STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

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W 0000 Bldg. 00	This visit was for a fundamental annual recertification and state licensure survey. Dates of Survey: 1/3/17, 1/4/17, 1/5/17 and 1/9/17. Facility Number: 000775 Provider Number: 15G255 AIMS Number: 100248960 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/25/17.	W 0000		
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 3 allegations of abuse, neglect or mistreatment reviewed, the facility failed	W 0153	**W153:** The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of	02/06/2017

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

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	to ensure an allegation of client to client abuse/mistreatment regarding client #1 was reported to BDDS (Bureau of Developmental Disabilities Services) within 24 hours of the facility's knowledge of the allegation in accordance with state law. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 1/3/17 at 1:02 PM. The review indicated the following: 1. BDDS report dated 9/8/16 indicated, "[Client #1] was in the cafe for morning break with his group. [Client #1] was holding a cup over another consumer's head, trying to get the attention of a staff member. Staff redirected [client #1] not to hold the cup over the consumer's head. [Client #1] complied, sat down and began eating his snack. [Client #1] once again be (sic) picked up the cup and held it over the same consumer's head to get staff attention. [Client #1] then hit the consumer in the head with the cup. Staff redirected [client #1] to sit the cup down and to not hold things over other peoples heads. [Client #1] then slammed the cup on the table, sat down and continued with his morning snack. Staff assessed the		unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. **Corrective Action:** ·The QIDP trained Day Program/workshop staff on Rescare's Abuse/Neglect Policy. (**Attachment A**) ·The QIDP provided an inservice to the Day Program regarding reporting all State reportable incidents within 24 hours as well as contact information for the provider. **(Attachment B)** **How we will identify others:** ·Day Program staff have been trained and will report all incidents to the provider immediately. ·Day Program administration will complete BDDS report within 24 hours of the reportable incident.	

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	other consumer- there were no apparent injuries, no redness, no bump, no marks. The consumer was frightened and cried. [Client #1] and the consumer were separated." The review indicated the date of the facility's knowledge of the allegation of client to client abuse/mistreatment involving client #1 was 9/2/16 and the date the facility reported the allegation to BDDS was 9/8/16. The review indicated the allegation of client to client abuse/mistreatment was not reported to BDDS within 24 hours of the facility's knowledge of the allegation. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/5/17 at 12:30 PM. QIDP #1 indicated allegations of abuse, neglect and mistreatment should be reported to BDDS within 24 hours of the facility's knowledge of the allegation. 9-3-1(b)(5) 9-3-2(a)		**Measures to be put in place:** ·All incidents will be reported to the provider immediately. ·All State reportable incidents will be reported to the State within 24 hours of the reportable incident. **Monitoring of Corrective Action:** ·QIDP will ensure all incidents that are reported that are State reportables have been submitted to the State within the perimeter of time allowed for reporting. ·Safety Committee reviews all incidents quarterly. **Completion Date: 2-6-17**	
W 0210 Bldg. 00	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate			

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	assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, record review and interview for 2 of 4 sampled clients (#1 and #4), the facility failed to reassess clients #1 and #4's sensorimotor skills in regards to clients #1 and #4's ambulation needs and/or needs for adaptive equipment. Findings include: Observations were conducted at the group home on 1/3/17 from 6:15 AM through 7:30 AM and 1/4/17 from 3:30 PM through 6:25 PM. Client #1 was observed through both observation periods walking freely around his home with no issues. Client #1's rollator walker was placed by the entrance of the front door. Client #4 was observed throughout both observation periods. Client #4 could not ambulate on his own and was unsteady. Client #4 had a gait belt and hand held staff assistance at all times. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 1/3/17 at 1:02 PM. The review indicated the following: 1. BDDS report dated 9/2/16 indicated,	W 0210	**W210:** Within 30 days of admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. **Corrective Action:** ·All Day Program staff are trained on client (1) walker and not to place unsecured items on the walker at any time. (**Attachment C**) ·The Nurse sent a referral to client (1) PCP for a new evaluation regarding a different type of walker. (**Attachment D)** ·The Nurse sent a referral to client (4) PCP for an evaluation for an assisted device for walking. (**Attachment E**) ·All staff trained on High Risk Fall Plans on client (1) and (4). (**Attachment F)**	02/06/2017

