and afternoon snack (Monday thru Friday)</li> <li>-3:00 - 4:00: Big Ball Volleyball (Monday thru Friday)</li> <li>-4:00 - 5:00: Meal prep and dinner (daily)</li> <li>-5:00 - 6:00: Clean up/goals (daily except Thursdays)</li> <li>-6:00 - 7:00: Rec Time (daily except Thursdays).</li> </ul> <p>On 10/22/19 at 11:37 AM, a review of client #7's undated Activities of Daily Living Schedule had the following activities planned:</p> <ul style="list-style-type: none"> <li>-6:00 - 7:00: Sleep (daily)</li> <li>-7:00 - 8:00: AM Hygiene and breakfast (daily)</li> <li>-8:00 - 9:00: Morning meds and chores (daily)</li> <li>-9:00 - 12:00: Day programming (Monday thru Friday)</li> <li>-12:00 - 12:30: Lunch - Noon Meds</li> <li>-12:30 - 2:30: Day programming (Monday thru Friday)</li> <li>-2:30 - 3:00: Incentive/token and afternoon snack (Monday thru Friday)</li> <li>-3:00 - 4:00: Big Ball Volleyball (Monday thru Friday)</li> <li>-4:00 - 5:00: Meal prep and dinner (daily)</li> <li>-5:00 - 6:00: Clean up/goals (daily except Thursdays)</li> <li>-6:00 - 7:00: Rec Time (daily except Thursdays).</li> </ul>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 10/22/19 at 2:00 PM, a review of client #8's undated Activities of Daily Living Schedule had the following activities planned:</p> <ul style="list-style-type: none"> <li>-6:00 - 7:00: Sleep (daily)</li> <li>-7:00 - 8:00: AM Hygiene and breakfast (daily)</li> <li>-8:00 - 9:00: Morning meds and chores (daily)</li> <li>-9:00 - 12:00: Day programming (Monday thru Friday)</li> <li>-12:00 - 12:30: Lunch - Noon Meds</li> <li>-12:30 - 2:30: Day programming (Monday thru Friday)</li> <li>-2:30 - 3:00: Incentive/token and afternoon snack (Monday thru Friday)</li> <li>-3:00 - 4:00: Big Ball Volleyball (Monday thru Friday)</li> <li>-4:00 - 5:00: Meal prep and dinner (daily)</li> <li>-5:00 - 6:00: Clean up/goals (daily except Thursdays)</li> <li>-6:00 - 7:00: Rec Time (daily except Thursdays).</li> </ul> <p>On 10/21/19 at 1:46 PM, client #4 stated "It is hard here because we can only leave campus once a week on outings or home visits. I currently do not go to workshop. At my team meetings, they are wanting me to do job training so I can go to the workshop but I don't want to work at the workshop. I would like to work at a local bakery to get ready for my future. I want to own my own bakery and do clothing design. I want out of here a couple of hours a day."</p> <p>Confidential interview (CI) #1 indicated she normally was in the movie room or in the library with clients. CI #1 indicated client #5 was constantly wanting to be up and moving when awake. CI #1 indicated there was no set schedule for client #5, due to some days he will sleep all day and other days he was up moving all day. CI #1 indicated client #5 ate when he wanted. CI #1 indicated client #5 was learning to interact with</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 0259  Bldg. 00	<p>his peers. CI #1 stated the facility was usually pretty easy and "laid back". CI #1 indicated dinner was usually at 5:00 PM, but can be delayed when clients want to help. On 10/23/19 at 12:05 PM, Qualified Intellectual Disabilities Professional (QIDP) #1 indicated the clients' active treatment schedules needed to be client specific and person centered based on their individual needs. QIDP #1 indicated the day program section for each of the clients needed to indicate the activities the clients were to engage in. On 10/23/19 at 9:36 AM, QIDP #2 and Behavior Clinician (BC) #1 were interviewed. QIDP #2 was asked how active treatment scheduling had been defined based on individualized scheduling. QIDP #2 stated, "Not very well for the most part". BC #1 stated, "We have the guys doing work days and for the others it's activities here. [Client #5] has road trips. It's not like [client #5] would go to cooking class". QIDP #2 stated, "I think the ISP (Individual Support Plan) goals says one or two times a week. It (activity schedule) may not even say that. It's just when they want to (take trips)". QIDP #2 indicated a Life Skills program had been initiated by a former employee. QIDP #2 was asked if the client activity schedules for clients not working Monday through Friday from 9:00 AM to 2:30 PM schedules should be filled in with individualized activities. QIDP #2 stated, "In general, it probably should be".</p> <p>5-2(e)</p> <p>483.440(f)(2) PROGRAM MONITORING &amp; CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.</p>	W 0259	W259 PROGRAM MONITORING	11/15/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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>Based on record review and interview for 3 of 8 clients in the sample (#1, #3 and #6) and one additional client (#18), the facility failed to ensure the clients' comprehensive functional assessments (CFA) were reviewed and updated at least annually.</p> <p>Findings include:</p> <ol style="list-style-type: none"> <li>1. Client #1's record was reviewed on 10/22/19 at 12:37 PM. Client #1's record included a CFA dated 3/30/18.</li> <li>2. Client #18's record was reviewed on 10/22/19 at 1:20 PM. Client #18's record included a CFA dated 3/16/18.</li> <li>3. Client #3's record was reviewed on 10/22/19 at 12:18 PM. Client #3's record included a CFA dated 12/1/17. There was no documentation indicating client #3's CFA was revised and/or updated since 12/1/17.</li> </ol> <p>On 10/22/19 at 12:45 PM, Qualified Intellectual Disabilities Professional (QIDP) #2 indicated the clients' CFAs should be updated annually. QIDP #2 stated the CFAs "didn't take a high priority."</p> <p>On 10/22/19 at 1:20 PM, the Executive Director (ED) indicated the clients' CFAs should be conducted upon admission and annually thereafter or when changes occurred.</p> <ol style="list-style-type: none"> <li>4. Client #6's record was reviewed on 10/23/19 at 9:20 AM. Client #6's record included a CFA dated 5/30/18. A current CFA was not available for review.