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	08/18/2017

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

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W 0000 Bldg. 00	This visit was for the pre-determined full recertification and state licensure survey. This visit included the investigation of Complaint #IN00233350. Complaint #IN00233350: Substantiated, Federal/State deficiencies related to the allegation are cited at W104, W149 and W157. This visit was done in conjunction with the PCR/Post Certification Revisit to the investigation of Complaint #IN00230822. Survey dates: August 14, 15, 16, 17 and 18, 2017. Facility Number: 004615 Provider Number: 15G723 AIM Number: 200528230 These federal deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 8/31/17.	W 0000		
W 0104	483.410(a)(1) GOVERNING BODY			

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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Bldg. 00	The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 1 of 2 sampled clients (A), and for one additional client (E), the facility's governing body failed to define neglect in relation to failure to implement client programming effectively in the agency's abuse/neglect/exploitation policy of April 2017. Findings include: The facility's Bureau of Developmental Disabilities Services/BDDS reports, incident reports and investigations were reviewed on 8/14/17 at 1:30 PM, 8/15/17 at 11:00 AM, 8/16/17 at 12:00 PM and 8/17/17 at 6:30 PM and indicated the following: 1. An investigation dated 6/11-20/17 indicated client E reported staff #9 went outside the facility and sat in his car leaving he and client A, two clients in the facility, unattended. The investigation substantiated the clients were left unattended. Staff #9 was terminated from employment. 2. A 6/14/17 BDDS report of a incident on 6/13/17 at 7:50 PM indicated client E was antagonizing one of his peers. He	W 0104	**W104:** The governing body must exercise general policy, budget, and operating direction over the facility. **Corrective Action: (Specific):** The operation standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual rights will be reviewed and revised to include failure to implement client programming could be considered neglect and will be investigated per policy if indicated. All staff at the home will be re-trained on the operations standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual rights. **How others will be identified: (Systemic):** The Area Supervisor will be at the home at least twice weekly to ensure that client program plans are being implemented as written, The Behavior Clinician will be at the home at least 10 hours per week to ensure that all client program	09/17/2017

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	was redirected but tried to elope and tried to break staff's car window. Police arrived and client E was subsequently Tasered and taken to the county jail. On 8/16/17 at 2:05 PM a police report regarding the above incident was reviewed. The local Sheriff's Incident Report was dated/timed 6/13/17 20:14 (8:14 PM) and indicated "Occurred Incident Type: Battery." The report indicated it was "Battery Bodily Injury." The sheriff's Incident Report indicated client E was arrested, and staff #1, #5 and #6 were listed as victims. An officer was dispatched to the facility on 6/13/17. The narrative portion of the report indicated the officer arrived at the facility and was told by a client "several subjects were fighting inside the residence." The officer found staff #5 and #6 attempting to restrain client E. Client E was slapping, head butting, kicking and attempting to bite staff #5 and #6. The officer ordered client E to stop fighting and to stop attempting to bite the others. Client E stated: "F--- You, B----." Staff #1 came and attempted to calm client E. Client E attempted to bite staff #1. Client E was ordered to stop but "opened his mouth and lunged at [staff #1]." Client E was Tasered by the officer. Client E stated: "I'll stop." The Taser was switched off. Client E was told to stay still and not to		plans are being implemented as written and changes are being made if indicated. **Measures to be put in place:** The operation standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual rights will be reviewed and revised to include failure to implement client programming could be considered neglect and will be investigated per policy if indicated. All staff at the home will be re-trained on the operations standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual rights. **Monitoring of Corrective:** The Area Supervisor will be at the home at least twice weekly to ensure that client program plans are being implemented as written, The Behavior Clinician will be at the home at least 10 hours per week to ensure that all client program plans are being implemented as written and changes are being made if indicated.	