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	"This afternoon when staff arrived to pick [client #1] up from the day program he came out of the building and started to run towards the van (with his walker) (sic) when she (staff) got to the curb it appeared as he just fell to the ground onto the concrete on his right knee and his face. Staff assisted him up (sic) checked for injuries finding a small abrasion on his right knee, a small abrasion across his cheekbone on the right side of his face and a small abrasion on his left ear. Staff cleaned the areas and took him to the emergency room for evaluation. At [hospital] Emergency Room a CT (computerized tomography) scan of his head was completed with negative results. He was released with orders to apply triple antibiotic ointment to abrasions, Tylenol for pain and to follow up with his PCP (Primary Care Physician)." -Follow up BDDS report dated 9/9/16 indicated, "[Client #1] is doing well (sic) abrasions healing and no complaints of pain. [Client #1] followed up with his PCP ." -BDDS report dated 10/12/16 indicated, "[Client #1] was walking to the game closet in the recreation room. [Client #1] tripped over his walker, falling on his hands and knees. Staff assessed [client		·QIDP implemented an exercise goal for client (4) to include ROM (Range of Motion) exercises. **(Attachment G)** ·All staff trained on client (1) goal for safe ambulation. **(Attachment H)** **How we will identify others:** ·IDT will review all goals and progress of goals quarterly at IDT meetings. ·The QIDP will change or update goals based on progress or change of needs for each client. ·Nurse will follow up on all referrals to PCP for changes in ambulation needs. ·Staff will conduct goal training at all opportunities formally and informally. **Measures to be put in place:** ·Nurse will follow up with PCP for clients served regarding all referrals for adaptive equipment.	

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	#1] for injuries. [Client #1's] right knee was red and there was a minor scratch approximately 1 inch long. No first aid treatment was needed." -Follow up BDDS report dated 11/7/16 indicated, "The redness on [client #1's] knee healed without bruising and the scratch healed without further intervention past first aid. [Client #1] does have a fall plan which is current and followed." -BDDS report dated 11/7/16 indicated, "[Client #1] was assisting his group with taking the trash bags to the dumpster. [Client #1] had a small bag of trash sitting on the 'seat' of his walker as he was heading to the dumpster. The bag fell off of his walker, causing him to trip. [Client #1] fell on his hands and knees. Staff assessed him for injuries. Scrape, approximately the size of a quarter on his left knee was noted. Scrape was washed with soap and water and a band aid was applied." -Follow up BDDS report dated 11/16/16 indicated, "[Client #1] is doing well and the scrape on his knee healed and is no longer visible. [Client #1] has had no complaints of pain. [Client #1] has a fall plan which is current and followed. As a preventive measure the staff received		·Nurse completes weekly check on all clients to ensure all appointments and referrals are followed through timely. **(Attachment I)** ·The IDT team will review goal progress quarterly at all IDT meetings. ·The QIDP will review goal progress monthly while completing consumer monthly summary. **(Attachment J)** ·Program Manager will complete quarterly book reviews**. (Attachment K)** **Monitoring of Corrective Action:** ·The Nurse will send weekly checklist to Nurse Manager, Area Supervisor and Program Manager for review and monitoring. ·The QIDP will send monthly summaries to the Program Manager for review and monitoring. ·IDT will review all goal progress quarterly. ·Program Manager will complete quarterly book	

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	training to not place unsecured items on the seat of the walker." Client #1's record was reviewed on 1/4/17 at 2:40 PM. Client #1 had a Risk plan for falls dated 8/19/16. Client #1's Fall Risk plan indicated the following: "a. Staff will ensure safety at all times. b. Staff will make sure environment is free of clutter. c. Staff will assist with ambulation anytime gait appears unsteady and/or on slippery or uneven surfaces. d. Staff will ensure he uses Rollator (4 wheel walker) at all times while ambulating while out of the home, [client #1] may ambulate without an assistive device while inside his home due to a familiar environment. e. Staff will cue [client #1] to ambulate slowly with rollator walker. f. Staff will take [client #1] to all medical appointments." Client #1's 8/15/16 OT/PT (Occupation Therapy/Physical Therapy) indicated, "[Client #1] continues to express dislike of current walker, would like to use a different 4 wheel walker. Patient can ambulate in home without walker. Patient should use walker when out of home for safety, with supervision in unfamiliar areas."		reviews for monitoring of goal completion and IDT meetings are held quarterly. ·Administrative staff will complete site reviews monthly for monitoring of program implementation and sent to the AED for monitoring. ·QIDP will review plans quarterly with IDT to ensure all issues are being addressed. **Completion Date: 2-6-17**	

