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

FORM APPROVED
OMB NO. 0938-0391

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	07/19/2021

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

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00355167. This visit was in conjunction with a post certification revisit (PCR) to the recertification and state licensure survey completed on 5/14/21. Complaint #IN00355167: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W104 and W231. Survey dates: 7/15/21, 7/16/21 and 7/19/21. Facility Number: 000775 Provider Number: 15G255 AIM Number: 100248960 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 7/27/21.	W 0000		
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 record review and interview for 1 of 3 sampled clients (A), the facility's governing body failed to exercise operating direction over the facility to ensure client A's behavioral strategies identified successful objectives to prevent continued reoccurrence of client A's refusal to use his medical bed which led to an incident on 6/3/21 that resulted in client A sustaining a shoulder injury.	W 0104	**W104:** The governing body must exercise general policy, budget and operating direction over the facility. **Corrective Action:** · IDT team met on 7/19/21 to discuss behavior plan strategies. **(Attachment A)** · QIDP will conduct observations weekly at the	08/12/2021

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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	Findings include: On 7/15/21 at 2:53 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying Investigative Summaries was completed. The reports indicated: -BDDS report dated 5/23/21 indicated, "Staff was using the bathroom heard (sic) and heard a loud thud come from [client A's] bedroom. When staff entered [client A's] bedroom he was laying on the floor on his right side beside his bed. Staff lifted him up off the floor and put him back in bed. Staff checked him for injuries but found no visual injuries. [Client A] has a bed alarm that did not sound. Staff found that [client A] had unplugged the bed alarm". Investigation summary dated 5/23/21 indicated, "Investigation type: Fall - not witnessed. Recommendations: 1) Reposition bed alarm so he couldn't unplug. 2) Staff will carry audio monitor on staff when [client A] is in bed. 3) Keep busy throughout day avoiding naps. 4) Coffee reinforcer if he sleeps in bed". -BDDS report dated 6/4/21 indicated, "[Client A] has been experiencing issues of refusing to sleep in his bed. He will beat on the walls while in bed with his right hand and arm and he uses the half bed rail to secure himself and slide out of the bed onto the floor. Staff monitor for bruising. Yesterday morning while staff was showering him they noticed bruising on his right shoulder collar bone area. The bruising measures approximately 6" (inches) from his shoulder down his back and 5" from his shoulder down his breast. He was taken to [hospital] in [city] for evaluation of the bruise. At the ER (emergency		location to ensure all plans in place are effective and discuss with staff any concerns they have. **(Attachment B)** · QIDP completed an addendum to client (A) plans to include updated behavioral strategies to offer additional options for refusals. **(Attachment C)** · All staff trained on QIDP addendum. **(Attachment D)** · Area Supervisor completes weekly checks at the facility to monitor for any concerns or issues. **(Attachment E)** · IDT will meet weekly to ensure all concerns, behavior changes and client concerns are identified and addressed. **(Attachment F)** · QIDP will initiate daily email updates to the team to discuss and monitor client (A) progress and any changes that need made to his plans. **(Attachment G)** · Site reviews are completed monthly by Rescare Management to ensure there are no environmental issues or concerns. **(Attachment H)** · Upon exiting with a surveyor Rescare Management will meet the day of the exit to discuss the findings and work on implantation of plans, changes to plans, trainings for staff. **(Attachment G)** · Area Supervisor as well as	

