| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
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| | 15G442 | A. BUILDING 00<br>B. WING | 10/07/2022 |

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| RES CARE COMMUNITY ALTERNATIVES SE IN | 402 EWING LN<br>JEFFERSONVILLE, IN 47130 |

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| W 0000<br><br>Bldg. 00 | This visit was for a pre-determined full annual recertification and state licensure survey. This visit included the investigations of complaint #IN00387669 and complaint #IN00389732.<br><br>Complaint #IN00387669: Substantiated; Federal and State deficiencies related to the allegation(s) are cited at W149, W154, W186 and W192.<br><br>Complaint #IN00389732: Substantiated; Federal and State deficiency related to the allegation(s) is cited at W149.<br><br>Survey Dates: 10/3/22, 10/4/22, 10/5/22, 10/6/22 and 10/7/22.<br><br>Facility Number: 000956<br>Provider Number: 15G442<br>AIM Number: 100244760<br><br>These deficiencies reflect state findings in accordance with 460 IAC 9.<br>Quality Review of this report completed by #15068 and #39778 on 10/25/22. | W 0000 | | |
| W 0149<br><br>Bldg. 00 | 483.420(d)(1)<br>STAFF TREATMENT OF CLIENTS<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br>Based on record review and interview for 1 of 3 sampled clients (A), and 1 additional client (former client H), the facility failed to implement its policy and procedures for prohibiting abuse, neglect, exploitation, mistreatment and/or violation of individual's rights (ANE) policy to prevent 1) the mistreatment of client A by former staff #1, and 2) | W 0149 | To correct the deficient practice all site staff have been re-trained on ResCare's ANE policy, all clients risk plans, and the notification process regarding change in condition. All investigation | 11/11/2022 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Patrick O'Heran | QIDP Manager | 11/04/2022 |

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| | staff failing to implement former client H's health risk plans regarding notifying nursing services and leaving former client H unattended during ambulation from the bathroom on 8/8/22 when ill with symptoms of vomiting.<br><br>Findings include:<br><br>1) On 10/4/22 at 8:45 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following which affected former client H:<br><br>-BDDS incident report dated 8/9/22 indicated, "[Former client H] was using the restroom as staff was in the office faxing paperwork to ResCare LPN (licensed practical nurse). Staff heard a noise come from (sic) restroom and immediately went to assess. Staff discovered [former client H] had fallen, and vomited, as she was exiting the restroom. Staff asked [former client H] if she was injured and she said yes, then pointed to her hip and back. ResCare LPN was contacted along with EMS (emergency medical services) and [former client H] was transported to the ER (emergency room).<br><br>Plan to Resolve: Once in the ER, hospital staff reported [former client H] began vomiting then went into cardiac arrest. They were able to resuscitate and were able to obtain a weak pulse. [Former client H] was intubated and transferred to ICU (intensive care unit) and admitted. No official diagnoses were given ... [Former client H] experienced cardiac arrest on two more occasions while in the ICU. [Former client H] passed away at approximately 9:30 PM on 8/8...".<br><br>Mortality Review Investigation dated 8/1/22 | | recommendations will be completed in a timely manner. Additional monitoring will be achieved by twice weekly administrative observations for a period of one month. To ensure no others were affected the nurse will review all HRPs to ensure they are accurate based on the client needs. Ongoing monitoring to be achieved by monthly site reviews completed by ResCare administrative staff. As well as the site nurse will review TMP/quick MAR documentation daily and do site visits at least weekly. The risk plans are reviewed quarterly by the nursing supervisor. | |

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| | through 8/11/22 indicated, "Scope of the Investigation: ResCare initiated an investigation into the circumstances of [former client H's] death to determine if she received quality services while residing in her group home ...<br><br>Summary of Interviews: [Former staff #1] ... reminded [former client H] she was going out for lunch, but [former client H] appeared hungry, as she was eating very quickly. Staff prompted [former client H] to slow down and assured her she could eat the food on her plate. Around 1:00 PM, [family] arrived to pick up [former client H]. [Former staff #1] left the home at this time as [staff #1] had arrived for her shift. At approximately 5:00 PM, [former staff #1] returned to the site to assist [staff #1] with (sic) evening routine. [Former client H] had returned from the outing with [family] and there were no concerns. [Former staff #1] left the site at 7:30 PM. After [former staff #1] left, she was informed by [staff #1], that [former client H] had vomited some... [Former staff #1] states they assumed [former client H] had eaten too much or maybe something didn't agree with her stomach and they decided they would monitor [former client H] ... [Former staff #1] arrived for day shift on 8/8 (2022) at approximately 7:30 AM. [Former client H] was awake, got dressed on her own and was not showing any signs of concern. As the day went on, [former staff #1] states [former client H] did vomit, however it was not enough to fill a medication cup. [Former staff #1] states she informed ResCare LPN, [Nurse], and they decided if the vomiting continued, they would get her in to see her doctor. [Former client H] did not eat lunch but said she was thirsty and got a drink. Around 1:30 PM, [former client H] was going to lay on the couch. [Former staff #1] asked [former client H] if she would like to go to her room and lay down instead, that she may be more comfortable in | | | |

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| | there. [Former client H] then went to her room. At 2:30 PM, [former staff #1] heard [former client H] go into the restroom. At 2:50 PM, [former staff #1] was in the office and heard [former client H] come out of the bathroom, then heard a noise come from that direction so she went to check on [former client H]. [Former staff #1] saw [former client H] had vomited and fell as she was exiting the restroom. [Former client H] was laying on her side and said she couldn't get up. She was asked if she was injured, she replied yes and pointed to her hip and back. [Former staff #1] contacted [Nurse] and EMS (emergency medical services). [Former client H] was transported to the ER (emergency room) for evaluation ...<br><br>[Staff #1]... states she came in to work on Sunday 8/7 (2022) at 1:00 PM and relieved staff [former staff #1]. [Staff #1] was told [former client H] ate a lot for lunch, even though she was going out for lunch with [family]. Shortly after [staff #1] arrived, [former client H] left with [family]. When [former client H] returned, there were no concerns reported from [family] or [former client H]. Sometime after 6:00 PM, [former client H] was sitting at the kitchen table and vomited a small amount. [Staff #1] asked [former client H] how she felt, and she said she was okay. [Staff #1] did not notice any other signs of illness or concern. [Former client H] got up from the table and went towards the restroom with [staff #1] following. [Staff #1] asked [former client H] what she had for lunch and she said a cheeseburger. [Staff #1] states she thought maybe the food didn't sit well on her stomach or maybe she ate too much. [Former client H] went to her room after using the restroom and went to bed. [Staff #1] completed bed checks throughout the night, every 2 hours and there were no signs of distress. [Former client H] did wake up 2 or 3 times to use the restroom, | | | |

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| | did not vomit but did spit in the sink as she was walking past it. [Former client H] woke up on Monday morning, 8/8 (2022), got dressed by herself and was ready for the day without concern. [Staff #1] left after [former staff #1] arrived for her shift around 8:30 AM ...<br><br>[Nurse]... On 8/8 (2022), [Nurse] contacted the [name] group home to speak with staff about paperwork she needed. When she called the home, [former staff #1] informed her that [former client H] did not eat lunch. [Former staff #1] also informed her that [former client H] vomited the night prior, after going out to eat with family and again on 8/8 (2022). [Former staff #1] informed [Nurse] that it was a small amount and wasn't enough to fill a med cup. [Former staff #1] told [Nurse] that [former client H] was then laying down in bed and doing fine, no fever or pain. [Nurse] instructed [former staff #1] to monitor and if [former client H] vomited again to let her know. [Nurse] received another call from [former staff #1], around 2:50 PM and she reported she heard a noise and when she went to assess, she discovered [former client H] fell and vomited coming out of the restroom. [Former client H] reported pain to her hip and back and [former staff #1] was instructed to call EMS for transportation to the ER. [Nurse] states prior to 8/8 (2022), there were no medical concerns or complaints reported to her regarding [former client H] ...<br><br>[Qualified Intellectual Disabilities Professional (QIDP)]... [QIDP] states she was in the office on 8/8 (2022) when [Nurse] asked her if she was aware [former client H] had vomited the night prior and that morning. [QIDP] stated she was not aware. This conversation took place around 1:00 PM. Later in the day, [Nurse] received a call from staff stating [former client H] had vomited again | | | |

