STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G127	A. BUILDING 00 B. WING	09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	1031 WEST ST NEW ALBANY, IN 47150

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W 0000 Bldg. 00	This visit was for an investigation of complaint #IN00303607. Complaint #IN00303607: Substantiated. Federal/state deficiencies related to the allegations were cited at W149, W157 and W289. Survey Dates: September 5, 6 and 12, 2019. Facility Number: 000664 Provider Number: 15G127 AIMS Number: 100234310 These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/24/19.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 3 of 4 investigations reviewed affecting 3 of 3 sampled clients (A, B and C) and 5 additional clients (D, E, F, G and H), the facility failed to ensure the facility's neglect/abuse/exploitation (A/N/E) policy was implemented in regards to client neglect (failure to prevent elopement and clients having access to alcoholic beverages), staff to client verbal abuse, and exploitation of clients (missing television sets). Findings include:	W 0149	1.The Program Manager will ensure the Area Supervisor and Residential Manager retrain direct care staff on the Abuse, Neglect and Exploitation Policy. Failure to follow policy will result in disciplinary action up to and including termination. 2.The facility investigated as a result it was determined the Televisions would be replaced. New TV's were purchased by the Program Manager and mounted permanently on the wall by	10/12/2019

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

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	The facility's Bureau of Developmental Disabilities Services/BDDS reports, incident reports and investigations were reviewed on 9/05/19 at 12:00 PM and 1:30 PM indicated the following: 1. An investigation dated 8/19-23, 2019 indicated reports clients D and G had "2 TV's (sic) being unaccounted for." The investigation's conclusion indicated: "1. [Client D] took his TV to the curb for trash pick up. 2. [Client G's] TV was taken to the curb for trash pick up. It is unknown how the TV got there or why." Interview with the QAC (Quality Assurance Coordinator) on 9/5/19 at 1:30 PM indicated it was not determined why client G's TV went missing. Staff did not intervene when they noticed the televisions were at the curb with the facility's trash. Interview with Program Director #1 on 9/5/19 at 12:43 PM indicated the televisions would be replaced by the facility to both clients. Observations were conducted at the facility on 9/5/19 from 4:20 PM until 5:55 PM. Client D and G's televisions had been replaced during the time of the observations. 2. A BDDS report dated 8/9/19 indicated an incident on 8/8/19 at 7:15 PM: "Narrative: [Client A] said he was leaving to use his alone time, staff reminded [Client A] he was unable to use alone time due to his cell phone not working, per his BSP (Behavior Support Plan). [Client A] left the home without telling staff, police were contacted for assist (sic) in locating. [Client A]		ResCare Maintenance to limit the chance of them being broken or damaged in the future. 3.The Nurse will schedule an appointment with client's Primary Care Physician by Oct 30, 2019 to insure there are no complications with moderate alcohol consumption (1-2 drinks a week). 4.If alcohol consumption is deemed safe QIDP will update ISP/BSP to allow for an offsite outing upon request of client to allow for 1-2 alcoholic beverages consumed with staff supervision no more than 1 time a week. Nurse will be notified and medicine adjusted as needed. 5.If alcohol consumption is deemed safe QIDP will train staff on updated ISP/BSP. Persons Responsible: Program Manager, Nursing, Area Supervisor, QIDP, Residential Manager, and DSP.	

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	returned home on his own, approximately 25 minutes later. [Client A] was located outside drinking a beer with his housemate, [Client B]. Staff redirected both individuals inside, no further incidents were noted. Plan to Resolve: [Client A] has alone time in his plans, however, his cell phone must be working in order for him to utilize his alone time, and his phone was not working at the time. No side effects, injuries or further incidents were reported as a result of this incident. Staff will continue to follow plans in place." Review of the accompanying client elopement investigation dated 8/9/19 (reported to the administrator 8/10/19) by QIDP (Qualified Intellectual Disability Professional) #1 indicated no mention of the beer clients A and B drank after client A's elopement. The issue of the beer drinking on facility grounds was not addressed for either client. Interview with client A on 9/5/19 at 4:30 PM indicated he had lost his privilege of going into the community alone after the elopement of 8/8/19 for a week until he had sufficient minutes of call time on his personal cell phone so he could be in contact with the facility during his time away. Client A stated he was told he would lose community access for "a month" if he continued to leave the facility without telling staff or having a cell phone that worked. Interview with QIDP #1 on 9/12/19 at 2:39 PM indicated client A had left the facility without permission on 8/9/19 and had brought back beer he shared with client B. The interview indicated consuming the beer had not been addressed in			