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	room) his blood pressure was low. Testing revealed he has a right shoulder AC (Acromioclavicular) joint separation ... He was released with a referral to see orthopedic for his shoulder". Investigation summary dated 6/11/21 indicated, "Summary: 1) [Client A] was taken to ER for evaluation of bruising to his shoulder on 6/3/21. 2) [Client A] has been experiencing behavioral issues of refusing to sleep in his bed. He will beat on the walls while in bed with his right hand and arm and he uses the half bed rail to secure himself and slide out of the bed onto the floor. 3) Review of behavioral incident reports find (sic) [client A] experienced behavioral incidents on 5/16/21 ... 5/23/21 at 8:45 PM ... 5/23/21 at 3:30 AM ... 5/24/21 at 1:00 AM ... 5/24/21 at 3:15 AM ... and 5/24/21 at 5:00 AM. 4) IDT (Interdisciplinary Team) met 5/25/21 behavioral changes made - padding / mat placed on wall to provide [client A] with cushion while striking the wall. 5) Staff have been monitoring for bruising due to these behaviors. 6) On 6/3/21 while staff was showering him they noticed bruising on his right shoulder collar bone area. The bruising measured approximately 6" from his shoulder down his back and 5" from his shoulder down his breast. 7) [Client A] was taken to [hospital] in [city] for evaluation of the bruise. At the ER his blood pressure was low. Testing revealed he has a right shoulder AC joint separation ... He was released with a referral to see orthopedic for his shoulder. 8) [Client A] follow-up with ortho-[city] today (6/9/21) - orders to rest and ice. 9) [Client A] refuses to sleep in his hospital bed with the pressure mattress ... Recommendations: Currently in PT (Physical Therapy) for strengthening. 2) Mat placed on wall to avoid future injury to his arm, hand, shoulder, rib cage,		the QIDP will conduct monthly house meetings with all staff to review plans and any concerns. **(Attachment G)** **Monitoring of Corrective Action:** · Area Supervisor submits weekly check to the Program Manager to ensure completion. · IDT meeting minutes are sent to the Program Manager upon completion of the meeting as well as filed in the clients home chart. · QIDP daily emails will include all team members for client (A). · Site reviews are entered into the CRM database for monitoring and to ensure completion. · All updates to the clients plans are sent to all team members, staff are trained on plans and changes to plans by the QIDP, plans are then filed in the home charts. **Completion Date: 8/12/21**	

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legs. 3) Discussing with wound care use of a pressure mattress - refuses to sleep on mattress ...".

On 7/16/21 at 10:15 AM client A's record was reviewed. The record indicated the following:

-IDT dated 5/25/21 indicated, "IDT held today to discuss [client A's] current behavioral issues surrounding his refusal to sleep in his hospital bed with the pressure release mattress". 1) Turn the hospital bed around to eliminate [client A] pulling the plug on the alarm ... 2) Reviewed observation of pressure release mat and found mattress does feel cold to touch, uncomfortable and when he sits up the mattress moves, and the cold metal bar goes into his legs - will discuss with wound doctor discontinuation of mattress. New hospital mattress will be delivered to home. 3) Process in place to order Amish bed. 4) The audio monitor will be carried by staff on their person when [client A] is in bed. 5) Promote and keep [client A] involved in activity / redirect to keep him busy throughout the day eliminating any naps. 6) Maintenance order completed to place mat on wall to avoid injury when striking the wall when in bed. Reactive strategy if [client A] is in bed during night screaming or yelling: 1) Staff will go to room and remind [client A] if he stays in bed and sleeps he will receive (in a special cup he has picked out) a cup of coffee prepared according to his diet plan; in addition to his regular morning coffee".

-Active Treatment Observation dated 5/27/21 indicated, "Stayed awake until 1 AM - did display agitation. [Client A] says he does not like his bed".

-Active Treatment Observation dated 6/3/21

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	indicated, "[Staff #8] could not convince [client A] to get into bed". -Active Treatment Observation dated 6/4/21 indicated, "[Staff #8] was worried about [client A] coming out of the bed once I leave, after helping put him in bed". -Active Treatment Observation dated 6/7/21 indicated, "Several incidents of refusal to stay in bed ... yelling, screaming, hitting walls - trying to get out of bed". -Active Treatment Observation dated 6/10/21 indicated, "Was very unhappy to be in his bedroom, chair, just was not happy throughout the night". -Active Treatment Observation dated 7/7/21 indicated, "Was not happy to be in bed, wanted back in his recliner and then back to his wheelchair then back to bed". -Behavior Support Plan (BSP) dated 6/11/21 indicated, "Definition of Behaviors: ... Refusals to stay in bed at bedtime defined as, "[Client A] will scream, yell 'Hey get me out of here'. [Client A] will beat, hit his bedroom wall, bed rails, unplug his bed alarm, throws his pillows on the floor, take hold of the bedrails and scoots out of the bed onto the floor and yells 'help' to get him into his recliner. Proactive Strategies indicated, "Keep [client A] involved in busy activities throughout the day. Staff will carry/wear audio monitor when [client A] is in bed. Ensure bed alarm is turned with cord toward the wall, and control/sensor unit hooked to the bottom of the bed. Mat to be on the wall next to bed to prevent bruising if [client A]			

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should beat/hit his wall next to his bed.

