STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G175	A. BUILDING 00 B. WING	01/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3607 MIDDLE RD JEFFERSONVILLE, IN 47130

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W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. Survey dates: January 22, 23, 24 and 25, 2019. Facility Number: 000709 Provider Number: 15G175 AIM Number: 100243190 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 and #27547 on 2/6/19.	W 0000		
W 0112 Bldg. 00	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. Based on record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure client #2's medical records were securely maintained and kept confidential. Findings include: On 1/23/19 at 9:19 AM, client #1's record was reviewed. No dental, hearing or vision records were available for review. On 1/23/19 at 9:37 AM, the Qualified Intellectual Disability Professional (QIDP) was asked where client #2's records for dental, hearing and vision could be found. The QIDP indicated further follow up would be needed with the Nurse.	W 0112	The Program Manager will ensure the Area Supervisor and Residential Manager retrain staff on HIPAA policy and procedures and transportation of HIPAA information. A secured lockable case was purchased for the transportation of HIPAA information. The Program Manager will ensure the Area Supervisor and Residential Manager retrain staff on proper reporting of incidents including missing client files.	03/01/2019

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

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	On 1/23/19 at 11:00 AM, the Program Manager (PM) was interviewed. The PM was asked where client #2's records for dental, hearing and vision could be found. The PM followed up through phone conversations with other staff members and then indicated client #2 went to the emergency room approximately seven months ago and the medical book was lost by emergency room staff. The PM was asked if the incident was reported and stated, "no incident was filed, it was the first they (Quality Assurance) had heard about it too". On 1/24/19 at 8:56 AM, a Bureau of Developmental Disabilities Services (BDDS) incident report was received for review. The BDDS report dated 1/23/19 indicated, "It was reported the book containing medical information for [client #2] is missing from the group home". Plan to resolve indicated, "An investigation has been initiated to determine the location of the book and the length of time it has been missing". On 1/24/19 at 3:33 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked if protected health information should remain secure. The QAM stated, "Absolutely." The QAM was asked if a policy was in place to protect heath information. The QAM stated, "Yes." The QAM was asked if the policy had been followed. The QAM stated, "No, absolutely not." On 1/24/19 at 5:25 PM, a policy titled Security of Protected Health Information (PHI) Under the Privacy Rule dated 9/8/09 was reviewed. The PHI policy indicated, "Records containing PHI are stored in a secured container during transport from one location to another. (i.e. trunk, securely closed box, etc.). Records containing PHI shall not		How was the clients' record missing for 7 months and the facility was not aware? The book went missing on September 8, 2018. When the book went missing proper reporting of the incident did not occur. Were any other clients affected by the deficient practice? No How will the facility monitor to ensure that records are up to date and maintained? Monitoring of Corrective Action: A member of the Site Review Team, consisting of the QA department, Program Managers, QIDP's, Nurse Manager, AED, and Area Supervisors will complete monthly site reviews of each location and document any issues/findings on the site review. Site Review will be reviewed by each Area Supervisor and Program Manager for that home and follow-up as necessary to correct all issues.	

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	be left in a vehicle at any time (i.e. staff only transports what records are necessary and immediately removes the records and secures then when arriving at destination)." 9-3-1(a)		Persons Responsible, Program Manager, Director of Nursing, Area Supervisor, Residential Manager	
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 10 incident reports reviewed affecting client #2, the facility failed to implement its policy and procedures regarding allegations of abuse and financial exploitation. Findings include: On 1/22/19 at 2:14 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 8/24/18 at 7:51 AM indicated, "It was reported [staff name], DSP (direct support professional) cursed at [client #2]". A review of the investigative summary dated 8/27/18 indicated under conclusion, "It is substantiated [staff name] used inappropriate verbal interactions with [client #2]". -BDDS report dated 12/7/18 at 10:23 AM indicated, "[Client #2] was given $80 by his father and staff stated she told the residential manager on Monday (12/3/18) morning where the money was put. The residential manager could not find the money on Tuesday (12/4/18) but did not fill out an incident report. The report was filed on	W 0149	The Program Manager will ensure the Area Supervisor and Residential Manager retrain staff on the Abuse, Neglect and Exploitation Policy and disciplinary action will be given if the policy is not followed. Area Supervisor and Residential Manager will ensure that the Abuse, Neglect and Exploitation Policy is followed. Monitoring of Corrective Action: The Program Manager, Area Supervisor and Residential Manager will ensure all incidents of possible abuse, neglect and exploitation are reported to the QA department.	03/01/2019

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	12/7/2018". A review of the investigative summary dated 12/14/18 indicated under conclusion, "It is substantiated [client #2] received $80 cash gift from his dad. It is substantiated he (client #2) gave the money to staff. It is unsubstantiated what happened to the money after [date]". Client #2 was reimbursed for the lost $80. -BDDS report dated 1/13/19 at 7:37 PM indicated, "[Client #2] reported a staff member grabbed him by the shirt then pushed a table up against him. The staff member in question was placed on administrative leave pending investigation". On 1/24/19 at 2:15 PM, a review of the investigative summary indicated under conclusion, "It is substantiated [staff name] pushed the kitchen table against [client #2]". "It is unsubstantiated [staff name] grabbed [client #2] by his shirt." On 1/24/19 at 3:33 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked if staff followed the Abuse, Neglect, Mistreatment or Violation of an Individual's Rights policy. The QAM stated, "No, they did not." On 1/24/19 at 5:25 PM, the policy Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or Violation of an Individual's Rights dated 3/8/18 was reviewed. The policy indicated, "ResCare strictly prohibits abuse, neglect, exploitation, mistreatment or violation of an Individual's rights". 9-3-2(a)		Persons Responsible: Program Manager, Area Supervisor, Residential Manager	
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual			

