PRINTED:	04/27/2022
FORM API	PROVED

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G167		(X2) MULTIPLE ( A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/01/2022	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
RES CAI	RE COMMUNITY A	ALTERNATIVES SE IN		CH LICK, IN 47432		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	-	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION	
TAG W 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG		DATE	
Bldg. 00						
Blag. 00		a predetermined full state licensure survey.	W 0000			
	Survey Dates: 3/28 and 4/1/22.	3/22, 3/29/22, 3/30/22, 3/31/22				
	Facility Number: 0 Provider Number: AIM Number: 100	15G167				
	accordance with 46	also reflect state findings in 50 IAC 9. this report completed by #15068				
W 0125	483.420(a)(3)					
Bldg. 00	The facility must clients. Therefore encourage individ rights as clients of citizens of the Un	F CLIENTS RIGHTS ensure the rights of all e, the facility must allow and dual clients to exercise their of the facility, and as lited States, including the aints, and the right to due				
	Based on observati review for 7 of 7 c (#1, #2, #3, #4, #5, ensure the clients h	ion, interview and record lients living in the group home #6 and #7), the facility failed to had the right to due process in ng of laundry and dishwasher	W 0125	To correct the deficient practice the locks have been removed from the chemical cabinetsAll site staff have been trained to ensure no unauthorized restrictions are bein usedAdditionally, the QIDP will review all client and to ensure the	g	
	Findings include:			chemical restriction is not neededlf needed, the IDT will		
		:29 AM to 7:53 AM, an		convene to adjust the plans and		
		onducted at the group home. At		submit to HRCOngoing monitorin	g	
	1 0:41 AM, staff #3	used keys to unlock a cabinet in	1	will be achieved through monthly		

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds 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 disclo 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.

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER 15G167		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 04/01/2022	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 749 SOUTH BEARS BEND ROAD					
RES CA		LTERNATIVES SE IN		FRENC	CH LICK, IN 47432		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	ROPRIATE	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION		TAG	ResCare administration		DATE
	the washer and lock staff #3 entered the a dishwasher pod fi	the cabinet. At 7:21 AM, medication room and retrieved rom a locked cabinet. This #2, #3, #4, #5, #6 and #7.			staff. Additionally, the HF committee will review res quarterly and as needed.		
	record was conduct Individual Support Modification of Ind -"Right to be modifi personal property: i Manner in which th Individual will be 1 with the assistance representative. Reason the modific the safeguards of fu so as to benefit the -Right to be Modifi Manner in which th Individual will be r	fied: Freedom to full access to funds. he right will be modified: imited to accessing funds only of and (sic) healthcare ration is needed: To provide for unds, and usage of such funds					
	Individual will be s within the commun Reason the modific social behavior and	upervised during activities					
	medications Manner in which th Administration of I Lithium Carb (carb (behavior support p Reason the modific	ed: Freedom from use of ne right will be modified: Effexor (depression) and onate) (depression) per BSP blan). Pation is needed: To aid in symptoms of depression and					

PRINTED: 04/27/2022

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 15G167		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 04/01/2022	
	PROVIDER OR SUPPLI	ER ALTERNATIVES SE IN	749 SO	ADDRESS, CITY, STATE, ZIP OUTH BEARS BEND R CH LICK, IN 47432		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) Completio Date
		cumentation client #1 needed a undry or dishwasher cleaning				
	record was condu	0 PM, a review of client #2's cted. Client #2's 5/27/21 ISP had dification of Individual's Rights:				
	personal property Manner in which Individual will be	dified: Freedom to full access to -funds. the right will be modified: limited to accessing funds only e of ResCare Group Home				
	IDT (Interdiscipli Reason the modif	ication is needed: To provide for funds, and usage of such funds				
	Manner in which Individual will be building and grou Individual will be within the commu Reason the modif	fied: Freedom of movement. the right will be modified: restricted to the areas of the nds supervised by staff. supervised during activities unity. ication is needed: To provide for e, and health of the individual.				
	medication. Manner in which Administration of Doxycycline (anti and Melatonin (sl Reason the modif [client #2's] Reyn which some areas in certain circums	fied: Freedom from use of the right will be modified: 'Diltiazem (high blood pressure), biotic), Zyrtec (antihistamine) eep) per Physicians Orders. ication is needed: To help with aud's Syndrome (a condition in of the body feel numb and cool tances), Rosacea (a condition as and often small, red, on the face).				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN OF C	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G167		A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/01/2022	
	VIDER OR SUPPLIE	R ALTERNATIVES SE IN	749 SC	ADDRESS, CITY, STATE, ZIP C DUTH BEARS BEND RO CH LICK, IN 47432			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
m M In or m II R th in -T resu SU O resu th In w w R R th so SU SU SU SU SU SU SU SU SU SU SU SU SU	edication. Ianner in which the adividual will be had with the assist anager/staff as a DT. eason the modifi- te safety, welfare adividual." There was no doce estriction from la upplies. In 3/29/22 at 2:40 cord was conduce the following Mode applies. In 3/29/22 at 2:40 cord was conduce the following Mode applies. Right to be mode resonal property Ianner in which the adividual will be ith the assistance presentative. eason the modifi- te safeguards of the ast to benefit the adividual will be uilding and groun- adividual will be uilding and groun- adividual will be adividual be advior and advidual be advidual	the right will be modified: limited to accessing funds only e of an healthcare acation is needed: To provide for funds, and usage of such funds e individual. fied: Freedom of movement the right will be modified: restricted to the areas of the nds supervised by staff. supervised during activities					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER 15G167		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 04/01/2022	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		749 SO	DDRESS, CITY, STATE, ZIP COD UTH BEARS BEND ROAD H LICK, IN 47432	)	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETIC DATE
		rumentation client #3 needed a undry or dishwasher cleaning					
	#4's 8/20/21 ISP M Rights. There was	5 PM, a focused review of client Addification of Individual's no documentation client #4 n from laundry or dishwasher					
	#5's 7/13/21 ISP M Rights was conduc documentation cli	3 PM, a focused review of client Aodification of Individual's cted. There was no ent #5 needed a restriction from sher cleaning supplies.					
	#6's 5/1/21 ISP M was conducted.	l PM, a focused review of client odification of Individual's Rights There was no documentation restriction from laundry or ng supplies.					
	and dishwasher su could consume the which clients were supplies, staff #3 s	) AM, staff #3 stated the laundry pplies were locked "so no one em". When staff #3 was asked e at risk of consuming cleaning stated, "I'm not sure who would, locked for safety."					
	Disabilities Profes time the pods show (Human Rights Co clients after they h risk of consumption was an unnecessar "I have never been	06 AM, the Qualified Intellectual asional (QIDP) stated, "The only ald be locked is if we have HRC ommittee) approval for the nave been determined to be at on." The QIDP indicated this ry restriction. The QIDP stated, n told any of the clients in the ted to consume these					