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	move. Client E refused, "growling and attempting to stand." A second cycle of the Taser was administered by the officer. Client E complied by staying still. He was placed in hand restraints and placed in a sitting position. He was taken to the county jail via ambulance. Staff #5 and #6 advised the officer client E had gotten angry with another resident over a loud radio. Staff #5 had gotten between client E and the other client. Staff #5 had scratches on his neck area. Staff #5 and #6 indicated they had both been "hit several times" by client E. 3. A BDDS report dated 6/15/17 indicated an incident on 6/14/17 at 9:30 PM. Client E was trying to "expose himself" to others. He went outside and threw a brick at his bedroom window. He was placed in a two man restraint (in his Behavior Program/agency approved technique). He was transported to a local hospital and released. A BDDS follow-up report dated 6/20/17 indicated client E was to be seen in court on 6/19/17 with battery as the charge. There was another court date set as 8/10/17 and he had been placed on 1:1 supervision (one staff to one client). 4. A BDDS report dated 6/17/17 at 8:30 AM indicated Client E was playing his music loudly disturbing a sleeping		**Completion date: 09/17/17**	

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	housemate. He was redirected and became physically aggressive. An approved restraint was used (YSIS/You're Safe, I'm Safe, agency approved behavior management techniques). Client E started to throw rocks at staff's car. Client E became aggressive physically and 911 was called for back up. The client was transported to a local hospital for evaluation. He was released with orders to follow up with his personal psychiatrist; nothing was changed at the hospital. 5. 6/19/17 BDDS report for incident 6/18/17 at 7:00 AM with client E. Client E was physically aggressive with staff and placed in a standing restraint for 10 minutes. It was an approved behavior management technique. 6. A BDDS report dated 6/20/17 indicated an incident with client E on 6/19/17 at 7:30 PM. Client E was walking with staff #7 in the neighborhood and found a length of metal rebar along the road. Client E beat a neighbor's mailbox with the metal bar. Staff #7 redirected the client but he was non-compliant. Staff restrained the client until police arrived. The client was arrested and transported to the county jail. The 6/26/17 follow-up BDDS report indicated client E was seen in court on			

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	6/23/17 and was released. He had another court date of 8/11/17. The client was transferred to another facility within the agency that is not in a subdivision with neighbors. On 8/16/17 at 2:15 PM a police report regarding the above incident was reviewed. The local Sheriff's Incident Report was dated/timed 6/19/17 19:45 (7:45 PM) and indicated "Occurred Incident Type: Criminal Mischief " and "Intimidation w/ (with) Weapon." The narrative portion of the Sheriff's Incident Report indicated two officers and a Captain were dispatched to the neighborhood of the facility on 6/19/17 at approximately 7:45 PM. On the scene was a local resident (identified as the caller and the victim), client E, and two staff (#7 and #8) who were restraining client E. The local resident indicated at "around 7:20 PM" his wife, who was outside the residence, came inside and told him two males (client E and staff #7) were outside and one had damaged their mailbox with a metal bar. The resident came outside and asked who had damaged the mailbox. Client E said he had damaged the mailbox. The report indicated client E started to approach the resident carrying the metal bar. The resident told client E to stop and informed him he had a firearm. Client E			

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	stopped but made verbal threats and stated he was going to "beat his ---." Staff #8 arrived at the residence and was able to restrain client E. Staff #7 and #8 removed the metal bar from client E. The report indicated client E was placed under arrest for criminal mischief and making threats. He was handcuffed and taken to the local jail. 7. BDDS report dated 7/26/17 indicated the BDDS Service Coordinator reported the facility's staffing ratio (staff to clients) was below minimum standards on 7/25/17 at 3:30 PM. The BDDS follow-up report dated 8/2/17 substantiated the allegation. One client was on an outing and 3 clients with one staff plus the house manager were at the facility. The house manager had a personal emergency and left the facility which left a 1 staff to three clients ratio (1:3). The report indicated the house manager would be disciplined. 8. An investigation dated 8/9-17/17 alleged staff #10 had pushed client C "up against the brick wall" in front of the house on 8/8/17. The investigation determined the allegation to be substantiated. Interview with the Quality Assurance Manager on 8/16/17 at 3:45 PM indicated the recommendation to terminate staff #10 from employment.			

