

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
W 0000 Bldg. 00	<p>This visit was for a pre-determined full recertification and state licensure survey. This visit resulted in an Immediate Jeopardy.</p> <p>Dates of Survey: January 13, 14, 15, 16, 17, 21, 22 and 23, 2020.</p> <p>Facility Number: 000693 Provider Number: 15G157 AIM Number: 100234510</p> <p>These federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 1/29/20.</p>	W 0000		
W 0102 Bldg. 00	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to meet the Condition of Participation: Governing Body. The facility's governing body failed to exercise operating direction over the facility by failing to prohibit abuse, neglect, and/or mistreatment and to prevent the neglect of client #1 regarding continued elopement and attempted self-harm.</p> <p>Findings include:</p> <p>Please refer to W104. For 1 of 3 sampled clients (#1), the facility's governing body failed to exercise operating direction over the facility by failing to prohibit abuse, neglect, and/or</p>	W 0102	<p>1.Based on client #1 assessment for an ESN placement the Facility brought in the ESN Behavior Clinician and the ESN QIDP to review current ISP/BSP collaborating with the ICF QIDP to review and update plans covering Client #1 elopement and self-harm.</p> <p>2.A thorough review of Client #1 plan resulted in updated plans produced by an IDT consisting of ESN Behavioral Clinician, ESN QIDP, ICF QIDP, Nursing Program Manager and Area Supervisor on 15Jan2020.</p>	02/22/2020

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
W 0104 Bldg. 00	<p>mistreatment and to prevent the neglect of client #1 regarding continued elopement and attempted self-harm.</p> <p>Please refer to W122. For 1 of 3 sampled clients (#1), the governing body failed to meet the Condition of Participation: Client Protections. The facility's governing body neglected to implement its policy and procedures to ensure their system to prohibit abuse, neglect, and/or mistreatment prevented neglect of client #1 regarding continued elopement and attempted self-harm.</p> <p>9-3-1(a)</p> <p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over</p>		<p>3.A sharps restriction was implemented in the Facility with HRC approval on 15JAN2020 this remained in effect until Client #1 was placed in a new Facility on 31Jan2020.</p> <p>4.Staff was trained on the updated ISP/BSP on 15JAN2020.</p> <p>5.Unannounced random daily observations begin at the Facility on 14JAN2020 to ensure plans are being implemented by staff. This remained in effect until Client #1 was placed in a new Facility on 31Jan2020.</p> <p>6.The Facility contacted the Bureau of Developmental Disabilities Services (BDDS) for Client #1 referral for an emergency CIH Wavier on 14JAN2020.</p> <p>7.The management team began daily update meeting on 14JAN2020 to ensure compliance and implement changes needed developing a transition plan and implementation of the CIH waiver. Daily meetings will continue until Conditions are lifted.</p> <p>Persons Responsible: Executive Director, Program Manager, Quality Assurance, Area Supervisor, Director of Nursing, Nurse, Behavior Clinician, QIDP, Residential Manager, and DSP.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>the facility.</p> <p>Based on observation, record review and interview for 6 of 6 clients living in the group home (#1, #2, #3, #4, #5 and #6), the facility's governing body failed to exercise operating direction over the facility by failing to ensure 1) the ceiling of the basement was free from rotten wood with water damage and the room where the furnace is located was free from a substance growing on the sink and floor, and 2) to prohibit abuse, neglect, and/or mistreatment and to prevent the neglect of client #1 regarding continued elopement and attempted self-harm.</p> <p>Findings include:</p> <p>1) On 1/13/20 from 4:11 PM to 6:16 PM, an observation was conducted at the group home.</p> <p>-At 5:32 PM, client #1 and the Qualified Intellectual Disability Professional (QIDP) took the surveyor to client #1's bedroom located in the basement of the home. Client #1 was asked if she liked her bedroom downstairs and she stated, "No". Client #1 was asked why she did not like her bedroom and stated, "Because I don't like being by myself".</p> <p>-At 5:40 PM, the QIDP indicated client #1 had moved into the basement bedroom at the end of December 2019. Client #1 then proceeded back upstairs and the QIDP assisted her to ensure client #1 returned with her one to one staffing ratio. A one foot by four foot section of the basement ceiling was missing which exposed five floor boards. One of the five floor boards was rotten and covered with a black stain.</p> <p>-At 5:45 PM, the QIDP accompanied the surveyor into the furnace room in the basement. A</p>	W 0104	<p>1. The facility will ensure all repairs are reported and completed in a timely manner. Staff will be retrained on the maintenance request process to ensure any and all staff are aware they can request a maintenance work order 24hours a day 7 days a week using 844-RESCARE.</p> <p>2. The Program Manager Contacted the Regional Maintenance Manager on 21JAN2020 and provided a list of deficiencies that needed to be repaired, replaced or resolved. All work orders were approved by the Executive Director and a contractor was hired on 22JAN2020.</p> <p>3. The basement ceiling repair was completed by the Contractor and inspected by the Program Manager 28JAN2020.</p> <p>4. The furnace room cleanup and repair was completed by the Contractor and inspected by the Program Manager 28JAN2020.</p> <p>5. Based on client #1 assessment for an ESN placement the Facility brought in the ESN Behavior Clinician and the ESN QIDP to review current ISP/BSP collaborating with the ICF QIDP to review and update plans covering Client #1 elopement and self-harm.</p> <p>6. A thorough review of Client #1 plan resulted in updated plans produced by an IDT consisting of</p>	02/22/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
W 0122 Bldg. 00	<p>substance covered the floor and large wash sink inside this room. The QIDP was asked what the yellowish substance was from and stated, "It looks like something backed up".</p> <p>On 1/21/20 at 2:41 PM, the QIDP was interviewed. The QIDP was asked about the environmental condition found in the basement. The QIDP indicated the home should be maintained in good repair and stated, "Work orders have been done. Some work has already started".</p> <p>On 1/21/20 at 2:53 PM, the Program Manager was interviewed. The Program Manager was asked about the environmental condition found in the basement. The Program Manager indicated the home should be maintained in good repair.</p> <p>2) Please refer to W149. For 1 of 3 sampled clients (client #1), the facility neglected to implement its policy and procedures to ensure their system to prohibit abuse, neglect, and/or mistreatment prevented neglect of client #1 regarding her continued behaviors of elopement and attempted self-harm.</p> <p>9-3-1(a)</p> <p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review, and interview, for 1 of 3 sampled clients (#1), the</p>	W 0122	<p>ESN Behavioral Clinician, ESN QIDP, ICF QIDP, Nursing Program Manager and Area Supervisor on 15Jan2020.</p> <p>7.A sharps restriction was implemented in the Facility with HRC approval on 15JAN2020 this remained in effect until Client #1 was placed in a new Facility on 31Jan2020.</p> <p>8.Staff was trained on the updated ISP/BSP on 15JAN2020.</p> <p>9.Unannounced random daily observations begin at the Facility on 14JAN2020 to ensure plans are being implemented by staff. This remained in effect until Client #1 was placed in a new Facility on 31Jan2020.</p> <p>10.The Facility contacted the Bureau of Developmental Disabilities Services (BDDS) for Client #1 referral for an emergency CIH Wavier on 14JAN2020.</p> <p>Persons Responsible: Executive Director, Program Manager, Regional Maintenance Manager, Maintenance, Quality Assurance, Area Supervisor, Director of Nursing, Nurse, Behavior Clinician, QIDP, Residential Manager, and DSP.</p> <p>1.Based on client #1 assessment for an ESN</p>	02/22/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its policy and procedures to ensure their system to prohibit abuse, neglect, and/or mistreatment prevented neglect of client #1 regarding continued elopement and attempted self-harm.</p> <p>This noncompliance resulted in an Immediate Jeopardy (IJ). The Immediate Jeopardy began on 11/3/19 at 12:00 PM. The Immediate Jeopardy was identified on 1/14/20 at 2:17 PM. The Agency's Executive Director (ED) was notified of the Immediate Jeopardy on 1/14/20 at 2:36 PM regarding the facility's systemic failure to ensure the implementation of the agency's policy and procedure to prohibit abuse, neglect, and mistreatment to prevent neglect of client #1 and to implement effective corrective measures to prevent the recurrence of client #1's continued elopement and self-harm.</p> <p>On 1/15/20 at 3:35 PM, the facility's 1/14/20 plan to remove the Immediate Jeopardy was reviewed and indicated the following:</p> <p>"The provider has implemented the following protective measures for the removal of the Immediate Jeopardy citation issued under Client Protections: 1. The client in question has been referred to the Bureau of Developmental Disabilities Services (BDDS) for an emergency CIH (Community Integration and Habilitation) waiver. A. BDDS verbally confirmed with ResCare on 1/14/20 stating the following: i. Approval for a waiver slot has been granted by BDDS state office and they have a waiver slot number. ii. They have a current Confirmation of Diagnosis and can proceed with the requested service change. iii. An ICAP (Inventory for Client and Agency Planning)</p>		<p>placement the Facility brought in the ESN Behavior Clinician and the ESN QIDP to review current ISP/BSP collaborating with the ICF QIDP to review and update plans covering Client #1 elopement and self-harm.</p> <p>2. A thorough review of Client #1 plan resulted in updated plans produced by an IDT consisting of ESN Behavioral Clinician, ESN QIDP, ICF QIDP, Nursing Program Manager and Area Supervisor on 15Jan2020.</p> <p>3. A sharps restriction was implemented in the Facility with HRC approval on 15JAN2020 this remained in effect until Client #1 was placed in a new Facility on 31Jan2020.</p> <p>4. Staff was trained on the updated ISP/BSP on 15JAN2020.</p> <p>5. Unannounced random daily observations begin at the Facility on 14JAN2020 to ensure plans are being implemented by staff. This remained in effect until Client #1 was placed in a new Facility on 31Jan2020.</p> <p>6. Staff received retraining on the One-to-One role covering questions on staff responsibilities during showers based on observations retraining completed on 17JAN2020.</p> <p>7. Koorsen Fire and Security was contacted to inspect and test the Alarm System to ensure the audible alerts were functioning properly. The Program Manager</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>assessment has been requested and expedited on 1/15/20 and BDDS has the names of 5 respondents from ResCare to interview for this assessment. 