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| | and fell and was complaining of back and hip pain. Staff was asking for permission to call EMS and [Nurse] told them to call...<br><br>[Area Supervisor (AS)]... AS was at the [name] group home on 8/8 (2022) from approximately 8:30 AM to 10:00 AM to work direct care while [former staff #1] took one of the clients to an appointment. [Former client H] stayed in her room for the majority of the time [AS] was working. As [AS] was preparing to leave, [former client H] came to the living room to watch TV (television). [AS] noticed [former client H] had food on her shirt, and she was also wearing a mask that was dirty. [AS] asked [former client H] to come with her to get cleaned up and asked staff (staff #1) what was going on with [former client H]. Staff (staff #1) reported [former client H] went out with family the day prior and she overate. Staff told [AS] she would sometimes do this, overeat. [AS] asked if [former client H] was sick and they said no. [AS] and. [staff #1] went with [former client H] to the bathroom, helped her get a clean shirt on and washed her face. [AS] gave staff a sprite to give [former client H] to see if it would settle her stomach and left ...<br><br>Factual Findings: 8/7 (2022) after 7:30 PM [former client H] vomited, a small amount, comparable to half a cup, while sitting at the kitchen table. 8/8 (2022) [former client H] vomited, staff reported it was, again, a small amount, not enough to fill a med (medication) cup. 8/8 (2022) at approximately 1:00 PM [Nurse] was notified that [former client H] had not eaten lunch and had vomited. [Nurse] advised staff to monitor and contact her if it happened again. 8/8 (2022) at 2:50 PM [former client H] exited the bathroom and fell, as staff was in the medication room. Staff immediately went to assess and discovered [former client H] had also | | | |

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| | vomited. The nurse was notified, and [former client H] was transported to the ER ...".<br><br>On 10/5/22 at 11:15 AM, a focused review of former client H's record was conducted. The record indicated the following:<br><br>-Health Risk Plan for Food Allergies dated 3/1/22 indicated, "Approach: ... Staff will notify the nurse and report any allergic reaction. If [former client H] exhibits any shortness of breath, difficulty breathing call 911 ..."<br><br>-Health Risk Plan for Choking dated 3/1/22 indicated, "Approach: ... Staff will monitor for episodes of vomiting, loss of appetite, restlessness, excessive belching, etc. and report to nurse. Should choking occur, staff will immediately dial 911, begin life saving techniques as learning (sic) in CPR (cardiopulmonary resuscitation) training, and then notify the nurse ...".<br><br>-Health Risk Plan for GERD (gastroesophageal reflux disease) dated 3/1/22 indicated, "Approach: ... Staff will monitor for and report symptoms of signs of epigastric (upper abdomen) discomfort i.e. bloating, belching, decreased appetite, and/or vomiting to nurse...".<br><br>-Fall Risk Plan dated 3/1/22 indicated, "Problem: Risk for falls due to hip deformity. Goal: Will have no injury from falls through March 2023. Approach: Staff will assist with ambulation as needed to ensure safety and ensure she is using a walker ...".<br><br>On 10/5/22 at 3:00 PM, the Indiana Department of Health (IDOH) Public Health Nurse Surveyor (PHNS) conducted an interview with the facility | | | |

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| | Nurse. The Nurse was asked if staff had reported former client H's illness with vomiting, loss of appetite and/or change of health status. The Nurse indicated she had contacted the home for some needed paperwork around 2 PM and while on the phone with former staff #1, she was informed former client H had a change in health status and loss of appetite. The Nurse was asked if staff should have reported to nursing former client H had vomited prior to the nurse calling the home for needed paperwork. The Nurse stated, "Nothing was reported to me". The Nurse was asked if she and/or nursing services should have been contacted when former client H experienced a health status change due to vomiting and loss of appetite. The Nurse stated, "Absolutely". The Nurse was asked about staff calling her prior to 911 once former client H indicated she was in pain and was unable to get up from the floor after experiencing a fall. The Nurse stated, "Yes. I think that was discussed as being redistributed (training). In the past, I would go over the 911 (seeking emergency service first)". The Nurse indicated staff should have called 911 prior to calling her. The Nurse was asked if the lack of staff notifying the nurse after former client H experienced signs and symptoms of vomiting and loss of appetite and leaving former client H unattended while ambulating on 8/8/22 was neglectful implementation of former client H's health risk plans. The Nurse stated, "I do feel it was neglectful".<br><br>On 10/6/22 at 2:44 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the competency of staff regarding not notifying nursing services after former client H's change in health status and when to call 911 in an emergency. The QIDP stated, "Yes. No one called [Nurse]. That's | | | |

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| | correct". The QIDP was asked if staff should have contacted nursing services when former client H experienced vomiting and loss of appetite. The QIDP stated, "Yeah". The QIDP was asked what staff intervention should have occurred when former client H indicated her back was hurt and she was unable to get up after the fall. The QIDP stated, "Call 911. I actually told her (former staff #1) after the incident to always call 911 in an emergency first". The QIDP was asked if the lack of staff notifying the nurse after former client H experienced vomiting and loss of appetite according to former client H's health risk plans and to leave former client H unattended while ambulating from the bathroom on 8/8/22 was neglectful implementation of former client H's health risk plans. The QIDP stated, "Yes, they should have paid more attention to what was going on".<br><br>2) On 10/4/22 at 8:45 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following which affected client A:<br><br>-BDDS incident report dated 9/3/22 indicated, "[Client A] reported to her guardian that staff was speaking to her inappropriately during an incident on 9/2/22 when [client A] had fallen (incident report number). Guardian also reported [client A] was taken to hospital with feces in her depends".<br><br>Investigation Summary dated 9/3/22 through 9/9/22 indicated, "An investigation was initiated when [client A] ... reported staff [former staff #1] had made inappropriate comments to [client A] ...<br><br>Summary of Interviews: | | | |

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| | [Client A] ... reported she was trying to get out of bed, to go to the restroom due to having defecated in her depends, but her mattress was sliding off the bed. [Client A] and the mattress fell to the floor. [Client A] yelled for staff to come and help her up because her legs were hurting. [Former staff #1] came into [client A's] bedroom and [client A] told [former staff #1] she couldn't get up because her legs were hurting. [Former staff #1] said she couldn't help [client A] because [former staff #1's] back might go out. [Former staff #1] also told [client A] that she wouldn't get up because [client A] wanted attention and [client A] was acting like a three-year-old. [Staff #1] came into [client A's] room and told her that [guardian] wanted her to go to the hospital and she needed to get her shoes and socks on. [Client A] then crawled to her recliner and pulled herself up into the chair. [Client A] stated she did not ask [former staff #1] to help her get cleaned up, but she also did not refuse for [former staff #1] to help her get cleaned up.<br><br>[Staff #1] ... worked on 9/2/22 clocking in at 11:09 AM and out at 8:31 PM. [Staff #1] reported she left the group home after clocking out and stopped at an [financial facility] when she got a call from [former staff #1] stating [client A] was on the floor and wouldn't get up... [Former staff #1] asked [staff #1] to return to the group home and assist in getting [client A] to get up from the floor. [Staff #1] arrived at the group home clocking back in at 9:05 PM. [Staff #1] went to [client A's] bedroom and [client A] was sitting on the floor. [Former staff #1] was also in [client A's] bedroom and [staff #1] heard [former staff #1] tell [client A] that she was just trying to get attention and she knew that [client A] could get up... [Staff #1] reported she did not know that [client A] had defecated in her depends and heard no one | | | |

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| | mention anything about it. [Staff #1] prompted [client A] to put her shoes and socks on because EMS (emergency medical services) was on the way to take her to the hospital and [client A] would see [guardian] there ...<br><br>[Guardian] ... reported he received a phone call from [former staff #1] on 9/2/22. [Former staff #1] told [guardian] that [client A] was getting out of bed when [client A] and her mattress slid off the bed and onto the floor. [Former staff #1] reported that [client A] would not get up and she wasn't cooperating or even trying to get up. [Former staff #1] also told [guardian] that [client A] had defecated in her depends. [Guardian] spoke with [client A] and told her she had to try to get up from the floor. [Client A] replied she was trying. [Guardian] met [client A] at the hospital and stayed with her until [client A] was admitted. An ER (emergency room) nurse reported she had assisted [client A] with cleaning up due to defecating in her depends. [Client A] also informed [guardian] that [former staff #1] told her she was acting like a three-year-old. A little later [client A] reported [former staff #1] told her that if [client A] didn't do better, she would be made to leave the group home. [Guardian] received a call from [client A] on 9/6/22 telling him that [former staff #1] had just called her and told her that because [client A] lied about her, she was suspended, and she hopes [client A] is put out of the group home.<br><br>[Qualified Intellectual Disabilities Professional (QIDP)] ... received a phone call from [former staff #1] reporting that [client A] was 'acting crazy'. [Former staff #1] said [client A] was on the floor and wouldn't get up and that she was going to call [client A's guardian] to come to the group home to get [client A] off the floor. [Former staff #1] told | | | |