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	the investigation. 3. An investigation dated July 1-11/2019 indicated staff #7 was alleged to have been "rude and disrespectful to clients (A, B, C, D, E, F and G)." Staff #7 was suspended and an investigation was initiated. The conclusion of the investigation indicated it was "substantiated that [staff #7] is verbally abusive to clients." Staff #7 was terminated from employment. The agency's policy date 7/10/19 (reviewed on 9/6/19 at 1:30 PM) "Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of an Individual's Rights" indicated: "ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare, local, state and federal guidelines. Although ResCare staff are instructed and encouraged to use the internal reporting system outlined below, any staff has the right to contact Adult Protective Services directly, should they suspect abuse, neglect, exploitation, mistreatment or violation of an Individual's rights. ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights. These include but are not limited to any of the following: corporal punishment i.e. forced physical activity, prone restraints, contingent exercise, hitting, pinching, the application of pain or noxious stimuli, the use of electric shock, the infliction of physical pain, seclusion in an area which exit is prohibited, an			

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	example of seclusion is locking an individual in their bedroom and not allowing them to leave, negative practice or overcorrection, visual or facial screening, verbal abuse including screaming, swearing, name-calling, belittling, damaging an individual's self-respect or dignity, failure to follow physician's orders, denial of sleep, shelter, food, drink, physical movement for prolonged periods of time, Medical treatment or care or use of bathroom facilities. The use of mechanical restraints except for when ordered as a medical restraint by a licensed physician or dentist is strictly prohibited. ResCare strictly prohibits the use of any other technique that incorporates the use of painful or noxious stimuli; incorporates denial of any health-related necessity; or degrades the dignity of an individual. Abuse, neglect, exploitation, mistreatment or violation of an Individual's rights may also be defined as forcing an individual to complete chores benefiting others without pay unless: (A) The Provider has obtained a certificate from the US Department of Labor to authorize employment; (B) The services are being performed in the individual's own home as a normal and customary part of housekeeping duties; or (C) Individual desires to perform volunteer work in the community. This includes that the individual should not be compelled to provide services for a provider, either by request of the provider, enticements or aversive techniques. All employees receive training upon hire regarding definitions/causes of different types of, how to identify and how to report abuse, neglect, exploitation, mistreatment or violation of an Individual's rights, as well as what to expect from an investigation. All employees receive this training upon hire and annually, thereafter.			

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	Procedures: 1. Any ResCare staff person who suspects an individual is the victim of abuse, neglect, exploitation or mistreatment of an individual should immediately notify the Program Manager, and then complete an Incident Report. The Program Manager will then notify the Executive Director. This step should be done within 24 hours... 7. If the allegation is substantiated, the staff person accused will follow progressive corrective action up to and including termination. 8. Any staff person who is discovered withholding information about alleged or observed abuse, neglect, exploitation, mistreatment or violation of an Individual's rights toward an individual may be subject to disciplinary action up to and including suspension or termination. 9. Any individual who has been a victim of substantiated abuse, neglect, exploitation, mistreatment or violation of an Individual's rights will be offered formal or informal counseling, as determined to be appropriate for the individual by the Interdisciplinary Team...." This federal tag relates to Complaint #IN00303607. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview 1 of 4 investigations reviewed affecting 2 of 3 sampled clients (A and B), the facility failed to implement	W 0157	1.The Nurse will schedule an appointment with the client's Primary Care Physician by Oct	10/12/2019

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	corrective measures in regards to clients consuming alcoholic beverages at the facility. Findings include: The facility's Bureau of Developmental Disabilities Services/BDDS reports, incident reports and investigations were reviewed on 9/05/19 at 1:30 PM indicated the following: A BDDS report dated 8/9/19 indicated an incident on 8/8/19 at 7:15 PM: "Narrative: [Client A] said he was leaving to use his alone time, staff reminded [Client A] he was unable to use alone time due to his cell phone not working, per his BSP (Behavior Support Plan). [Client A] left the home without telling staff, police were contacted for assist (sic) in locating. [Client A] returned home on his own, approximately 25 minutes later. [Client A] was located outside drinking a beer with his housemate, [Client B]. Staff redirected both individuals inside, no further incidents were noted. Plan to Resolve: [Client A] has alone time in his plans, however, his cell phone must be working in order for him to utilize his alone time, and his phone was not working at the time. No side effects, injuries or further incidents were reported as a result of this incident. Staff will continue to follow plans in place." Review of the accompanying client elopement investigation dated 8/9/19 (reported to the administrator 8/10/19) by QIDP (Qualified Intellectual Disability Professional) #1 indicated no mention of the beer clients A and B drank after		30, 2019 to insure there are no complications with moderate alcohol consumption (1-2 drinks a week). 2.If alcohol consumption is deemed safe QIDP will update ISP/BSP to allow for an offsite outing upon request of the client to allow for 1-2 alcoholic beverages consumed with staff supervision no more than 1 time a week. The Nurse will be notified and medicine adjusted as needed. 3.If alcohol consumption is deemed safe QIDP will train staff on updated ISP/BSP. Persons Responsible: Program Manager, Nursing, Area Supervisor, QIDP, Residential Manager, and DSP.	