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	The Agency's Operation Standard Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment and Violation of an Individual's Rights (revised 04/17) was reviewed on 8/16/2017 at 3:30 PM. The policy indicated all allegations would be investigated and addressed. The review indicated the agency prohibited "abuse, neglect, exploitation, mistreatment or violation of an Individual's rights. These include and are defined as any of the following: corporal punishment i.e. forced physical activity, hitting, pinching, the application of pain or noxious stimuli, the use of electric shock, the infliction of physical pain, seclusion in an area which exit is prohibited, verbal abuse including screaming, swearing, name-calling, belittling, damaging an individual's self-respect or dignity, failure to follow physician's orders, denial of sleep, shelter, food, drink, physical movement for prolonged periods of time, Medical treatment or care of use of bathroom facilities. Abuse, neglect, exploitation, mistreatment or violation of an Individual's rights may also be defined as forcing an individual to complete chores benefiting others without pay unless: (A) The Provider has obtained a certificate from the US Department of Labor to authorize employment; (B) The			

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	services are being performed in the individual's own home as a normal and customary part of housekeeping duties; or (C) An individual desires to perform volunteer work in the community." The review of the policy failed to indicate a definition of client neglect as pertaining to the agency's ability/inability to implement behavior management techniques to address client behavior. The abuse/neglect policy did not address failure to implement client programming. Interview with QA #1 (Quality Assurance) on 8/16/17 at 3:30 PM indicated agency policy prohibited abuse and neglect of clients. Interview with QAM #1 (Quality Assurance Manager) on 8/16/17 at 3:30 PM indicated the Agency's most recent abuse/neglect policy was the one of April 2017. This federal tag relates to Complaint #IN00233350. 9-3-1(a)			
W 0149	483.420(d)(1)			

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Bldg. 00	STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 2 sampled clients (A), and two additional clients (C and E) for 8 of 12 investigations of abuse/neglect reviewed, the facility failed to ensure the facility's neglect/abuse/mistreatment policy was implemented in staff neglect. The facility failed to define neglect in relation to failure to implement client programming effectively. Findings include: The facility's Bureau of Developmental Disabilities Services/BDDS reports, incident reports and investigations were reviewed on 8/14/17 at 1:30 PM, 8/15/17 at 11:00 AM, 8/16/17 at 12:00 PM and 8/17/17 at 6:30 PM and indicated the following: 1. An investigation dated 6/11-20/17 indicated client E reported staff #9 went outside the facility and sat in his car leaving he and client A, two clients in the facility, unattended. The investigation substantiated the clients were left unattended. Staff #9 was terminated from employment. 2. A 6/14/17 BDDS report of a incident	W 0149	**W149:** That facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. **Corrective Action: (Specific):** The operation standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual rights will be reviewed and revised to include failure to implement client programming could be considered neglect and will be investigated per policy if indicated. All staff at the home will be re-trained on the operations standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual rights. **How others will be identified: (Systemic):** The Area Supervisor will be at the home at least twice weekly to ensure that client program	09/17/2017