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| | [QIDP] she has too much stuff to do than to deal with [client A]. [Former staff #1] stated she 'did not have time for this' and she needs 'to get up and quit acting like a baby'. [QIDP] asked to speak to [client A] and [former staff #1] gave the phone to [client A]. [QIDP] asked [client A] what happened. [Client A] reported her mattress fell off the bed and she had fallen with it and now her leg wouldn't work. [Client A] told [QIDP] that [former staff #1] told her she needed to get up and that she was acting like a three-year-old. [QIDP] spoke with [guardian], and he reported that [client A] told him that [former staff #1] said [client A] was acting like a three-year-old and acting like a baby. On 9/6/22 [QIDP] received a text from [guardian] telling her that [client A] had just called him. [Client A] reported [former staff #1] had called her and told her it was her fault [former staff #1] was suspended and that she had lied about [former staff #1] and [former staff #1] hopes [client A] gets taken out of the group home.<br><br>[Former staff #1] ... stated she did tell [client A] she wasn't trying to get up and she was doing this to get attention. [Former staff #1] told [client A] she was not going to help her up because [former staff #1] was not going to throw her back out. [Former staff #1] called [guardian] to let him know what was happening and that [client A] wasn't trying to get up. [Former staff #1] felt [client A] was seeking attention by not getting up and called [guardian] to have him come over and persuade [client A] to get up ... [Former staff #1] does not recall telling [client A] she was acting like a baby or acting like a three-year-old ... [Former staff #1] reported [client A] had defecated in her pants and [former staff #1] asked her if she could assist her in (sic) changing clothes. [Former staff #1] stated [client A] told her no she didn't want [former staff #1] to clean her up ...[Former | | | |

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| | staff #1] denied calling the group home on 9/6/22 and speaking with [client A] ...<br><br>[Former staff #2]... reported she worked at [group home] on 9/6/22. At a little past noon, the phone rang, and the caller identified herself as [former staff #1] and asked to speak with [client A]. [Former staff #2] was not aware [former staff #1] was suspended and gave the phone to [client A]...<br><br>Factual Findings: ... [Staff #1] and [former staff #1] reported [former staff #1] did tell [client A] that she was attention seeking when she would not get up from floor. [Former staff #1] stated she told [client A] if she couldn't help herself, she may have to leave the group home. [Client A] reported to [QIDP] and [guardian] that [former staff #1] told her she was acting like a three-year-old. [Former staff #2] stated she was working on 9/6/22 when (sic) phone rang, and caller asked to speak to [client A] and identified herself as [former staff #1]. Caller ID (identification) on (sic) phone at [group home name] shows a call was received at 12:10 PM on 9/6/22 from [former staff #1's] phone number. [Former staff #1] did not assist [client A] in changing her clothes before going to (sic) hospital. [Former staff #1] immediately resigned (sic) her position upon being placed on suspension ... Conclusion: It is substantiated [former staff #1] made inappropriate comments to [client A]. Recommendations: List [former staff #1] as non-rehire. In-service staff on ANE (abuse, neglect and Exploitation policy). In-service staff regarding notifying Nurse and Supervisor for all falls ...".<br><br>On 10/6/22 at 2:44 PM, the QIDP was interviewed. The QIDP was asked about former staff #1 mistreating client A. The QIDP indicated the incident had occurred. The QIDP stated, "It was | | | |

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| | verbal. Speaking unkind and yelling at her when she was injured. She (client A) was relying on staff's help when she was hurt". The QIDP indicated the Abuse, Neglect and Exploitation policy should be implemented at all times.<br><br>On 10/6/22 at 3:46 PM, the Operations Support Specialist (OSS) was interviewed. The OSS was asked about implementation of the Abuse, Neglect, Exploitation, Mistreatment and/or Violation of Individual's Rights policy due to client A's mistreatment by former staff #1, and the lack of implementation of former client H's health risk plan for notifying the Nurse of her health status change and then leaving her unattended during ambulation from the bathroom on 8/8/22. The OSS stated, "Right". The OSS was asked if the ANE policy should be implemented at all times. The OSS stated, "Absolutely".<br><br>On 10/7/22 at 10:37 AM, the Program Manager (PM) was interviewed. The PM was asked about implementation of the Abuse, Neglect, Exploitation, Mistreatment and/or Violation of Individual's Rights policy due to client A's mistreatment by former staff #1, and the lack of implementation of former client H's health risk plan for notifying the Nurse of her health status change and then leaving her unattended during ambulation from the bathroom on 8/8/22. The PM indicated the mistreatment to client A should not have happened and stated, "That's probably why she (former staff #1) quit so promptly". The PM was asked about staff neglecting to notify nursing services about former client H's health status change due to signs and symptoms of vomiting and leaving her unattended during ambulation from the bathroom on 8/8/22. The PM stated, "Yeah". The PM was asked how former client H's health risk plans should have been implemented. | | | |

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| | The PM stated, "They should have called the Nurse when she was sick and be with [former client H] in the bathroom. We're going to have to go over the ANE (abuse, neglect and exploitation) policy. I may make a test with scenarios. It goes back to plans and following them. That's neglectful. They should have been more attentive when she was sick. We'll create something and go deeper into the plans and the ANE policy".<br><br>On 10/7/22 at 11:24 AM, a review of the Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights (ANE) policy dated 8/31/22 was conducted. The ANE policy indicated, "ResCare staff actively advocate for the rights and safety of all individuals ... ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights ...".<br><br>This federal tag relates to complaints #IN00389732 and #IN00387669.<br><br>9-3-2(a) | | | |
| W 0154<br><br>Bldg. 00 | 483.420(d)(3)<br>STAFF TREATMENT OF CLIENTS<br>The facility must have evidence that all alleged violations are thoroughly investigated.<br>Based on record review and interview for 1 additional client (former client H), the facility failed to thoroughly investigate the events surrounding former client H's change in health status and fall resulting in injury.<br><br>Findings include:<br><br>On 10/4/22 at 8:45 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation | W 0154 | To correct the deficient practice all staff responsible for investigations have been re-trained on thorough investigations by the ED. Additional monitoring will be achieved by the ED reviewing all investigations for thoroughness prior to review. As well as all mortality reviews will be reviewed by the ResCare regional management team prior to | 11/11/2022 |

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| | summaries was conducted. The review indicated the following which affected former client H:<br><br>-BDDS incident report dated 8/9/22 indicated, "[Former client H] was using the restroom as staff was in the office faxing paperwork to ResCare LPN (licensed practical nurse). Staff heard a noise come from (sic) restroom and immediately went to assess. Staff discovered [former client H] had fallen, and vomited, as she was exiting the restroom. Staff asked [former client H] if she was injured and she said yes, then pointed to her hip and back. ResCare LPN was contacted along with EMS (emergency medical services) and [former client H] was transported to the ER (emergency room).<br><br>Plan to Resolve: Once in the ER, hospital staff reported [former client H] began vomiting then went into cardiac arrest. They were able to resuscitate and were able to obtain a weak pulse. [Former client H] was intubated and transferred to ICU (intensive care unit) and admitted. No official diagnoses were given ... [Former client H] experienced cardiac arrest on two more occasions while in the ICU. [Former client H] passed away at approximately 9:30 PM on 8/8...".<br><br>Mortality Review Investigation dated 8/1/22 through 8/11/22 indicated, "Scope of the Investigation: ResCare initiated an investigation into the circumstances of [former client H's] death to determine if she received quality services while residing in her group home ...<br><br>Summary of Interviews: [Former staff #1] ... reminded [former client H] she was going out for lunch, but [former client H] appeared hungry, as she was eating very quickly. Staff prompted [former client H] to slow down and assured her | | completion. Ongoing monitoring will be achieved by the peer review committee reviewing and discussing all investigations for appropriate corrective actions and thoroughness. | |