Refusal to stay in bed: Ask [client A] to identify why he is upset and provide [client A] with an opportunity to tell staff what is bothering him. Try to meet what [client A] needs or wants. If [client A] wants out of bed transfer him to where he wants to be (wheelchair/recliner/ couch). After some time if [client A] appears sleepy or asks to go to bed transfer him to his bed. If unable to meet his request and [client A] continues to display agitation discuss with [client A] the importance of getting a good night's sleep. Remind [client A] that if he sleeps in his bed all night, he will get a special coffee in a special cup in the morning ...".

On 7/16/21 at 11:12 AM, the Qualified Intellectual Disabilities Professional (QIDP) and the Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDPs were asked why client A had sustained a shoulder injury identified within the 6/3/21 BDDS incident report. The QIDPs indicated the investigation had determined client A's shoulder injury was contributed to client A's behavior for refusing to sleep in his medical bed and the use of his air flow mattress.

The QIDP's were asked why client A's behavioral strategies for the refusal to use his bed failed to prevent his shoulder injury identified on 6/3/21. The QIDP stated, "We identified the mattress was the issue. We ordered the mattress (replacement), but it didn't come in until the 3rd (6/3/21). The QIDPD stated, "We were not forcing him to stay in the bed and to offer alternatives for sleeping". The QIDPs were asked when the mattress had been found to be the source of client A's refusal to use his medical

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	bed. The QIDPs indicated during the 5/25/21 IDT meeting. The QIDPs indicated the replacement mattress did not arrive until 6/3/21 and was after client A had already sustained the shoulder injury. The QIDPs were asked why client A's behavioral strategies to redirect and use an incentive with coffee continued after the IDT on 5/25/21 if the mattress and bed combination had been identified as the perpetuating issues that contributed to client A's behavior which was also supported from the Active Treatment observations of client A's dislike for his bed. The QIDPs indicated the alternative sleeping arrangements with a more relaxed bedtime schedule and use of his rocker recliner and wheelchair were not realized until after the injury on 6/3/21 and once the new mattress was obtained 8 days later after the IDT on 5/25/21. On 7/16/21 at 11:33 AM, the Program Manager (PM) was interviewed. The PM was asked about client A's behavioral strategies for the refusal to use his bed and the lack of successful objectives implemented between the 5/25/21 IDT identifying the medical bed and air flow mattress as the perpetuating issues for client A's behavior prior to the shoulder injury sustained on 6/3/21. The PM stated, "I can agree we didn't find an alternative. We knew it was an issue and we didn't provide an alternative (sleeping arrangement before injury on 6/3/21). I can see that". This federal tag relates to complaint #IN00355167. 9-3-1(a)			

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W 0231 Bldg. 00	483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A's behavioral strategies identified successful objectives to prevent continued reoccurrence of client A's refusal to use his medical bed which led to an incident on 6/3/21 that resulted in client A sustaining a shoulder injury. Findings include: On 7/15/21 at 2:53 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying Investigative Summaries was completed. The reports indicated: -BDDS report dated 5/23/21 indicated, "Staff was using the bathroom heard (sic) and heard a loud thud come from [client A's] bedroom. When staff entered [client A's] bedroom he was laying on the floor on his right side beside his bed. Staff lifted him up off the floor and put him back in bed. Staff checked him for injuries but found no visual injuries. [Client A] has a bed alarm that did not sound. Staff found that [client A] had unplugged the bed alarm". Investigation summary dated 5/23/21 indicated, "Investigation type: Fall - not witnessed. Recommendations: 1) Reposition bed alarm so he couldn't unplug. 2) Staff will carry audio monitor on staff when [client A] is in bed. 3) Keep busy throughout day avoiding naps. 4) Coffee reinforcer if he sleeps in bed".	W 0231	**W231:** The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. **Corrective Action:** · IDT team met on 7/19/21 to discuss behavior plan strategies. **(Attachment A)** · QIDP will conduct observations weekly at the location to ensure all plans in place are effective and discuss with staff any concerns they have. **(Attachment B)** · QIDP completed an addendum to client (A) plans to include updated behavioral strategies to offer additional options for refusals. **(Attachment C)** · All staff trained on QIDP addendum. **(Attachment D)** · Area Supervisor completes weekly checks at the facility to monitor for any concerns or issues. **(Attachment E)** · IDT will meet weekly to ensure all concerns, behavior changes and client concerns are identified and addressed. **(Attachment F)** · QIDP will initiate daily	08/12/2021