2. An interdisciplinary team meeting was held for the client in question and the following was put in place: a. 1:1 One-to-One) staffing for the client in question will continue during waking hours. b. A sharps restriction will be implemented in the home and the appropriate HRC (Human Rights Committee) approvals will be in place. c. Updated Behavioral Support Plan has been created and staff will be trained on that implementation by 1/15/20. d. A member of the management team will do unannounced drop in visits daily until the IJ is corrected, effective 1/15/20. 3. The management team will meet daily as of 1/14/20 to review any issues involving the client in question and to review the plans in place to ensure overall compliance and will implement any changes as needed. The management team will also develop transition plans for implementation of the CIH waiver during these same daily meetings".</p> <p>During observation, record review, and interviews on 1/15/20 from 2:53 PM to 4:16 PM, clients #1 and #3 were at the group home with staff #7. Client #1 was in her bedroom laying down on her bed.</p> <p>-At 3:05 PM, client #1 came out to the living room with staff #7. Staff #7 was asked if other people were present at the home. Client #3 indicated she thought staff #4 was present and staff #7 clarified by stating, "No, [staff #4] is not here. It's just us (client #1, client #3 and staff #7)". Staff #7 was asked if only one staff person was present with 2 clients. Staff #7 stated, "Yeah".</p> <p>-At 3:09 PM, client #1 made a phone call to a family member and discussed her behavior of</p>		<p>received instructions on reset and testing from Koorsen.</p> <p>8. Instructions for testing and resetting the security system was developed by Koorsen and staff trained on the procedure, a daily testing schedule was posted in the home by the Program Manager and those test continued until Client #1 was placed in another Facility.</p> <p>9. The Facility contacted the Bureau of Developmental Disabilities Services (BDDS) for Client #1 referral for an emergency CIH Wavier on 14JAN2020.</p> <p>10. The management team began daily update meeting on 14JAN2020 to ensure compliance and implement changes needed developing a transition plan and implementation of the CIH waiver. Daily meetings will continue until Conditions are lifted.</p> <p>Persons Responsible: Executive Director, Program Manager, Koorsen Fire and Security, Quality Assurance, Area Supervisor, Director of Nursing, Nurse, Behavior Clinician, QIDP, Residential Manager, and DSP.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>elopement and self-harm and how it affected family visits. At 3:14 PM, client #1 was no longer on the phone discussing visitation and her behavior plan.</p> <p>-At 3:17 PM, staff #7 asked client #1 if she had showered. Client #1 shook her head no and indicated she wanted to go downstairs to her previous bedroom to obtain clean clothing for her shower. Client #1 and staff #7 went downstairs to obtain client #1 clean clothing.</p> <p>-At 3:20 PM, client #1 and staff #7 returned upstairs. Staff #7 asked client #3 if other staff usually go inside the bathroom with client #1 or sit outside. Client #3 stated, "Usually they wait outside and if she yells for help with her hair they go inside". Staff #7 then used a phone to call and asked questions about the one to one staffing while client #1 showered.</p> <p>-At 3:24 PM, staff #7 was asked if her question during the phone call concerning the one to one staffing during client #1's shower had been answered. Staff #7 stated, "Yeah, [staff #1] (house manager) said to stand out in the hall. I was not sure because her (client #1) BSP (Behavior Support Plan) is not real clear on showering".</p> <p>-At 3:25 PM, the Area Supervisor entered the home to complete an unannounced drop in visit.</p> <p>-At 3:27 PM, staff #1 entered the home.</p> <p>-At 3:31 PM, the Qualified Intellectual Disability Professional (QIDP) entered the home.</p> <p>-At 3:34 PM, staff #7 asked client #1 if she was finished showering. Client #1 indicated she was finished and stated, "Yeah".</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>-At 3:35 PM, the QIDP provided a copy of the provider's corrective action plan to remove the Immediate Jeopardy.</p> <p>-At 3:39 PM, client #1 returned from showering to the kitchen where she ate a cucumber slice from a food tray. Staff #7 asked if she wanted to put shoes on and help take the trash out. Client #1 agreed and at 3:41 PM client #1 and staff #7 went outside with a trash bag from the kitchen.</p> <p>-At 3:48 PM, the Area Supervisor indicated she had finished doing a sweep of sharp objects at the home. The Area Supervisor was asked if she realized staff #7 was the only staff person present at the home upon her entry with clients #1 and #3. The Area Supervisor stated, "Yes, I did". The Area Supervisor was asked about the one-to-one staffing during the client's shower and if client #1 was line of sight or arms reach and how client #1's behavior plan defined the role. The Area Supervisor stated, "Ok, we'll review those areas and I'll be sure to communicate about staffing and the plan".</p> <p>-At 4:03 PM, staff #1 (house manager) was asked about client #1 and client #3 being at the home with only staff #7. Staff #1 stated, "That was because [client #3] had alone time". Staff #1 was asked if staff #7 contacted her about clarification for the one-to-one role during client #1's shower time. Staff #1 stated, "Yes, she was calling to see she should be in there while she showered (bathroom). She can be in the doorway with the door open. It has a corner so she (client #1) can't be seen".</p> <p>-At 4:13 PM, the QIDP was asked about client #1's behavior plan and the one-to-one staffing during</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>showers. The QIDP reviewed client #1's plan and then stated, "Her plan doesn't say anything about her showering". The QIDP provided a copy of the 1/15/20 Behavior Support Plan for review. The Behavior Support Plan did not indicate the one-to-one staffing role during client #1's shower activities.</p> <p>During observation, record review, and interviews on 1/16/20 from 1:41 PM to 3:04 PM, the Qualified Intellectual Disability Professional (QIDP) answered the door. Present at the home was the QIDP, staff #1, staff #7 as the one-to-one with client #1, client #3, Program Manager and staff #5 for receipt of training. The QIDP pointed out a placard listing staff names and contact numbers to call during alone time and the instruction of client #1's one-to-one staffing not to leave client #1 unattended during other housemates alone time.</p> <p>-At 1:48 PM, client #1 was seated at a dining room table with coloring materials out on the table. Staff #7 was seated next to client #1 at the dining room table.</p> <p>-At 1:49 PM, client #1's bedroom was observed. Client #1's bedroom did not have her clothing as it remained downstairs in her previous bedroom. The dresser in client #1's upstairs bedroom was empty and hygiene items had been removed. The QIDP noticed a decorative item hanging by a cord from client #1's upstairs bedroom wall. The QIDP indicated to the Program Manager the need to remove the screw. The Program Manager went outside and obtained a screw driver and removed the screw from client #1's bedroom wall at 1:51 PM. During this time client #1 entered her bedroom and hugged the QIDP. Client #1 and the QIDP began discussing the loss of a family visitation because of client #1's behavior earlier in</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>the day. The QIDP explained why the screw had to be removed, but the decoration was still client #1's personal item. The QIDP asked client #1 if she had brushed her teeth.</p> <p>-At 1:54 PM, client #1 returned to the dining area to retrieve her hygiene items and tooth brush from the medication administration room adjacent to the dining room. As client #1 walked past she reached out and touched the surveyor's arm and said hello. Client #1 was asked how she was doing. Client #1 stated, "Not good. I had a bad day, Monday and I want to see my grandma". Client #1 continued on into the dining room and the QIDP stated, "Because she had behaviors this morning she will not have a Monday visit with grandma".</p> <p>-At 2:00 PM, client #1 returned from obtaining her hygiene items and tooth brush and went to the bathroom. Staff #7 assisted client #1 in the bathroom.</p> <p>-At 2:01 PM, 3 internal incident reports were provided for review which indicated client #1 had attempted elopement and exhibited physical aggression. Client #1 made it to the street in one attempt elopement which required You're Safe I'm Safe (Behavior Intervention) to be used and 2 episodes of physical aggression which required You're Safe I'm Safe behavioral intervention.</p> <p>-At 2:05 PM, staff #1 went off shift and staff #5 asked client #1 if she wanted to play games. Client #1 picked out a memory game. Client #3, client #1, staff #7 and staff #5 began playing the memory game.</p> <p>-At 2:12 PM, the QIDP provided a revised Behavior Support Plan (BSP) dated 1/16/20 for</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>client #1. The QIDP stated, "So, we added hair bands, pens and pencils (restricted sharp objects). We explained the one-to-one means eye sight with staff in the same room. We added room sweeps of the living room, bathroom, kitchen and dining room. It's (room sweep) to be done before she comes into the room. We're going to make sure there are no cleaning supplies. We did a [client #1] (section of the plan) with her one-to-one by herself on the van, she (client #1) will be in the back with child locks on. The toileting / hygiene protocol changed". The QIDP was asked how the protocol changed and stated, "Staff will stay in eye sight while she showers. All hygiene items are added to the list, so they're back in here (medication administration room). When toileting, staff keep eye sight (line of sight). All rooms are to be swept and identified the rooms". The QIDP was asked if all staff received training on the revised 1/16/20 Behavior Support Plan for client #1. The QIDP stated, "No. Everyone here (working with client #1). The staff that will be present (working with client #1) will be trained (prior to working with client #1)". The QIDP was asked if more training of the revised 1/16/20 Behavior Plan was needed. The QIDP stated, "Yes".</p> <p>-At 2:29 PM, the Program Manager indicated a pick list (provider service options) had been signed by client #1's guardian, forwarded to Bureau of Developmental Disabilities Services (BDDS) and a voice mail left for client #1's BDDS Service Coordinator. The Program Manager stated, "She (guardian) signed all releases (transition paper work) as well. We explained everything going on. She (guardian) is very supportive of things going on. We have a process we follow, but I'm guessing she will be considered an emergency placement. I would think within a</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130	
