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	02/01/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a fundamental annual recertification and state licensure survey. Dates of Survey: 1/29/18, 1/30/18, 1/31/18 and 2/1/18. 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 2/8/18.	W 0000		
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 1 of 4 sampled clients (#3), the facility failed to ensure client #3 received a hearing screening on an annual basis. Findings include: Client #3's record was reviewed on 1/30/18 at 10:00 AM. Client #3 did not have an annual hearing screening. RN #1 was interviewed on 1/31/18 at 3:00 PM. RN #1 indicated client #3's last annual hearing exam was 11/7/2008. RN #1 indicated client #3 should have a hearing screening on an annual basis or as recommended by his doctor. RN #1 indicated she	W 0323	**W323:** The facility must provide or obtain annual physical examinations of each client that at a minimum includes and evaluation of vision and hearing. **Corrective Action:** ·Nurse scheduled a	02/01/2018

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

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	was new to the home and has scheduled a hearing screening for client #3. 9-3-6(a)		hearing evaluation for client (3) for 1/31/18 (**Attachment A**). **How we will identify others:** ·Weekly checks (**Attachment B**) are completed by the Nurse to ensure all appointments are in compliance. **Measures to be put in place:** ·Site Supervisor will ensure all appointments are scheduled according to client need. ·Nurse will complete a weekly check during visits to the home to ensure all appointments are scheduled and completed as scheduled. ·Site Supervisor will send all appointments scheduled to the Area Supervisor for monitoring of completion. ·Area Supervisor will send all appointments scheduled to the Program Manager for monitoring of completion.	

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			Monitoring of Corrective Action: ·Site Supervisor will ensure all clients are taken to appointments as scheduled. ·Area Supervisor will monitor all upcoming appointments and remind the Site Supervisor. ·Nurse will send weekly check to the Nurse Manager, Area Supervisor and Program Manager for monitoring and to ensure completion. **Completion Date: 2/1/18**	
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview for 1 of 4 sampled clients (#1 and #3) plus 1 additional client (#7), the facility failed to ensure clients #1, #3 and #7's routine medications were administered as ordered by their physicians. Findings include: The facility's BDDS (Bureau of Developmental	W 0368	**W368:** The facility for drug administration must assure that all drugs, including those that are self-administered are administered without error.	02/23/2018

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	Disabilities Services) reports were reviewed on 1/31/18 at 9:18 AM. The review indicated the following: BDDS report dated 8/3/17 indicated, "This morning while the nurse was completing her weekly audit she discovered that [client #1] is missing one pill of his Lorazepam 0.5 mg (milligram). [Client #1] is doing well and has not experienced any negative effects from this incident. An investigation has been initiated. The nurse provided training to the staff including retraining of medication administration, proper completion of buddy checks following each medication pass and control count documentation." -BDDS report dated 8/3/17 indicated, "This morning while the nurse was completing her weekly audit she discovered the following med (medication) error. [Client #3] receives Phenobarbital 32.4 mg at 7 AM. On 7/9/17 staff gave an extra dose of the Phenobarbital 32.4 mg. Staff gave the morning dose of Phenobarbital 32.4 mg and then gave the Phenobarbital 32.4 mg at 7 PM med pass in error. [Client #3] is doing well and did not experience any negative effects from this med error. The nurse provided training to the staff including retraining of medication administration, proper completion of buddy checks following each medication pass and control count documentation. As further preventative measures all administration of medication policy and procedures will be followed." -BDDS report dated 8/3/17 indicated, "This morning while the nurse was completing her weekly audit she discovered the following med (medication) error. On 7/27/17 staff did not give [client #3] his Phenobarbital 32.4 mg at the 7 AM		**Corrective Action:** ·All staff retrained on medication administration. **(Attachment C)** ·Investigation completed for alleged missing medication. (**Attachment D**) ·Staff received a medication error as a result of giving client (3) an extra dose of Phenobarbital. (**Attachment E)** ·Staff received a medication error as a result of giving client (3) his ordered dose of Phenobarbital. **(Attachment F)** ·Staff received a medication error as a result of giving client (1) his ordered dose of Xanax. **(Attachment G)** ·Staff received a medication error as a result of giving client (7) his ordered dose of Risperdal. **(Attachment H)** ·Staff received a	