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	client A's elopement. The issue of the beer drinking on facility grounds was not addressed for either client. Client A's record was reviewed on 9/5/19 at 2:09 PM and indicated an Individual Support Plan (ISP) dated 2/20/19 and a Behavior Support Plan (BSP) dated 8/9/19. The ISP and the BSP did not address consumption of alcoholic beverages (beer). Client B's record was reviewed on 9/5/19 at 3:38 PM and indicated an ISP dated 4/11/19 and a BSP dated 8/28/19. The ISP and the BSP did not address consumption of alcoholic beverages (beer) for client B. Interview with client A on 9/5/19 at 4:30 PM indicated he had lost his privilege of going into the community alone after the elopement of 8/8/19 for a week until he had sufficient minutes of call time on his personal cell phone so he could be in contact with the facility during his time away. Client A stated he was told he would lose community access for "a month" if he continued to leave the facility without telling staff or having a cell phone that worked. Interview with QIDP #1 on 9/12/19 at 2:39 PM indicated client A had left the facility without permission on 8/9/19 and had brought back beer he shared with client B. The interview indicated consuming the beer had not been addressed in the investigation. This federal tag relates to Complaint #IN00303607. 9-3-2(a)			
W 0289	483.450(b)(4) MGMT OF INAPPROPRIATE CLIENT			

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Bldg. 00	BEHAVIOR The use of systematic interventions to manage inappropriate client behavior must be incorporated into the client's individual program plan, in accordance with §483.440(c)(4) and (5) of this subpart. Based on record review and interview for 2 of 3 sampled clients (A and B), the facility failed to ensure methods were included in the clients' program plans to address alcoholic beverage consumption and the loss of community access. Findings include: The facility's Bureau of Developmental Disabilities Services/BDDS reports, incident reports and investigations were reviewed on 9/05/19 at 12:00 PM and 1:30 PM indicated the following BDDS report dated 8/9/19 indicated an incident on 8/8/19 at 7:15 PM: "Narrative: [Client A] said he was leaving to use his alone time, staff reminded [Client A] he was unable to use alone time due to his cell phone not working, per his BSP (Behavior Support Plan). [Client A] left the home without telling staff, police were contacted for assist in locating. [Client A] returned home on his own, approximately 25 minutes later. [Client A] was located outside drinking a beer with his housemate, [Client B]. Staff redirected both individuals inside, no further incidents were noted. Plan to Resolve: [Client A] has alone time in his plans, however, his cell phone must be working in order for him to utilize his alone time, and his phone was not working at the time. No side effects, injuries or further incidents were reported as a result of this	W 0289	1.The Nurse will schedule an appointment with the client's Primary Care Physician to ensure there are no complications with moderate alcohol consumption (1-2 drinks a week). 2.If alcohol consumption is deemed safe QIDP will update ISP/BSP to allow for an offsite outing upon request of the client to allow for 1-2 alcoholic beverages consumed with staff supervision no more than 1 time a week. The Nurse will be notified and medicine adjusted as needed. 3.If alcohol consumption is deemed safe QIDP will train staff on updated ISP/BSP. Persons Responsible: Program Manager, Nursing, Area Supervisor, QIDP, Residential Manager, and DSP.	10/12/2019

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	incident. Staff will continue to follow plans in place." Review of the accompanying client elopement investigation dated 8/9/19 (reported to the administrator 8/10/19) by QIDP (Qualified Intellectual Disability Professional) #1 indicated no mention of the beer clients A and B drank after client A's elopement. The issue of the beer drinking on facility grounds was not addressed for either client. Client A's record was reviewed on 9/5/19 at 2:09 PM and indicated an Individual Support Plan (ISP) dated 2/20/19 and a Behavior Support Plan (BSP) dated 8/9/19. The ISP and the BSP did not address consumption of alcoholic beverages (beer) or the loss of community access for client A. Client B's record was reviewed on 9/5/19 at 3:38 PM and indicated an ISP dated 4/11/19 and a BSP dated 8/28/19. The ISP and the BSP did not address consumption of alcoholic beverages (beer) for client B. Interview with client A on 9/5/19 at 4:30 PM indicated he had lost his privilege of going into the community alone after the elopement of 8/8/19 for a week until he had sufficient minutes of call time on his personal cell phone so he could be in contact with the facility during his time away. Client A stated he was told he would lose community access for "a month" if he continued to leave the facility without telling staff or having a cell phone that worked. Interview with QIDP #1 on 9/12/19 at 2:39 PM indicated client A had left the facility without permission on 8/9/19 and had brought back beer he shared with client B. The interview indicated			

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	consuming the beer had not been addressed in the investigation. The interview indicated the use of beer and the loss of community access time were not included in client A's program plans. This federal tag relates to Complaint #IN00303607. 9-3-5(a)			