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	-BDDS report dated 6/4/21 indicated, "[Client A] has been experiencing issues of refusing to sleep in his bed. He will beat on the walls while in bed with his right hand and arm and he uses the half bed rail to secure himself and slide out of the bed onto the floor. Staff monitor for bruising. Yesterday morning while staff was showering him they noticed bruising on his right shoulder collar bone area. The bruising measures approximately 6" (inches) from his shoulder down his back and 5" from his shoulder down his breast. He was taken to [hospital] in [city] for evaluation of the bruise. At the ER (emergency room) his blood pressure was low. Testing revealed he has a right shoulder AC (Acromioclavicular) joint separation ... He was released with a referral to see orthopedic for his shoulder". Investigation summary dated 6/11/21 indicated, "Summary: 1) [Client A] was taken to ER for evaluation of bruising to his shoulder on 6/3/21. 2) [Client A] has been experiencing behavioral issues of refusing to sleep in his bed. He will beat on the walls while in bed with his right hand and arm and he uses the half bed rail to secure himself and slide out of the bed onto the floor. 3) Review of behavioral incident reports find (sic) [client A] experienced behavioral incidents on 5/16/21 ... 5/23/21 at 8:45 PM ... 5/23/21 at 3:30 AM ... 5/24/21 at 1:00 AM ... 5/24/21 at 3:15 AM ... and 5/24/21 at 5:00 AM. 4) IDT (Interdisciplinary Team) met 5/25/21 behavioral changes made - padding / mat placed on wall to provide [client A] with cushion while striking the wall. 5) Staff have been monitoring for bruising due to these behaviors. 6) On 6/3/21 while staff was showering him they noticed bruising on his right shoulder collar bone area. The bruising		email updates to the team to discuss and monitor client (A) progress and any changes that need made to his plans. **(Attachment G)** · Site reviews are completed monthly by Rescare Management to ensure there are no environmental issues or concerns. **(Attachment H)** · Client (A) mattress was previously replaced and upon return from a recent hospital admission and egg crate pad was placed on top of his current mattress for added protection from skin issues. **(Attachment I)** · Area Supervisor as well as the QIDP will conduct monthly house meetings with all staff to review plans and any concerns. **(Attachment G)** **Monitoring of Corrective Action:** · QIDP will send all meeting notes, updated plans to the Program Manager for review. · Area Supervisor will send completed weekly checks to the Program Manager. · QIDP will conduct IDT meetings with all team members quarterly and as needed. · The QIDP will review all program plans quarterly and as needed and will also be noted when completing consumer monthly summaries.	

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	measured approximately 6" from his shoulder down his back and 5" from his shoulder down his breast. 7) [Client A] was taken to [hospital] in [city] for evaluation of the bruise. At the ER his blood pressure was low. Testing revealed he has a right shoulder AC joint separation ... He was released with a referral to see orthopedic for his shoulder. 8) [Client A] follow-up with ortho-[city] today (6/9/21) - orders to rest and ice. 9) [Client A] refuses to sleep in his hospital bed with the pressure mattress ... Recommendations: Currently in PT (Physical Therapy) for strengthening. 2) Mat placed on wall to avoid future injury to his arm, hand, shoulder, rib cage, legs. 3) Discussing with wound care use of a pressure mattress - refuses to sleep on mattress ...". On 7/16/21 at 10:15 AM client A's record was reviewed. The record indicated the following: -IDT dated 5/25/21 indicated, "IDT held today to discuss [client A's] current behavioral issues surrounding his refusal to sleep in his hospital bed with the pressure release mattress". 1) Turn the hospital bed around to eliminate [client A] pulling the plug on the alarm ... 2) Reviewed observation of pressure release mat and found mattress does feel cold to touch, uncomfortable and when he sits up the mattress moves, and the cold metal bar goes into his legs - will discuss with wound doctor discontinuation of mattress. New hospital mattress will be delivered to home. 3) Process in place to order Amish bed. 4) The audio monitor will be carried by staff on their person when [client A] is in bed. 5) Promote and keep [client A] involved in activity / redirect to keep him busy throughout the day eliminating any naps. 6) Maintenance order completed to place mat on wall to avoid injury when striking the wall		· Area Supervisor will send monthly house meeting inservice to the Program Manager for review. **Completion Date: 8/12/21**	