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| | she could eat the food on her plate. Around 1:00 PM, [family] arrived to pick up [former client H]. [Former staff #1] left the home at this time as [staff #1] had arrived for her shift. At approximately 5:00 PM, [former staff #1] returned to the site to assist [staff #1] with (sic) evening routine. [Former client H] had returned from the outing with [family] and there were no concerns. [Former staff #1] left the site at 7:30 PM. After [former staff #1] left, she was informed by [staff #1], that [former client H] had vomited some... [Former staff #1] states they assumed [former client H] had eaten too much or maybe something didn't agree with her stomach and they decided they would monitor [former client H] ... [Former staff #1] arrived for day shift on 8/8 (2022) at approximately 7:30 AM. [Former client H] was awake, got dressed on her own and was not showing any signs of concern. As the day went on, [former staff #1] states [former client H] did vomit, however it was not enough to fill a medication cup. [Former staff #1] states she informed ResCare LPN, [Nurse], and they decided if the vomiting continued, they would get her in to see her doctor. [Former client H] did not eat lunch but said she was thirsty and got a drink. Around 1:30 PM, [former client H] was going to lay on the couch. [Former staff #1] asked [former client H] if she would like to go to her room and lay down instead, that she may be more comfortable in there. [Former client H] then went to her room. At 2:30 PM, [former staff #1] heard [former client H] go into the restroom. At 2:50 PM, [former staff #1] was in the office and heard [former client H] come out of the bathroom, then heard a noise come from that direction so she went to check on [former client H]. [Former staff #1] saw [former client H] had vomited and fell as she was exiting the restroom. [Former client H] was laying on her side and said she couldn't get up. She was asked if she was injured, she replied yes and pointed to her hip | | | |

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| | and back. [Former staff #1] contacted [Nurse] and EMS (emergency medical services). [Former client H] was transported to the ER (emergency room) for evaluation ...<br><br>[Staff #1]... states she came in to work on Sunday 8/7 (2022) at 1:00 PM and relieved staff [former staff #1]. [Staff #1] was told [former client H] ate a lot for lunch, even though she was going out for lunch with [family]. Shortly after [staff #1] arrived, [former client H] left with [family]. When [former client H] returned, there were no concerns reported from [family] or [former client H]. Sometime after 6:00 PM, [former client H] was sitting at the kitchen table and vomited a small amount. [Staff #1] asked [former client H] how she felt, and she said she was okay. [Staff #1] did not notice any other signs of illness or concern. [Former client H] got up from the table and went towards the restroom with [staff #1] following. [Staff #1] asked [former client H] what she had for lunch and she said a cheeseburger. [Staff #1] states she thought maybe the food didn't sit well on her stomach or maybe she ate too much. [Former client H] went to her room after using the restroom and went to bed. [Staff #1] completed bed checks throughout the night, every 2 hours and there were no signs of distress. [Former client H] did wake up 2 or 3 times to use the restroom, did not vomit but did spit in the sink as she was walking past it. [Former client H] woke up on Monday morning, 8/8 (2022), got dressed by herself and was ready for the day without concern. [Staff #1] left after [former staff #1] arrived for her shift around 8:30 AM ...<br><br>[Nurse]... On 8/8 (2022), [Nurse] contacted the [name] group home to speak with staff about paperwork she needed. When she called the home, [former staff #1] informed her that [former | | | |

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| | client H] did not eat lunch. [Former staff #1] also informed her that [former client H] vomited the night prior, after going out to eat with family and again on 8/8 (2022). [Former staff #1] informed [Nurse] that it was a small amount and wasn't enough to fill a med cup. [Former staff #1] told [Nurse] that [former client H] was then laying down in bed and doing fine, no fever or pain. [Nurse] instructed [former staff #1] to monitor and if [former client H] vomited again to let her know. [Nurse] received another call from [former staff #1], around 2:50 PM and she reported she heard a noise and when she went to assess, she discovered [former client H] fell and vomited coming out of the restroom. [Former client H] reported pain to her hip and back and [former staff #1] was instructed to call EMS for transportation to the ER. [Nurse] states prior to 8/8 (2022), there were no medical concerns or complaints reported to her regarding [former client H] ...<br><br>[Qualified Intellectual Disabilities Professional (QIDP)]... [QIDP] states she was in the office on 8/8 (2022) when [Nurse] asked her if she was aware [former client H] had vomited the night prior and that morning. [QIDP] stated she was not aware. This conversation took place around 1:00 PM. Later in the day, [Nurse] received a call from staff stating [former client H] had vomited again and fell and was complaining of back and hip pain. Staff was asking for permission to call EMS and [Nurse] told them to call...<br><br>[Area Supervisor (AS)]... AS was at the [name] group home on 8/8 (2022) from approximately 8:30 AM to 10:00 AM to work direct care while [former staff #1] took one of the clients to an appointment. [Former client H] stayed in her room for the majority of the time [AS] was working. As [AS] was preparing to leave, [former client H] | | | |

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| | came to the living room to watch TV (television). [AS] noticed [former client H] had food on her shirt, and she was also wearing a mask that was dirty. [AS] asked [former client H] to come with her to get cleaned up and asked staff (staff #1) what was going on with [former client H]. Staff (staff #1) reported [former client H] went out with family the day prior and she overate. Staff told [AS] she would sometimes do this, overeat. [AS] asked if [former client H] was sick and they said no. [AS] and. [staff #1] went with [former client H] to the bathroom, helped her get a clean shirt on and washed her face. [AS] gave staff a sprite to give [former client H] to see if it would settle her stomach and left ...<br><br>Factual Findings: 8/7 (2022) after 7:30 PM [former client H] vomited, a small amount, comparable to half a cup, while sitting at the kitchen table. 8/8 (2022) [former client H] vomited, staff reported it was, again, a small amount, not enough to fill a med (medication) cup. 8/8 (2022) at approximately 1:00 PM [Nurse] was notified that [former client H] had not eaten lunch and had vomited. [Nurse] advised staff to monitor and contact her if it happened again. 8/8 (2022) at 2:50 PM [former client H] exited the bathroom and fell, as staff was in the medication room. Staff immediately went to assess and discovered [former client H] had also vomited. The nurse was notified, and [former client H] was transported to the ER ...".<br><br>The investigation failed to conclude:<br><br>1) former staff #1, staff #1, and the Area Supervisor's failure to notify nursing services about signs and symptoms of vomiting and loss of appetite according to former client H's health risk plans; | | | |

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| | 2) if former client H used her walker and what she might have hit and/or landed on at impact to result in her spinal injury;<br><br>3) to reconcile a discrepancy from interview which indicated former client H experienced a limited amount of vomit to only fill a medication cup and the apparent cause due to slipping in vomit on the floor;<br><br>4) staff knowledge of former client H's sickness with vomiting which indicated additional staff supports required to ensure her safety during ambulation on 8/8/22 and not to be left unattended;<br><br>5) former staff #1's initial telephone call during the emergency was to the nurse and not 911;<br><br>6) former client H's fall risk plan lacked intervention strategies to protect a person if a spinal injury is indicated while waiting for emergency services to take over the accident scene.<br><br>On 10/6/22 at 3:46 PM, the Operations Support Specialist (OSS) was interviewed. The OSS was asked about the thoroughness of the mortality review and the lack of the investigation to make a conclusion for the six areas above. The OSS indicated the mortality review should make a determination concerning staff competency issues, the lack of implementation of former client H's health risk plans, and any staff failure to intervene and/or communicate appropriately during an emergency. The OSS stated, "Yes, I'm going to go through all of this with them (investigators)". The OSS indicated further follow up was needed. | | | |

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| RES CARE COMMUNITY ALTERNATIVES SE IN | 402 EWING LN<br>JEFFERSONVILLE, IN 47130 |