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	on 6/13/17 at 7:50 PM indicated client E was antagonizing one of his peers. He was redirected but tried to elope and tried to break staff's car window. Police arrived and client E was subsequently Tasered and taken to the county jail. On 8/16/17 at 2:05 PM a police report regarding the above incident was reviewed. The local Sheriff's Incident Report was dated/timed 6/13/17 20:14 (8:14 PM) and indicated "Occurred Incident Type: Battery." The report indicated it was "Battery Bodily Injury." The sheriff's Incident Report indicated client E was arrested, and staff #1, #5 and #6 were listed as victims. An officer was dispatched to the facility on 6/13/17. The narrative portion of the report indicated the officer arrived at the facility and was told by a client "several subjects were fighting inside the residence." The officer found staff #5 and #6 attempting to restrain client E. Client E was slapping, head butting, kicking and attempting to bite staff #5 and #6. The officer ordered client E to stop fighting and to stop attempting to bite the others. Client E stated: "F--- You, B----." Staff #1 came and attempted to calm client E. Client E attempted to bite staff #1. Client E was ordered to stop but "opened his mouth and lunged at [staff #1]." Client E was Tasered by the officer. Client E stated:		plans are being implemented as written, The Behavior Clinician will be at the home at least 10 hours per week to ensure that all client program plans are being implemented as written and changes are being made if indicated. **Measures to be put in place:** The operation standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual rights will be reviewed and revised to include failure to implement client programming could be considered neglect and will be investigated per policy if indicated. All staff at the home will be re-trained on the operations standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual rights. **Monitoring of Corrective:** The Area Supervisor will be at the home at least twice weekly to ensure that client program plans are being implemented as written, The Behavior Clinician will be at the home at least 10 hours per week to ensure that all client program plans are being implemented	

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	"I'll stop." The Taser was switched off. Client E was told to stay still and not to move. Client E refused, "growling and attempting to stand." A second cycle of the Taser was administered by the officer. Client E complied by staying still. He was placed in hand restraints and placed in a sitting position. He was taken to the county jail via ambulance. Staff #5 and #6 advised the officer client E had gotten angry with another resident over a loud radio. Staff #5 had gotten between client E and the other client. Staff #5 had scratches on his neck area. Staff #5 and #6 indicated they had both been "hit several times" by client E. 3. A BDDS report dated 6/15/17 indicated an incident on 6/14/17 at 9:30 PM. Client E was trying to "expose himself" to others. He went outside and threw a brick at his bedroom window. He was placed in a two man restraint (in his Behavior Program/agency approved technique). He was transported to a local hospital and released. A BDDS follow-up report dated 6/20/17 indicated client E was to be seen in court on 6/19/17 with battery as the charge. There was another court date set as 8/10/17 and he had been placed on 1:1 supervision (one staff to one client). 4. A BDDS report dated 6/17/17 at 8:30		as written and changes are being made if indicated. **Completion date: 09/17/17**	

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	AM. Client E was playing his music loudly disturbing a sleeping housemate. He was redirected and became physically aggressive. An approved restraint was used (YSIS/You're Safe, I'm Safe, agency approved behavior management techniques). Client E started to throw rocks at staff's car. Client E became aggressive physically and 911 was called for back up. The client was transported to a local hospital for evaluation. He was released with orders to follow up with his personal psychiatrist; nothing was changed at the hospital. 5. 6/19/17 BDDS report for incident 6/18/17 at 7:00 AM with client E. Client E was physically aggressive with staff and placed in a standing restraint for 10 minutes. It was an approved behavior management technique. 6. A BDDS report dated 6/20/17 indicated an incident with client E on 6/19/17 at 7:30 PM. Client E was walking with staff #7 in the neighborhood and found a length of metal rebar along the road. Client E beat a neighbor's mailbox with the metal bar. Staff #7 redirected the client but he was non-compliant. Staff restrained the client until police arrived. The client was arrested and transported to the county jail. The 6/26/17 follow-up BDDS report			

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	indicated client E was seen in court on 6/23/17 and was released. He had another court date of 8/11/17. The client was transferred to another facility within the agency that is not in a subdivision with neighbors. On 8/16/17 at 2:15 PM a police report regarding the above incident was reviewed. The local Sheriff's Incident Report was dated/timed 6/19/17 19:45 (7:45 PM) and indicated "Occurred Incident Type: Criminal Mischief " and "Intimidation w/ (with) Weapon" The narrative portion of the Sheriff's Incident Report indicated two officers and a Captain were dispatched to the neighborhood of the facility on 6/19/17 at approximately 7:45 PM. On the scene was a local resident (identified as the caller and the victim), client E, and two staff (#7 and #8) who were restraining client E. The local resident indicated at "around 7:20 PM" his wife, who was outside the residence, came inside and told him two males (client E and staff #7) were outside and one had damaged their mailbox with a metal bar. The resident came outside and asked who had damaged the mailbox. Client E said he had damaged the mailbox. The report indicated client E started to approach the resident carrying the metal bar. The resident told client E to stop and			

