PRINTED:	08/24/2022
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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FO	R MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-039
	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 15G159		(X2) MULTIPLE C A. BUILDING B. WING	construction (X. 00	3) DATE SURVEY COMPLETED 07/28/2022
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	1337 E	ADDRESS, CITY, STATE, ZIP COD E SOUTHVIEW LN I, IN 47454	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
N 0000					
Bldg. 00	dg. 00 This visit was for a focused fundamental recertification and state licensure survey. Survey Dates: July 25, 26, 27 and 28, 2022		W 0000		
	accordance with 4	15G159 00243150 also reflect state findings in			
W 0125 Bldg. 00	The facility must clients. Therefor encourage individ rights as clients of citizens of the Ur right to file compl process. Based on observat review for 7 of 7 c (#1, #2, #3, #4, #5	OF CLIENTS RIGHTS ensure the rights of all e, the facility must allow and dual clients to exercise their of the facility, and as hited States, including the laints, and the right to due ion, interview and record lients living in the group home , #6 and #7), the facility failed to had the right to due process in	W 0125	To correct the deficient practice a site staff will be trained rights restrictions and locking the client's property. Additionally, the	
	regard to locking s group home office Findings include: On 7/25/22 from 3 from 6:03 AM to 8 conducted at the g observations, the f	 and the right to due process in analytic food and bananas in the and medication area. :50 PM to 5:31 PM and 7/26/22 3:15 AM, observations were roup home. During the following food items were d group home office: Hostess 		IDT will convene to discuss Clier #6 Behavior plan to address food seeking. Additional monitoring w be achieved through weekly observation by the AS, QIDP, or RM for one month to ensure no unnecessary restrictions are in place. To ensure no others were affected the QIDP will review all other clients' plans to ensure all	nt J III

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.

	R MEDICARE & MEDIC	AID SERVICES				0	MB NO. 0938-0
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G159	A.	MULTIPLE CO BUILDING WING	onstruction 00	СОМ	e survey pleted 8/2022
				STREET	ADDRESS, CITY, STATE, ZIP COI		
NAME OF	PROVIDER OR SUPPLIEF	R			SOUTHVIEW LN	<u>,</u>	
RES CA	RE COMMUNITY A	LTERNATIVES SE IN			, IN 47454		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)		COMPLETI DATE
	Cup Cakes, Swiss I bars, cheese slices a clients had access tr 7/26/22, the clients' locked medication of the following food variety pack of chip observations, client attempt to eat food for dinner and break affected clients #1, On 7/26/22 at 7:15 indicated the snacks office area due to c behavior. On 7/26/22 at 9:08 #6's record was com Individual Support Support Plan (BSP) food and drinks to b include food seekin On 7/26/22 at 9:10 indicated the snacks to client #6's food s "[Client #6] is noto get in the others' lun clients' lunchboxes from eating out of t "On-going issue. N On 7/26/22 at 9:13 Disabilities Profess the restriction need indicated the food se	AccessionRolls, sodas, fruit and grainand bananas. None of theto the locked office. Onlunchboxes were stored in theroom. In the medication area,items were stored: Cheetos,ps, and Twinkies. During the#6 did not food seek orexcept for the food preparedkfast. These restrictions#2, #3, #4, #5, #6 and #7.AM, the Lead Staff (LS)s and drinks were locked in thelient #6's food seekingAM, a focused review of clientducted. Client #6's 7/22/22Plan and 7/22/22 Behavioro did not indicate the need forpe locked. The BSP did notg as a targeted behavior.AM, the Area Supervisor (AS)s and drinks were locked dueeeking. The AS stated,rious for food seeking. Willnches." The AS indicated thewere locked to keep client #6hem. The AS stated it was anIeeds to be in a plan."AM, the Qualified Intellectualional (QIDP) Lead indicateded to be in a plan. The QIDPshould not be locked at thethere was a plan addressing			restrictions in place are a and in the plan. Ongoing monitoring will be achieve through a monthly site re- completed by ResCare administration.	g ved	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G159		(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 07/28/2022	
	PROVIDER OR SUPPLIE	ER ALTERNATIVES SE IN	1337 E	ADDRESS, CITY, STATE, ZIP COD E SOUTHVIEW LN , IN 47454	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0227 Bldg. 00	food and drinks sh stated "don't have human rights com QIDP stated "the i in a locked area." 9-3-2(a) 483.440(c)(4) INDIVIDUAL PR The individual pr specific objective client's needs, as comprehensive a paragraph (c)(3) Based on observat review for 1 of 4 r facility failed to en address food seeks Findings include: On 7/25/22 from 3 from 6:03 AM to conducted at the g observations, the f stored in the locket Cup Cakes, Swiss bars, cheese slicess clients had access 7/26/22, client #6' locked medication the following food variety pack of ch observations, clien attempt to eat food for dinner and bre	 assessment required by by of this section. c) the near section. c) the nea	W 0227	To correct the deficient practice the IDT will convene to discuss Client #6 Behavior plan to addre food seeking. Additional monitoring will be achieved through weekly observations by the AS, QIDP, or RM for one month to ensure each client has appropriate plans in place. To ensure no others were affected t QIDP will review all other clients plans to ensure all current behaviors are addressed within the BSP. Ongoing monitoring will be achieved through a monthly site review completed by ResCare administration.	he