STATEME	FEMENT OF DEFICIENCIES       X1) PROVIDER/SUPPLIER/CLIA         PLAN OF CORRECTION       IDENTIFICATION NUMBER         15G167		CORRECTION IDENTIFICATION NUMBER A. BUILDING 00		
	PROVIDER OR SUPPLIE	R R LTERNATIVES SE IN	749 SC	ADDRESS, CITY, STATE, ZIP COD DUTH BEARS BEND ROAD CH LICK, IN 47432	-
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	9-3-2(a)				
W 0159	483.430(a) QIDP				
Bldg. 00	be integrated, co	ordinated and monitored by			
	QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional		W 0159	To correct the deficient practi the QIDP will be re-trained or quarterly reviewsThe QIDP w create a quarterly meeting schedule for each client and a QIDP LeadUpon completion of quarterly, the QIDP will subm documentation to the QIDP L for reviewOngoing monitoring be achieved through weekly of meetings to ensure all quarter and annuals are scheduled/documented	n rill to the of the it the ead g will QIDP

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: W4GO11 Facility ID: 000701

If continuation sheet Page 6 of 8

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	rement of deficiencies       X1) PROVIDER/SUPPLIER/CLIA         PLAN OF CORRECTION       IDENTIFICATION NUMBER         15G167		(X2) MULTIPLE C A. BUILDING B. WING	00	CON 04/0	te survey 1pleted 01/2022
	PROVIDER OR SUPPLII	R ALTERNATIVES SE IN	749 SC	ADDRESS, CITY, STATE, ZIP DUTH BEARS BEND R CH LICK, IN 47432		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	I SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
	-	uarterly review on 3/2/22. There reviews present.				
	record was conduct the following train -"[Client #2] will with 2 verbal prom- month across 6 co- -[Client #2] will in prompts 40% of of consecutive month -[Client #2] will in than 2 bath towels fewer verbal prom- month for 6 month -[Client #2] will in fewer verbal prom- month for 6 month -[Client #2] will in fewer verbal prom- month for 6 month -[Client #2] will in month for 6 month -[Client #2] will in medication box ar- time with one verbal	maintain social distancing daily npts 80% of opportunities per nsecutive months by 11/27/21. dentify a quarter with 3 verbal pportunities per month across 6 ns by 11/27/21. use one wash cloth and no more when showering with 2 or upts 70% of opportunities per ns by 11/27/21. shower for 30 minutes with 2 or upts 60% opportunities per				
	-	rterly reviews on 4/17/21 and ere no other quarterly reviews				
	record was conduct had the following -"[Client #3] will gestural prompts ( consecutive month -[Client #3] will in 2 verbal prompts ( across 6 consecutive	training objectives: complete his shower with 50% of opportunities across 6				

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	ULTIPLE CC JILDING	DNSTRUCTION 00	(X3) DATE COMPI	
	or condensiv	15G167	B. W		<u></u>	04/01/2022	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		749 SO	ADDRESS, CITY, STATE, ZIP COD OUTH BEARS BEND ROAD CH LICK, IN 47432	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	<ul> <li>40% of the opportune</li> <li>40% of the opportune</li> <li>-[Client #3] will brich brich by 9/01/22.</li> <li>-[Client #3] will brich by 9/01/22.</li> <li>-Client #3 had quarter</li> <li>3/2/22. There were present.</li> <li>On 3/31/22 at 10:14</li> <li>ISP was to be reviewed by the quarterly reviewed by the quarter of the qu</li></ul>	bennies with 2 verbal prompts nities across 6 consecutive ng his hearing aid to staff to vith 2 or fewer verbal prompts ortunities across 6 consecutive " terly reviews on 3/4/21 and no other quarterly reviews 4 AM, the QIDP indicated the wed every 3 months. The QIDP s responsible for completing vs. I know that I have had the I am not sure where the					

W4GO11 Facility ID: 000701