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	15G723	A. BUILDING 00 B. WING	08/18/2017

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	informed him he had a firearm. Client E stopped but made verbal threats and stated he was going to "beat his ---." Staff #8 arrived at the residence and was able to restrain client E. Staff #7 and #8 removed the metal bar from client E. The report indicated client E was placed under arrest for criminal mischief and making threats. He was handcuffed and taken to the local jail. 7. BDDS report dated 7/26/17 indicated the BDDS Service Coordinator reported the facility's staffing ratio (staff to clients) was below minimum standards on 7/25/17 at 3:30 PM. The BDDS follow-up report dated 8/2/17 substantiated the allegation. One client was on an outing and 3 clients with one staff plus the house manager were at the facility. The house manager had a personal emergency and left the facility which left a 1 staff to three clients ratio (1:3). The report indicated the house manager would be disciplined. 8. An investigation dated 8/9-17/17 alleged staff #10 had pushed client C "up against the brick wall" in front of the house on 8/8/17. The investigation determined the allegation to be substantiated. Interview with the Quality Assurance Manager on 8/16/17 at 3:45 PM indicated the recommendation to			

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	terminate staff #10 from employment. The Agency's Operation Standard Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment and Violation of an Individual's Rights (revised 04/17) was reviewed on 8/16/2017 at 3:30 PM. The policy indicated all allegations would be investigated and addressed. The review indicated the agency prohibited "abuse, neglect, exploitation, mistreatment or violation of an Individual's rights. These include and are defined as any of the following: corporal punishment i.e. forced physical activity, hitting, pinching, the application of pain or noxious stimuli, the use of electric shock, the infliction of physical pain, seclusion in an area which exit is prohibited, verbal abuse including screaming, swearing, name-calling, belittling, damaging an individual's self-respect or dignity, failure to follow physician's orders, denial of sleep, shelter, food, drink, physical movement for prolonged periods of time, Medical treatment or care of use of bathroom facilities. Abuse, neglect, exploitation, mistreatment or violation of an Individual's rights may also be defined as forcing an individual to complete chores benefiting others without pay unless: (A) The Provider has obtained a certificate from the US Department of			

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	Labor to authorize employment; (B) The services are being performed in the individual's own home as a normal and customary part of housekeeping duties; or (C) An individual desires to perform volunteer work in the community." The review of the policy failed to indicate a definition of client neglect as pertaining to the agency's ability/inability to implement behavior management techniques to address client behavior. The abuse/neglect policy did not address failure to implement client programming. Interview with QA #1 (Quality Assurance) on 8/16/17 at 3:30 PM indicated agency policy prohibited abuse and neglect of clients. Interview with QAM #1 (Quality Assurance Manager) on 8/16/17 at 3:30 PM indicated the Agency's most recent abuse/neglect policy was the one of April 2017. This federal tag relates to Complaint #IN00233350. 9-3-2(a)			

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W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 2 sampled clients (A), and two additional clients (C and E) and for 8 of 12 investigations of abuse/neglect reviewed, the facility failed to ensure the facility implemented corrective measures in regards to staff neglect of clients and client to client abuse. Findings include: The facility's Bureau of Developmental Disabilities Services/BDDS reports, incident reports and investigations were reviewed on 8/14/17 at 1:30 PM, 8/15/17 at 11:00 AM, 8/16/17 at 12:00 PM and 8/17/17 at 6:30 PM and indicated the following: 1. A 6/14/17 BDDS report of a incident on 6/13/17 at 7:50 PM indicated client E was antagonizing one of his peers. He was redirected but tried to elope and tried to break staff's car window. Police arrived and client E was subsequently Tasered and taken to the county jail.	W 0157	**W157:** If the alleged violation is verified, appropriate corrective action must be taken. **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 E was moved to an alternate placement. **How others will be identified: (Systemic):** The Area Supervisor will be at the home at least twice weekly to ensure that client program plans are being implemented as written, The Behavior Clinician will be at the home at least 10 hours per week to ensure that all client program plans are being implemented as written and changes are	09/17/2017