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/28/2022 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE indicated the snacks and drinks were locked in the office area due to client #6's food seeking behavior. On 7/26/22 at 9:08 AM, a focused review of client #6's record was conducted. Client #6's 7/22/22 Individual Support Plan and 7/22/22 Behavior Support Plan (BSP) did not indicate the need for food and drinks to be locked. The BSP did not include food seeking as a targeted behavior. On 7/26/22 at 9:10 AM, the Area Supervisor (AS) indicated the snacks and drinks were locked due to client #6's food seeking. The AS stated, "[Client #6] is notorious for food seeking. Will get in the others' lunches." The AS indicated the clients' lunchboxes were locked to keep client #6 from eating out of them. The AS stated it was an "On-going issue. Needs to be in a plan." On 7/26/22 at 9:13 AM, the Qualified Intellectual Disabilities Professional (QIDP) Lead indicated the restriction needed to be in a plan. The QIDP indicated the food should not be locked at the group home unless there was a plan addressing the need. On 7/26/22 at 10:37 AM, the QIDP indicated the food and drinks should not be locked. The QIDP stated "don't have written informed consent and human rights committee consent for it." The QIDP stated "the intent was to keep extras stored in a locked area." 9-3-4(a) W 0249 483.440(d)(1) **PROGRAM IMPLEMENTATION** Bldg. 00 As soon as the interdisciplinary team has formulated a client's individual program plan, Event ID: XBQ211 Facility ID: 000695 Page 4 of 11 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER

15G159

STATEMENT OF DEFICIENCIES

NAME OF PROVIDER OR SUPPLIER

AND PLAN OF CORRECTION

PRINTED: 08/24/2022 FORM APPROVED

			101	
			ОМ	B NO. 0938-039
A. E	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 07/28/2022	
	1337 E	ADDRESS, CITY, STATE, ZIP COD SOUTHVIEW LN IN 47454		
	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)		ΓE	(X5) COMPLETION DATE

(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETIO
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	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	W 0249	To correct the deficient practice all	08/28/202
	interview for 2 of 3 clients in the sample (#1 and		site staff will be re-trained on all	
	#2) and one additional client (#6), the facility		clients' ISP goals as well as	
	failed to ensure client #1 used or was offered to		implementing plans as written.	
	use wrist weights due to hand tremors during		Additionally, an ISP goal will be	
	meals, client #2 used a paper Medication		created for Client #1 regarding her	
	Administration Record during her medication pass		wrist weights. To help de-sense	
	and client #6's closet door was locked as indicated		client #1 as well as document any	
	in her program plans.		refusals. Client #6 ISP will be	
			updated to reflect the current	
	Findings include:		progress of not needing a lock on	
			the closet door. Additional	
	1) On 7/25/22 from 3:50 PM to 5:31 PM, an		monitoring will be achieved	
	observation was conducted at the group home.		through weekly observations by	
	At 4:13 PM, client #2 received her medications		the AS, QIDP, or RM for one	
	from staff #3. Client #2 was not asked or		month to ensure staff are	
	prompted to document the medications she took		implementing plans as written.	
	on a paper Medication Administration Record.		Ongoing monitoring will be	
			achieved through routine	
	On 7/26/22 at 9:47 AM, a review of client #2's		observations and staff meetings	
	record was conducted. Client #2's 3/1/22		completed by the AS, QIDP, or	
	Individual Support Plan (ISP) indicated, "[Client		RM to ensure staff are following	
	#2] will let staff know what time she is to take her		plans as written.	
	medications and state the medication she is to			
	take. [Client #2] will use a paper MAR			
	(Medication Administration Record) to record her			
	medication that she has taken"			
	On 7/26/22 at 10:33 AM, the Qualified Intellectual			
	Disabilities Professional (QIDP) indicated client			
	#2's goal to use a paper MAR should have been			
	implemented as written.			
	On 7/26/22 at 9:15 AM, the QIDP Lead indicated			

