STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 00 B. WING	02/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(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
W 0000 Bldg. 00	This visit was for a PCR (Post Certification Revisit) to the PCR completed 12/5/16 to the annual recertification and state licensure survey completed on 7/29/16. This visit was done in conjunction with the PCR (Post Certification Revisit) to the investigation of complaint #IN00210610. Dates of Survey: 1/31/17, 2/1/17, 2/2/17 and 2/6/17. Facility Number: 004615 Provider Number: 15G723 AIMS Number: 200528230 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/16/17.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and	W 0102		02/23/2017

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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	interview for 1 of 2 sampled clients (A), the governing body failed to meet the Condition of Participation: Governing Body. The governing body neglected to implement its written policy and procedures to prevent abuse/neglect in regard to the safety of client A. The governing body neglected to ensure facility staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The governing body neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A. The governing body failed to ensure a thorough investigation was completed of an vehicle accident involving client A. Findings include: 1. The facility's governing body neglected to implement its policy and procedures to prevent abuse/neglect in regard to the safety of client A. The facility's governing body neglected to ensure facility staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The facility's governing body neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A. The facility's governing body failed to ensure		**W102:** The facility must ensure that specific governing body and management requirements are met. **Corrective Action:** **(Specific):** All staff at the home will be re-trained on The Operation Standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment or violation of individual rights, Client A's Behavior Support Plan and the enhanced supervision levels while in the home, during transportation and while in the community. All staff will be re-trained on ensuring that the enhanced supervision for Client A is implemented as written in the Behavior Support Plan. An investigation in to the vehicle accident has been completed. The QA Manager will be re-trained on the completion of a thorough investigation for those incidents that require an investigation. Client A is moving to an alternate location that will reduce the need for enhanced supervision levels and assist him in focusing on and	

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	a thorough investigation of a vehicle accident involving client A. The facility's governing body failed to ensure there were sufficient staff deployed in the home to ensure supervision of client A. The facility's governing body failed to ensure client A's BSP (Behavior Support Plan) was implemented. Please see W104. 2. The governing body failed to meet the Condition of Participation: Client Protections for client A. The governing body neglected to implement its written policy and procedures to prevent abuse/neglect in regard to the safety of client A. The governing body neglected to ensure facility staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The governing body neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A. The governing body failed to ensure a thorough investigation of an vehicle accident involving client A. Please see W122. 9-3-1(a)		working toward meeting his behavioral goals. **How others will be identified: (Systemic):** All staff at the home will be re-trained on the Behavior Support Plans for all other individuals in the home. Administrative Observations have been implemented in the home by administrative staff to ensure that all client plans are being implemented as written. The Behavior Clinician and the QIDP are completing observations in the home. Immediate re-training for staff is being completed if necessary during observation periods. The Program Manager and the QA will review incident reports for the home at least five times weekly for the next 30 days and at least twice weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough.	

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			Measures to be put in place: All staff at the home will be re-trained on The Operation Standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment or violation of individual rights. All staff at the home will be re-trained on Client A's Behavior Support Plan and the enhanced supervision levels while in the home, during transportation and while in the community. All staff will be re-trained on ensuring that the enhanced supervision for Client A is implemented as written in the Behavior Support Plan. An investigation in to the vehicle accident will be completed. The QA Manager will be re-trained on the completion of a thorough investigation for those incidents that require an investigation be completed. Client A is moving to an alternate location that will reduce the need for enhanced supervision levels and assist him in focusing on and working toward meeting his behavioral goals.	

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			Monitoring of Corrective Action: All staff at the home will be re-trained on the Behavior Support Plans for all other individuals in the home. Administrative Observations have been implemented in the home by administrative staff to ensure that all client plans are being implemented as written. The Behavior Clinician and the QIDP are completing observations in the home. Immediate re-training for staff is being completed if necessary during observation periods. The Program Manager and the QA will review incident reports for the home at least five times weekly for the next 30 days and at least twice weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough. **Completion date: 2/23/17**	