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| | This federal tag relates to complaint #IN00387669.<br><br>9-3-2(a) | | | |
| W 0186<br><br>Bldg. 00 | 483.430(d)(1-2)<br>DIRECT CARE STAFF<br>The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.<br><br>Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit.<br>Based on record review and interview for 1 of 3 sampled clients (A), and 1 additional client (former client H), the facility failed to ensure staff were deployed in a manner to 1) implement client A's fall risk plan, and 2) implement former client H's fall risk plan.<br><br>Findings include:<br><br>On 10/4/22 at 8:45 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following which affected client A and former client H:<br><br>1) BDDS incident report dated 9/3/22 indicated, "Staff reported to QIDP (Qualified Intellectual Disabilities Professional) that [client A] had fallen on the floor when she was attempting to get to her chair from her bed and that she had defecated on herself. [Client A] reported to staff she could not get up. Nurse was contacted and advised [Client A] to be taken to ER (emergency room) for evaluation. [Client A] was evaluated and admitted | W 0186 | To correct the deficient practice will meet to discuss the current needs of the current clients to determine the level of oversight needed. All site staff will be re-trained on all client's risk plans, as well as following plans as written. Additional monitoring will be achieved by twice weekly administrative observations for a period of one month. Ongoing monitoring will be achieved by the QIDP/AS/Nurse observing and developing staff at least weekly. | 11/11/2022 |

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| | to hospital for Neurological concerns".<br><br>Investigation Summary dated 9/2/22 indicated, "Description of incident: [Client A] fell off her bed on her way to her chair. Her mattress had slid off her bed. She fell to her bottom and hollered for staff. She had hurt her back and defecated on herself. She was upset and wanted to go to the hospital. Staff spoke to her guardian and she was transported to [hospital] by EMS (emergency medical services) for assessment of her back ... What was the client doing prior to the fall? [Client A] was in her bedroom. Was staff with the client and assisting her/him? No. What was staff doing when the fall occurred? Staff was in the kitchen area. Where was other staff at the time of the fall if more than one employee was on duty at the time? N/A (not applicable) ... Does this consumer have a history of falls? Yes, she recently had a foot injury so she was still a bit unsteady... Conclusion:... [Client A] fell off her bed due to a slipped mattress. She fell to the ground. [Client A] was inspected for injury and the Nurse asked her to be sent to the hospital. [Nurse] is updating fall risk plan to include non-slip socks inside the home. Recommendations: [Client A] agreed she would wear non-slip socks in the home so that she won't have another fall. [Client A] also was asked to check her mattress. She has never had this type of fall before, so it believed the non-slip socks will help".<br><br>-BDDS incident report dated 9/16/22 indicated, "It was reported [client A] was in the hallway on her way to the living room when she fell. [Client A] got up from floor with no assistance and reported the fall to staff. [Client A] was using her walker at time of fall. [Client A] reported she had on (sic) pain and was not injured. Plan to Resolve: Staff reminded [client A] to walk slower in the future. | | | |

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| | [Client A] has a Fall Risk Plan that was being followed at time of fall".<br><br>Investigation Summary dated 9/15/22 indicated, "Description of incident: [Client A] was coming towards the kitchen area down the hallway. She fell and said that she was going too fast down the hall. She said she was okay and had no problem. She was using her walker when she fell. What was the client doing prior to the fall? She was on her way from her bedroom to the kitchen walking with her walker. Was staff with the client and assisting her/him? No. What was the staff doing when the fall occurred? Staff were in the kitchen/dining room area. Where was other staff at the time of the fall if more than one employee was on duty at the time? She was also in the kitchen area. Does this consumer have a history of falls? Yes ... If a fall assessment was completed, were any changes needed / implemented? She has been dealing with a toe injury and a back injury so current changes have been made... Do any changes need to be made to prevent future occurrences? [Client A] needs to be reminded to slow down ... Conclusion: ... [Client A] fell while walking too quickly to the kitchen. Due to recent injuries, she has a walker and continues to be more stable on her feet but tends to move too quickly. Recommendations: Staff will be retrained to remind [client A] to slow down when walking".<br><br>On 10/4/22 at 2:40 PM, client A's record was reviewed. The record indicated the following:<br><br>-Fall Risk Plan dated 5/14/22 indicated, "1) Staff will assist [client A] with ambulation as necessary to ensure safety. 2) Staff will ensure [client A] wears appropriate shoes, tennis shoes or soled shoes...". | | | |

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| | On 10/6/22 at 2:44 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about client A's incidents with falls, staff knowledge of client A's injury to her foot and being unsteady, and staffing supports not being in the location where client A's falls occurred. The QIDP stated, "Sometimes there is one staff at night, but maybe staff should walk down the hallway every 30 minutes". The QIDP was asked if staff were deployed appropriately during these instances of unwitnessed falls for client A. The QIDP stated client A's falls were "excessive". The QIDP was asked about adequate staffing supports to ensure implementation fall risk plans. The QIDP stated, "I think staff need to check on them. I would say every 30 minutes... Like [client A], if they would have noticed her mattress was falling off they could have fixed that".<br><br>2) BDDS incident report dated 7/11/22 indicated, "It was reported [former client H] was in her room when staff heard her yell and fall. Staff went to [former client H] and she was on the floor sitting on her bottom. Staff asked [former client H] what had happened and [former client H] said she fell backwards while trying to get out of her chair. Staff did skin assessment and reported no injuries. Nurse was contacted. Plan to Resolve: Staff will continue to report all falls".<br><br>Investigation Summary dated 7/11/22 through 7/13/22 indicated, "Description of incident: Staff heard [former client H] fall and went to check on her. [Former client H] was sitting on her bottom on the floor. [Former client H] said she had fallen when she was trying to get up from her chair. Staff helped her up and checked her over. When asked, [former client H] said her butt hurt a little bit. Staff called the nurse and indicated to [former client H] | | | |

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| | if she had any further issues to let staff know... What was the client doing prior to the fall? She was in her room at her desk doing her writing. Was staff with the client and assisting her/him? No. What was staff doing when the fall occurred? Staff was in the living room cleaning. Where was other staff at the time of the fall if more than one employee was on duty at the time? N/A. What did staff do immediately after the fall? When [former staff #1] heard the fall she went in to help [former client H] up and check her for injuries. Does this consumer have a history of falls? Yes ... Conclusion: [Former client H] had a fall in her room. [Former client H] did not have any injury. [Former client H's] chair caused the fall. Recommendations: [Former client H's] chair will be replaced with a non-wheeled chair to avoid future occurrences".<br><br>-BDDS incident report dated 8/9/22 indicated, "[Former client H] was using the restroom as staff was in the office faxing paperwork to ResCare LPN (licensed practical nurse). Staff heard a noise come from restroom and immediately went to assess. Staff discovered [former client H] had fallen, and vomited, as she was exiting the restroom. Staff asked [former client H] if she was injured and she said yes, then pointed to her hip and back. ResCare LPN was contacted along with EMS (emergency medical services) and [former client H] was transported to the ER (emergency room). Plan to Resolve: Once in the ER, hospital staff reported [former client H] began vomiting then went into cardiac arrest. They were able to resuscitate and were able to obtain a weak pulse. [Former client H] was intubated and transferred to ICU (intensive care unit) and admitted. No official diagnoses were given ... [Former client H] experienced cardiac arrest on two more occasions while in the ICU. [Former client H] passed away at | | | |

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| | approximately 9:30 PM on 8/8...".<br><br>Investigation Summary dated 8/8/22 indicated, "Description of incident: [Former client H] was in the restroom; staff was in the office area and heard a noise. When staff walked toward [former client H], she was on the floor and appeared to have slipped in vomit. [Former client H] was alert and said her back hurt. Staff contacted the nurse who advised staff to call EMS for transport to the ER ... Witness Statements: 8.8.22 [Former staff #1] ... I was in the office/kitchen area, and I heard a noise. I went over towards [former client H's] side of the house and [former client H] had fallen just inside the bathroom. I went to help her up, but [former client H] said her back hurt. I called Nurse [name] and [nurse] said to call 911. When EMS got here, they got her on the stretcher and transported her to the ER ... What was the client doing prior to the fall? [Former client H] was laying down in her room then got up to use the restroom. Was staff with the client and assisting her/him? No. Staff was in the kitchen/office area at the time. [Former client H] does not require 1:1 staff while ambulating. What was staff doing when the fall occurred? The staff was in the kitchen/office area faxing documentation to the nurse. Where was other staff at the time of the fall if more than one employee was on duty at the time? N/A ... Conclusion: [Former client H] had a fall due to possibly slipping in her own vomit as she was exiting the bathroom. Recommendations: N/A - [Former client H] passed away at the hospital. Death investigation completed, please refer to investigation for further details/information surrounding [former client H's] death".<br><br>On 10/5/22 at 11:15 AM, a focused review of former client H's record was conducted. The | | | |