(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)
	<p>week".</p> <p>-At 2:34 PM, client #1 used the phone and spoke with her family. Client #1 was upset about not being able to visit due to her behavior.</p> <p>-At 2:42 PM, client #1 spoke with the QIDP after finishing her memory game. Then client #1 explained to the QIDP she would not try to run (elope) again and that she wants to visit her grandma. The QIDP explained to client #1 if she was able to decide to attempt elopement she could also determine not to attempt elopement. The Program Manager then continued the conversation with client #1 in support of good choice making.</p> <p>-At 2:45 PM, client #1 asked staff #7 if she could have some water. Client #1 retrieved a bottle of water to drink and began watching television at 2:47 PM.</p> <p>-At 2:54 PM, client #1 began changing clothes as she was preparing to go with staff #5 and client #3 to pick up client #2 from day program. At 2:57 PM, client #1 had finished changing and began putting her shoes on.</p> <p>-At 2:58 PM, staff #7 completed a sweep of the vehicle for sharp objects. At 3:00 PM, client #1, client #3, staff #5 and staff #7 left to go pick up client #2 from day program.</p> <p>During observation, record review, and interviews on 1/17/20 from 11:05 AM to 12:12 PM, client #1, staff #7 and a maintenance person were at the home.</p> <p>-At 11:08 AM, client #1 was seated in a rocking chair watching a movie. Staff #7 indicated staff #1</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>was working and had left to take the clients to work. Client #1 on occasion would close her eyes and then return to watching the movie.</p> <p>-At 11:15 AM, client #1 yawned and indicated a hello by shaking her head up and down. Client #1 then closed her eyes.</p> <p>-At 11:17 AM, observation of the kitchen found no sharp objects.</p> <p>-At 11:19 AM, observation of client #1's bedroom found no sharp objects or personal hygiene items present.</p> <p>-At 11:20 AM, observation of the upstairs bathroom adjacent to client #1's bedroom found no sharp objects or personal hygiene items.</p> <p>-At 11:21 AM, client #1 was asked if she had a good night. Client #1 stated, "Yeah" and continued to watch the movie. Staff #7 was asked how client #1's evening had been behaviorally and indicated she was not aware of issues and stated, "I left at 4 PM though".</p> <p>-At 11:27 AM, the Assistant Executive Director entered the home through the back door. Staff #7 asked how he got inside the home because the audible alarm had not sounded. The Assistant Executive Director indicated he had come through the back door and went to investigate why the alarm had not sounded.</p> <p>-At 11:31 AM, the Assistant Executive Director discussed with the maintenance person about leaving only the storm door closed and by leaving the wooden door open the audible alarm system would not work as he entered in and out of the home. Client #1 continued to watch her movie in</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>the common living area.</p> <p>-At 11:33 AM, the maintenance person exited and reentered the home through the back door. No alarm sounded. Client #1 and staff #7 were in the common living area watching a movie.</p> <p>-At 11:59 AM, the maintenance person exited and reentered the home through the back door. No alarm sounded. Client #1 and staff #7 were in the common living area watching a movie.</p> <p>-At 12:01 PM, staff #7 asked client #1 if she wanted to wash her hands and prepare lunch.</p> <p>-At 12:03 PM, client #1 got apple sauce, Jell-O, and lunch meat out of the refrigerator. Staff #7 asked client #1 if she wanted orange juice or milk to drink. Client #1 stated, "Orange Juice". The back door was left open with only the storm door closed. The audible alarm would not function when the doors were left in this manner.</p> <p>-At 12:06 PM, client #1 and staff #7 made themselves sandwiches to eat for lunch. The maintenance person was in the dining room using a pneumatic nail gun to hang trim. Client #1 and staff #7 went back into the common living area to eat their lunch while the maintenance person worked in the dining area. The back door was left open with only the storm door closed. The audible alarm would not function with the doors in these positions.</p> <p>-At 12:08 PM, client #1 was asked if she had a good evening and morning. Client #1 stated "Yes" and picked out another movie to watch while she and staff #7 ate their lunch.</p> <p>-At 12:12 PM, the Qualified Intellectual Disability</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>Professional (QIDP) was interviewed on the phone. The QIDP was asked how client #1 had been doing and indicated she had been doing well and stated, "Yes, that is my understanding". The QIDP was asked if client #1 had any behavioral episodes or incidents and stated, "No, no behaviors". The QIDP then indicated the Program Manager was on the phone coordinating transition plans for client #1 and stated, "[Program Manager] is on the phone and believes they have a place for her to move. If grandma (guardian) agrees she would move on the 27th (January 2020)".</p> <p>During observation, record review, and interviews on 1/21/20 from 10:35 AM to 12:11 PM, client #1, client #3, client #5, client #6, staff #1 and staff #3 were present at the home.</p> <p>-At 10:41 AM, staff #1 stated, "We had a rough morning". Client #1, client #3 and client #5 were in the common living area watching a movie. Staff #1 indicated client #1 had to receive a PRN (as needed) behavioral medication due to attempted elopement and physical aggression earlier in the morning.</p> <p>-At 10:42 AM, client #1 asked staff #1 about going to visit her grandma. Staff #1 explained to client #1 her behavior plan and the need to go 7 days without trying to elope she could maintain her weekly visitation with her grandma and stated, "If no more, you can go next Tuesday".</p> <p>-At 10:44 AM, staff #1 was asked about client #1's morning and stated, "It's just been attempt after attempt. Staff #1 indicated client #1 had not succeeded in elopements. Staff #1 was asked how things went over the weekend. Staff #1 stated, "Just attempts. I even tell her she is safe and tried</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>rubbing her back". Client #5 and client #6 entered the kitchen area. Client #5 indicated she would be leaving to go to work and needed to be there at 11 AM and client #6 indicated she was home because of no school due to the end of the grading quarter for teachers. Client #1 was seated in the common living area watching a movie.</p> <p>-At 10:49 AM, client #1 got up and went into the bathroom indicating her stomach did not feel well. Staff #1 indicated she and staff #3 were not sure if client #1 put something into her mouth during behavioral episodes this morning or if her stomach was not feeling well from placing her hands down her throat. Both staff #1 and staff #3 did not see an object client #1 had placed in her mouth, but when talking with client #1 a string was indicated, but client #1 did not know where the string had come from.</p> <p>-At 10:51 AM. Client #1 returned to her bedroom and then back out to the living room and then hugged staff #3. At 10:53 AM, staff #3 asked client #1 if she was doing ok. Client #1 shook her head no and asked if she could call her grandma and went and got the phone.</p> <p>-At 10:55 AM, staff #1 took client #5 to work. Clients #3 and #6 accompanied and went with staff #1 and client #5 into the community to drop client #5 off for work.</p> <p>-At 10:56 AM, client #1 returned to her room. Staff #3 asked client #1 if she wanted to color or her books. Client #1 stated, "No" and laid down in her bed. Staff #3 followed client #1 into her bedroom and had her books in her hand.</p> <p>-At 11:00 AM, client #1 returned to the living room and staff #3 placed client #1's books on the</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130	
(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)
	<p>shelf in the common living area.</p> <p>-At 11:03 AM, client #3, client #6 and staff #1 returned to the home and began preparing food to eat. At 11:08 AM, client #6 began eating a breakfast sandwich and eggs.</p> <p>-At 11:09 AM, client #1 asked if she could speak with staff #1. Client #1 and staff #1 reviewed the 7 days of no attempted elopement and ability to maintain visitation with her grandma.</p> <p>-At 11:12 AM, client #1 began preparing her lunch and making a sandwich. Client #1 went into the dining room and began to eat.</p> <p>-At 11:17 AM, client #1 stated to staff #3, "I'm done" and went to the kitchen and returned to entryway of medication administration room and asked staff #1 if she could go to day program. Staff #1 indicated to client #1 if she had a good morning she could go to day program the next day.</p> <p>-At 11:20 AM, client #1 asked staff #3 if she could go to the library. Staff #3 indicated to client #1 she had to have no behaviors for 2 hours.</p> <p>-At 11:22 AM, client #1 finished eating her lunch and returned to the kitchen for cleanup. No sharp objects were observed unattended by staff #1 or staff #3. Client #1 returned to the common living area and began watching a movie. During this time, staff #1 provided internal incident reports for behavioral episodes exhibited by client #1 during the morning. Staff #1 was asked when the PRN Ativan 1 mg (milligram) was administered. Staff #1 reviewed the internal incident report and stated, "10:05 AM".</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>-At 11:30 AM, staff #3 asked client #1 if she was tired. Client #1 shook her head yes and then went into her bedroom and laid down. Staff #3 followed and began completing charting from working with client #1.</p> <p>-At 11:44 AM, staff #3 was asked about client #1's stomach bothering her and if she had ingested something. Staff #3 indicated she had not seen client #1 put anything into her mouth and stated, "I don't know if it was just that her hands were dirty or dust". Staff #3 indicated she had not observed client #1 placing anything into her mouth. Staff #1 indicated it could be from placing her hand in her mouth and stated, "She's does that sometimes".</p> <p>The Immediate Jeopardy was removed on 1/21/20 at 12:46 PM when through observation, interview and record review, it was determined that the facility had implemented the plan of action to remove the Immediate Jeopardy and the steps taken removed the immediacy of the problem. Even though the facility's corrective actions removed the Immediate Jeopardy, the facility remained out of compliance at a Condition level (Client Protections). The facility needed to ensure staff supervised client #1, the group home was monitored by the agency, and ensure policy and procedure for abuse, neglect, and/or mistreatment was followed. The facility needed to develop and implement effective corrective measures to prevent recurrence of elopement and self-harm behaviors to ensure the effectiveness of its plan of removal to ensure client #1's protection.</p> <p>Findings include:</p> <p>Please refer to W149. The facility neglected to implement its policy and procedures to ensure</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