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W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 1 of 2 sampled clients (A), the facility's governing body neglected to implement its policy and procedures to prevent abuse/neglect in regard to the safety of client A. The facility's governing body neglected to ensure facility staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The facility's governing body neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A. The facility's governing body failed to ensure a thorough investigation of an vehicle accident involving client A. The facility's governing body failed to ensure there were sufficient staff deployed in the home to ensure supervision of client A. The facility's governing body failed to ensure client A's BSP (Behavior Support Plan) was implemented. Findings include: 1. The facility's governing body neglected to prevent abuse/neglect in regard to the safety of client A. The facility's governing body neglected to	W 0104	**W104:** The governing body must exercise general policy, budget and operating direction over the facility. **Corrective Action:** **(Specific):** Client A is moving to an alternate location that will reduce the need for enhanced supervision levels and assist him in focusing on and working toward meeting his behavioral goals. All staff at the home will be re-trained on Client A's Behavior Support Plan and the enhanced supervision levels while in the home, during transportation and while in the community, ensuring that the enhanced supervision for Client A is implemented as written in the Behavior Support Plan and the Operation Standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment or violation of individual rights. An investigation in to the vehicle accident will be	02/23/2017

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	ensure facility staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The facility's governing body neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A. Please see W149. 2. The facility's governing body failed to ensure a thorough investigation was completed of a vehicle accident involving client A. Please see W154. 3. The facility's governing body failed to ensure there was sufficient staff deployed in the home to ensure supervision of client A. Please see W186. 4. The facility's governing body failed to ensure client A's BSP (Behavior Support Plan) was implemented. Please see W249. This deficiency was cited on 12/5/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-1(a)		completed. The QA Manager will be re-trained on the completion of a thorough investigation for those incidents that require an investigation be completed. **How others will be identified: (Systemic):** Administrative Observations have been implemented in the home by administrative staff to ensure that all client plans are being implemented as written, provide immediate re-training and re-direction as needed and training on the survey process, federal regulations, active treatment and implementation of plans. The Behavior Clinician and the QIDP are completing observations in the home. Immediate re-training for staff is being completed if necessary during observation periods. The Program Manager and the QA will review incident reports for the home at least five times weekly for the next 30 days and at least twice weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely	

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			and the peer review will review investigations at least weekly to ensure that investigations are thorough. **Measures to be put in place:** Client A is moving to an alternate location that will reduce the need for enhanced supervision levels and assist him in focusing on and working toward meeting his behavioral goals. All staff at the home will be re-trained on Client A's Behavior Support Plan and the enhanced supervision levels while in the home, during transportation and while in the community, ensuring that the enhanced supervision for Client A is implemented as written in the Behavior Support Plan and the Operation Standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment or violation of individual rights. An investigation in to the vehicle accident will be completed. The QA Manager will be re-trained on the completion of a thorough investigation for those incidents that require an investigation be completed.	

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			Monitoring of Corrective Action: Administrative Observations have been implemented in the home by administrative staff to ensure that all client plans are being implemented as written, provide immediate re-training and re-direction as needed and training on the survey process, federal regulations, active treatment and implementation of plans. The Behavior Clinician and the QIDP are completing observations in the home. Immediate re-training for staff is being completed if necessary during observation periods. The Program Manager and the QA will review incident reports for the home at least five times weekly for the next 30 days and at least twice weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough.	

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			Completion date: 2/23/17	
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 2 sampled clients (A). The facility neglected to implement its written policy and procedures to prevent abuse/neglect in regard to the safety of client A. The facility neglected to ensure facility staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The facility neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A. The facility failed to ensure a thorough investigation was completed of a vehicle accident involving client A. Findings include: 1. The facility neglected to implement its written policy and procedures to prevent abuse/neglect in regard to the safety of client A. The facility neglected to ensure	W 0122	**W122:** The facility must ensure that specific client protections requirements are met. **Corrective Action:** **(Specific):** All staff at the home will be re-trained on The Operation Standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment or violation of individual rights. All staff at the home will be re-trained on Client A's Behavior Support Plan and the enhanced supervision levels while in the home, during transportation and while in the community. All staff will be re-trained on ensuring that the enhanced supervision for Client A is implemented as written in the Behavior Support Plan. An investigation in to the vehicle accident will be completed. The QA Manager will be re-trained on the completion of a thorough investigation for those incidents that require an	02/23/2017