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| | record indicated the following:<br><br>-Fall Risk Plan dated 3/1/22 indicated, "Problem: Risk for falls due to hip deformity. Goal: Will have no injury from falls through March 2023. Approach: Staff will assist with ambulation as needed to ensure safety and ensure she is using a walker ...".<br><br>-Autopsy Report dated 9/2/22 indicated, "Death is due to Cervical (neck) spine fracture, resulting from a fall... Cause: 1) Cervical spine fracture. 2) Accidental fall ...".<br><br>On 10/5/22 at 3:00 PM, the Indiana Department of Health (IDOH) Public Health Nurse Surveyor (PHNS) conducted an interview with the facility Nurse. The Nurse was asked about former client H's fall risk plan and intervention strategies. The Nurse stated, "Staff are to ensure [former client H] is using her walker, clear the environment, and notify the nurse if she falls". The Nurse was asked if former client H should have left unattended in the bathroom when she had been ill and vomiting or if staff should have been present in the bathroom with her. The Nurse stated, "Yes. I think they should have monitored more closely".<br><br>On 10/6/22 at 2:44 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about former client H's incidents of unwitnessed falls and staff not being deployed in the location where the falls had occurred. The QIDP stated, "Sometimes there is one staff at night, but maybe staff should walk down the hallway every 30 minutes". The QIDP was asked about former client H being unattended in the bathroom and a lack of staffing supports during ambulation when it was known she had been vomiting. The QIDP stated, "I feel there | | | |

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should have been a little more attention to [former client H]". The QIDP was asked about adequate staffing supports to ensure implementation of the clients' fall risk plans. The QIDP stated, "I think staff needs to check on them. I would say every 30 minutes". The QIDP indicated further review of staff deployment related to unwitnessed and/or unsupervised client falls was needed.

On 10/6/22 at 3:46 PM, the Operations Support Specialist (OSS) was interviewed. The OSS was asked about client A's and former client H's incidents with falls, staff knowledge of client A's injury to her foot and being unsteady, and staffing supports not being in the location where falls occurred. The OSS stated, "Yeah. There is a safety department that I believe includes all QA (Quality Assurance) departments which tracks and trends to come up with recommendations". The OSS indicated trends such as unwitnessed falls, could be shared with the safety committee to develop further recommendations. The OSS stated, "We need the QIDPs identifying the trends on a weekly or monthly basis, so it's not going the 3 months span (prior to recommendations by the safety committee)". The OSS indicated further follow up was needed.

On 10/7/22 at 10:37 AM, the Program Manager (PM) was interviewed. The PM was asked about client A's and former client H's incidents with falls, staff knowledge of client A's injury to her foot and being unsteady, and staffing supports not being in the location where falls occurred. The PM stated, "I think we'll need more oversight".

This federal tag relates to complaint #IN00387669.

9-3-3(a)

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| W 0192<br><br>Bldg. 00 | 483.430(e)(2)<br>STAFF TRAINING PROGRAM<br>For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs.<br>Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), and 4 additional clients (D, E, F and G), the facility failed to ensure staff were competent in 1) the administration of medications for clients A, B, C, D, E, F and G, and 2) the notification of nursing services of the health status change and when to call 911 during an emergency for former client H.<br><br>Findings include:<br><br>1) Observations were conducted at the group home on 10/3/22 from 3:59 PM to 5:57 PM and on 10/4/22 from 6:38 AM to 8:25 AM. At 4:24 PM, staff #1 unlocked the medication cabinet in the medication administration room and prepared for the 4:00 PM medication administration routine for clients A and G. Once staff #1 had completed the medication administration with client A and client G, staff #1 was asked if she had any concerns and/or issues regarding medications for clients A, B, C, D, E, F and G. Staff #1 stated at 4:38 PM as she unlocked and opened a second cabinet, "No (pharmacy issues). We've had issues with med (medication) errors and a new staff". Staff #1 presented 4 plastic bags each with notes and medication tablets within each baggie. Staff #1 stated, "I'm going to destroy them". Staff #1 indicated the medication tablets within the baggies had been found in various locations throughout the home, on the floor, and within client bedrooms.<br><br>A review of the contents within the plastic bags indicated the following: | W 0192 | To correct the deficient practice all site staff will be re-trained on the competency based medication administration training. As well as the notification process regarding change in condition. Additional monitoring will be achieved by twice weekly medication pass observations for a period of one month. Ongoing monitoring will be achieved by at least monthly medication pass observations to be completed by the RM, AS or Nurse. The Director of nursing will monitor the nursing services by meeting weekly with the site nurse to discuss the ongoing needs at the site. | 11/11/2022 |

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-Plastic bag #1 had a white tablet broken into 2 pieces with a note inside which indicated, "Found in hall, 9-13 (2022)". The note did not indicate which hallway, the location in the hall, or to whom the tablet belonged to.

-Plastic bag #2 had a peach-colored tablet, a round white tablet, and an oblong cream-colored tablet with a note inside which indicated, "Found 9-16 (2022) on [client B's] bedroom floor".

-Plastic bag #3 had a white oblong tablet with a note inside which indicated, "[client A] Raloxisene (sic/treat bone loss) 60 mg (milligrams) tabs (tablet) by mouth (7PM)".

-Plastic bag #4 had a round white tablet with a note which indicated, "[Client A] Bupropion (depression) 300 mg".

At 6:53 AM, the Area Supervisor (AS) prepared and administered client C's morning medications. Client C took her morning medications with water while inside the medication room and left. At 6:54 AM, the AS was asked about the tablets of medications found and placed inside the 4 plastic bags. The AS stated, "We're having issues with a new staff who is dropping meds. She (staff #1) has told me about the issue. Per the clients, she (new staff) is passing the meds in their bedrooms. We've done (sic) a training last week". The AS was asked who completed the training. The AS stated, "I did". The AS was asked if the nurse had retrained staff. The AS stated, "No".

On 10/4/22 at 8:05 AM, a folder containing reports of medication errors was reviewed. The review indicated the following:

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| | -Medication Error Report dated 9/23/22 indicated, "Individuals Name: [Staff #4]... List medications or treatments involved in error. Bupropion 300 mg... Additional information: I found a Bupropion pill on desk chair in office. 2 people in house takes this, [client A] and [client C]. More likely it would be [client A]".<br><br>-Medication Error Report dated 9/16/22 indicated, "Individuals Name: [Staff #4]... List medications or treatments involved in error. Amlodipiene (sic/high blood pressure) 8A morning med found in hallway that [client D's] bedroom is on (sic)".<br><br>On 10/4/22 at 8:09 AM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the tablets of medications within the 4 plastic bags found throughout various locations within the group home. The QIDP indicated she had found another tablet just prior to the surveyor's arrival on the floor near the medication administration room entryway. The QIDP indicated the tablet was a small peach-colored tablet and when she attempted to pick up the tablet it was soft, as if it had been in someone's mouth. The QIDP was asked whose medication tablet she had found on the floor. The QIDP stated, "I don't know. When I picked it up, it was like it had been in someone's mouth". The QIDP was asked what medication it was believed to have been. The QIDP stated, "Hydrochlorothiazide (high blood pressure). It was a water pill. It helps with edema".<br><br>At 8:13 AM, the QIDP unlocked the medication cabinet and obtained the 4 plastic bags with medication tablets and stated, "I'm going to take these and destroy them". At 8:15 AM, the QIDP searched the office for the medication tablet she had found on the floor earlier on 10/4/22. The AS | | | |

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| | indicated the tablet was on the corner of the desk. After more searching, the QIDP used a rubber glove and found the tablet within the trash can so all could be destroyed and disposed of.<br><br>On 10/4/22 at 8:45 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted. The review indicated the following which affected client D:<br><br>-BDDS incident report dated 9/18/22 indicated, "[Client D's] 8:00 AM Amlodipiene (sic) was found on the floor in the hallway by her bedroom door. Plan to Resolve: Nurse was notified. Staff making the error will be in-serviced. [Client D] has not experienced any ill side effects from the missed medication".<br><br>-No other incident reports were available for review for the 6 month period to indicate medications found and not administered to clients A, B, C, D, E, F and G.<br><br>On 10/4/22 at 2:51 PM, the Nurse was interviewed. The Nurse was asked about client medications being found on the floor and throughout various locations in the group home. The Nurse stated, "That doesn't make sense to me either. They (staff) have been trained that they need to check and make sure they swallow them before leaving the med room". The nurse was asked about 4 plastic bags with medications and notes indicating a history existed at the group home of clients not taking their medications. The Nurse stated, "If they found them on the floor they need to contact nursing. We would report that. One, to know that it was found and two, to replace the med". The Nurse was asked if there was a competency issue with the medication administration process at the group home. The | | | |

