

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>12/06/2018</b>
NAME OF PROVIDER OR SUPPLIER <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000  Bldg. 00	<p>This visit was for a PCR (Post Certification Revisit) to the extended annual recertification and state licensure survey completed on 10/5/18.</p> <p>Survey Date: December 6, 2018</p> <p>Facility Number: 013405 Provider Number: 15G811 AIM Number: 201267570</p> <p>This deficiency also reflects state findings in accordance with 410 IAC 16.2-5.</p> <p>Quality Review of this report completed by #15068 on 12/18/18.</p>	W 0000		
W 0249  Bldg. 00	<p>483.440(d)(1) <b>PROGRAM IMPLEMENTATION</b></p> <p>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.</p> <p>Based on interview and record review for 1 of 4 sample clients (#1), the facility failed to implement client #1's Diabetes Control Plan (DCP).</p> <p>Findings include:</p> <p>Client #1's record was reviewed on 12/6/18 at 2:39 PM. The review indicated the following:</p> <p>1. Client #1's Blood Sugar Record (BSR) dated November 2018 indicated the following:</p>	W 0249	<p><b>W 249</b></p> <p><b>The facility ensures that each client receives continuous active treatment</b></p> <p><b>All individuals will be assessed, at least annually and ongoing for all needed interventions and opportunities for training and independence.</b></p> <p><b>The IDT for each client meets to assess changes and needs</b></p>	12/07/2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosed days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2018
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>"11/4/18: Bedtime Blood Sugar: (Empty)."</p> <p>"11/22/18: Bedtime Blood Sugar: (Empty)."</p> <p>Client #1's BSR dated December 2018 indicated the following:</p> <p>"12/4/18: Dinner Blood Sugar: (Empty)."</p> <p>"12/5/18: Dinner Blood Sugar: (Empty)."</p> <p>Client #1's DCP was dated 11/10/18. The DCP indicated, "[Client #1] will need to check his blood glucose... prior to all meals and at bedtime...".</p> <p>Nursing Care Manager (NCM) #1 was interviewed on 12/6/18 at 3:30 PM. NCM #1 indicated client #1's DCP should be followed as written. NCM #1 stated, "[Client #1's] blood sugar should be checked prior to each meal, at bedtime, and whenever the staff is concerned about his health."</p> <p>2. Client #1's BSR dated November 2018 recorded client #1's carbohydrate intake at each meal. The BSR indicated the following:</p> <p>"11/6/18: Dinner: 85 carbohydrates."</p> <p>"11/7/18: Dinner: 82 carbohydrates."</p> <p>"11/8/18: Lunch: 95 carbohydrates."</p> <p>"11/10/18: Lunch: 100 carbohydrates."</p> <p>"11/16/18: Lunch: 90 carbohydrates."</p> <p>"11/10/18: Lunch: 85 carbohydrates."</p> <p>"11/10/18: Dinner: 82 carbohydrates."</p>		<p><b>necessary. Progress toward goals and objectives will be assessed at least monthly and documented on the monthly review form.</b></p> <p><b>All staff are trained upon hire, and ongoing on diabetic care plans for client #1.</b></p> <p><b>This happens in a number of ways:</b></p> <p><b>1) all staff are trained on client HRP's</b></p> <p><b>2) all staff are trained on client BSP's and</b></p> <p><b>3) all staff are trained on client ISP's.</b></p> <p><b>Staff receive continuous and ongoing training anytime a component of a care plan is changed. This training is documented in the form of staff in-service forms, as well as initial new hire training.</b></p> <p><b>Training occurs regularly and is ongoing.</b></p> <p><b>**please note that the care plans's for client #1 state that "...client #1 will eat family style with the other clients for meals. He is prompted at scheduled meal times and snacks to "eat sensibly" and not overconsume. If his intake becomes excessive, staff need to remind and prompt him that he's being excessive and to make wise food choices. He can have sweets, sugars, and carbohydrates in moderation, but needs to mix with a protein. He will be encouraged to make</b></p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 12/06/2018
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>"11/22/18: Lunch: 120 carbohydrates."</p> <p>"11/22/18: Dinner: 82 carbohydrates."</p> <p>"11/26/18: Lunch: 89 carbohydrates."</p> <p>"11/30/18: Dinner: 122 carbohydrates."</p> <p>Client #1's BSR dated December 2018 recorded client #1's carbohydrate intake at each meal. The BSR indicated the following:</p> <p>"12/1/18: Lunch: 76 carbohydrates."</p> <p>"12/2/18: Lunch: 80 carbohydrates."</p> <p>Client #1's DCP was dated 11/10/18. The DCP indicated, "[Client #1's] endocrinologist (diabetes specialist) has ordered a restriction of 75 carbohydrates per meal... Staff need to work with [client #1] and plan each meal before eating, not to exceed 75 carbohydrates and to make wise food choices...".</p> <p>NCM #1 was interviewed on 12/6/18 at 3:30 PM. NCM #1 indicated client #1's DCP should be followed as written. NCM #1 stated, "[Client #1's] carbohydrate intake is restricted to 75 carbohydrates per meal. Staff should follow his plan and encourage him to stay within the 75 carbohydrates." NCM #1 indicated the carbohydrate restriction was ordered by client #1's diabetes specialist.</p> <p>This deficiency was cited on 10/5/18. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>5-7.1(a)</p>		<p><b><i>wise choices in the foods that he consumes."</i></b></p> <p><b>On the occasion that Client #1 makes the choice to consume an item that is not recommended per his care plan, the food choice and carb amount will be reported to the nurse and insulin adjusted as needed, and per his written plans. All staff will follow client care plans to the full extent of their ability, while allowing client #1 some freedom of choice as well. Staff and nursing will follow diabetic guidelines to ensure that he remains healthy.</b></p> <p><b>Client #1 has in his ISP goal training on the following:</b></p> <p><b>Self-Med administration (checking his blood sugar), dietary compliance (educating on the importance of consuming a protein at snack/meal time), Increasing dietary compliance (recording his meal intake and using the Carb manual to calculate carbs). All staff are trained on the components of the ISP and assisting him with managing his diabetes.</b></p> <p><b>Nursing will continue to communicate with the primary care physician and the endocrinologist to ensure that client #1 continues to become healthier and also to continue</b></p>	

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

PRINTED: 01/08/2019

FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER <b>15G811</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED <b>12/06/2018</b>
NAME OF PROVIDER OR SUPPLIER  <b>RES-CARE INC</b>		STREET ADDRESS, CITY, STATE, ZIP COD <b>1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			<b>his increased levels of independence during the time that he has lived in this facility. Facility administration will conduct daily active treatment observations, on a variety shifts to ensure that active treatment needs for all clients are being met, and that staff demonstrate an understanding of individual goals and active treatment.</b>	