W 0149 Bldg. 00	<p>their system to prohibit and prevent abuse, neglect, and/or mistreatment was implemented for client #1. The facility neglected to ensure effective corrective measures were taken to address client #1's continued behavioral episodes of elopement and attempted self-harm.</p> <p>9-3-2(a)</p> <p>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 observation, record review, and interview, for 1 of 3 sampled clients (client #1), the facility neglected to implement its policy and procedures to ensure their system to prohibit abuse, neglect, and/or mistreatment prevented neglect of client #1 regarding her continued behaviors of elopement and attempted self-harm.</p> <p>Findings include:</p> <p>On 1/13/20 at 3:10 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports was completed. The reports indicated:</p> <p>1)-BDDS report dated 11/3/19 indicated, "It was reported [client #1] went out the door and was running down the street with staff following her. Staff was able to verbally redirect [client #1] to go back home. [Client #1] was never out of line of sight".</p> <p>2)-BDDS report dated 11/3/19 indicated, "It was reported [client #1] had been in her room watching a movie. A housemate told staff that [client #1] had ran (sic) out the front door. [Client #1] was</p>	W 0149	<p>1.Based on client #1 assessment for an ESN placement the Facility brought in the ESN Behavior Clinician and the ESN QIDP to review current ISP/BSP collaborating with the ICF QIDP to review and update plans covering Client #1 elopement and self-harm.</p> <p>2.A thorough review of Client #1 plan resulted in updated plans produced by an IDT consisting of ESN Behavioral Clinician, ESN QIDP, ICF QIDP, Nursing Program Manager and Area Supervisor on 15Jan2020.</p> <p>3.A sharps restriction was implemented in the Facility with HRC approval on 15JAN2020 this remained in effect until Client #1 was placed in a new Facility on 31Jan2020.</p> <p>4.Staff was trained on the updated ISP/BSP on 15JAN2020.</p> <p>5.Unannounced random daily observations begin at the Facility</p>	02/22/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>out of line of sight of staff for 1 minute. Staff followed [client #1] down the street. Staff attempted to verbally redirect [client #1] but then had to initiate one-man YSIS (You're Safe I'm Safe - behavioral intervention). [Client #1] returned home and went in her room to watch a movie. [Client #1] then tried to open her window to elope. Staff initiated two-man YSIS for 3 minutes then again initiated YSIS for 5 minutes. [Client #1] again tried to elope thru (sic) her window. Staff blocked window and [client #1] kicked staff and attempted to bite staff. Staff initiated two-man YSIS for 4 minutes. No injuries were reported from the use of YSIS".</p> <p>The Elopement/Missing Person Investigation Summary dated 11/3/19 indicated, "Her 1:1 (one staff to one client) staff had walked out of her room to the hallway and [client #1] slipped out the door. Staff followed her but she was out of sight due (sic) the trees and shrubs lining the road".</p> <p>Review of the Interdisciplinary Team (IDT) Meeting dated 11/3/19 attached with the investigation summary indicated the plan of action was, "[Client #1] was out of sight for less than a minute. Her BSP (Behavior Support Plan) was reviewed and no changes were made. She (client #1) has 1:1 supervision. An elopement investigation was completed".</p> <p>3)-BDDS report dated 11/3/19 indicated, "It was reported [client #1] told staff to let her run. When staff blocked the exit, [client #1] began to bite, scratch, and kick staff. [Client #1] then attempted to swallow the plastic wrap from a box of Christmas cards. Staff attempted to verbally redirect [client #1] to spit out the plastic and [client #1] refused. Staff initiated YSIS until [client #1] calmed".</p>		<p>on 14JAN2020 to ensure plans are being implemented by staff. This remained in effect until Client #1 was placed in a new Facility on 31Jan2020.</p> <p>6. Staff received retraining on the One-to-One role covering questions on staff responsibilities during showers based on observations retraining completed on 17JAN2020.</p> <p>7. The Facility contacted the Bureau of Developmental Disabilities Services (BDDS) for Client #1 referral for an emergency CIH Wavier on 14JAN2020.</p> <p>Persons Responsible: Executive Director, Program Manager, Quality Assurance, Area Supervisor, Director of Nursing, Nurse, Behavior Clinician, QIDP, Residential Manager, and DSP.</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>4)-BDDS report dated 11/4/19 indicated, "It was reported [client #1] wanted staff tuck in to bed (to tuck her into bed), staff was unable to do it at that moment. Staff then saw [client #1] attempting to go out the back door and staff blocked the door. [Client #1] attempted to bite and pinch staff. Staff initiated one-man YSIS for 5 minutes until [client #1] calmed. Staff then assisted [client #1] to bed then left the room. [Client #1] went out the front door and ran down the street with staff following, [client #1] was out of line of sight for 5 seconds. [Client #1] sat down in the road and a second staff picked [client #1] up in her car and took her home. [Client #1] then attempted to elope thru (sic) the back door and staff initiated one-man YSIS for 5 minutes. No injuries were reported from the use of YSIS".</p> <p>5)-BDDS report dated 11/4/19 indicated, "It was reported [client #1] was in her room then went to the kitchen and attempted to elope thru (sic) back door. Staff was able to block door. [Client #1] attempted to push, bite and pinch staff so two-man YSIS was initiated for 5 minutes until [client #1] calmed. [Client #1] then went in (the) kitchen and attempted to get a butter knife and told staff she wanted to hurt herself. Staff initiated one-man YSIS for 5 minutes until [client #1] calmed. [Client #1] was transported to ER (emergency room) for psych (psychiatric) evaluation. While at the hospital, [client #1] continued aggressive behaviors and staff initiated one-man YSIS off and on for an hour with breaks every 5 minutes. No injuries were reported from the use of YSIS. [Client #1] was discharged with instructions on how to cope with anger".</p> <p>6)-BDDS report dated 11/5/19 indicated, "[Client #1] was putting her hands down her pants and</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>sticking her hands in her mouth. Staff redirected, she continued and one-man You're Safe I'm Safe was utilized. [Client #1] was released and she began to tear papers off the wall of the med (medication) room, she put a thumb tack in her mouth, staff used one-man You're Safe I'm Safe, [client #1] spit the thumb tack out and YSIS was released".</p> <p>7)-BDDS report dated 11/19/19 indicated, "[Client #1] attempted to elope, but staff was able to verbally redirect her, and she reentered the home. She then became physically aggressive toward staff and 1-person YSIS was implemented for less than 1 minute twice to stop the aggression. [Client #1] then took the tie from her robe and attempted to choke herself. Staff again implemented 1-person YSIS for less than 30 seconds and the behavior stopped. [Client #1] again became physically aggressive toward staff and 1-person YSIS was implemented 3 times for less than 1 minute each time ...Plan to resolve: Due to ongoing behaviors, [Psychiatric Hospital] was contacted and [client #1] was provided medical transport there for inpatient treatment. ResCare remains in contact with the hospital for updates and discharge planning".</p> <p>8)-BDDS report dated 11/29/19 indicated, "It was reported [client #1] walked out the door and began walking toward the street with staff following. Staff attempted to redirect [client #1] when [client #1] began to run. Staff ran with her and initiated one-man YSIS for 2 seconds when [client #1] dropped to the ground. A second staff walked over to [client #1] and [client #1] got up and went in the house. [Client #1] then told staff she was going to run again. When [client #1] went toward the door staff initiated one-man YSIS for 5 seconds when [client #1] bit staff. A second staff</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>then assisted with YSIS using a two-man technique for 2 minutes. [Client #1] then got a pen and attempted to stab herself with it. Staff initiated one-man YSIS for 1 second and a second staff assisted and two-man YSIS was done for 2 minutes until [client #1] calmed. [Client #1] was never out of line of sight of staff. No injuries were reported from the use of YSIS".</p> <p>9)-BDDS report dated 12/1/19 indicated, "It was reported [client #1] was sleeping when staff went to the restroom. When staff returned [client #1] was gone and could not be located. Staff called police for assistance. [Client #1] was returned after 5 minutes. After police left, [client #1] told staff she was going to bust the windows in her room. Staff initiated one-man YSIS for 2 minutes. No injuries were reported from the incident. [Client #1] was out of line of sight of staff for approximately 10 minutes".</p> <p>The Elopement/Missing Person Investigation Summary dated 11/30/19 indicated, "Her 1:1 staff had gone to use the restroom and left her unattended".</p> <p>Review of the Interdisciplinary Team Meeting dated 11/30/19 attached with the investigation summary indicated the plan of action was, "[Client #1] eloped for 5 minutes. Her BSP (Behavior Support Plan) was reviewed and no changes were made. She (client #1) has 1:1 supervision. An elopement investigation was completed".</p> <p>10)-BDDS report dated 12/1/19 indicated, "It was reported [client #1] continued her behaviors throughout the afternoon. Each incident began with [client #1] laying in her bed. [Client #1] hit, kicked, bit, and pinched staff 11 times. [Client #1] attempted to elope 5 times. [Client #1] threw a</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>snow globe at her window attempting to break the window. [Client #1] attempted to use markers to stab herself and attempted to cut herself with glass. Staff initiated one-man YSIS 7 times and two-man YSIS 8 times for a total of 54 minutes with breaks every minute. No injuries were reported from the use of YSIS or from SIB (self-injurious behavior)".</p> <p>11)-BDDS report dated 12/1/19 indicated, "It was reported [client #1] was watching TV when she began hitting, kicking, pinching and biting staff. Staff initiated one-man YSIS for 1 minute. A few minutes later, [Client #1] again began to pinch, bite, hit and kick staff. Staff initiated one-man YSIS for 1 minute. [Client #1] was then transported to [Name] Behavioral Center for evaluation".