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| | Nurse stated, "Absolutely. We'll retrain".<br><br>On 10/6/22 at 2:44 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the competency of staff regarding medication administration due to the history of pills being found on the floor and throughout the group home. The QIDP stated, "They should be retrained on the process". The QIDP was asked to describe the process staff should follow to competently administer medicines to clients A, B, C, D, E, F and G. The QIDP stated, "The client should come in the room (medication administration room). Have a glass of water. Go over their goals. Scan it (into the electronic medication administration record) and follow the computer, the label (prescription) and make sure they take the medicines with the swishing of water". The QIDP indicated medication should not be found on the floor and throughout various locations of the group home. The QIDP indicated the medication administration process should include ensuring each client was administered and swallowed their medications within the medication administration room prior to the client leaving the room.<br><br>On 10/6/22 at 3:46 PM, the Operations Support Specialist (OSS) was interviewed. The OSS was asked about the competency of staff regarding medication administration due to the history of pills being found on the floor and throughout the group home. The OSS stated, "Staff have to pass their medication training. All medications should be administered in the medication room. You (staff) need to make sure the client is in the med (medication) room and takes the medicine. That makes no sense as to why they're found throughout the house. We need retraining and administrative oversight for a while". | | | |

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On 10/7/22 at 10:37 AM, the Program Manager (PM) was interviewed. The PM was asked about the tablets of medicine found throughout the group home on the floor and in client bedrooms. The PM stated, "I don't know why any med (medicine) would be out of the office (medication administration room). No med should go out of the office. We'll have to retrain on that. I don't know why [Nurse] did not know about it. We'll retrain and do med observations there".

2) On 10/4/22 at 8:45 AM, a review of the facility Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following which affected former client H:

-BDDS incident report dated 8/9/22 indicated, "[Former client H] was using the restroom as staff was in the office faxing paperwork to ResCare LPN (licensed practical nurse). Staff heard a noise come from (sic) restroom and immediately went to assess. Staff discovered [former client H] had fallen, and vomited, as she was exiting the restroom. Staff asked [former client H] if she was injured and she said yes, then pointed to her hip and back. ResCare LPN was contacted along with EMS (emergency medical services) and [former client H] was transported to the ER (emergency room).

Plan to Resolve: Once in the ER, hospital staff reported [former client H] began vomiting then went into cardiac arrest. They were able to resuscitate and were able to obtain a weak pulse. [Former client H] was intubated and transferred to ICU (intensive care unit) and admitted. No official diagnoses were given ... [Former client H] experienced cardiac arrest on two more occasions

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| | while in the ICU. [Former client H] passed away at approximately 9:30 PM on 8/8...".<br><br>Mortality Review Investigation dated 8/1/22 through 8/11/22 indicated, "Scope of the Investigation: ResCare initiated an investigation into the circumstances of [former client H's] death to determine if she received quality services while residing in her group home ... Summary of Interviews: [Former staff #1] ... reminded [former client H] she was going out for lunch, but [former client H] appeared hungry, as she was eating very quickly. Staff prompted [former client H] to slow down and assured her she could eat the food on her plate. Around 1:00 PM, [family] arrived to pick up [former client H]. [Former staff #1] left the home at this time as [staff #1] had arrived for her shift. At approximately 5:00 PM, [former staff #1] returned to the site to assist [staff #1] with (sic) evening routine. [Former client H] had returned from the outing with [family] and there were no concerns. [Former staff #1] left the site at 7:30 PM. After [former staff #1] left, she was informed by [staff #1], that [former client H] had vomited some... [Former staff #1] states they assumed [former client H] had eaten too much or maybe something didn't agree with her stomach and they decided they would monitor [former client H] ... [Former staff #1] arrived for day shift on 8/8 (2022) at approximately 7:30 AM. [Former client H] was awake, got dressed on her own and was not showing any signs of concern. As the day went on, [former staff #1] states [former client H] did vomit, however it was not enough to fill a medication cup. [Former staff #1] states she informed ResCare LPN, [Nurse], and they decided if the vomiting continued, they would get her in to see her doctor. [Former client H] did not eat lunch but said she was thirsty and got a drink. Around 1:30 PM, [former client H] was going to lay on the | | | |

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| | couch. [Former staff #1] asked [former client H] if she would like to go to her room and lay down instead, that she may be more comfortable in there. [Former client H] then went to her room. At 2:30 PM, [former staff #1] heard [former client H] go into the restroom. At 2:50 PM, [former staff #1] was in the office and heard [former client H] come out of the bathroom, then heard a noise come from that direction so she went to check on [former client H]. [Former staff #1] saw [former client H] had vomited and fell as she was exiting the restroom. [Former client H] was laying on her side and said she couldn't get up. She was asked if she was injured, she replied yes and pointed to her hip and back. [Former staff #1] contacted [Nurse] and EMS (emergency medical services). [Former client H] was transported to the ER (emergency room) for evaluation ...<br><br>[Staff #1]... states she came in to work on Sunday 8/7 (2022) at 1:00 PM and relieved staff [former staff #1]. [Staff #1] was told [former client H] ate a lot for lunch, even though she was going out for lunch with [family]. Shortly after [staff #1] arrived, [former client H] left with [family]. When [former client H] returned, there were no concerns reported from [family] or [former client H]. Sometime after 6:00 PM, [former client H] was sitting at the kitchen table and vomited a small amount. [Staff #1] asked [former client H] how she felt, and she said she was okay. [Staff #1] did not notice any other signs of illness or concern. [Former client H] got up from the table and went towards the restroom with [staff #1] following. [Staff #1] asked [former client H] what she had for lunch and she said a cheeseburger. [Staff #1] states she thought maybe the food didn't sit well on her stomach or maybe she ate too much. [Former client H] went to her room after using the restroom and went to bed. [Staff #1] completed | | | |

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| | bed checks throughout the night, every 2 hours and there were no signs of distress. [Former client H] did wake up 2 or 3 times to use the restroom, did not vomit but did spit in the sink as she was walking past it. [Former client H] woke up on Monday morning, 8/8 (2022), got dressed by herself and was ready for the day without concern. [Staff #1] left after [former staff #1] arrived for her shift around 8:30 AM ...<br><br>[Nurse]... On 8/8 (2022), [Nurse] contacted the [name] group home to speak with staff about paperwork she needed. When she called the home, [former staff #1] informed her that [former client H] did not eat lunch. [Former staff #1] also informed her that [former client H] vomited the night prior, after going out to eat with family and again on 8/8 (2022). [Former staff #1] informed [Nurse] that it was a small amount and wasn't enough to fill a med cup. [Former staff #1] told [Nurse] that [former client H] was then laying down in bed and doing fine, no fever or pain. [Nurse] instructed [former staff #1] to monitor and if [former client H] vomited again to let her know. [Nurse] received another call from [former staff #1], around 2:50 PM and she reported she heard a noise and when she went to assess, she discovered [former client H] fell and vomited coming out of the restroom. [Former client H] reported pain to her hip and back and [former staff #1] was instructed to call EMS for transportation to the ER. [Nurse] states prior to 8/8 (2022), there were no medical concerns or complaints reported to her regarding [former client H] ...<br><br>[Qualified Intellectual Disabilities Professional (QIDP)]... [QIDP] states she was in the office on 8/8 (2022) when [Nurse] asked her if she was aware [former client H] had vomited the night prior and that morning. [QIDP] stated she was not | | | |