</li> </ol> <p>On 10/23/19 at 12:50 PM QIDP #1 was interviewed. QIDP #1 was asked if a current CFA could be provided for review. QIDP #1 indicated a current CFA was needed for client #6 and stated, "He</p>		<p>&amp; CHANGE- At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. The facility ensures the clients' comprehensive functional assessments (CFA) are reviewed and updated at least annually. All clients needs will be assessed, at least annually, and noted on the client's Comprehensive Functional Assessment. Client's who are deemed unable to exercise their rights as citizens, including the rights to file complaint and to due process will be assisted in obtaining a health care representative or legal guardian. The Program Manager, Nurse Manager and QIDP will monitor ongoing progress of each individual and will note such on the monthly, quarterly and annual reviews, which are also reviewed by the individual's team. The Executive Director will in-service facility QIDP's and the Program Manager on the need and requirement to have an updated CFA at least annually and as needed. The monthly review form will be updated to include a mechanism to document verification that the CFA for each individual is current. The Program Manager will review each monthly review to ensure that this standard has been met.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 0331  Bldg. 00	<p>(client #6) should have had one (CFA) done in 4/2019". QIDP #1 indicated a CFA should be completed within 30 days from admission and annually thereafter.</p> <p>5-2(e)</p> <p>483.460(c)</p> <p><b>NURSING SERVICES</b></p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on observation, record review, and interview for 1 additional client (#18), the facility's nursing services failed to provide monitoring of client #18's medication administration and treatments.</p> <p>Findings include:</p> <p>Observations were done at the facility on 10/21/19 from 1:20 PM to 2:33 PM, 4:16 PM to 6:23 PM, and on 10/22/19 from 7:00 AM to 8:50 AM. During the observations, client #18's bedroom had a bedside table which stored a suction machine with supplies for suctioning client #18's Tracheostomy (airway on the neck) and G-Tube (stomach feeding tube). The table storing the suction machine and supplies was covered in drips of an unidentified tan liquid. The suction machine also had the liquid present on the exterior of the machine. The floor surrounding the bedside table had multiple dried drips of an unidentified tan liquid. The vest treatment machine was on the floor between the bed and the bedside table. The machine had multiple dried drips of an unidentified tan liquid. The recliner in client #18's room had multiple dried drips of an unidentified tan liquid on both arm rests, and either side of the seat cushion. The floor to the left side of the recliner had a 6 inch by 8 inch wet liquid on the</p>	W 0331	<p>Person's Responsible- ED, DON, QIDPs and Program Manager</p> <p>Date of Completion- 11/15/2019</p> <p>W331 NURSING SERVICES-The facility must provide clients with nursing services in accordance with their needs. The facility's nursing services provide monitoring of all clients medication administration and treatments. All nurses have been retrained on medication administration policies. The Nurse Manager will monitor the QuickMar for accuracy.</p> <p>Persons Responsible- Nurses and Nurse Manager</p> <p>Completion Date- 11/15/2019</p>	11/15/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>floor.</p> <p>On 10/22/19 at 8:10 AM, LPN (Licensed Practical Nurse) #1 handed client #18 two small water bottles. One water bottle contained water and the other bottle had a pink liquid inside. LPN #1 stated, "Go do your vest (treatment vest) and then take your meds (medications)." Client #18 walked to his room, sat on the floor and immediately began his vest treatment at 8:10 AM. LPN #1 was not present in his room during the vest treatment. At 8:18 AM, client #18 turned off his vest treatment machine and sat down in his recliner. Client #18 prepared his G-Tube by adding and extension tubing set. Client #18 then administered the bottle with pink liquid through his G-Tube. Client #18 did not utilize the water to flush his G-Tube. LPN #1 was not present in his room during the G-Tube medication administration.</p> <p>Client #18 was interviewed on 10/22/19 at 8:10 AM. When asked how long he does his vest treatment, client #18 stated, "Ten minutes." The timer on the machine was set to ten minutes. Client #18 indicated he performs suction treatment of his tracheostomy with the supplies at bedside. Client #18 stated, "I do it myself. I use this (a suction attachment) when I need it." When asked if the nurses assist with the suctioning, client #18 stated, "No. I do it myself. I do the vest treatment myself too."</p> <p>Client #18's Physician's Orders (POs) were reviewed during the medication reconciliation on 10/22/19 at 11:10 AM. Client #18's POs dated for 10/1/19 through 10/31/19 indicated the following:</p> <ul style="list-style-type: none"> <li>- "Flush G-Tube with 8 ounces of water with meal and medications."</li> </ul>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/25/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(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>- "Compression vest for 10 minutes prior to all feeding and medications."</p> <p>- "Suction tracheostomy as needed for excess secretions."