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	On 8/16/17 at 2:05 PM a police report regarding the above incident was reviewed. The local Sheriff's Incident Report was dated/timed 6/13/17 20:14 (8:14 PM) and indicated "Occurred Incident Type: Battery." The report indicated it was "Battery Bodily Injury." Sheriff's Incident Report indicated client E was arrested, and staff #1, #5 and #6 were listed as victims. An officer was dispatched to the facility on 6/13/17. The narrative portion of the report indicated the officer arrived at the facility and was told by a client "several subjects were fighting inside the residence." The officer found staff #5 and #6 attempting to restrain client E. Client E was slapping, head butting, kicking and attempting to bite staff #5 and #6. The officer ordered client E to stop fighting and to stop attempting to bite the others. Client E stated: "F--- You, B----." Staff #1 came and attempted to calm client E. Client E attempted to bite staff #1. Client E was ordered to stop but "opened his mouth and lunged at [staff #1]." Client E was Tasered by the officer. Client E stated: "I'll stop." The Taser was switched off. Client E was told to stay still and not to move. Client E refused, "growling and attempting to stand." A second cycle of the Taser was administered by the officer. Client E complied by staying still. He was placed in hand restraints and placed		being made if indicated. All client Behavior Support Plans will be reviewed to ensure no changes need to be made and all staff will be re-trained on all client behavior support plans **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. Client E was moved to an alternate placement. **Monitoring of Corrective Action:** The Area Supervisor will be at the home at least twice weekly to ensure that client program plans are being implemented as written, The Behavior Clinician will be at the home at least 10 hours per week to ensure that all client program plans are being implemented as written and changes are being made if indicated. All client Behavior Support Plans will be reviewed to ensure no changes need to be made and all staff will be re-trained on all client behavior support plans	

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	in a sitting position. He was taken to the county jail via ambulance. Staff #5 and #6 advised the officer client E had gotten angry with another resident over a loud radio. Staff #5 had gotten between client E and the other client. Staff #5 had scratches on his neck area. Staff #5 and #6 indicated they had both been "hit several times" by client E. 2.. A BDDS report dated 6/15/17 indicated an incident on 6/14/17 at 9:30 PM. Client E was trying to "expose himself" to others. He went outside and threw a brick at his bedroom window. He was placed in a two man restraint (in his Behavior Program/agency approved technique). He was transported to a local hospital and released. A BDDS follow-up report dated 6/20/17 indicated client E was to be seen in court on 6/19/17 with battery as the charge. There was another court date set as 8/10/17 and he had been placed on 1:1 supervision (one staff to one client). 3. A BDDS report dated 6/17/17 at 8:30 AM indicated client E was playing his music loudly disturbing a sleeping housemate. He was redirected and became physically aggressive. An approved restraint was used (YSIS/You're Safe, I'm Safe, agency approved behavior management		**Completion date: 09/17/17**	

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	techniques). Client E started to throw rocks at staff's car. Client E became aggressive physically and 911 was called for back up. The client was transported to a local hospital for evaluation. He was released with orders to follow up with his personal psychiatrist; nothing was changed at the hospital. 4. 6/19/17 BDDS report for incident 6/18/17 at 7:00 AM with client E. Client E was physically aggressive with staff and placed in a standing restraint for 10 minutes. It was an approved behavior management technique. 5. A BDDS report dated 6/20/17 indicated an incident with client E on 6/19/17 at 7:30 PM. Client E was walking with staff #7 in the neighborhood and found a length of metal rebar along the road. Client E beat a neighbor's mailbox with the metal bar. Staff #7 redirected the client but he was non-compliant. Staff restrained the client until police arrived. The client was arrested and transported to the county jail. The 6/26/17 follow-up BDDS report indicated client E was seen in court on 6/23/17 and was released. He had another court date of 8/11/17. The client was transferred to another facility within the agency that is not in a subdivision with neighbors.			