</p> <p>12)-BDDS report dated 12/9/19 indicated, "[Client #1] walked out the front door, with staff following, and immediately began to run from the home. Staff followed, never losing sight. Staff attempted verbal redirection, which was unsuccessful, and staff placed [client #1] in one-person You're Safe I'm Safe. [Client #1] sat down then got into staff's car and returned to the group home. Upon return, [client #1] attempted to leave the home on 4 occasions, verbal redirection was unsuccessful and YSIS was used each time for 2-3 minutes. [Client #1] was physically aggressive towards staff and grabbing their chest, [Client #1] was placed in YSIS 4 times for 2 to 5 minutes each time. Staff contacted the nurse and QIDP for approval to administer her PRN (as needed), Ativan (anxiety medication) 1 mg (milligram). Approval was obtained and the medication was administered ...".</p> <p>13)-BDDS report dated 12/12/19 indicated, "It was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>reported from 11:55 AM until 3:50 PM [client #1] attempted to elope 3 times, was physically aggressive with staff 8 times, 2 episodes of SIB, and was placed in YSIS 6 times as follows. One-man for 4 minutes, one-man for 3 minutes, one-man for 2 minutes, two-man for 8 minutes, and one-man for 3 minutes. Every instance of YSIS, staff gave breaks every 1 minute. [Client #1] received fifteen 1 ½ inch scratches on her right hand and arm from the episodes of SIB and a bite mark on her right hand".</p> <p>14)-BDDS report dated 12/13/19 indicated, "It was reported from 10:50 AM until 2:19 PM [client #1] was physically aggressive toward staff 12 times, attempted to elope 9 times, had 3 episodes of SIB biting herself, ate crayons, and attempted to eat the cap from a marker. YSIS was initiated 16 times as follows: ... [Client #1] received a 1 ½ inch scratch on her left wrist and five 1 inch bruises on her right upper arm from continuing physical aggression during YSIS. [Client #1] received a PRN med (medication) for aggression".</p> <p>15)-BDDS report dated 12/13/19 indicated, "It was reported from 5:00 PM until 6:33 PM [client #1] was physically aggressive toward staff 7 times and attempted to elope 19 times. YSIS was initiated 20 times as follows:... No injuries were reported from these incidents".</p> <p>16)-BDDS report dated 12/14/19 indicated, "It was reported from 7:50 AM until 8:45 AM [client #1] was physically aggressive toward staff 4 times and attempted to elope 4 times. Staff initiated YSIS 4 times as follows: ... Approval was obtained to administer PRN med (medication) for anxiety and aggression ...".</p> <p>17)-BDDS report dated 1/6/20 indicated, "[Client</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>#1] was redirected inside by staff, she sat down and became upset because she wanted to 'run away'. [Client #1] was aggressive towards staff, You're Safe I'm Safe one person was utilized for 2 minutes. [Client #1] started to color, and attempted to eat one of the crayons, staff got the crayon away from her and she began to pinch and hit staff. YSIS 1 person was utilized for 2 minutes. [Client #1] sat on her bed, got up and was aggressive with staff, YSIS 1 person used again for approximately 20 minutes with 1 minute breaks in between. The team was contacted for approval to administer her PRN, Ativan 1 mg. Plans were followed, approval was obtained and the PRN administered".</p> <p>18)-BDDS report dated 1/11/20 indicated, "It was reported [client #1] ran out the front door with staff following behind. [Client #1] started running through the woods and staff lost sight of her. Police were called for assistance. [Client #1] was out of sight for 9 minutes when staff located [client #1]. Staff was able to verbally redirect [client #1] back to the group home. Upon arrival home, [client #1] began to hit staff and staff initiated one-man YSIS for 1 minute until [client #1] calmed. [Client #1] then told staff that she was running away and attempted to elope. Staff initiated one-man YSIS for 2 minutes until [client #1] calmed. [Client #1] received a ½ (inch) cut on her right great toe from running in the woods. No injuries were reported from the use of YSIS".</p> <p>In addition to the BDDS incident reports above, client #1 had an additional 29 incident reports of physical aggression, self-injurious behavior and elopement behaviors between the periods of 11/4/19 to 1/13/20.</p> <p>On 1/13/20 from 4:11 PM to 6:16 PM and 1/14/2020</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130	
(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)
	<p>from 6:20 AM to 8:24 AM, observations were conducted at the group home.</p> <p>-At 5:32 PM, client #1 and the Qualified Intellectual Disability Professional (QIDP) took the surveyor to client #1's bedroom located in the basement of the home. Client #1 was asked if she liked her bedroom downstairs and she stated, "No". Client #1 was asked why she did not like her bedroom and stated, "Because I don't like being by myself".</p> <p>-At 5:40 PM, the QIDP indicated client #1 had moved into the basement bedroom at the end of December 2019. Client #1 then proceeded back upstairs and the QIDP assisted her to ensure client #1 returned with her one to one staffing ratio.</p> <p>-At 5:51 PM, a miniature sewing machine with a needle, a small plastic bag with three needles and 8 small metal brackets were found adjacent to client #1's dresser on shelving. The QIDP was asked about those items from client #1's bedroom. The QIDP indicated the needles and small metal brackets should not have been left in client #1's bedroom.</p> <p>On 1/14/20 at 2:02 PM, client #1's record was reviewed. The record indicated the following:</p> <p>-Interdisciplinary Team Meeting dated 11/3/19 indicated the plan of action as, "[Client #1] was out of sight for less than a minute. Her BSP (Behavior Support Plan) was reviewed and no changes were made. She (client #1) has 1:1 supervision. An elopement investigation was completed".</p> <p>-Interdisciplinary Team Meeting dated 11/30/19</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>indicated the plan of action as, "[Client #1] eloped for 5 minutes. Her BSP (Behavior Support Plan) was reviewed and no changes were made. She (client #1) has 1:1 supervision. An elopement investigation was completed".</p> <p>-Confirmation of Diagnosis form dated 7/24/19 indicated, "Primary diagnosis: Severe IDD (Intellectual Developmental Disability). Secondary diagnosis: Depressive D/O (disorder), Psychosis Nos (unspecified psychosis), Neuro (Neurological) Cognitive D/O".</p> <p>-Psychiatric Follow up dated 1/10/20 indicated, "F/U (Follow-up) visit from [name] psychiatric hospital. Pt (patient) was recently admitted to [name] psych unit due to behavior...". The follow up consult had a letter dated 8/9/19 attached and indicated, "...It appears that she (client #1) was admitted to the [name] psych institute at least a couple times. This had happened when she had eloped from the facility. When I saw the patient today, she was sitting in a chair. She is on one on one observation at this time due to elopement risk; however, patient says that she would not do that, although staff reports that she had said that in the past but then later on she would elope...".</p> <p>-Behavior Support Plan (BSP) dated 1/6/20 indicated, "Behavioral History: [Client #1] is an energetic young lady. At times, she will communicate her needs in an inappropriate manner. Typical behaviors for [client #1] are stealing, inappropriate sexual behaviors, verbal disruption, lying/telling stories, inappropriate social boundaries, and noncompliance". Client #1's BSP indicated target behaviors as, "Verbal Disruption, Lying/telling stories, Non-compliance, Stealing, Inappropriate Social Boundaries, Suicidal Ideation/SIB (self-injurious behavior) and Leaving</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>Assigned Area/Elopement". Client #1's medication reduction plan in the BSP indicated the following medications for treatment of targeted behaviors as, "Buspirone, Haldol, Paxil, Remeron, Cogentin and Ativan PRN (as needed)". Client #1's BSP indicated the following reactive procedures:</p> <p>"If she (client #1) engages in Self- Injurious Behavior:</p> <ul style="list-style-type: none"> -Immediately notify the RM (Residential Manager) -Block any of the behaviors she is using to harm herself -If you are attempting to block and she is still able to continue to harm herself, staff should use YSIS (You're Safe I'm Safe) to maintain hers and others' safety -Once she has calmed down staff should release her from the hold -Follow instructions set by the RM -Let her know that staff are there to assist her and help keep her safe. <p>If she (client #1) engages in elopement/leaving assigned area:</p> <ul style="list-style-type: none"> -If she is attempting to leave an area or eloping, request that she go with staff and/or go to an area away from the source of what may be frustrating/bothering -If she continues to attempt to leave or does leave, immediately follow her and continue to redirect her back to the assigned area or an area where you can problem solve with her -If she complies provide abundant praise and work with her on what is bothering her -If [client #1] continues to leave the assigned area, use the You're Safe I'm Safe (YSIS) procedures in the following order: One-person YSIS, 			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>Two-person YSIS</p> <p>-If YSIS is used, immediately notify the RM of the incident</p> <p>-If she gets out and staff have no idea where she is the RM is to be called and someone is to immediately to (sic) go out and look for her</p> <p>-The second staff will report the elopement to the Residential Manager</p> <p>-If only one staff available staff will report the elopement to the Residential Manager</p> <p>-If she elopes police will be called into the law enforcement as an 'Assist to Locate Only.'</p> <p>Staffing as of 12/9/19:</p> <p>-Due to recent episodes of elopement and leaving the assigned area, [client #1] will be placed on 1:1 supervision between 8am to 10pm, daily 10pm until 8 am, she can be checked every 15 minutes. Staff will sign the 15-minute supervision forms found in the front of the white book.</p> <p>-Further reduction TBD (to be determined). Due to the frequency of these behaviors, once [client #1] has had 15 days with no elopement, then a taper to 15 min checks, etc. can occur.</p> <p>-If [client #1] has behaviors when she is up with the other clients in the main living areas, then she will be moved to her bedroom as an identified calming place.</p> <p>-Documentation and IR's (incident reports) are essential for communication of her behaviors.</p> <p>-Staff are to change every 2 hours for her 1:1 supervision".</p> <p>On 1/13/20 at 2:07 PM, the QIDP was interviewed. The QIDP was asked about client #1's elopement incident on 1/11/20. The QIDP stated, "She had her one to one staffing, but got out of the house. We have a plan to visit grandma if she doesn't elope. We have a day set aside every week. Saturday, she got out away from staff for 9</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130	
(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)