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	toward independence. Based on record review and interview for 1 of 3 sampled clients (#3), the facility failed to ensure client #3's risk plan included restriction of peanuts and staff supports to limit intake. Findings include: The facility's Bureau of Developmental Disabilities Services (BDDS) incident reports were reviewed on 1/22/19 at 2:14 PM. The review indicated the following: -BDDS report dated 12/10/18 at 10:34 AM indicated, "[Client #3] was eating breakfast and began vomiting. Staff cleaned him up and sent him to his room to lay down. He continued to throw up so staff called the nurse and was advised to send him to [hospital name]. [Client #3] was admitted to the hospital for a small bowel obstruction, intractable vomiting, nausea ...." - BDDS report dated 12/13/18 at 8:59 AM indicated, "[Client #3] began vomiting in the van on the way to Day Program. Staff brought him back to the house and called his doctor because he had a scheduled appointment at 11:30am that same day. Doctor advised to take him to the hospital to be admitted ...." -BDDS report dated 12/26/18 at 8:40 AM, "[Client #3] was sitting on the couch when he began vomiting. Staff cleaned him and was advised by nurse to call 911. He was taken to [hospital name] and treated for nausea and abdominal pain ...." On 1/23/19 at 9:37 AM, client #3's record was reviewed. Client #3's record indicated: -Risk plan dated 12/1/18 indicated under dietary	W 0240	Nursing has updated the risk plan and train all residential staff and day program staff on plan revisions. All employees have been trained on the updated risk plan on the standard and disciplinary action will be given if the risk plan is not followed. Monitoring of Corrective Action: The Program Manager, Area Supervisor and Residential Manager will ensure all staff are trained on and implement risk plans correctly. Persons Responsible: Nursing Manager, Program Manager, Area Supervisor, Residential Manager	02/24/2019

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	restrictions, "Low fat, low cholesterol, NCS (No Concentrated Sweets)". Under the section titled "Specific Skills to Maintain/Acquire" the risk plan indicated, "[Client #3] has the ability to feed self safely. Staff should sit with [client #3] during all meals and provide prompts and assistance as needed". -Hospital Discharge Summary Report dated 12/9/18 indicated, "Pt (patient) had a small bowel obstruction from eating too many peanuts. Please limit future peanut intake to no more than a handful at a time". The risk plan did not identify restriction of peanuts or the staff supports to limit intake. On 1/25/19 at 9:31 AM, an interview with the Nurse was completed. The Nurse was asked if peanuts were identified as a restriction for client #3. The Nurse stated, "We need to watch him for that". The Nurse then indicated the risk plan would need updated and stated, "We have to watch him for coffee and shoveling things into his mouth too". 9-3-4(a)			
W 0323 Bldg. 00	483.460(a)(3)(i) PHYSICIAN SERVICES The facility must provide or obtain annual physical examinations of each client that at a minimum includes an evaluation of vision and hearing. Based on record review and interview for 2 of 3 clients in the sample (#1 and #3), the facility failed to ensure clients #1 and #3 had vision examinations. Findings include: On 1/23/19 at 9:19 AM, client #1's record was	W 0323	Optometry appointments have been scheduled for clients #1, and client #3. Nursing has retrained all staff on medical appointment procedures. Area Supervisor and Residential Manager will ensure that all appointments are attended	02/24/2019

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	reviewed. Client #1's record indicated: -An eye doctor order and progress note dated 12/14/16 indicated, "Opacified (sic) Posterior Capsule (artificial lens) S/P (post) Cataract Surgon (sic) ....Good ocular health ....No glasses required ....return in 1 yr (year)". A hand written note on the consult form indicated "12/14/17 1:45 PM" as a return visit date. There was no documentation client #1 had a vision examination since 12/14/16. On 1/23/19 at 9:49 AM, client #3 record was reviewed. Client #3's record indicated: -An eye doctor order and progress note dated 5/2/16 indicated, "Hyperopia (images focus behind the retina) no glasses required, Lid cysts (abnormal, closed sac-like structures) Return visit 2 years". A hand written note on the consult form indicated "5/2018" as a return visit. There was no documentation client #3 had a vision examination since 5/2/16. On 1/24/19 at 2:39 PM, the Nurse was interviewed. The Nurse was asked if client #1 and client #3's follow up eye appointments should have been completed. The Nurse stated, "Yes." 9-3-6(a)		as scheduled. No other clients were affected by this deficiency. The facility has implemented an appointment tracking form to ensure tracking of upcoming appointments. All employees have been trained on medical appointment tracking and disciplinary action will be given if appointment tracking is not implemented correctly. Monitoring of Corrective Action: The Program Manager, Area Supervisor and Residential Manager will ensure all staff are trained on and implement appointment tracking correctly. Persons Responsible: Nursing Manager, Program Manager, Area Supervisor, Residential Manager	