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	On 8/16/17 at 2:15 PM a police report regarding the above incident was reviewed. The local Sheriff's Incident Report was dated/timed 6/19/17 19:45 (7:45 PM) and indicated "Occurred Incident Type: Criminal Mischief " and "Intimidation w/ (with) Weapon" The narrative portion of the Sheriff's Incident Report indicated two officers and a Captain were dispatched to the neighborhood of the facility on 6/19/17 at approximately 7:45 PM. On the scene was a local resident (identified as the caller and the victim), client E, and two staff (#7 and #8) who were restraining client E. The local resident indicated at "around 7:20 PM" his wife, who was outside the residence, came inside and told him two males (client E and staff #7) were outside and one had damaged their mailbox with a metal bar. The resident came outside and asked who had damaged the mailbox. Client E said he had damaged the mailbox. The report indicated client E started to approach the resident carrying the metal bar. The resident told client E to stop and informed him he had a firearm. Client E stopped but made verbal threats and stated he was going to "beat his ---." Staff #8 arrived at the residence and was able to restrain client E. Staff #7 and #8 removed the metal bar from client E. The			

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	report indicated client E was placed under arrest for criminal mischief and making threats. He was handcuffed and taken to the local jail. Confidential interview #1 stated client E continued to have "Unmanageable" behaviors given the tools (behavior management approved techniques) used by the agency. Interview with Program Director #1 was conducted on 8/16/17 at 1:15 PM. The interview indicated client E was moved to another facility within the agency so he would not be in a subdivision with lots of neighbors. The interview indicated client E was on 1:1 supervision (one staff to one client) to manage his behavior. When asked why client E was not moved to a more restrictive setting due to his behaviors, PD #1 indicated it was the BDDS/Bureau of Developmental Disabilities Services that determined placements in the state. This federal tag relates to complaint #IN00233350. 9-3-2(a)			

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W 0189 Bldg. 00	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation and interview for 1 of 2 sampled clients (B), the facility failed to ensure staff was trained to conduct blood glucose monitoring appropriately. Findings include: Observations on 8/15/17 of the medication administration were conducted from 7:00 AM until 7:34 AM. At 7:15 AM, staff #2 administered client B's medications and checked his blood glucose twice. Client B did not wash or otherwise sanitize his hands prior to taking the medications or testing his blood glucose (his blood was taken from his right index finger twice). Staff #2 did not wear gloves or wash his hands prior to the testing. Interview with LPN #1 on 8/15/17 at 11:15 AM indicated staff would need to be retrained on hand washing for clients and the use of gloves when testing blood	W 0189	**W189:** The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently, and competently. **Corrective Action: (Specific):** All staff working at the home will be re-trained on conducting blood glucose monitoring, hand washing, use of gloves during blood glucose testing and prompting all individuals to wash their hands prior to medication administration. **How others will be identified: (Systemic):** The nurse will be in the home at least twice weekly for the next 30 days then at least weekly thereafter to complete a random medication observation on staff conducting blood glucose	09/17/2017

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	glucose. 9-3-3(a)		monitoring to ensure that it is being conducted appropriately. The medications observations completed by the nurse will be submitted to the Program Manager. **Measures to be put in place:** All staff working at the home will be re-trained on Glucometer training by the site nurse. **Monitoring of Corrective Action:** The nurse will be in the home at least twice weekly for the next 30 days then at least weekly thereafter to complete a random medication observation on staff conducting blood glucose monitoring to ensure that it is being conducted appropriately. The medications observations completed by the nurse will be submitted to the Program Manager. **Completion date: 09/17/17**	