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	facility staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The facility neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A. Please see W149. 2. The facility failed to ensure a thorough investigation was completed of a vehicle accident involving client A. Please see W154. 3. The facility failed to ensure there was sufficient staff deployed in the home to ensure supervision of client A. Please see W186. 4. The facility failed to ensure client A's BSP (Behavior Support Plan) was implemented. Please see W249. 9-3-2(a)		investigation be completed. Client A is moving to an alternate location that will reduce the need for enhanced supervision levels and assist him in focusing on and working toward meeting his behavioral goals. **How others will be identified: (Systemic):** Administrative Observations have been implemented in the home by administrative staff to ensure that all client plans are being implemented as written. The Behavior Clinician and the QIDP are completing observations in the home. Immediate re-training for staff is being completed if necessary during observation periods. The Program Manager will review incident reports for the home with QA at least five times weekly for the next 30 days and at least twice weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough. **Measures to be put in place:** All staff at the home	

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			will be re-trained on The Operation Standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment or violation of individual rights. All staff at the home will be re-trained on Client A's Behavior Support Plan and the enhanced supervision levels while in the home, during transportation and while in the community. All staff will be re-trained on ensuring that the enhanced supervision for Client A is implemented as written in the Behavior Support Plan. An investigation in to the vehicle accident will be completed. The QA Manager will be re-trained on the completion of a thorough investigation for those incidents that require an investigation be completed. Client A is moving to an alternate location that will reduce the need for enhanced supervision levels and assist him in focusing on and working toward meeting his behavioral goals. **Monitoring of Corrective Action:** Administrative Observations have been implemented in the home by administrative staff to ensure	

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			that all client plans are being implemented as written. The Behavior Clinician and the QIDP are completing observations in the home. Immediate re-training for staff is being completed if necessary during observation periods. The Program Manager will review incident reports for the home with QA at least five times weekly for the next 30 days and at least twice weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough. **Completion date: 2/23/17**	
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.	W 0149	**W149:** That facility must develop and implement written policies	02/23/2017

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	Based on observation, record review and interview for 1 of 2 sampled clients (A), the facility neglected to implement its written policy and procedures to prevent abuse/neglect in regard to the safety of client A. The facility neglected to ensure facility staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The facility neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A. Findings include: Observation was conducted at the group home on 2/1/17 from 1:52 PM through 2:41 PM. At 1:52 PM House Manager (HM) #1, staff #1 and #2 were observed in the living room with client B. Client A was in his room alone sweeping the floor. Client C was in his room alone. At 2:10 PM HM #1 went into client A's room and helped him put his broom back together then returned to the living room. Client A remained in his room alone for the remainder of the observation period. The BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed on 1/31/17 at 1:30 PM. The BDDS reports indicated the following: -BDDS report dated 1/3/17, "[Client A] was in the van with staff going on an outing when he unbuckled his seatbelt and came to the front of the van. Before staff could stop the van, [client A] attempted to take a drink which was in the cup holder and then hit staff, causing staff to run off		and procedures that prohibit mistreatment, neglect or abuse of the client. **Corrective Action: (Specific):** Client A is moving to an alternate location that will reduce the need for enhanced supervision levels and assist him in focusing on and working toward meeting his behavioral goals. Client A's Behavior Support Plan has been updated to include enhanced supervision levels while at the day service as well as during transportation on the van which includes a one to one defined as within 5 feet at all times when in the community and outside the home including while at the ResCare Day Service and a one to one defined as sitting next to him in the van or in the seat directly in front of him during transport. The one to one staff during transport in the van is staff in addition to the driver. All staff at the home will be re-trained on The Operation Standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment or violation of individual rights. All staff at the home has been trained on the updated plan for Client A. Administrative Observations are being completed in the home to ensure that staff is implementing all client program plans as written and providing on-site training with staff as needed. In addition, the	