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/28/2022 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE client #2's goal to use a paper MAR should have been implemented as written. On 7/26/22 at 9:15 AM, the Area Supervisor indicated client #2's goal to use a paper MAR should have been implemented as written. 2) On 7/25/22 from 3:50 PM to 5:31 PM and 7/26/22 from 6:03 AM to 8:15 AM, observations were conducted at the group home. During the observations, client #6's closet in her bedroom was not locked. There was no lock on the closet door. On 7/26/22 at 9:08 AM, a focused review of client #6's record was conducted. Client #6's 7/22/22 ISP indicated in the Modification of Individual's Rights section, "Right to be Modified: Access to closet. Manner in which the right will be modified: Individual will be restricted from accessing closet due to inappropriate toileting in the closet. Closet door will be locked, and staff will assist individual each time she needs to access closet. Reason the modification is needed: Inappropriate toileting individual has historically used the closet instead of bathroom facilities to evacuate both bowel and bladder " On 7/26/22 at 10:32 AM, the QIDP indicated client #6 did not need the closet locked anymore. The QIDP indicated client #6 just had her annual meeting and she did not discuss it at the time. The QIDP stated client #6 "doesn't need it. That's on me. I'll change it." The QIDP indicated the plan needed to be implemented as written until the plan was changed. On 7/26/22 at 9:15 AM, the QIDP Lead indicated client #6's closet should have been locked as indicated in her ISP. Event ID: XBQ211 Facility ID: 000695 Page 6 of 11 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/28/2022 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE On 7/26/22 at 9:15 AM, the Area Supervisor indicated client #6's closet should have been locked as indicated in her ISP. 3) On 7/25/22 from 11:40 AM to 1:04 PM, an observation was conducted at client #1's outside services day program. At 11:40 AM, client #1 was eating her lunch. Client #1 had tremors in her right hand/arm as she ate. Client #1 was using her left hand to hold her right hand steady so she could get food to her mouth. Client #1 was not wearing wrist weights. Client #1 was not offered wrist weights. Client #1 was assisted hand over hand by day program staff #1 to eat her lunch due to her tremors. On 7/25/22 at 12:37 PM, day program staff #1 indicated client #1 had tremors due to side effects of her seizure medications. Staff #1 indicated client #1 needed hand over hand assistance with eating. Staff #1 stated "today was a bad day ... Usually doesn't need hand over hand assistance." On 7/25/22 from 3:50 PM to 5:31 PM, an observation was conducted at the group home. At 4:42 PM, dinner started. Client #1 struggled to keep food on her utensils due to her tremors. Client #1 was not wearing wrist weights. Client #1 was not offered wrist weights throughout her meal. On 7/25/22 at 5:01 PM, the Lead Staff (LS) indicated client #1 had wrist weights to help with her tremors and to steady her hand however she refused to wear the wrist weights. The LS opened a drawer in the kitchen and showed the surveyor several wrist weights in the drawer. The LS stated, "[Client #1] don't (sic) like to wear wrist weights. Has them but doesn't want to wear