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	2. BDDS report dated 10/26/16 indicated, "During the night staff heard a noise from [client #4's] bedroom (sic) they immediately went to his bedroom and [client #4] was sitting on the floor next to his bed and end table. Staff helped him up and checked him for injuries finding a 1/2 inch scratch on his left wrist. [Client #4] is doing well and has not complained of any pain and (sic) no negative effects from this incident." -Follow up BDDS report dated 11/7/16 indicated, "[Client #4] is doing well and the scratch on his wrist healed without further intervention past first aid. The end table next to his bed which had scratched his wrist was removed from the bedroom and [client #4] has had no further issues. [Client #4] has a fall plan which is current and followed." Client #4's record was reviewed on 1/4/17 at 2:09 PM. Client #4 had a Risk plan for falls dated 10/18/16. Client #4's Fall Risk plan indicated the following: "a. Staff will encourage [client #4] to remain independent with ambulation by providing stand by assist and hold his hand while ambulating. b. Staff will encourage [client #4] to utilize handrails in shower for standing and sitting. c. Staff will take [client #4] to all medical			

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	appointments as ordered and PRN (as needed). d. Staff will ensure [client #4] is wearing his gait belt while up out of bed. e. Staff to remain in line of sight while [client #4] is toileting. Do not leave [client #4] alone on toilet. f. Staff to assist [client #4] with all ADLs (Daily Living skills)." Client #4's 3/17/16 OT/PT indicated, "Main difficulty is right foot and leg turning out while walking. Minimum aid for transfer, Minimum aid for ambulation with handheld assistance. Bilateral hamstring tightness, ankle turned out and collapsed. Continue to use gait belt, continue ROM (Range of Motion)." QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/5/17 at 12:30 PM. QIDP #1 indicated she thought client #4 would benefit from a walker because he cannot walk alone, and he is unsteady. QIDP #1 indicated client #1 falls because he gets in a hurry and the walker was put in place to help him with falls. QIDP #1 indicated the walker put in place to help client #1 from falling is not preventing him from getting in a hurry and tripping. QIDP indicated she felt like perhaps they should try a different walker. QIDP indicated the assessments in the clients' records were			

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	the most current. 9-3-4(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure client #3's medication goals and dining plans were implemented. Findings include: Observations were conducted at the group home on 1/4/17 from 3:30 PM through 6:25 PM. Client #3 was observed throughout the observation period. On 1/4/17 Client #3 participated in the 4 PM medication pass with staff #4. Client #3 received Thioridazine (schizophrenia) 75 mg (milligram), and Metoclopramide (Gastroesophageal reflux) 5 mg	W 0249	**W249:** 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.	02/06/2017

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	(milligram) in applesauce. Staff #4 was interviewed on 1/4/17 during the 4 PM medication pass. Staff #4 indicated client #3 was to receive his medication in applesauce due to being a choking risk. On 1/3/17 at 7:00 AM, client #3 got up and came to the kitchen table for breakfast. Client #3 was seated at the table alone. At 7:01 AM, staff #1 indicated he gave client #3 his medicine at the kitchen table instead of having him come to the medication room. Staff #1 got client #3's medication and Boost pudding supplement and brought them to him at the table and observed client #3 take them. Client #3's records were reviewed on 1/4/17 at 3:03 PM. Client #3's 10/1/16 Dining plan indicated, "[Client #3] takes his medications in soft foods followed by honey thick liquids." There were no observations of client #3 being given honey thickened liquids after medication pass. Client #3's 10/1/16 ISP (Individualized Service Plan) indicated client #3 had a medication goal to get his Boost pudding out of the refrigerator each morning in the medication room for his medication pass. Staff #4 was interviewed on 1/4/17 during the 4 PM medication pass. Staff		**Corrective Action:** ·All staff trained on dining plans for client (3) regarding medication administration. (**Attachment L**) ·All staff trained on medication administration goals**. (Attachment M)** ·All staff trained on medication administration.**(Attachment M)** **How we will identify others:** ·Nurse will train all staff on medication administration policies and procedures. ·Nurse will train all staff on dining plans annually and in accordance with any changes to dining plans**.** ·QIDP will train all staff on client goals annually and in accordance with any changes to goals**.** ·All trainings are sent to Human Resources for filing and kept in training books at the facility. **Measures to be put in**	