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	the road and hit a sign. Staff redirected [client A] and he got back into his seat and no other issues were noted on the drive back to the home. The nurse was contacted and [client A] was transported to the ER (Emergency Room) for evaluation. Upon arrival to the ER, [client A] was assessed and no new orders or diagnosis were given. [Client A] will follow up with his PCP (Primary Care Physician) as needed and staff will continue to monitor [client A] and report any complaints or concerns to the team. The team has met and [client A's] BSP (Behavior Support Plan) will be updated stating while [client A] is being transported his 1:1 (one on one) staff will sit directly next to him during the entirety of the transport and there will be another staff to drive the vehicle. Staff will be trained on the update and the plans are being implemented immediately." -BDDS report dated 1/11/17, "[Client A] was in the TV room at day program while another client began to have a behavior. Staff went to attend to the other client and calm them down. After 3-4 minutes staff looked back into the TV room and discovered [client A] had eloped. The team was notified of the information. Area Supervisor found [client A] about 1.5 miles from the office at a nearby business within 10 to 15 minutes of eloping. Police were called by the local business and arrived simultaneously as did the area supervisor. [Client A] was transported back to the office where he was examined by the nurse. All vitals were noted to be stable and there were no visible injuries. The team and guardian were notified of the information. Staff was placed on leave pending investigation into the incident." Client A's BSP was reviewed on 2/1/17 at 2:42 PM. Client A's 1/27/17 BSP indicated, "Staff will keep [client A] within line of sight while awake and 15 minute checks while asleep. This will		Behavior Clinician has completed observations during transport and in the community to ensure that Client A's plan is being implemented as written. **How others will be identified: (Systemic):** Administrative Observations have been implemented in the home by administrative staff to ensure that all client plans are being implemented as written. The Behavior Clinician and the QIDP are completing observations in the home. Immediate re-training for staff is being completed if necessary during observation periods. The Program Manager will review incident reports for the home with QA at least five times weekly for the next 30 days then at least twice weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough. All staff at the home has been trained on the Behavior Support Plans for all other clients in the home. **Measures to be put in place:** Client A is moving to an alternate location that will reduce the need for enhanced supervision levels and assist him in focusing on and working toward meeting his behavioral goals. Client A's Behavior Support Plan has been	

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	ensure staff personnel are able to promptly intervene if there is an impulsive event to occur and to prevent elopement. Staff will be one on one with [client A]; defined as within 5 feet of staff at all times when in the community due to unsafe pedestrian skills and elopement. The community is defined as any location outside of the home, which includes the day program. Due to unsafe behavior and physical aggression while in a vehicle (sic). The following will be implemented by staff personnel and explained to [client A] before each van ride. [Client A] is never to sit immediately in the row behind the driver. There should always be one row to make sure the driver can see him coming over the seat and get pulled over before [client A] gets to the driver. [Client A] will be 2:1 (two staff to one client) due to his impulsivity and physical aggression in the vehicle. One staff member should be either in the seat in front of [client A] to make sure he is unable to get to the driver or seated beside [client A] for the same reason. Staff should work diligently to keep [client A] within safe distance of themselves and other housemates to decrease incidents of physical aggression toward others." Program Manager (PM) #1 was interviewed on 2/1/17 at 3:01 PM. PM #1 indicated client A should be in line of sight supervision at all times when he is at home. PM #1 indicated client A should be 1 on 1 with staff when outside of the home. PM #1 indicated client A eloped from the day program due to staff misunderstanding they needed to stay with him while at the facility day program. PM #1 indicated when staff wrecked the van there was only one staff in the vehicle. PM #1 indicated staff did not call anyone until they had arrived back home to her knowledge. PM #1 indicated the only damage during the wreck was a mirror was knocked off of the van. PM #1		updated to include enhanced supervision levels while at the day service as well as during transportation on the van which includes a one to one defined as within 5 feet at all times when in the community and outside the home including while at the ResCare Day Service and a one to one defined as sitting next to him in the van or in the seat directly in front of him during transport. The one to one staff during transport in the van is staff in addition to the driver. All staff at the home will be re-trained on The Operation Standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment or violation of individual rights. All staff at the home has been trained on the updated plan for Client A. Administrative Observations are being completed in the home to ensure that staff is implementing all client program plans as written and providing on-site training with staff as needed. In addition, the Behavior Clinician has completed observations during transport and in the community to ensure that Client A's plan is being implemented as written. **Monitoring of Corrective Action:** Administrative Observations have been implemented in the home by administrative staff to ensure that all client plans are being	