	<p>minutes". The QIDP was asked where client #1 ran to. The QIDP stated, "She ran up the street by the high school where she claimed to have been raped last year. They called police, but when staff got the van to follow her she was already walking back". The QIDP indicated they are still working on the investigation for the 1/11/20 elopement incident. The QIDP indicated client #1's doctor approved Extensive Support Needs (ESN) placement through her level of care and stated, "Her COD (Confirmation of Diagnosis) was signed by the doctor determining her level of care as ESN. We have to provide care until there is an opening". The QIDP was asked who communicates availability for placement. The QIDP stated, "My understanding is the ESNs are filled up and she (client #1) is on a priority list". The QIDP indicated team meetings had been conducted concerning client #1's behavioral episodes and for placement/discharge from inpatient treatment services. When asked about the results of client #1's discharge from inpatient psychiatric services, the QIDP indicated not much change had occurred and stated, "She was as good as gold while she was there".</p> <p>On 1/13/20 at 2:42 PM, the Program Manager was interviewed. The Program Manager was asked client #1's staffing and level of care. The Program Manager stated, "We still have to keep her safe until placed". The Program Manager indicated client #1's staffing was increased months prior to the 1/11/20 elopement incident and stated, "She is on one to one staffing and at times two to one staffing". The Program Manager indicated the team's response to client #1's recent behavioral incidents had included psychiatric inpatient services. The Program Manager indicated client #1 was approved by the physician for ESN level of care since July of 2019 pending placement</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
W 0164 Bldg. 00	<p>opportunities.</p> <p>On 1/14/20 at 3:12 PM, the Abuse, Neglect, Exploitation, Mistreatment and or a Violation of Individual's Rights (ANE) policy dated 7/10/19 was reviewed. The ANE policy indicated, "ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights".</p> <p>9-3-2(a)</p> <p>483.430(b)(1)</p> <p>PROFESSIONAL PROGRAM SERVICES</p> <p>Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan.</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure client #1 received Behavioral Supports from a Behavior Specialist to address continued behavioral episodes of elopement and self-harm.</p> <p>Findings include:</p> <p>On 1/13/20 at 3:10 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports was completed. The reports indicated:</p> <p>1)-BDDS report dated 11/3/19 indicated, "It was reported [client #1] went out the door and was running down the street with staff following her. Staff was able to verbally redirect [client #1] to go back home. [Client #1] was never out of line of sight".</p> <p>2)-BDDS report dated 11/3/19 indicated, "It was</p>	W 0164	<p>1.Based on client #1 assessment for an ESN placement the Facility brought in the ESN Behavior Clinician and the ESN QIDP to review current ISP/BSP collaborating with the ICF QIDP to review and update plans covering Client #1 elopement and self-harm.</p> <p>2.A thorough review of Client #1 plan resulted in updated plans produced by an IDT consisting of ESN Behavioral Clinician, ESN QIDP, ICF QIDP, Nursing Program Manager and Area Supervisor on 15Jan2020.</p> <p>3.Staff was trained on the updated ISP/BSP on 15JAN2020.</p> <p>4.The Facility contacted the Bureau of Developmental Disabilities Services (BDDS) for Client #1 referral for an emergency</p>	02/22/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>reported [client #1] had been in her room watching a movie. A housemate told staff that [client #1] had ran (sic) out the front door. [Client #1] was out of line of sight of staff for 1 minute. Staff followed [client #1] down the street. Staff attempted to verbally redirect [client #1] but then had to initiate one-man YSIS (You're Safe I'm Safe - behavioral intervention). [Client #1] returned home and went in her room to watch a movie. [Client #1] then tried to open her window to elope. Staff initiated two-man YSIS for 3 minutes then again initiated YSIS for 5 minutes. [Client #1] again tried to elope thru (sic) her window. Staff blocked window and [client #1] kicked staff and attempted to bite staff. Staff initiated two-man YSIS for 4 minutes. No injuries were reported from the use of YSIS".</p> <p>The Elopement/Missing Person Investigation Summary dated 11/3/19 indicated, "Her 1:1 (one staff to one client) staff had walked out of her room to the hallway and [client #1] slipped out the door. Staff followed her but she was out of sight due (sic) the trees and shrubs lining the road".</p> <p>Review of the Interdisciplinary Team (IDT) Meeting dated 11/3/19 attached with the investigation summary indicated the plan of action was, "[Client #1] was out of sight for less than a minute. Her BSP (Behavior Support Plan) was reviewed and no changes were made. She (client #1) has 1:1 supervision. An elopement investigation was completed".</p> <p>3)-BDDS report dated 11/3/19 indicated, "It was reported [client #1] told staff to let her run. When staff blocked the exit, [client #1] began to bite, scratch, and kick staff. [Client #1] then attempted to swallow the plastic wrap from a box of Christmas cards. Staff attempted to verbally</p>			<p>CIH Wavier on 14JAN2020.</p> <p>Persons Responsible: Executive Director, Program Manager, Quality Assurance, Area Supervisor, Director of Nursing, Nurse, Behavior Clinician, QIDP, Residential Manager, and DSP.</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>redirect [client #1] to spit out the plastic and [client #1] refused. Staff initiated YSIS until [client #1] calmed".</p> <p>4)-BDDS report dated 11/4/19 indicated, "It was reported [client #1] wanted staff tuck in to bed (to tuck her into bed), staff was unable to do it at that moment. Staff then saw [client #1] attempting to go out the back door and staff blocked the door. [Client #1] attempted to bite and pinch staff. Staff initiated one-man YSIS for 5 minutes until [client #1] calmed. Staff then assisted [client #1] to bed then left the room. [Client #1] went out the front door and ran down the street with staff following, [client #1] was out of line of sight for 5 seconds. [Client #1] sat down in the road and a second staff picked [client #1] up in her car and took her home. [Client #1] then attempted to elope thru (sic) the back door and staff initiated one-man YSIS for 5 minutes. No injuries were reported from the use of YSIS".</p> <p>5)-BDDS report dated 11/4/19 indicated, "It was reported [client #1] was in her room then went to the kitchen and attempted to elope thru (sic) back door. Staff was able to block door. [Client #1] attempted to push, bite and pinch staff so two-man YSIS was initiated for 5 minutes until [client #1] calmed. [Client #1] then went in (the) kitchen and attempted to get a butter knife and told staff she wanted to hurt herself. Staff initiated one-man YSIS for 5 minutes until [client #1] calmed. [Client #1] was transported to ER (emergency room) for psych (psychiatric) evaluation. While at the hospital, [client #1] continued aggressive behaviors and staff initiated one-man YSIS off and on for an hour with breaks every 5 minutes. No injuries were reported from the use of YSIS. [Client #1] was discharged with instructions on how to cope with anger".</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>6)-BDDS report dated 11/5/19 indicated, "[Client #1] was putting her hands down her pants and sticking her hands in her mouth. Staff redirected, she continued and one-man You're Safe I'm Safe was utilized. [Client #1] was released and she began to tear papers off the wall of the med (medication) room, she put a thumb tack in her mouth, staff used one-man You're Safe I'm Safe, [client #1] spit the thumb tack out and YSIS was released".</p> <p>7)-BDDS report dated 11/19/19 indicated, "[Client #1] attempted to elope, but staff was able to verbally redirect her, and she reentered the home. She then became physically aggressive toward staff and 1-person YSIS was implemented for less than 1 minute twice to stop the aggression. [Client #1] then took the tie from her robe and attempted to choke herself. Staff again implemented 1-person YSIS for less than 30 seconds and the behavior stopped. [Client #1] again became physically aggressive toward staff and 1-person YSIS was implemented 3 times for less than 1 minute each time ...Plan to resolve: Due to ongoing behaviors, [Psychiatric Hospital] was contacted and [client #1] was provided medical transport there for inpatient treatment. ResCare remains in contact with the hospital for updates and discharge planning".</p> <p>8)-BDDS report dated 11/29/19 indicated, "It was reported [client #1] walked out the door and began walking toward the street with staff following. Staff attempted to redirect [client #1] when [client #1] began to run. Staff ran with her and initiated one-man YSIS for 2 seconds when [client #1] dropped to the ground. A second staff walked over to [client #1] and [client #1] got up and went in the house. [Client #1] then told staff</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>she was going to run again. When [client #1] went toward the door staff initiated one-man YSIS for 5 seconds when [client #1] bit staff. A second staff then assisted with YSIS using a two-man technique for 2 minutes. [Client #1] then got a pen and attempted to stab herself with it. Staff initiated one-man YSIS for 1 second and a second staff assisted and two-man YSIS was done for 2 minutes until [client #1] calmed. [Client #1] was never out of line of sight of staff. No injuries were reported from the use of YSIS".</p> <p>9)-BDDS report dated 12/1/19 indicated, "It was reported [client #1] was sleeping when staff went to the restroom. When staff returned [client #1] was gone and could not be located. Staff called police for assistance. [Client #1] was returned after 5 minutes. After police left, [client #1] told staff she was going to bust the windows in her room. Staff initiated one-man YSIS for 2 minutes. No injuries were reported from the incident. [Client #1] was out of line of sight of staff for approximately 10 minutes".</p> <p>The Elopement/Missing Person Investigation Summary dated 11/30/19 indicated, "Her 1:1 staff had gone to use the restroom and left her unattended".</p> <p>Review of the Interdisciplinary Team Meeting dated 11/30/19 attached with the investigation summary indicated the plan of action was, "[Client #1] eloped for 5 minutes. Her BSP (Behavior Support Plan) was reviewed and no changes were made. She (client #1) has 1:1 supervision. An elopement investigation was completed".