</p> <p>LPN #1 was interviewed on 10/22/19 at 8:39 AM. LPN #1 indicated client #18 utilizes a vest treatment to loosen secretions prior to medication and feedings. LPN #1 stated, "He does the vest treatment in his room. I don't know how long he does it. I think it's set on a timer." LPN #1 indicated client #18 has a tracheostomy which requires suctioning. LPN #1 stated, "I come down and suction him when he asks me to. He doesn't do it himself." After observing client #18's bedroom, LPN #1 stated, "[Client #18's] room is disgusting. I don't know what that liquid everywhere is. I would guess it's fluid from the suction machine." LPN #1 indicated client #18 was being seen by an infectious disease specialist for an infection in his tracheostomy. LPN #1 stated, "I don't know what the infection is, but I think all his trash should be hazardous because of it." LPN #1 indicated client #18 self administers his medications. LPN #1 stated, "I just mix up his medications like I did this morning. He comes down and administers them by himself. Afterwards he should flush his G-Tube with the 8 ounces of water." LPN #1 indicated she was unsure how long client #18's vest treatment lasted this morning. LPN #1 indicated she was unsure if client #18 took his morning medications. LPN #1 stated, "I didn't watch any of that. So I don't know what he did."</p> <p>Regional Nursing Manager (RNM) #1 was interviewed on 10/23/19 at 11:18 AM. RNM #1 stated, "Clients should be supervised at all times during medications and treatments to ensure</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/25/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(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 0369 Bldg. 00	<p>physician's orders are being followed." RNM #1 stated, "It is the nurses responsibility to ensure treatments and medications are administered." RNM #1 indicated she was unaware client #18 was suctioning himself, providing vest treatments, and administering medications without supervision. RNM #1 stated, "Even if [client #18] is independent in these skills, the nurse should still be monitoring him."</p> <p>5-4</p> <p>483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review, and interview for 1 of 8 sample clients (#5), plus 2 additional clients (#10 and #18), the facility failed to ensure clients #5, #10, and #18's medications were administered without error.</p> <p>Findings include:</p> <p>1. Observations were conducted at the facility on 10/21/19 from 4:12 PM to 6:23 PM. At 5:26 PM, Licensed Practical Nurse (LPN) #1 administered client #5's eye drops. During the observation, LPN #1 placed one drop of Artificial Tears (eye re-wetting drop) in each of client #5's eyes.</p> <p>Client #5's Physician's Orders (POs) were reviewed during the medication reconciliation on 10/22/19 at 11:10 AM. Client #5's POs dated for 10/1/19 through 10/31/19 indicated, "Artificial Tears Solution: Instill one drop in both eyes twice daily at 8:00 AM and 8:00 PM."</p>	W 0369	<p>W369 DRUG ADMINISTRATION-The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. The facility will ensure that all client medications are administered without error.</p> <p>All nurses have been retrained on medication administration policies. The Nurse Manager will monitor the QuickMar for accuracy. Active treatment observations will occur, at least daily, for 30 days. During these active treatment observations, at least one med pass per day will be observed. Administrative staff, including the DON will monitor to ensure that med administration is occurring without error. After 30 days the</p>	11/15/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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>The facility failed to administer client #5's eye drops at the scheduled time.</p> <p>2. Observations were conducted at the facility on 10/22/19 from 7:00 AM to 8:50 AM. At 7:41 AM, LPN #1 administered client #10's morning medications. LPN #1 walked over to client #10, who was seated in a chair, and handed him a medicine cup with 9 pills inside, and a cup in which she had mixed two liquid medications in. The cup had Miramax (constipation) and Actualize (constipation) mixed with water. LPN #1 then turned around and walked back to the nurse's cabinet and began putting away client #10's medication containers. LPN #1 did not observe client #10 consuming his morning pills or the liquid medication mixture she had prepared. Client #10 threw his cups in the garbage can next to the nurse's cabinet. At 7:47 AM, the surveyor obtained gloves and pulled the liquid medication mixture cup from the garbage can. The cup had residue along the sides and liquid still covering the bottom of the cup. LPN #1 stated, "That's Miramax and Actualize inside the cup. [Client #10] didn't take it all. He threw it away while I wasn't watching." When asked how much of the medication client #10 received, LPN #1 stated, "He probably got 95% of it. I don't know." When asked how much of the medication client #10 should receive during medication pass, LPN #1 stated, "He should get 100% of his medications."</p> <p>Client #10's POs were reviewed during the medication reconciliation on 10/22/19 at 11:10 AM. Client #10's PO's dated for 10/1/19 through 10/31/19 indicated the following:</p> <ul style="list-style-type: none"> <li>- "Miramax Powder: Mix 34 grams in 8 ounces of liquid and give by mouth twice daily at 8:00 AM and 8:00 PM."</li> </ul>	<p>Regional Director will assess if med administration observation can be decreased from daily observations to lesser frequency. Ongoing, the DON will observe med passes on a variety of shifts and without prior notice to the LPN on shift to ensure that med administration is occurring appropriately.</p> <p>Persons Responsible: ED, QIDP, DON, PM Date of correction: 11/15/2019</p> <p>Persons Responsible- Nurses and Nurse Manager Completion Date- 11/15/2019</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<ul style="list-style-type: none"> <li>- "Actualize: Give 30 ML (Milliliters) by mouth twice daily at 8:00 AM and 8:00 PM."</li> <li>- "Mouth checks with medication pass. Thorough mouth checks with every medication pass. Open mouth, lift tongue, pull down bottom lip."