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	indicated there was no investigation completed for the van wreck. PM #1 indicated client A's BSP has been adjusted to incorporate these incidents. Behavioral Consultant (BC) was interviewed on 2/1/17 at 9:20 AM. BC indicated client A had recently had a medication change. BC stated, "he will generally undergo a few weeks of worse behaviors before they can tell if the medications are helping him or not." BC indicated client A's BSP had been revised since a previous roommate had moved and with the elopement from day program. ResCare 1/2016 Abuse, Neglect, Exploitation, Mistreatment or Violation of Individual Rights policy was reviewed on 2/1/17 at 12:36 PM. ResCare Policy indicated, "All allegations of 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." 9-3-2(a)		implemented as written. The Behavior Clinician and the QIDP are completing observations in the home. Immediate re-training for staff is being completed if necessary during observation periods. The Program Manager will review incident reports for the home with QA at least five times weekly for the next 30 days then at least twice weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough. All staff at the home has been trained on the Behavior Support Plans for all other clients in the home. **Completion date: 2/23/17**	
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 4 allegations of abuse, neglect or injuries of unknown origin reviewed, the facility failed to ensure a thorough investigation was completed of a vehicle accident involving client A.	W 0154	**W154:** The facility must have evidence that all alleged violations are thoroughly investigated.	02/23/2017

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	Findings include: The BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed on 1/31/17 at 1:30 PM. The BDDS reports indicated the following: -BDDS report dated 1/3/17, "[Client A] was in the van with staff going on an outing when he unbuckled his seatbelt and came to the front of the van. Before staff could stop the van, [client A] attempted to take a drink which was in the cup holder and then hit staff, causing staff to run off the road and hit a sign. Staff redirected [client A] and he got back into his seat and no other issues were noted on the drive back to the home. The nurse was contacted and [client A] was transported to the ER (Emergency Room) for evaluation. Upon arrival to the ER, [client A] was assessed and no new orders or diagnosis were given. [Client A] will follow up with his PCP (Primary Care Physician) as needed and staff will continue to monitor [client A] and report any complaints or concerns to the team. The team has met and [client A's] BSP (Behavior Support Plan) will be updated stating while [client A] is being transported his 1:1 (one on one) staff will sit directly next to him during the entirety of the transport and there will be another staff to drive the vehicle. Staff will be trained on the update and the plans are being implemented immediately." No investigation was completed for this incident. Program Manager (PM) #1 was interviewed on 2/1/17 at 3:01 PM. PM #1 indicated there was no investigation done for this incident. Quality Assurance (QA) was interviewed on 2/1/17 at 3:01 PM. QA indicated there was no investigation done for this incident. QA indicated there is normally no investigation done for vehicle		**Corrective Action: (Specific):** An investigation in to the vehicle accident will be completed. The QA Manager will be re-trained on the completion of a thorough investigation for those incidents that require an investigation be completed. **How others will be identified: (Systemic):** The Program Manager will review incident reports for the home with QA at least five times weekly for the next 30 days then at least twice weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough. **Measures to be put in place:** An investigation in to the vehicle accident will be completed. The QA Manager will be re-trained on the completion of a thorough investigation for those	

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	accidents. 9-3-2(a)		incidents that require an investigation be completed. **Monitoring of Corrective Action:** The Program Manager will review incident reports for the home with QA at least five times weekly for the next 30 days then at least twice weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough. **Completion date: 2/23/17**	

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W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. 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. Based on observation, interview and record review for 1 of 2 sampled clients (A), the facility failed to ensure there was sufficient staff deployed in the home to ensure supervision of client A. Findings include: Observation was conducted at the group home on 2/1/17 from 1:52 PM through 2:41 PM. At 1:52 PM House Manager (HM) #1, staff #1 and #2 were observed in the living room with client B. Client A was in his room alone sweeping the floor. Client C was in his room alone. At 2:10 PM	W 0186	**W186:** The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. **Corrective Action: (Specific):** Client A's Behavior Support Plan has been updated to include enhanced supervision levels while at the day service as well as during transportation on the van which includes a one to one defined as within 5 feet at all times when in the community and outside the home including while at the ResCare Day Service and a one to one defined as sitting next to him in the van or in the seat directly in front of him during transport. The one to one staff	02/23/2017