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| | aware. This conversation took place around 1:00 PM. Later in the day, [Nurse] received a call from staff stating [former client H] had vomited again and fell and was complaining of back and hip pain. Staff was asking for permission to call EMS and [Nurse] told them to call...<br><br>[Area Supervisor (AS)]... AS was at the [name] group home on 8/8 (2022) from approximately 8:30 AM to 10:00 AM to work direct care while [former staff #1] took one of the clients to an appointment. [Former client H] stayed in her room for the majority of the time [AS] was working. As [AS] was preparing to leave, [former client H] came to the living room to watch TV (television). [AS] noticed [former client H] had food on her shirt, and she was also wearing a mask that was dirty. [AS] asked [former client H] to come with her to get cleaned up and asked staff (staff #1) what was going on with [former client H]. Staff (staff #1) reported [former client H] went out with family the day prior and she overate. Staff told [AS] she would sometimes do this, overeat. [AS] asked if [former client H] was sick and they said no. [AS] and [Staff #1] went with [former client H] to the bathroom, helped her get a clean shirt on and washed her face. [AS] gave staff a sprite to give [former client H] to see if it would settle her stomach and left ...<br><br>Factual Findings: 8/7 (2022) after 7:30 PM [former client H] vomited, a small amount, comparable to half a cup, while sitting at the kitchen table. 8/8 (2022) [former client H] vomited, staff reported it was, again, a small amount, not enough to fill a med (medication) cup. 8/8 (2022) at approximately 1:00 PM [Nurse] was notified that [former client H] had not eaten lunch and had vomited. [Nurse] advised staff to monitor and contact her if it happened again. 8/8 (2022) at 2:50 PM [former | | | |

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| | client H] exited the bathroom and fell, as staff was in the medication room. Staff immediately went to assess and discovered [former client H] had also vomited. The nurse was notified, and [former client H] was transported to the ER ...".<br><br>On 10/5/22 at 11:15 AM, a focused review of former client H's record was conducted. The record indicated the following:<br><br>-Health Risk Plan for Food Allergies dated 3/1/22 indicated, "Approach: ... Staff will notify the nurse and report any allergic reaction. If [former client H] exhibits any shortness of breath, difficulty breathing call 911 ..."<br><br>-Health Risk Plan for Choking dated 3/1/22 indicated, "Approach: ... Staff will monitor for episodes of vomiting, loss of appetite, restlessness, excessive belching, etc. and report to nurse. Should choking occur, staff will immediately dial 911, begin life saving techniques as learning (sic) in CPR (cardiopulmonary resuscitation) training, and then notify the nurse ...".<br><br>-Health Risk Plan for GERD dated 3/1/22 indicated, "Approach: ... Staff will monitor for and report symptoms of signs of epigastric (upper abdomen) discomfort i.e. bloating, belching, decreased appetite, and/or vomiting to nurse...".<br><br>-Fall Risk Plan dated 3/1/22 indicated, "Problem: Risk for falls due to hip deformity. Goal: Will have no injury from falls through March 2023. Approach: Staff will assist with ambulation as needed to ensure safety and ensure she is using a walker ...".<br><br>On 10/6/22 at 2:44 PM, the Qualified Intellectual | | | |

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| | Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the staff competency to notify nursing services based on former client H's change in health status and when to call 911 in an emergency. The QIDP stated, "Yes. No one called [Nurse]. That's correct". The QIDP was asked if staff should have contacted nursing services when former client H experienced vomiting and loss of appetite. The QIDP stated, "Yeah". The QIDP was asked what staff intervention should have occurred when former client H was indicated her back was hurt and unable to get up from the fall. The QIDP stated, "Call 911. I actually told her (former staff #1) after the incident to always call 911 in an emergency first". The QIDP indicated the clients health risk plans would be reviewed to determine if revision pertaining emergency intervention steps followed by a staff training on calling 911, when to contact the nurse, and any revised health risk plans.<br><br>On 10/6/22 at 3:46 PM, the Operations Support Specialist (OSS) was interviewed. The OSS was asked about the competency of staff implementation to notify nursing services based on former client H's change in health status and when to call 911 in an emergency. The OSS stated, "Sure. I'll talk with DON (Director of Nursing) about that. That's something we'll review". The OSS indicated further review with the DON would be completed to include staff competency for when to notify nursing, when to call 911, and a discussion about emergency intervention steps by staff outlined within the clients' health risk plans during an emergency.<br><br>On 10/7/22 at 10:37 AM, the Program Manager (PM) was interviewed. The PM was asked about the competency of staff implementation to notify nursing services based on former client H's | | | |

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| | change in health status and when to call 911 in an emergency. The PM stated, "We need more in-depth training ... If it's a nursing issue, communicate with the Nurse. We need to put that in nursing services hands and not presume like she overate. More intensive training".<br><br>This federal tag relates to complaint #IN00387669.<br><br>9-3-3(a) | | | |
| W 0227<br><br>Bldg. 00 | 483.440(c)(4)<br>INDIVIDUAL PROGRAM PLAN<br>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.<br>Based on record review and interview for 1 of 3 sampled clients (C), the facility failed to ensure client C had a fall risk plan after an incident of a fall on 9/7/22.<br><br>Findings include:<br><br>On 10/4/22 at 8:45 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following which affected client C:<br><br>-BDDS incident report dated 9/8/22 indicated, "It was reported [client C] was on her way to the restroom when she slipped and fell in the utility room due to water on the floor. Staff assisted [client C] from the floor and completed skin assessment. [Client C] sustained a faint red mark on her left foot that disappeared later in the evening". | W 0227 | To correct the deficient practice a fall risk plan has been created for client C and all staff have been trained the plan. The QIDP and Nurse will be re-trained investigation recommendations are . Additional monitoring will be achieved by twice weekly administrative observations for a period of one month to ensure staff are implementing the plan as written. To ensure no others were affected the nurse will review all risk plans to ensure they are accurate and implemented appropriately. Ongoing monitoring will be achieved by ResCare administrative staff completing monthly site reviews. | 11/11/2022 |

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| | Investigation Summary dated 9/7/22 through 9/8/22 indicated, "Description of incident: [Client C] went to the bathroom area quickly. When she got there she went to shut the door and then felt herself slipping on wet towels on the floor. She fell to her bottom and had some tenderness to her bottom and her left foot had a slight red mark ... What was the client doing prior to the fall? [Client C] was rushing to the bathroom. Was staff with the client and assisting her/him? No. What was staff doing when the fall occurred? The staff was in the kitchen/dining room area. Where was other staff at the time of the fall if more than one employee was on duty at the time? In the med office ... Does this consumer have a history of falls? No ... Does the client have a fall risk plan? If so, was the plan followed? No ... Conclusion: ... [Client C] was running towards the restroom and slipped on wet towels. She fell to the ground. [Client C] was inspected for injury and a small red area on her left foot was found. [Nurse] is creating a fall risk (plan)".<br><br>On 10/4/22 at 1:39 PM, client C's record was reviewed. The record indicated the following:<br><br>-No fall risk plan was available for review.<br><br>On 10/6/22 at 1:30 PM, the Nurse was interviewed. The Nurse was asked about client C's need for a fall risk plan. The Nurse reviewed client C's electronic record and stated, "No, I do not (have a risk plan done), but will make one right now. Per this plan, the main intervention is that staff will keep the environment free from obstacles to prevent falls. Before that she did not need a plan". The Nurse indicated client C's fall risk plan would include staff prompting for a safe pace and trained across all appropriate settings to prevent falls. | | | |

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| | On 10/6/22 at 2:44 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about client C's fall on 9/7/22, the recommendation from the investigation that a plan was needed, and if the plan was available for review. The QIDP stated, "No. She doesn't. She could have a basic plan though to prompt her to slow down". The QIDP was asked if further follow up was needed. The QIDP stated, "Yes. To slow down and clear walkway".<br><br>On 10/6/22 at 3:46 PM, the Operations Support Specialist (OSS) was interviewed. The OSS was asked about client C's fall on 9/7/22, and the recommendation from the investigation that a fall risk plan was needed. The OSS stated, "Absolutely". The OSS indicated further follow up was needed to ensure staff training across all appropriate settings to ensure staff competency for prompting client C to slow down if needed and the importance of maintaining an environment free from obstructions.<br><br>On 10/7/22 at 10:37 AM, the Program Manager (PM) was interviewed. The PM was asked about client C's fall on 9/7/22 and the recommendation from the investigation for the need of a fall risk plan. The PM stated, "Oh. I think that was more environmental. The leak occurred and we fixed it pretty quickly. It was due to condensation. It was a chain of events". The PM was asked if client C needed a fall risk plan to prompt her to slow down and ensure her path of ambulation was free from obstacles and hazards. The PM stated, "I get that". The PM indicated further follow would be completed to ensure client C's newly developed fall risk plan was trained across all appropriate settings.<br><br>9-3-4(a) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G442 | A. BUILDING 00<br>B. WING | 10/07/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RES CARE COMMUNITY ALTERNATIVES SE IN | 402 EWING LN<br>JEFFERSONVILLE, IN 47130 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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