</li> </ul> <p>3. Observations were conducted at the facility on 10/22/19 from 7:00 AM to 8:50 AM. At 8:10 AM, LPN #1 handed client #18 two small water bottles. One water bottle contained just water and the other bottle had pink liquid inside. LPN #1 stated, "Go do your vest (treatment vest) and then take your meds (medications)." Client #18 walked to his room, sat on the floor and immediately began his vest treatment at 8:10 AM. Neither LPN #1 or other staff were present in his room during the vest treatment. At 8:18 AM, client #18 turned off his vest treatment machine and sat down in his recliner. Client #18 prepared his G-Tube (stomach feeding tube) by adding and extension tubing set. Client #18 then administered the bottle with pink liquid through his G-Tube. Client #18 did not utilize the water to flush his G-Tube. Neither LPN #1 or other staff were present in his room during the G-Tube medication administration.</p> <p>Client #18 was interviewed on 10/22/19 at 8:10 AM. When asked how long he does his vest treatment, client #18 stated, "Ten minutes." The timer on the machine was set to ten minutes.</p> <p>Client #18's POs were reviewed during the medication reconciliation on 10/22/19 at 11:10 AM. Client #18's PO's dated for 10/1/19 through 10/31/19 indicated the following:</p> <ul style="list-style-type: none"> <li>- "Centrum Liquid (vitamin replacement): Give 1 tablespoonful, 15 ML, per G-Tube once daily at</li> </ul>			

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

PRINTED: 12/12/2019

FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/25/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(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>8:00 AM.</p> <p>- "Clozapine (bipolar) tablet 50 MG (Milligrams): Give 1 tablet per G-Tube once daily at 8:00 AM."</p> <p>- "Culturelle Capsule (probiotic): Give 1 capsule per G-Tube once daily at 8:00 AM."</p> <p>- "Pepcid (reflux) tablet 20 MG: Give 1 tablet per G-Tube twice daily at 8:00 AM and 8:00 PM."</p> <p>- "Prozac (bipolar) solution: Give 1 teaspoonful, 5 ML, per G-Tube every morning at 8:00 AM."</p> <p>- "Glycopyrrol (excessive secretions) tablet 2 MG: Give 1 tablet per G-Tube every 8 hours starting at 8:00 AM."</p> <p>- "Tenex (bipolar) tablet 1 MG: Give 1 tablet per G-Tube three times daily at 8:00 AM, 4:00 PM, and 8:00 PM."</p> <p>- "Loratadine (allergies) tablet 10 MG: Give 1 tablet per G-Tube daily at 8:00 AM."</p> <p>- "Oyster Shell Calcium (osteoporosis) tablet 500 MG: Give 1 tablet per G-Tube twice daily at 8:00 AM and 8:00 PM."</p> <p>- "Potassium Chloride (supplement) solution: Give 5.25 ML per G-Tube once daily at 9:00 AM."</p> <p>- "Prednisone (cerebral palsy) tablet 10 MG: Give 1 tablet per G-Tube once daily at 9:00 AM."</p> <p>- "Robafen (excessive secretions) solution: Give 20 ML per G-Tube five times a day at 5:00 AM, 9:00 AM, 2:00 PM, 4:00 PM, and 8:00 PM."</p> <p>- "Silace (constipation) solution: Give 15 ML per</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 0440  Bldg. 00	<p>G-Tube once daily at 8:00 AM."</p> <p>- "Valproic Acid (bipolar) solution: Give 25 ML per G-Tube twice daily at 9:00 AM and 10:00 PM."</p> <p>- "Zyrtec (allergies) solution: Give 10 ML per G-Tube once daily at 9:00 AM."</p> <p>- "Flush G-Tube with 8 ounces of water with meal and medications."</p> <p>- "Compression vest for 10 minutes prior to all feeding and medications."</p> <p>Regional Nursing Manager (RNM) #1 was interviewed on 10/23/19 at 11:18 AM. RNM #1 indicated clients #5, #10, and #18's medications and treatments should be given as ordered by the physician. RNM #1 stated, "Clients should be supervised at all times during medications and treatments to ensure physician's orders are being followed."</p> <p>5-4</p> <p>483.470(i)(1) <b>EVACUATION DRILLS</b> The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview for 20 of 20 clients living in the facility (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20), the facility failed to conduct quarterly evacuation drills for each shift of personnel.</p> <p>Findings include:</p> <p>On 10/22/19 at 11:13 AM, a review of the facility's evacuation drills was conducted. The facility</p>	W 0440	<p>W440 EVACUATION DRILLS- The facility must hold evacuation drills at least quarterly for each shift of personnel. The facility will conduct quarterly evacuation drills for each shift of personnel.</p> <p>A schedule has been developed and implemented to ensure that evacuation drills are completed quarterly. All staff have been retrained on evacuation drills and</p>	11/15/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/25/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(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 0454 Bldg. 00	<p>failed to conduct quarterly evacuation drills for each shift of personnel affecting clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20.</p> <p>-During the day shift (8:00 AM to 4:00 PM), the facility conducted one day shift evacuation drill (on 6/4/19) between 10/22/18 through 10/22/19.</p> <p>-During the evening shift (4:00 PM to 12:00 AM), the facility conducted two evening shift drills (on 12/27/18 and 7/31/19) between 10/22/18 and 10/22/19.</p> <p>-During the night shift (12:00 AM to 8:00 AM), the facility conducted two night shift drills (on 6/30/19 and 9/30/19) between 10/22/18 and 10/22/19.</p> <p>On 10/22/19 at 11:27 AM, Qualified Intellectual Disabilities Professional #2 indicated the facility should have conducted one evacuation drill per shift per quarter.</p> <p>On 10/22/19 at 11:38 AM, the Executive Director indicated the facility should have conducted one evacuation drill per shift per quarter.</p> <p>483.470(l)(1) <b>INFECTON CONTROL</b> The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation, record review, and interview for 1 additional client (#18), the facility failed to ensure client #18's room was maintained in a sanitary condition. Findings include: Observations were conducted at the facility on</p>	W 0454	<p>the schedule for completing drills. The Resident Managers and Program Manager will monitor for completion as scheduled.</p> <p>Persons Responsible- Resident Managers and Program Manager Completion Date- 11/15/2019</p>	11/15/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/25/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(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