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	medication pass. On 7/28/17 staff did not give [client #3] his Phenobarbital 32.4 mg at the 7 AM medication pass. [Client #3] is doing well and did not experience any negative effects from this medication error. The nurse provided training to the staff including retraining of medication administration, proper completion of buddy checks following each medication pass and control count documentation. As further preventative measures all administration of medication policy and procedures will be followed." -BDDS report dated 12/4/17 indicated, "This morning during the 7 AM med pass buddy check staff discovered a med error had occurred on 12/2/17 at the 9 PM med pass. The med error staff failed to administer [client #1's] Xanax 0.5 mg at the 12/2 9 PM med pass. [Client #1] is doing well and suffered no negative effects from this med error. The nurse provided training to the staff including retraining of medication administration, proper completion of buddy checks following each medication pass and control count documentation. As further preventative measures all administration of medication policy and procedures will be followed." -BDDS report dated 1/24/18 indicated, "[Client #7] receives Risperdal 1 mg in the morning and 2 mg tab in the evenings. The nurse completed a medication audit and discovered on 1/1/18 that staff gave [client #7] his morning Risperdal of 1 mg at the evening med dose and did not give the evening dose of 2 mg omitting 1 mg of the Risperdal for the day. [Client #7] is doing well and and suffered no negative effects from this med error. The nurse provided training to the staff including retraining of medication administration, proper completion of buddy checks following		medication error as a result of giving client (7) the incorrect dose of Risperdal. **(Attachment I)** ·Staff received a medication error as a result of giving client (7) the wrong dose of Risperdal. **(Attachment J)** ·Staff received a medication error as a result of giving client (7) the wrong dose of Risperdal. **(Attachment K)** ·Staff received a medication error as a result of giving client (7) the wrong dose of Risperdal. **(Attachment L)** ·Staff received a medication error as a result of giving client (7) the wrong dose of Risperdal. **(Attachment M)** **How we will identify others:** ·Site Supervisor will conduct med pass observations weekly. ·Nurse will complete	

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	each medication pass and control count documentation. As further preventative measures all administration of medication policy and procedures will be followed." -BDDS report dated 1/24/18 indicated, "[Client #7] receives Risperdal 1 mg in the morning and 2 mg tab in the evenings. The nurse completed a medication audit and discovered on 12/30/17 that staff gave [client #7] his morning Risperdal of 1 mg at the evening med dose and gave his evening med dose of 2 mg during the 9 PM med pass for an extra 2 mg of Risperdal for the day. [Client #7] is doing well and and suffered no negative effects from this med error. The nurse provided training to the staff including retraining of medication administration, proper completion of buddy checks following each medication pass and control count documentation. As further preventative measures all administration of medication policy and procedures will be followed." -BDDS report dated 1/24/18 indicated, "[Client #7] receives Risperdal 1 mg in the morning and 2 mg tab in the evenings. The nurse completed a medication audit on 1/24/18. The home had several med errors of [client #7's] Risperdal giving 1/2 tabs instead of whole tabs resulting in having no supply of the Risperdal 1/2 mg tabs. On 1/23/18 [client #7] did not receive his 1 mg (1/2 tab) due to no supply. [Client #7] is doing well and and suffered no negative effects from this med error. The nurse provided training to the staff including retraining of medication administration, proper completion of buddy checks following each medication pass and control count documentation. As further preventative measures all administration of medication policy and procedures will be followed."		weekly medication observations. ·Staff trained annually on medication administration. **Measures to be put in place:** ·Site Supervisor will conduct med pass observations weekly. ·All staff in serviced on medication administration. ·All staff trained annually on medication administration. ·Nurse completes weekly medication pass observations. **Monitoring of Corrective Action:** ·Site Supervisor will conduct med pass observations 2 times a week for no less than 30 days. ·Site Supervisor will report any issues with medication administration to the Area Supervisor, Program Manager and Nurse immediately.	

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	medication audit and discovered on 12/29/17 that staff gave [client #7] his morning Risperdal of 1 mg at the evening med dose not giving his evening dose of 2 mg for an error of omitting 1 mg of the Risperdal for the day. [Client #7] is doing well and and suffered no negative effects from this med error. The nurse provided training to the staff including retraining of medication administration, proper completion of buddy checks following each medication pass and control count documentation. As further preventative measures all administration of medication policy and procedures will be followed." RN #1 was interviewed on 1/31/18 at 3:00 PM. RN #1 indicated medications should be given according to Physician's Orders. RN #1 indicated IDT meetings were held for the medication errors. RN #1 indicated staff have been retrained by the nurse on medication administration as well as buddy checks. 9-3-6(a)			