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XBQ211 Facility ID: 000695

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 07/28/2022 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE them." The LS did not provide the wrist weights to client #1. None of the staff asked or prompted client #1 to wear her wrist weights throughout dinner. On 7/26/22 from 6:03 AM to 8:15 AM, an observation was conducted at the group home. At 7:29 AM, breakfast started. Client #1 was not offered or prompted to use her wrist weights. Throughout breakfast, client #1 used her left hand to steady her right hand due to her tremors. On 7/26/22 at 9:26 AM, a review of client #1's record was conducted. Client #1's 7/16/21 Dining Plan indicated, "Mealtime Adaptive Equipment: Wear weights or use weighted utensils and weighted divided plate...." Client #1's 7/13/22 Individual Support Plan indicated, ".... She has care plans for risk for falls due to unsteady gait & (and) has tremors, which she has wrist weights, weighted plates & silverware to use while eating " On 7/26/22 at 9:18 AM, the Area Supervisor (AS) indicated client #1 should use or be offered her wrist weights. The AS indicated she was not aware of client #1's refusing to use them. The AS indicated client #1's refusing to wear her wrist weights was not communicated to her. On 7/26/22 at 9:20 AM, the QIDP Lead indicated client #1 should be offered and encouraged to wear her wrist weights. He indicated the staff should document client #1's refusals to wear her wrist weights. On 7/26/22 at 11:12 AM, the QIDP indicated client #1's dining plan should be implemented as written for the use of her wrist weights. Event ID: XBQ211 Facility ID: 000695 Page 8 of 11 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15G159 B. WING 07/28/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE On 7/26/22 at 11:12 AM, the nurse indicated client #1's plan should be implemented as written for the use of the wrist weights. The nurse indicated the wrist weights were a part of her dining plan. 9-3-4(a) W 0382 483.460(I)(2) DRUG STORAGE AND RECORDKEEPING Bldg. 00 The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 7 of 7 W 0382 To correct the deficient practice all 08/28/2022 clients living in the group home (#1, #2, #3, #4, #5, site staff will be trained to ensure #6 and #7), the facility failed to ensure the clients' all medications are securely medications were secured at all times throughout locked. Additional monitoring will the survey. be achieved through weekly observations by the AS, QIDP, Findings include: Nurse or RM for one month to ensure the medications are On 7/25/22 from 3:50 PM to 5:31 PM, an secure. As well as daily calls will observation was conducted at the group home. be made to the home to ensure From 3:50 PM to 5:17 PM, the medication area and remind staff that the door was open. The lower right desk drawer in medications are always locked. the office was ajar. There was a note taped to the Ongoing monitoring will be drawer which indicated, "DO NOT SHUT." There achieved through a monthly site were several medications stored in the unlocked review completed by ResCare drawer. The medications included the following: administration to ensure client #7's Dok (constipation), client #5's stool medications are always secured. softener caps, client #2's Baclofen (cerebral palsy), client #7's aller-chlor (allergies), Acetaminophen for fever or pain (no specific client identified), client #6's Fluoxetine (depression), client #4's aller-chlor (allergies), client #3's aller-chlor (allergies), client #6's allergy tab, client #2's acetaminophen (fever or pain), client #1's Divalproex (seizures), client #4's Mucinex (congestion), client #3's Mi-acid (gas), client #4's acetaminophen (fever or pain), and client #6's Levothyroxine (underactive thyroid). XBQ211 Event ID: Facility ID: 000695 Page 9 of 11 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15G159 B. WING 07/28/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE At 5:20 PM, the Lead Staff closed the office door. At 5:27 PM, the office door was closed but not locked. This affected clients #1, #2, #3, #4, #5, #6 and #7. On 7/25/22 at 5:23 PM, the Lead Staff indicated the staff keep the office door closed due to the medications stored in the room. On 7/26/22 at 10:47 AM, the nurse indicated the drawer in the medication area should have been locked. On 7/26/22 at 10:48 AM, the Qualified Intellectual Disabilities Professional indicated the drawer in the medication area should have been locked. On 7/26/22 at 10:49 AM, the Area Supervisor indicated the drawer in the medication area should have been locked. 9-3-6(a) W 0454 483.470(I)(1) INFECTION CONTROL Bldg. 00 The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation and interview for 7 of 7 W 0454 To correct the deficient practice all 08/28/2022 clients living in the group home (#1, #2, #3, #4, #5, site staff will be trained to ensure #6 and #7), the facility failed to ensure the clients' clients' hygiene supplies are hairbrushes and hair ties were stored in separate always kept separate. containers. Additionally, each client will be provided with their own hygiene Findings include: caddy to ensure their items are separate from others. Additional On 7/25/22 from 3:50 PM to 5:31 PM and 7/26/22 monitoring will be achieved from 6:03 AM to 8:15 AM, observations were through weekly observations by conducted at the group home. During the the AS, QIDP, or RM for one observations, there was a plastic container in the month to ensure hygiene items Event ID: XBQ211 Facility ID: 000695 Page 10 of 11 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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JAME OF PROVIDE	=	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G159			(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		
	R OR SUPPLIER	ATIVES SE IN		1337 E	ADDRESS, CITY, STATE, ZIP COD SOUTHVIEW LN IN 47454		
TAGREFmedic#5's, #were rtouchi#4's hashared#6's hashared#3's hashared#3's hashared#3's hashared#3's hashared#3's hashared#3's hashared#3's hashared#3's hashared0n 7/2indicaseparaOn 7/2clientstheir hclientstheir hclients	SUMMARY STATEM ACH DEFICIENCY MUS GULATORY OR LSC IDI ation room with clier 6's and #7's hairbrush not stored separately. ng each other. On 7/ air was brushed with container. On 7/25/ air was brushed with container. On 7/26/ air was brusher with 1 container. 26/22 at 10:11 AM, the littles Professional (Q ents' hairbrushes show tely. 26/22 at 10:26 AM, the meeded to have indiv airbrushes in. The Q	ENT OF DEFICIENCIE T BE PRECEDED BY FULL ENTIFYING INFORMATION Its #1's, #2's, #3's, #4's, nes. The hairbrushes The hairbrushes were 25/22 at 4:26 PM, client her brush from the 22 at 4:35 PM, client her brush from the 22 at 6:32 AM, client her brush from the 22 at 8:00 AM, client ner brush from the the Area Supervisor ushes should be stored the Qualified Intellectual PIDP) Lead indicated and be stored the QIDP indicated the vidual baskets to store IDP indicated the not be stored together.		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) are stored separately. Ong monitoring will be achieved through a monthly site revi completed by ResCare administration to ensure hy supplies are stored separa	poing J ew /giene	(X5) COMPLETION DATE

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