</p> <p>10)-BDDS report dated 12/1/19 indicated, "It was reported [client #1] continued her behaviors throughout the afternoon. Each incident began</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>with [client #1] laying in her bed. [Client #1] hit, kicked, bit, and pinched staff 11 times. [Client #1] attempted to elope 5 times. [Client #1] threw a snow globe at her window attempting to break the window. [Client #1] attempted to use markers to stab herself and attempted to cut herself with glass. Staff initiated one-man YSIS 7 times and two-man YSIS 8 times for a total of 54 minutes with breaks every minute. No injuries were reported from the use of YSIS or from SIB (self-injurious behavior)".</p> <p>11)-BDDS report dated 12/1/19 indicated, "It was reported [client #1] was watching TV when she began hitting, kicking, pinching and biting staff. Staff initiated one-man YSIS for 1 minute. A few minutes later, [Client #1] again began to pinch, bite, hit and kick staff. Staff initiated one-man YSIS for 1 minute. [Client #1] was then transported to [Name] Behavioral Center for evaluation".</p> <p>12)-BDDS report dated 12/9/19 indicated, "[Client #1] walked out the front door, with staff following, and immediately began to run from the home. Staff followed, never losing sight. Staff attempted verbal redirection, which was unsuccessful, and staff placed [client #1] in one-person You're Safe I'm Safe. [Client #1] sat down then got into staff's car and returned to the group home. Upon return, [client #1] attempted to leave the home on 4 occasions, verbal redirection was unsuccessful and YSIS was used each time for 2-3 minutes. [Client #1] was physically aggressive towards staff and grabbing their chest, [Client #1] was placed in YSIS 4 times for 2 to 5 minutes each time. Staff contacted the nurse and QIDP for approval to administer her PRN (as needed), Ativan (anxiety medication) 1 mg (milligram). Approval was obtained and the medication was</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>administered ...".</p> <p>13)-BDDS report dated 12/12/19 indicated, "It was reported from 11:55 AM until 3:50 PM [client #1] attempted to elope 3 times, was physically aggressive with staff 8 times, 2 episodes of SIB, and was placed in YSIS 6 times as follows. One-man for 4 minutes, one-man for 3 minutes, one-man for 2 minutes, two-man for 8 minutes, and one-man for 3 minutes. Every instance of YSIS, staff gave breaks every 1 minute. [Client #1] received fifteen 1 ½ inch scratches on her right hand and arm from the episodes of SIB and a bite mark on her right hand".</p> <p>14)-BDDS report dated 12/13/19 indicated, "It was reported from 10:50 AM until 2:19 PM [client #1] was physically aggressive toward staff 12 times, attempted to elope 9 times, had 3 episodes of SIB biting herself, ate crayons, and attempted to eat the cap from a marker. YSIS was initiated 16 times as follows: ... [Client #1] received a 1 ½ inch scratch on her left wrist and five 1 inch bruises on her right upper arm from continuing physical aggression during YSIS. [Client #1] received a PRN med (medication) for aggression".</p> <p>15)-BDDS report dated 12/13/19 indicated, "It was reported from 5:00 PM until 6:33 PM [client #1] was physically aggressive toward staff 7 times and attempted to elope 19 times. YSIS was initiated 20 times as follows:... No injuries were reported from these incidents".</p> <p>16)-BDDS report dated 12/14/19 indicated, "It was reported from 7:50 AM until 8:45 AM [client #1] was physically aggressive toward staff 4 times and attempted to elope 4 times. Staff initiated YSIS 4 times as follows: ... Approval was obtained to administer PRN med (medication) for anxiety and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>aggression ...".</p> <p>17)-BDDS report dated 1/6/20 indicated, "[Client #1] was redirected inside by staff, she sat down and became upset because she wanted to 'run away'. [Client #1] was aggressive towards staff, You're Safe I'm Safe one person was utilized for 2 minutes. [Client #1] started to color, and attempted to eat one of the crayons, staff got the crayon away from her and she began to pinch and hit staff. YSIS 1 person was utilized for 2 minutes. [Client #1] sat on her bed, got up and was aggressive with staff, YSIS 1 person used again for approximately 20 minutes with 1 minute breaks in between. The team was contacted for approval to administer her PRN, Ativan 1 mg. Plans were followed, approval was obtained and the PRN administered".</p> <p>18)-BDDS report dated 1/11/20 indicated, "It was reported [client #1] ran out the front door with staff following behind. [Client #1] started running through the woods and staff lost sight of her. Police were called for assistance. [Client #1] was out of sight for 9 minutes when staff located [client #1]. Staff was able to verbally redirect [client #1] back to the group home. Upon arrival home, [client #1] began to hit staff and staff initiated one-man YSIS for 1 minute until [client #1] calmed. [Client #1] then told staff that she was running away and attempted to elope. Staff initiated one-man YSIS for 2 minutes until [client #1] calmed. [Client #1] received a ½ (inch) cut on her right great toe from running in the woods. No injuries were reported from the use of YSIS".</p> <p>In addition to the BDDS incident reports above, client #1 had an additional 29 incident reports of physical aggression, self-injurious behavior and elopement behaviors between the periods of</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>11/4/19 to 1/13/20.</p> <p>On 1/13/20 from 4:11 PM to 6:16 PM and 1/14/2020 from 6:20 AM to 8:24 AM, observations were conducted at the group home.</p> <p>-At 5:32 PM, client #1 and the Qualified Intellectual Disability Professional (QIDP) took the surveyor to client #1's bedroom located in the basement of the home. Client #1 was asked if she liked her bedroom downstairs and she stated, "No". Client #1 was asked why she did not like her bedroom and stated, "Because I don't like being by myself".</p> <p>-At 5:40 PM, the QIDP indicated client #1 had moved into the basement bedroom at the end of December 2019. Client #1 then proceeded back upstairs and the QIDP assisted her to ensure client #1 returned with her one to one staffing ratio.</p> <p>-At 5:51 PM, a miniature sewing machine with a needle, a small plastic bag with three needles and 8 small metal brackets were found adjacent to client #1's dresser on shelving. The QIDP was asked about those items from client #1's bedroom. The QIDP indicated the needles and small metal brackets should not have been left in client #1's bedroom.</p> <p>On 1/14/20 at 2:02 PM, client #1's record was reviewed. The record indicated the following:</p> <p>-Interdisciplinary Team Meeting dated 11/3/19 indicated the plan of action as, "[Client #1] was out of sight for less than a minute. Her BSP (Behavior Support Plan) was reviewed and no changes were made. She (client #1) has 1:1 supervision. An elopement investigation was</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>completed".</p> <p>-Interdisciplinary Team Meeting dated 11/30/19 indicated the plan of action as, "[Client #1] eloped for 5 minutes. Her BSP (Behavior Support Plan) was reviewed and no changes were made. She (client #1) has 1:1 supervision. An elopement investigation was completed".</p> <p>-Confirmation of Diagnosis form dated 7/24/19 indicated, "Primary diagnosis: Severe IDD (Intellectual Developmental Disability). Secondary diagnosis: Depressive D/O (disorder), Psychosis Nos (unspecified psychosis), Neuro (Neurological) Cognitive D/O".</p> <p>-Psychiatric Follow up dated 1/10/20 indicated, "F/U (Follow-up) visit from [name] psychiatric hospital. Pt (patient) was recently admitted to [name] psych unit due to behavior...". The follow up consult had a letter dated 8/9/19 attached and indicated, "...It appears that she (client #1) was admitted to the [name] psych institute at least a couple times. This had happened when she had eloped from the facility. When I saw the patient today, she was sitting in a chair. She is on one on one observation at this time due to elopement risk; however, patient says that she would not do that, although staff reports that she had said that in the past but then later on she would elope...".</p> <p>-Behavior Support Plan (BSP) dated 1/6/20 indicated, "Behavioral History: [Client #1] is an energetic young lady. At times, she will communicate her needs in an inappropriate manner. Typical behaviors for [client #1] are stealing, inappropriate sexual behaviors, verbal disruption, lying/telling stories, inappropriate social boundaries, and noncompliance". Client #1's BSP indicated target behaviors as, "Verbal</p>				

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130	
(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)
	<p>Disruption, Lying/telling stories, Non-compliance, Stealing, Inappropriate Social Boundaries, Suicidal Ideation/SIB (self-injurious behavior) and Leaving Assigned Area/Elopement". Client #1's medication reduction plan in the BSP indicated the following medications for treatment of targeted behaviors as, "Buspirone, Haldol, Paxil, Remeron, Cogentin and Ativan PRN (as needed)". Client #1's BSP indicated the following reactive procedures:</p> <p>"If she (client #1) engages in Self- Injurious Behavior:</p> <ul style="list-style-type: none"> -Immediately notify the RM (Residential Manager) -Block any of the behaviors she is using to harm herself -If you are attempting to block and she is still able to continue to harm herself, staff should use YSIS (You're Safe I'm Safe) to maintain hers and others' safety -Once she has calmed down staff should release her from the hold -Follow instructions set by the RM -Let her know that staff are there to assist her and help keep her safe. <p>If she (client #1) engages in elopement/leaving assigned area:</p> <ul style="list-style-type: none"> -If she is attempting to leave an area or eloping, request that she go with staff and/or go to an area away from the source of what may be frustrating/bothering -If she continues to attempt to leave or does leave, immediately follow her and continue to redirect her back to the assigned area or an area where you can problem solve with her -If she complies provide abundant praise and work with her on what is bothering her 			(X5) COMPLETION DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>-If [client #1] continues to leave the assigned area, use the You're Safe I'm Safe (YSIS) procedures in the following order: One-person YSIS, Two-person YSIS</p> <p>-If YSIS is used, immediately notify the RM of the incident</p> <p>-If she gets out and staff have no idea where she is the RM is to be called and someone is to immediately to (sic) go out and look for her</p> <p>-The second staff will report the elopement to the Residential Manager</p> <p>-If only one staff available staff will report the elopement to the Residential Manager</p> <p>-If she elopes police will be called into the law enforcement as an 'Assist to Locate Only.'</p> <p>Staffing as of 12/9/19:</p> <p>-Due to recent episodes of elopement and leaving the assigned area, [client #1] will be placed on 1:1 supervision between 8am to 10pm, daily 10pm until 8 am, she can be checked every 15 minutes. Staff will sign the 15-minute supervision forms found in the front of the white book.</p> <p>-Further reduction TBD (to be determined). Due to the frequency of these behaviors, once [client #1] has had 15 days with no elopement, then a taper to 15 min checks, etc. can occur.</p> <p>-If [client #1] has behaviors when she is up with the other clients in the main living areas, then she will be moved to her bedroom as an identified calming place.</p> <p>-Documentation and IR's (incident reports) are essential for communication of her behaviors.</p> <p>-Staff are to change every 2 hours for her 1:1 supervision".</p> <p>On 1/13/20 at 2:07 PM, the QIDP was interviewed. The QIDP was asked about client #1's elopement incident on 1/11/20. The QIDP stated, "She had her one to one staffing, but got out of the house.</p>			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130	