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	#4 indicated client #3 was to receive his medication in applesauce due to being a choking risk. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/5/17 at 12:30 PM. QIDP #1 indicated goals and dining plans should be followed. QIDP #1 indicated she was unaware morning staff was not following medication goals and she would address the issue. QIDP #1 indicated client #3 should get his own Boost and take his medication in the medication room. 9-3-4(a)		**place:** ·All staff will follow dining plans for all consumers. ·All staff will follow medication administration plans and procedures. ·QIDP will review goal completion monthly when completing consumer monthly summaries. **Monitoring of Corrective Action:** ·The Site Supervisor will observe medication administration 1 time weekly to ensure staff are following proper procedures. ·Area Supervisor will complete weekly checks to ensure completion of goal training and medication administration. ·Program Manager will review Area Supervisor weekly check for monitoring and completion. ·The QIDP will review all goal completion monthly when completing consumer monthly summaries.	

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W 0460 Bldg. 00	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, interview and record review for 2 of 4 sampled clients (#1 and #4), the facility failed to serve adequate amounts of food to ensure the clients received enough food to eat per the facility's menus and/or diets. The facility failed to ensure clients #1 and #4's dining plans were followed in regard to portions and texture. Findings include: Observations were conducted at the group home on 1/4/17 from 3:30 PM through 6:25 PM. Client #4 was observed in the group home throughout the observation period. During the 1/4/17 observation period at 5:06 PM, the week 3 2008 dinner menu was reviewed. The dinner menu was 1 slice of pizza, 1 cup garden salad, dressing, cookie of day, 1/2 cup fruit and 1 cup skim milk. At 5:07 PM HM (House Manager) #1 indicated they would be substituting the pizza with	W 0460	**W460:** Each client must receive a nourishing, well balanced diet including modified and specially-prescribed diets. **Corrective Action:** ·Nurse will train all staff on dining plans for client (1) and (4**). (Attachment M)** ·Nurse will review all recommendations from the dietician and alter plans accordingly. ·Site Supervisor will complete a mealtime observation 2 times weekly to ensure dining plans are followed as written and trained.	02/06/2017

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	lasagna and the house salad with corn. At 5:51 PM client #1 was observed eating a whole piece of garlic bread. Client #1's garlic bread was not cut into pieces. At 6:10 PM client #4 had his food chopped for him. Client #4 was not served garlic bread. At 6:19 PM client #4 had eaten all the food on his plate and tried to scrape more. Staff #3 was asked if he thought client #4 should be offered more food because he did not eat bread with his meal. Staff #3 stated, "He (client #4) can have more corn." Staff #3 gave client #4 another spoonful of corn. Client #4 ate all of the corn. Client #1's record was reviewed on 1/4/17 at at 2:40 PM. Client #1's 3/1/16 dining plan indicated client #1 should receive a regular, NAS (no added sodium) diet, with food cut into 1 inch pieces. Client #4's record was reviewed on 1/4/17 at 2:09 PM. Client #4's 10/14/16 dining plan indicated, "Fruits and vegetables are soft and cut into small 1/2 inch pieces or chopped. All canned fruits are pureed except peaches and pears which are diced. Soft mashed fresh fruit. Corn is cream style...." Client #4's 10/28/16 Nutrition Assessment indicated, "[Client #4] had lost 12 pounds and was to receive seconds."		**How we will identify others:** ·Nurse will provide training on dining plans annually and as needed. ·Nurse will review all recommendations from dietician and alter plans and train staff as needed per the dietician. ·Site Supervisor will complete mealtime observations. **Measures to be put in place:** ·All staff will follow dining plans on all consumers. ·The Site Supervisor will conduct mealtime observations 2 times weekly. ·Nurse will review all dietician recommendations and change plans accordingly. **Monitoring of Corrective Action:**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 1/5/17 at 12:30 PM. QIDP #1 indicated dining plans should be followed. QIDP #1 indicated she thought client #4 needed more food because of his small stature. QIDP #1 indicated client #4 should receive second portions. 9-3-8(a)		·The Site Supervisor will send mealtime observation to Area Supervisor for review and monitoring of completion. ·Nurse will review all recommendations from the dietician and note those on weekly check and submit to Nurse Manager, Area Supervisor and Program Manager for review and monitoring of completion. **Completion Date: 2-6-17**	