	<p>10/21/19 from 1:20 PM to 2:33 PM, 4:16 PM to 6:23 PM, and on 10/22/19 from 7:00 AM to 8:50 AM. During the observations, client #18's bedroom had a bedside table which stored a suction machine with supplies for suctioning client #18's Tracheostomy (airway on the neck) and G-Tube (stomach feeding tube). The table storing the suction machine and supplies was covered in drips of an unidentified tan liquid. The suction machine also had the liquid present on the exterior of the machine. The floor surrounding the bedside table had multiple dried drips of an unidentified tan liquid. The vest treatment machine was on the floor between the bed and the bedside table. The machine had multiple dried drips of an unidentified tan liquid. The recliner in client #18's room had multiple dried drips of an unidentified tan liquid on both arm rests, and either side of the seat cushion. The floor to the left side of the recliner had a 6 inch by 8 inch wet liquid on the floor.</p> <p>Client #18's record was reviewed on 10/22/19 at 1:20 PM. The review indicated the following:</p> <p>Client #18's Health Risk Plan (HRP) for his Tracheostomy was dated 3/29/19. The HRP indicated, "... Staff will follow protocols for infection control...".</p> <p>Client #18's Laboratory Results (LRs) dated 5/15/19 indicated client #18 had a culture performed on his Sputum (mixture of saliva and spit). The LR indicated, "Heavy growth... Has been determined of being a positive ESBL (Extended Spectrum Beta-Lactamase) producer and reported to infection control...".</p> <p>Client #18's LRs dated 6/6/19 indicated client #18 had a culture performed on his Sputum. The LR</p>		<p>walk throughs to ensure compliance with keeping individuals rooms in a sanitary manner. This is to ensure that all client rooms are maintained in a sanitary condition. Any individual who is assessed as unable to maintain a sanitary room, will be addressed in the CFA and with a training goal as indicated below. The Executive Director will review daily environmental walk through forms, as completed each day by the PM or designee to ensure that all deficient practices are corrected each day.</p> <p>The CFA for client #18 will be re-assessed to ensure that it addresses the ability of client #18 to keep his room in sanitary condition. Facility QIDP's will ensure that an appropriate training objective is implemented into the ISP of this client to ensure that training on maintaining a clean and sanitary room is established. All staff will be in-serviced on the updated goal in the ISP.</p> <p>The facility employs two QIDP's to ensure that individual program plans, staff training, and active treatment are occurring. The Executive Director will directly train all Q's as well as the Program Manager on how to implement active treatment and ensure that it is occurring in real time on the residential hall. The Executive Director will develop a</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>indicated, "E-Coli (Escherichia coli)... Has been determined of being a positive ESBL producer and reported to infection control...".</p> <p>Client #18's Doctor Exam Form (DEF) dated 6/13/19 indicated client #18 had been seen by his Primary Care Physician (PCP) for the treatment of ESBL in his tracheostomy.</p> <p>Client #18's Therapy and Procedure Form (TPF) dated 6/14/19 indicated client #18 had been seen for treatment of the ESBL in his tracheostomy. The TPF indicated client #18 had received IV (Intravenous) antibiotic therapy at the hospital.</p> <p>Client #18's DEF dated 6/19/19 indicated client #18 had been seen by his PCP for the treatment of ESBL in his tracheostomy.</p> <p>Client #18's LRs dated 6/22/19 indicated client #18 had a culture performed on his Sputum. The LR indicated, "E-Coli... Has been determined of being a positive ESBL producer and reported to infection control...".</p> <p>Client #18's [Hospital] Discharge Form (HDF) dated 6/28/19 indicated client #18 had been seen at the hospital for treatment of the infection in his tracheostomy. The HDF indicated, "Contact precautions (gown and gloves)...".</p> <p>Client #18's TPF dated 7/2/19 indicated client #18 had been seen for treatment of the ESBL in his tracheostomy. The TPF indicated client #18 had received IV antibiotic therapy at the hospital.</p> <p>Client #18's TPF dated 7/3/19 indicated client #18 had been seen for treatment of the ESBL in his tracheostomy. The TPF indicated client #18 had received IV antibiotic therapy at the hospital.</p>		<p>schedule and checklist to ensure that active treatment observations are occurring by QIDP's and the Program Manager, on the floor, on all shifts, at least 7 days per week, for 30 days. If progress is seen towards staff understanding of goal implementation, then the frequency of observations may be reduced to 5 times per week for 30 days subsequent to this. Pending successful demonstration of active treatment active treatment observations will be reduced to the standard of 3 times per week.</p> <p>Persons Responsible- ED, QIDP, PM</p> <p>Date of Completion- 11/15/2019</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>Client #18's TPF dated 7/7/19 indicated client #18 had been seen for treatment of the ESBL in his tracheostomy. The TPF indicated client #18 had received IV antibiotic therapy at the hospital.