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	HM #1 went into client A's room and helped him put his broom back together then returned to the living room. Client A remained in his room alone for the remainder of the observation period. The BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed on 1/31/17 at 1:30 PM. The BDDS reports indicated the following: -BDDS report dated 1/3/17, "[Client A] was in the van with staff going on an outing when he unbuckled his seatbelt and came to the front of the van. Before staff could stop the van, [client A] attempted to take a drink which was in the cup holder and then hit staff, causing staff to run off the road and hit a sign. Staff redirected [client A] and he got back into his seat and no other issues were noted on the drive back to the home. The nurse was contacted and [client A] was transported to the ER (Emergency Room) for evaluation. Upon arrival to the ER, [client A] was assessed and no new orders or diagnosis were given. [Client A] will follow up with his PCP (Primary Care Physician) as needed and staff will continue to monitor [client A] and report any complaints or concerns to the team. The team has met and [client A's] BSP (Behavior Support Plan) will be updated stating while [client A] is being transported his 1:1 (one on one) staff will sit directly next to him during the entirety of the transport and there will be another staff to drive the vehicle. Staff will be trained on the update and the plans are being implemented immediately." -BDDS report dated 1/11/17, "[Client A] was in the TV room at day program while another client began to have a behavior. Staff went to attend to the other client and calm them down. After 3-4 minutes staff looked back into the TV room and discovered [client A] had eloped. The team was		during transport in the van is staff in addition to the driver. All staff at the home has been trained on the updated plan for Client A. Administrative Observations are being completed in the home to ensure that staff is implementing all client program plans as written and providing on-site training with staff as needed. In addition, the Behavior Clinician has completed observations during transport and in the community to ensure that Client A's plan is being implemented as written. Client A is moving to an alternate location that will reduce the need for enhanced supervision levels and assist him in focusing on and working toward meeting his behavioral goals. **How others will be identified: (Systemic):** Administrative Observations in addition to the weekly observations being completed by the QIDP and the Behavior Clinician have been implemented in the home by administrative staff to ensure that all client plans are being implemented as written and providing additional training to staff as needed. The Program Manager will review incident reports for the home with QA at least five times weekly for the next 30 days then at least twice weekly thereafter to ensure that incidents requiring an	

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	notified of the information. Area Supervisor found [client A] about 1.5 miles from the office at a nearby business within 10 to 15 minutes of eloping. Police were called by the local business and arrived simultaneously as area supervisor. [Client A] was transported back to the office where he was examined by the nurse. All vitals were noted to be stable and there were no visible injuries. The team and guardian were notified of the information. Staff was placed on leave pending investigation into the incident." Client A's BSP was reviewed on 2/1/17 at 2:42 PM. Client A's 1/27/17 BSP indicated, "Staff will keep [client A] within line of sight while awake and 15 minute checks while asleep. This will ensure staff personnel are able to promptly intervene if there is an impulsive event to occur and to prevent elopement. Staff will be one on one with [client A]; defined as within 5 feet of staff at all times when in the community due to unsafe pedestrian skills and elopement. The community is defined as any location outside of the home, which includes the day program. Due to unsafe behavior and physical aggression while in a vehicle. The following will be implemented by staff personnel and explained to [client A] before each van ride. [Client A] is never to sit immediately in the row behind the driver. There should always be one row to make sure the driver can see him coming over the seat and get pulled over before [client A] gets to the driver. [Client A] will be 2:1 (two staff to one client) due to his impulsivity and physical aggression in the vehicle. One staff member should be either in the seat in front of [client A] to make sure he is unable to get to the driver or seated beside [client A] for the same reason. Staff should work diligently to keep [client A] within safe distance of themselves and other housemates to decrease incidents of physical aggression toward others."		investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough. All staff at the home has been trained on the Behavior Support Plans for all other clients in the home. **Measures to be put in place:** Client A's Behavior Support Plan has been updated to include enhanced supervision levels while at the day service as well as during transportation on the van which includes a one to one defined as within 5 feet at all times when in the community and outside the home including while at the ResCare Day Service and a one to one defined as sitting next to him in the van or in the seat directly in front of him during transport. The one to one staff during transport in the van is staff in addition to the driver. All staff at the home has been trained on the updated plan for Client A. Administrative Observations are being completed in the home to ensure that staff is implementing all client program plans as written and providing on-site training with staff as needed. In addition, the Behavior Clinician has completed observations during transport and in the community to ensure that Client A's plan is being implemented as written. Client A	