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W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 1 of 2 sampled clients (B), the facility failed to ensure staff was trained to conduct blood glucose monitoring appropriately to prevent cross contamination/possibility of infection. Findings include: Observations on 8/15/17 of the medication administration were conducted from 7:00 AM until 7:34 AM. At 7:15 AM, staff #2 administered client B's medications and checked his blood glucose twice. Client B did not wash or otherwise sanitize his hands prior to taking the medications or testing his blood glucose (his blood was taken from his right index finger twice). Staff #2 did not wear gloves or wash his hands prior to the testing. Interview with LPN #1 on 8/15/17 at 11:15 AM indicated staff should promote handwashing for	W 0455	**W455:** There must be an active program for the prevention, control, and investigation of infection and communicable disease. **Corrective Action: (Specific):** All staff working at the home will be re-trained on infection control blood and body fluids operation standard, conducting blood glucose monitoring, hand washing, use of gloves during blood glucose testing and	09/17/2017

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	clients and wearing gloves when testing blood glucose was best practice. 9-3-7(a)		prompting all individuals to wash their hands prior to medication administration. **How others will be identified: (Systemic):** The nurse will be in the home at least twice weekly for the next 30 days then at least weekly thereafter to complete a random medication observation on staff conducting blood glucose monitoring to ensure that it is being conducted appropriately. The medications observations completed by the nurse will be submitted to the Program Manager. **Measures to be put in place:** All staff working at the home will be re-trained on infection control blood and body fluids operation standard, conducting blood glucose monitoring, hand washing, use of gloves during blood glucose testing and prompting all individuals to wash their hands prior to medication administration. **Monitoring of Corrective Action:** The nurse will be in the home at least twice weekly for the next 30 days then at least weekly thereafter to complete a random medication observation on staff	

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			conducting blood glucose monitoring to ensure that it is being conducted appropriately. The medications observations completed by the nurse will be submitted to the Program Manager. **Completion date: 09/17/17**	
W 9999 Bldg. 00	State Findings: The following Community Residential Facilities for Persons with Developmental Disabilities rule was not	W 9999	**W9999:** The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met.	09/17/2017

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	met: 460 IAC 9-3-4 Active Treatment Services. (b) The provider shall obtain day services for each resident which: (1) meet the criteria and certification requirements established by the division of aging and rehabilitative services for all day service providers; (2) meet the resident's active treatment needs set forth in the resident's individual program plan as determined by the interdisciplinary team conference with preference for services in the least restrictive environment. This state rule was not met as evidenced by: Based on observation, record review and interview, the facility failed to meet the active treatment needs pertaining to day services programming for 1 of 2 sampled clients (B) and one additional client (D). Findings include: Clients B and D were at the facility on 8/15/17 at from 6:15 AM until 10:15 AM. After breakfast and medications, clients B and D went back to their bedrooms and slept. They did not go to the workshop or the [recreation center]		**Corrective Action: (Specific):** All Staff at the home will be re-trained on ensuring the all individual's attend day service as indicated. **How others will be identified: (Systemic):** The QIDP will follow up with staff at least twice weekly for the next 30 days then at least weekly thereafter to ensure that all individuals are attending day service as indicated. **Measures to be put in place:** All Staff at the home will be re-trained on ensuring the all individual's attend day service as indicated. **Monitoring of Corrective Action:):** The QIDP will follow up with staff at least twice weekly for the next 30 days then at least weekly thereafter to ensure that all individuals are attending day service as indicated. **Completion date: 09/17/17**	

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	08/18/2017

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

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	with clients A and C. No alternative day service was observed to be provided for clients B and D. Review of client B's record on 8/16/17 at 8:26 AM indicated no contraindication to attending a day program. Review of client D's record on 8/16/17 at 3:44 PM indicated no contraindication to attending a day program. Interview with PD/Program Director #1 on 8/18/17 at 4:06 PM indicated clients B and D refused to go to work. QIDP/Qualified Intellectual Disabilities Professional #1 was unavailable for interview during the survey. 9-3-4(b)(1)(2)			