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	when in bed. Reactive strategy if [client A] is in bed during night screaming or yelling: 1) Staff will go to room and remind [client A] if he stays in bed and sleeps he will receive (in a special cup he has picked out) a cup of coffee prepared according to his diet plan; in addition to his regular morning coffee". -Active Treatment Observation dated 5/27/21 indicated, "Stayed awake until 1 AM - did display agitation. [Client A] says he does not like his bed". -Active Treatment Observation dated 6/3/21 indicated, "[Staff #8] could not convince [client A] to get into bed". -Active Treatment Observation dated 6/4/21 indicated, "[Staff #8] was worried about [client A] coming out of the bed once I leave, after helping put him in bed". -Active Treatment Observation dated 6/7/21 indicated, "Several incidents of refusal to stay in bed ... yelling, screaming, hitting walls - trying to get out of bed". -Active Treatment Observation dated 6/10/21 indicated, "Was very unhappy to be in his bedroom, chair, just was not happy throughout the night". -Active Treatment Observation dated 7/7/21 indicated, "Was not happy to be in bed, wanted back in his recliner and then back to his wheelchair then back to bed". -Behavior Support Plan (BSP) dated 6/11/21 indicated, "Definition of Behaviors: ... Refusals to stay in bed at bedtime defined as, "[Client A]			

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(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

will scream, yell 'Hey get me out of here'. [Client A] will beat, hit his bedroom wall, bed rails, unplug his bed alarm, throws his pillows on the floor, take hold of the bedrails and scoots out of the bed onto the floor and yells 'help' to get him into his recliner.

Proactive Strategies indicated, "Keep [client A] involved in busy activities throughout the day. Staff will carry/wear audio monitor when [client A] is in bed. Ensure bed alarm is turned with cord toward the wall, and control/sensor unit hooked to the bottom of the bed. Mat to be on the wall next to bed to prevent bruising if [client A] should beat/hit his wall next to his bed.

Refusal to stay in bed: Ask [client A] to identify why he is upset and provide [client A] with an opportunity to tell staff what is bothering him. Try to meet what [client A] needs or wants. If [client A] wants out of bed transfer him to where he wants to be (wheelchair/recliner/ couch). After some time if [client A] appears sleepy or asks to go to bed transfer him to his bed. If unable to meet his request and [client A] continues to display agitation discuss with [client A] the importance of getting a good night's sleep. Remind [client A] that if he sleeps in his bed all night, he will get a special coffee in a special cup in the morning ...".

On 7/16/21 at 11:12 AM, the Qualified Intellectual Disabilities Professional (QIDP) and the Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDPs were asked why client A had sustained a shoulder injury identified within the 6/3/21 BDDS incident report. The QIDPs indicated the investigation had determined client A's shoulder injury was contributed to client A's

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	15G255	A. BUILDING 00 B. WING	07/19/2021

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	behavior for refusing to sleep in his medical bed and the use of his air flow mattress. The QIDP's were asked why client A's behavioral strategies for the refusal to use his bed failed to prevent his shoulder injury identified on 6/3/21. The QIDP stated, "We identified the mattress was the issue. We ordered the mattress (replacement), but it didn't come in until the 3rd (6/3/21). The QIDPD stated, "We were not forcing him to stay in the bed and to offer alternatives for sleeping". The QIDPs were asked when the mattress had been found to be the source of client A's refusal to use his medical bed. The QIDPs indicated during the 5/25/21 IDT meeting. The QIDPs indicated the replacement mattress did not arrive until 6/3/21 and was after client A had already sustained the shoulder injury. The QIDPs were asked why client A's behavioral strategies to redirect and use an incentive with coffee continued after the IDT on 5/25/21 if the mattress and bed combination had been identified as the perpetuating issues that contributed to client A's behavior which was also supported from the Active Treatment observations of client A's dislike for his bed. The QIDPs indicated the alternative sleeping arrangements with a more relaxed bedtime schedule and use of his rocker recliner and wheelchair were not realized until after the injury on 6/3/21 and once the new mattress was obtained 8 days later after the IDT on 5/25/21. On 7/16/21 at 11:33 AM, the Program Manager (PM) was interviewed. The PM was asked about client A's behavioral strategies for the refusal to use his bed and the lack of successful objectives implemented between the 5/25/21 IDT			

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	identifying the medical bed and air flow mattress as the perpetuating issues for client A's behavior prior to the shoulder injury sustained on 6/3/21. The PM stated, "I can agree we didn't find an alternative. We knew it was an issue and we didn't provide an alternative (sleeping arrangement before injury on 6/3/21). I can see that". This federal tag relates to complaint #IN00355167. 9-3-4(a)			