(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
	<p>We have a plan to visit grandma if she doesn't elope. We have a day set aside every week. Saturday, she got out away from staff for 9 minutes". The QIDP was asked where client #1 ran to. The QIDP stated, "She ran up the street by the high school where she claimed to have been raped last year. They called police, but when staff got the van to follow her she was already walking back". The QIDP indicated they are still working on the investigation for the 1/11/20 elopement incident. The QIDP indicated client #1's doctor approved Extensive Support Needs (ESN) placement through her level of care and stated, "Her COD (Confirmation of Diagnosis) was signed by the doctor determining her level of care as ESN. We have to provide care until there is an opening". The QIDP was asked if client #1 had a formal behavior specialist on her team. The QIDP stated, "No, that's me. ESN (group homes) has a Behavior Specialist". The QIDP was asked what would prevent client #1 from having a Behavior Specialist. The QIDP stated, "Just the program (needed to live in an ESN group home)". The QIDP was asked if the provider had Behavior Specialist employed as a resource. The QIDP stated, "Yes, she (behavior specialist) just does ESN (group homes)". The QIDP indicated the Program Manager or Executive Director might be able to clarify and answer what the ESN Behavior Specialist role and work availability.</p> <p>On 1/13/20 at 2:42 PM, the Program Manager was interviewed. The Program Manager was asked what ESN level supports client #1 received and if it included a Behavior Specialist. The Program Manager stated, "No, only staffing. We still have to keep her safe until placed". The Program Manager was asked if client #1 could receive ESN level staffing if it could include a Behavioral Specialist. The Program Manager stated, "That</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
W 0312 Bldg. 00	<p>has not been something pursued, we consulted about writing the behavior support plan". The Program Manager indicated client #1's staffing was increased months prior to the 1/11/20 elopement incident and stated, "She is on one to one staffing and at times two to one staffing". The Program Manager indicated the team's response to client #1's recent behavioral incidents had included psychiatric inpatient services. The Program Manager indicated client #1 was approved by the physician for ESN level of care since July of 2019 pending placement opportunities.</p> <p>9-3-3(a)</p> <p>483.450(e)(2) DRUG USAGE Drugs used for control of inappropriate behavior must be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and eventual elimination of the behaviors for which the drugs are employed.</p> <p>Based on record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure client #2's behavior support plan included a medication reduction plan listing all current psychotropic medications.</p> <p>Findings include:</p> <p>On 1/21/20 at 12:52 PM, client #2's record was reviewed. The record indicated the following:</p> <p>-Individual Support Plan (ISP) dated 10/15/19 indicated, "Right to be modified: Freedom from use of medication. Manner in which the right will be modified: Administration of Klonopin (control seizure), Cogentin (control muscle</p>		W 0312	<p>1.The QIPD will update Client #2 BSP to ensure drugs used for control of inappropriate behavior are only used as an integral part of the clients Individual Program Plan and directed specifically towards the reduction and eventual elimination of the behavior for which the drugs are employed and current.</p> <p>2.The QIDP will train all Staff on the updated BSP.</p> <p>3.A Facility representative will review BSP monthly to ensure they are accurate and up to date.</p>	02/22/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>spasms/tremors) and Zoloft (to treat panic disorder and anxiety) per ISP Behavior Plan. Reason the modification is needed: To prevent further disruptive behaviors. Less restrictive measures that have been attempted: Verbal redirection, verbal praise. Services that will be provided in order that the right may be restored: medication reduction plan and behavior support plan per ISP. Length of Modification: 6 months: Review Date: 4.20. 12 months: Review Date: 10.20".</p> <p>-Psychiatric consult dated 12/2/19 indicated, "Recommendation: At this time, patient will be continued on Clozaril (antipsychotic medication), Depakote (treat seizure disorders and depression), Risperdal (to treat schizophrenia and bipolar disorder), and Cogentin as before. Since she is feeling depressed and down, I will increase her Zoloft to 50 mg a day. She will be seen by me again in about 2 to 3 months".</p> <p>Medication Administration Record dated January 3, 2020 indicated the following prescribed medications, "Benztropine .5 mg (milligram), Clozapine (Equivalent to Clozaril) 100 mg, Divalproex (Equivalent to Depakote) 500 mg and Risperidone (Equivalent to Risperdal) 3 mg.</p> <p>-Behavior Support Plan (BSP) dated 12/5/19 indicated, "Medication Reduction Plan: Zoloft, Diagnosis Depression, Cogentin, Diagnosis Schizoaffective, Clonipin (sic), Diagnosis Anxiety".</p> <p>Client #2's behavior plan did not have a medication reduction plan based on behavior for Benztropine .5 mg, Clozapine 100 mg, Divalproex 500 mg and Risperidone 3 mg.</p>		Persons Responsible: Program Manager, Director of Nursing, Nurse, Area Supervisor, QIDP, Residential Manager, and DSP.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
W 0322 Bldg. 00	<p>On 1/21/20 at 2:41 PM, the Qualified Intellectual Disability Professional (QIDP) was interviewed. The QIDP was asked about client #2's current psychotropic medications listed in the medication reduction plan of the 8/8/19 Behavior Support Plan. The QIDP indicated medications listed in the medication reduction plan needed further review and revision. The QIDP was asked if client #2's medication reduction plan was current and listed all psychotropic medication and stated, "No, it needs revised".</p> <p>9-3-5(a)</p> <p>483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. Based on record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure client #1 received a follow up consultation for nail care with her podiatrist.</p> <p>Findings include:</p> <p>On 1/14/20 at 2:02 PM, client #1's record was reviewed. The record indicated the following:</p> <p>-Individual Support Plan dated 3/20/19 indicated, "She (client #1) has good mobility and understands the importance of good hygiene but needs to be reminded. She needs several verbal prompts to complete ADL (adult daily living) living skills ...".</p> <p>-Podiatry consult dated 7/18/19 indicated, "Toe nail trim. Diagnosis debridement (removal of damaged tissue) of digits 1-5 bilateral. F/U (Follow up) in 10 weeks. Return visit 9/26/19 at 1:30 PM".</p>	W 0322	<p>1.The facility must provide or obtain preventive and general medical care of each client in the Facility</p> <p>2.Appointment for Client #1 will be scheduled for nail care with a Podiatrist.</p> <p>3.Staff will be retrained on ensuring the clients make it to their scheduled appointments. The staff in the Facility will be retrained on the client appointment procedure.</p> <p>Persons Responsible: Direct Support Professionals, Residential Manager, Area Supervisor, Program Manager, Nursing, Director of Nursing</p>	02/22/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130	
(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
W 0348 Bldg. 00	<p>On 1/21/20 at 2:46 PM, the Nurse was interviewed. The Nurse was asked about client #1's follow up visit with the podiatrist. The Nurse stated, "Further follow up is needed". The Nurse indicated no further podiatry documentation was available for review. The Nurse indicated the need to follow up with the podiatrist was identified as a part of client #1's transition planning.</p> <p>9-3-6(a)</p> <p>483.460(e)(1) DENTAL SERVICES</p> <p>The facility must provide or make arrangements for comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists either through organized dental services in-house or through arrangement.</p> <p>Based on record review and interview for 1 of 3 clients in the sample (#1), the facility failed to ensure client #1 had a follow up dental examination as ordered.</p> <p>Findings include:</p> <p>On 1/14/20 at 2:02 PM, client #1's record was reviewed. A dental order and progress note dated 9/30/19 indicated, "Treated #30 w/ (with) root canal, 9/30/19. Follow up w/ general dentist ASAP (as soon as possible) for restoration". No other dental documentation was available for review.</p> <p>On 1/21/20 at 2:41 PM, the Qualified Intellectual Disability Professional (QIDP) was interviewed. The QIDP was asked about dental follow up from client #1's 9/30/19 dental procedure. The QIDP indicated medical appointments which were needed had been identified and a list was made as</p>	W 0348	<p>1.The facility will provide comprehensive diagnostic and treatment services for each client from qualified personnel, including licensed dentists and dental hygienists.</p> <p>2.Appointment for Client #1 will be scheduled for Dental Care.</p> <p>3.Staff will be retrained on ensuring the clients make it to their scheduled appointments. The staff in the Facility will be retrained on the client appointment procedure.</p> <p>Persons Responsible: Direct Support Professionals, Residential Manager, Area Supervisor,</p>	02/22/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G157	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	(X3) DATE SURVEY COMPLETED 01/23/2020
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3011 APACHE DR JEFFERSONVILLE, IN 47130		
(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
	<p>part of client #1's transition planning. The QIDP indicated further follow up with a dentist was required.</p> <p>On 1/21/20 at 2:46 PM, the Nurse was interviewed. The Nurse was asked about dental follow up from client #1's 9/30/19 dental procedure. The Nurse stated, "Follow up is needed". The Nurse indicated no further follow up documentation could be provided for review and client #1 required further follow up with a dentist. The Nurse indicated this information would be shared as part of client #1's transition planning.</p> <p>9-3-6(a)</p>		Program Manager, Nursing, Director of Nursing	