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	Program Manager (PM) #1 was interviewed on 2/1/17 at 3:01 PM. PM #1 indicated client A should be in line of sight at all times when he is at home. PM #1 indicated client A should be 1 on 1 with staff when outside of the home. PM #1 indicated client A eloped from the day program due to staff misunderstanding they needed to stay with him while at the facility day program. PM #1 indicated when staff wrecked the van there was only one staff in the vehicle. PM #1 indicated staff did not call anyone until they had arrived back home to her knowledge. PM #1 indicated the only damage during the wreck was a mirror was knocked off of the van. PM #1 indicated there was no investigation completed for the van wreck. PM #1 indicated client A's BSP has been adjusted to incorporate these incidents. This deficiency was cited on 12/5/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-3(a)		is moving to an alternate location that will reduce the need for enhanced supervision levels and assist him in focusing on and working toward meeting his behavioral goals. **Monitoring of Corrective Action:** Administrative Observations in addition to the weekly observations being completed by the QIDP and the Behavior Clinician have been implemented in the home by administrative staff to ensure that all client plans are being implemented as written and providing additional training to staff as needed. The Program Manager will review incident reports for the home with QA at least five times weekly for the next 30 days then at least twice weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough. All staff at the home has been trained on the Behavior Support Plans for all other clients in the home. **Completion date: 2/23/2017**	

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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 2 sampled clients (A), the facility failed to ensure client A's (line of sight supervision) BSP (Behavior Support Plan) was implemented. Findings include: Observation was conducted at the group home on 2/1/17 from 1:52 PM through 2:41 PM. At 1:52 PM House Manager (HM) #1, staff #1 and #2 were observed in the living room with client B. Client A was in his room alone sweeping the floor. Client C was in his room alone. At 2:10 PM HM #1 went into client A's room and helped him put his broom back together then returned to the living room. Client A remained in his room alone for the remainder of the observation period. The BDDS (Bureau of Developmental Disabilities Services) Reports were reviewed on 1/31/17 at 1:30 PM. The BDDS reports indicated	W 0249	**W249:** As soon as the interdisciplinary team has formulated a clients' 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. **Corrective Action: (Specific):** Administrative Observations are being completed in the home to ensure that staff is implementing all client	02/23/2017

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	the following: -BDDS report dated 1/3/17, "[Client A] was in the van with staff going on an outing when he unbuckled his seatbelt and came to the front of the van. Before staff could stop the van, [client A] attempted to take a drink which was in the cup holder and then hit staff, causing staff to run off the road and hit a sign. Staff redirected [client A] and he got back into his seat and no other issues were noted on the drive back to the home. The nurse was contacted and [client A] was transported to the ER (Emergency Room) for evaluation. Upon arrival to the ER, [client A] was assessed and no new orders or diagnosis were given. [Client A] will follow up with his PCP (Primary Care Physician) as needed and staff will continue to monitor [client A] and report any complaints or concerns to the team. The team has met and [client A's] BSP (Behavior Support Plan) will be updated stating while [client A] is being transported his 1:1 (one on one) staff will sit directly next to him during the entirety of the transport and there will be another staff to drive the vehicle. Staff will be trained on the update and the plans are being implemented immediately." -BDDS report dated 1/11/17, "[Client A] was in the TV room at day program while another client began to have a behavior. Staff went to attend to the other client and calm them down. After 3-4 minutes staff looked back into the TV room and discovered [client A] had eloped. The team was notified of the information. Area Supervisor found [client A] about 1.5 miles from the office at a nearby business within 10 to 15 minutes of eloping. Police were called by the local business and arrived simultaneously as area supervisor. [Client A] was transported back to the office where he was examined by the nurse. All vitals were noted to be stable and there were no visible		program plans as written and providing on-site training with staff as needed. In addition, the Behavior Clinician has completed observations during transport and in the community to ensure that Client A's plan is being implemented as written. Client A's Behavior Support Plan has been updated to include enhanced supervision levels while at the day service as well as during transportation on the van which includes a one to one defined as within 5 feet at all times when in the community and outside the home including while at the ResCare Day Service and a one to one defined as sitting next to him in the van or in the seat directly in front of him during transport. The one to one staff during transport in the van is staff in addition to the driver. All staff at the home has been trained on the updated plan for Client A. **How others will be identified: (Systemic):** Administrative Observations in addition to the weekly	