</p> <p>Client #18's DEF dated 7/10/19 indicated client #18 had been seen by his PCP for the treatment of ESBL in his tracheostomy.</p> <p>Client #18's DEF dated 9/4/19 indicated client #18 had been seen by an infectious disease specialist for the treatment of ESBL in his tracheostomy. The DEF indicated client #18 was prescribed monthly antibiotic treatment for the infection.</p> <p>Client #18's LRs dated 9/6/19 indicated client #18 had a culture performed on his Sputum. The LR indicated, "E-Coli... Has been determined of being a positive ESBL producer and reported to infection control...".</p> <p>Center for Disease Control (CDC) website was reviewed on 10/23/19 at 4:00 PM. The CDC's website indicated, "ESBL (Multi-drug resistant organisms)... Contact Precautions recommended in settings with evidence of ongoing transmission... increased risk for transmission with wounds that cannot be contained by dressings... Clean and disinfect surfaces and equipment that may be contaminated with pathogens, including those that are in close proximity to the patient (e.g., bed rails, over bed tables) and frequently-touched surfaces in the patient care environment (e.g., door knobs, surfaces in and surrounding toilets in patients' rooms) on a more frequent schedule compared to that for minimal touch surfaces...".</p> <p>Licensed Practical Nurse (LPN) #1 was</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 <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/25/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(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 0455 Bldg. 00	<p>interviewed on 10/22/19 at 8:00 AM and 8:39 AM. LPN #1 indicated client #18 had an infection in his tracheostomy. LPN #1 stated, "I don't know what the infection is. He goes to an infectious disease specialist because of it." LPN #1 indicated she was unsure what infection control precautions were implemented for client #18. LPN #1 stated, "I don't know what his precautions are. I never looked. When I change his tracheostomy I wear a mask and gloves. He wears a mask over the tracheostomy to protect everyone else." After observing client #18's bedroom, LPN #1 stated, "[Client #18's] room is disgusting. I don't know what that liquid everywhere is. I would guess it's fluid from the suction machine." When asked if client #18's infection is easily spread, LPN #1 stated, "I really don't know. I'm not sure how serious his infection is."</p> <p>Regional Nursing Manager (RNM) #1 was interviewed on 10/23/19 at 11:18 AM. RNM #1 indicated client #18 was diagnosed with ESBL in the spring. RNM #1 indicated client #18 was on contact precautions. RNM #1 stated, "Contact precautions mean gloves and a gown are worn when dealing with [client #18's] tracheostomy." RNM #1 indicated infection control is important. RNM #1 stated, "Infection control is the responsibility of the nursing staff. All bodily fluids should be cleaned from surfaces immediately." RNM #1 indicated she was unaware client #18's room had unidentified dry and wet liquids on the counter, floor, and recliner in his room.</p> <p>5-5.1</p> <p><b>483.470(l)(1)</b> <b>INFECTION CONTROL</b> There must be an active program for the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>prevention, control, and investigation of infection and communicable diseases.</p> <p>Based on observation, record review, and interview for 4 of 8 sample clients (#1, #3, #5, and #6), plus 4 additional clients (#10, #11, #14 and #16), the facility failed to ensure Licensed Practical Nurse (LPN) #1 sanitized her hands prior to administering clients #1, #3, #5, #6, #10, #11, #14, and #16's medications.</p> <p>Findings include:</p> <p>Observations were done at the facility on 10/21/19 from 4:12 PM to 6:23 PM.</p> <ul style="list-style-type: none"> <li>- At 4:18 PM, LPN #1 prepared and administered client #16's afternoon medications. LPN #1 did not sanitize or wash her hands prior to administering client #16's medications.</li> <li>- At 4:20 PM, LPN #1 prepared and administered client #6's afternoon medications. LPN #1 did not sanitize or wash her hands prior to administering client #6's medications.</li> <li>- At 4:25 PM, LPN #1 prepared and administered client #3's afternoon medications. LPN #1 did not sanitize or wash her hands prior to administering client #3's medications.</li> <li>- At 4:33 PM, LPN #1 prepared and administered client #11's afternoon medications. LPN #1 did not sanitize or wash her hands prior to administering client #11's medications.</li> <li>- At 5:26 PM, LPN #1 prepared and administered client #5's afternoon medications, including eye drops. LPN #1 did not sanitize or wash her hands prior to administering client #5's medications.</li> </ul>	W 0455	<p>W455 INFECTION CONTROL- There must be an active program for the prevention, control, and investigation of infection and communicable diseases. The facility will ensure all nursing staff sanitize their hands prior to administering medications. Nursing staff have been retrained on medication administration policy and hand sanitizing. All staff have been retrained on hand washing and the importance of hand sanitization in maintaining health.</p> <p>Persons Responsible- Nursing Staff, Nurse Manager, Program Manager and all staff Date of Completion- 11/15/2019</p>	11/15/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/25/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(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 6:11 PM, LPN #1 prepared and administered client #1's evening medications, including an injectable insulin. LPN #1 did not sanitize or wash her hands prior to administering client #1's medications.</p> <p>Observations were done at the facility on 10/22/19 from 7:00 AM to 8:50 AM.</p> <p>- At 7:23 AM, LPN #1 prepared and administered client #14's morning medications. LPN #1 did not sanitize or wash her hands prior to administering client #14's medications.