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RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(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
	injuries. The team and guardian were notified of the information. Staff was placed on leave pending investigation into the incident." Client A's BSP was reviewed on 2/1/17 at 2:42 PM. Client A's 1/27/17 BSP indicated, "Staff will keep [client A] within line of sight while awake and 15 minute checks while asleep. This will ensure staff personnel are able to promptly intervene if there is an impulsive event to occur and to prevent elopement. Staff will be one on one with [client A]; defined as within 5 feet of staff at all times when in the community due to unsafe pedestrian skills and elopement. The community is defined as any location outside of the home, which includes the day program. Due to unsafe behavior and physical aggression while in a vehicle. The following will be implemented by staff personnel and explained to [client A] before each van ride. [Client A] is never to sit immediately in the row behind the driver. There should always be one row to make sure the driver can see him coming over the seat and get pulled over before [client A] gets to the driver. [Client A] will be 2:1 (two staff to one client) due to his impulsivity and physical aggression in the vehicle. One staff member should be either in the seat in front of [client A] to make sure he is unable to get to the driver or seated beside [client A] for the same reason. Staff should work diligently to keep [client A] within safe distance of themselves and other housemates to decrease incidents of physical aggression toward others." Client A's previous BSP dated 9/27/16 indicated, "[Client A] should be in line of sight at all times, and one to one supervision while in the shower." Program Manager (PM) #1 was interviewed on 2/1/17 at 3:01 PM. PM #1 indicated client A should be in line of sight at all times when he is at home. PM #1 indicated client A should be 1 on 1		observations being completed by the QIDP and the Behavior Clinician have been implemented in the home by administrative staff to ensure that all client plans are being implemented as written and providing additional training to staff as needed. The Program Manager will review incident reports for the home with QA at least five times weekly for the next 30 days then at least twice weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough. All staff at the home has been trained on the Behavior Support Plans for all other clients in the home. **Measures to be put in place:** Client A's Behavior Support Plan has been updated to include enhanced supervision levels while at the day service as well as during transportation on the van which includes a one to one defined as within 5 feet at all times when in the community and outside the home	

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	with staff when outside of the home. PM #1 indicated client A eloped from the day program due to staff misunderstanding they needed to stay with him while at the facility day program. This deficiency was cited on 12/5/16. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-4(a)		including while at the ResCare Day Service and a one to one defined as sitting next to him in the van or in the seat directly in front of him during transport. The one to one staff during transport in the van is staff in addition to the driver. All staff at the home has been trained on the updated plan for Client A. Administrative Observations are being completed in the home to ensure that staff is implementing all client program plans as written and providing on-site training with staff as needed. In addition, the Behavior Clinician has completed observations during transport and in the community to ensure that Client A's plan is being implemented as written. **Monitoring of Corrective Action:** Administrative Observations in addition to the weekly observations being completed by the QIDP and the Behavior Clinician have been implemented in the home by administrative staff to ensure that all client plans are being implemented as written and providing additional	

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			training to staff as needed. The Program Manager will review incident reports for the home with QA at least five times weekly for the next 30 days then at least twice weekly thereafter to ensure that incidents requiring an investigation have an investigation initiated timely and the peer review will review investigations at least weekly to ensure that investigations are thorough. All staff at the home has been trained on the Behavior Support Plans for all other clients in the home. **Completion date: 2/23/2017**	