</p> <p>- At 7:25 AM, LPN #1 prepared and administered client #1's morning medications. During the administration, client #1 complained of foot pain and LPN #1 took off client #1's shoes and examined his feet. LPN #1 did not sanitize or wash her hands prior to administering client #1's medications.</p> <p>- At 7:41 AM, LPN #1 prepared and administered client #10's morning medications, including preparing two liquid medications. LPN #1 did not sanitize or wash her hands prior to administering client #10's medications.</p> <p>- At 7:48 AM, LPN #1 washed her hands at the sink inside the nurse's station.</p> <p>During observations at the facility on 10/21/19 and 10/22/19, LPN #1 did not wash her hands at the sink with soap and water, use hand sanitizer, or wear and change gloves between client medication administration.</p> <p>The facility's policy on Medication Administration (MA) dated 1/10/18 was reviewed on 10/23/19 at 12:15 PM. The MA indicated, "...Wash hands</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 0460  Bldg. 00	<p>(prior to preparing medications)...".</p> <p>Regional Nursing Manager (RNM) #1 was interviewed on 10/23/19 at 11:18 AM. RNM #1 indicated staff should be washing or sanitizing their hands between clients when providing care. RNM #1 stated, "Nurses should be in control of infection control protocols. They should be the role models for other staff on the unit."</p> <p>5-5.1</p> <p>483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review, and interview for 1 of 8 sampled clients (#1), the facility failed to ensure client #1 followed his carbohydrate restriction in his prescribed diet.</p> <p>Findings include:</p> <p>Observations were done at the facility on 10/21/19 from 4:12 PM to 6:23 PM. At 6:06 PM, Licensed Practical Nurse (LPN) #1 stood at the dining room table next to client #1. LPN #1 had a binder, note paper, and a pen in her hand. LPN #1 and client #1 searched the binder, containing carbohydrate counts)and counted the total carbohydrates for his dinner. LPN #1 stated, "[Client #1], that's 80 carbs (carbohydrates) for your dinner." Client #1 then ate a grilled cheese sandwich, broccoli with cheese sauce, scalloped potatoes and fruit for his dinner.</p> <p>Client #1's record was reviewed on 10/22/19 at 12:37 PM. The review indicated the following:</p>	W 0460	<p>W460 FOOD AND NUTRITION SERVICES- Each client receives a nourishing, well-balanced diet including modified and specially-prescribed diets. The facility will ensure client #1 follows his carbohydrate restriction in his prescribed diet.</p> <p>Client #1 has guardian and Human Rights Committee approved plan to address his dietary needs. All staff have been retrained regarding Client #1's plans to ensure compliance. Nursing staff, QIDPs and Program Manager will monitor for compliance.</p> <p>Persons Responsible- All staff, Nursing Staff, Nurse Manager, QIDPs and Program Manager</p> <p>Date of Completion- 11/15/2019</p>	11/15/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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's Diabetes Control Plan (DCP) dated 4/9/19 indicated, "... 75 carbs per meal.... 30 carbs per snack...". The DCP indicated the carbohydrate restriction was ordered by client #1's endocrinologist (diabetes specialist).</p> <p>Client #1's Blood Sugar Record (BSR) dated August 2019 indicated the following:</p> <p>"8/3/19: Breakfast, 76 carbohydrates."</p> <p>"8/3/19: Dinner, 80 carbohydrates."</p> <p>"8/5/19: Breakfast, 78 carbohydrates."</p> <p>"8/6/19: Breakfast, 78 carbohydrates."</p> <p>"8/9/19: Lunch, 76 carbohydrates."</p> <p>"8/11/19: Lunch, 78 carbohydrates."</p> <p>"8/13/19: Dinner, 80 carbohydrates."</p> <p>"8/13/19: Bedtime Snack, 40 carbohydrates."</p> <p>"8/17/19: Bedtime Snack, 60 carbohydrates."</p> <p>"8/18/19: Lunch, 76 carbohydrates."</p> <p>"8/18/19: Dinner, 80 carbohydrates."</p> <p>"8/23/19: Breakfast, 86 carbohydrates."</p> <p>"8/25/19: Breakfast, 78 carbohydrates."</p> <p>"8/28/19: Lunch, 81 carbohydrates."</p> <p>"8/29/19: Dinner, 104 carbohydrates."</p> <p>"8/30/19: Lunch, 80 carbohydrates."</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 <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/25/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(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
	<p>Client #1's BSR dated September 2019 indicated the following:</p> <p>"9/12/19: Dinner, 77 carbohydrates."</p> <p>"9/13/19: Dinner, 77 carbohydrates."</p> <p>"9/14/19: Lunch, 86 carbohydrates."</p> <p>"9/17/19: Breakfast, 77 carbohydrates."</p> <p>"9/22/19: Breakfast, 88 carbohydrates."</p> <p>Client #1's BSR dated October 2019 indicated the following:</p> <p>"10/6/19: Morning Snack, 44 carbohydrates."</p> <p>"10/6/19: Bedtime Snack, 70 carbohydrates."</p> <p>"10/8/19: Dinner, 80 carbohydrates."</p> <p>"10/13/19: Dinner, 79 carbohydrates."</p> <p>"10/15/19: Lunch, 81 carbohydrates."</p> <p>"10/17/19: Dinner, 80 carbohydrates."</p> <p>"10/18/19: Lunch, 80 carbohydrates."</p> <p>"10/20/19: Dinner, 76 carbohydrates."</p> <p>"10/21/19: Lunch, 78 carbohydrates."</p> <p>"10/21/19: Dinner, 80 carbohydrates."</p> <p>LPN #1 was interviewed on 10/23/19 at 6:11 PM. LPN #1 indicated client #1 had 80 carbs at dinner. LPN #1 stated, "He's only supposed to have 75</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 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 0473  Bldg. 00	<p>grams of carbs at dinner and 30 grams of carbs during meals. That's part of his plan." LPN #1 indicated client #1 has a diagnosis of diabetes. LPN #1 indicated client #1's dietary plan should be followed due to his medical condition.</p> <p>5-5.1</p> <p>483.480(b)(2)(ii) MEAL SERVICES Food must be served at appropriate temperature. Based on observation and interview for 8 of 8 sample clients (#1, #2, #3, #4, #5, #6, #7, and #8), plus 11 additional clients (clients #9, #10, #11, #12, #13, #14, #15, #16, #17, #19, and #20), the facility failed to ensure staff served the clients' food at an appropriate temperature.</p> <p>Findings include:</p> <p>Observations were conducted at the facility on 10/21/19 from 1:21 pm to 6:20 pm. Staff #19 began prepping for dinner at 4:36 pm. There were two ovens in the kitchen, each with a four burner cooktop. At 5:10 pm, client #7 walked into the kitchen and asked to help. Staff #19 assisted client #7 in putting on gloves. At 5:17 pm, scalloped potatoes and broccoli with cheese had been scooped into serving dishes, placed on trays for each table and covered with plastic film. Client #7 opened the oven, "Almost done (ham loaf). I checked them for you." At 5:20 pm, staff #19 began scooping scalloped potatoes into a blender and added broth. Staff #19 stated, "We have to puree the food for [client #20]." Staff #19 poured the pureed potatoes into a bowl for [client #19], covered it with plastic wrap and put it onto a tray on the counter. At 5:32 pm, staff #19 took the ham loaf out of the oven and set it on the counter.</p>	W 0473	<p>W473 MEAL SERVICES- Food must be served at appropriate temperature. All staff are trained in new hire orientation and at least annually thereafter regarding proper serving temperature of food. Staff have been retrained regarding serving temperatures. Resident Managers and Program Manager will monitor to ensure food serving temperatures are correct.</p> <p>Date of Completion- 11/15/2019 Person Responsible- All staff, Resident Manager and Program Manager</p>	11/15/2019

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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 9999  Bldg. 00	<p>Staff #19 began preparing grilled cheese sandwiches. While the grilled cheese sandwiches were cooking, staff #19 began slicing ham loaf, placing it onto serving plates, covering it with plastic wrap, and placing the plates onto trays on the counter. Grilled cheese sandwiches were wrapped in foil and placed onto the trays. At 6:02 pm, staff took the serving trays to the tables and clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #19, and #20 began to eat.</p> <p>An interview was conducted with staff #10 (Kitchen Manager) on 10/23/19 at 10:09 am. When asked what time dinner should be served, staff #10 stated, "They eat around 5:30 if there's not a crisis." When asked why clients were asking for grilled cheese sandwiches, staff #10 indicated the grilled cheese was an alternate option. Staff #10 stated, "He should have taken a count for grilled cheese ahead of time, so they could plan ahead." When asked if there is a way to keep food warm while waiting or other items to be finished, staff #10 stated, "If they want to, they can put the oven on warm to keep the hot foods hot." When asked if staff are trained in regards to temperature of the food being served, staff #10 stated, "We do food safety training when staff are first hired in." On 10/24/19 at 2:39 PM, the Executive Director (ED) indicated the timeframe for serving food removed from a heat source was 15 minutes. The ED stated, "We clearly didn't follow our training. We didn't do what we are supposed to do."</p> <p>5-5.1</p> <p>State Findings</p>	W 9999	W9999 At the time of	11/15/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2019
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(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
	<p>The following Comprehensive Care Facility rules were not met:</p> <p>410 IAC 16.2-5-1.4 PERSONNEL</p> <p>(1.) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview for 2 of 3 employee files reviewed (staff #14 and staff #17), the facility failed to ensure annual Mantoux (5TU, PPD) tuberculosis (TB) screenings were conducted.</p> <p>Findings include:</p> <p>On 10/22/19 at 11:12 AM, a review of the facility's employee files was conducted and indicated the following:</p> <ul style="list-style-type: none"> <li>-Staff #14's employee file had no results for Mantoux (5TU, PPD) tuberculosis (TB) screening. No documentation was available for review.</li> <li>-Staff #17's employee file had no results for Mantoux (5TU, PPD) tuberculosis (TB) screening since 12/12/17.</li> </ul> <p>On 10/22/19 at 11:22 AM, the Human Resource (HR) Specialist was interviewed. The HR Specialist was asked if current TB screenings for staffs #14 and #17 could be provided for review. The HR Specialist indicated further follow up was required and stated, "I'll bring them over to you."</p>		<p>employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The facility will ensure annual Mantoux (5TU, PPD) tuberculosis (TB) screenings are conducted. On 10/30/2019 and 10/31/2019 the facility conducted a TB screening clinic to ensure all employees had received annual Mantoux (5TU, PPD) tuberculosis (TB) screenings. A quarterly audit of Human Resource files will be conducted to ensure compliance.</p> <p>Date of Completion- 11/15/2019 Persons Responsible- Nursing staff and Human Resource Specialist</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 <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/25/2019</b>
NAME OF PROVIDER OR SUPPLIER <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(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
	On 10/22/19 at 2:47 PM, interview with Human Resource (HR) Specialist and Executive Director (ED) was completed. The ED indicated current TB screening was not available but should be done every year, per the policy. The HR Specialist indicated she would follow up with the Nurse who administer the TB screenings and stated, "If able to find (TB screenings for staff #14 and #17), I will provide them tomorrow." The facility did not provide TB screenings for staff #14 and #17 to review.  5-1.4(f)(1)			