STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G194	A. BUILDING 00 B. WING	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	115 STONEGATE BEDFORD, IN 47421

(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 0000 Bldg. 00	This visit was for a Post Certification Revisit (PCR) to the pre-determined full recertification and state licensure survey and to the Covid-19 focused infection control survey completed on 9/3/21. Survey Dates: October 20 and 21, 2021 Facility Number: 000724 Provider Number: 15G194 AIM Number: 100243320 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/5/21.	W 0000		
W 0125 Bldg. 00	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. Based on observation, interview and record review for 2 of 3 clients in the sample (#1 and #6), the facility failed to ensure the clients had the right to due process in regard to staff moving their dressers in front of their closet doors backward to restrict the clients' access to their clothes and possessions. Findings include: On 10/20/21 from 12:00 PM to 2:36 PM, an	W 0125	To correct the deficient practice all site staff have been re-trained on client rights, unapproved restrictions, and the HRC policy by the Assistant Executive director. The restriction has been corrected as of 10-21-21. The IDT for clients #1 and #6 will convene to discuss the need for interventions regarding clothing.	11/20/2021

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

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	observation was conducted at the group home. From 12:00 PM to 1:04 PM, there were two dressers turned backward in front of client #1's and #6's closet doors blocking access to the closets and the dressers (the drawers of the dressers were up against the closet doors). Client #1's closet door was also locked. The closets and dressers were full of client #1's and client #6's clothing. At 1:04 PM, the Associate Executive Director (AED) moved the dressers due to the surveyor asking the AED about the dressers. On 10/20/21 at 3:34 PM, a focused review of client #1's record was conducted. Client #1's 10/29/21 Individual Support Plan and 10/29/21 Behavior Support Plan did not include restrictions to his clothing including his closet and dresser. On 10/20/21 at 3:35 PM, a focused review of client #6's record was conducted. Client #6's 3/11/21 Individual Support Plan and 3/11/21 Behavior Support Plan did not include restrictions to his clothing including his closet and dresser. On 10/20/21 at 12:58 PM, the Area Supervisor (AS) indicated she was not aware of plans for clients #1 and #6 addressing the dressers blocking the closet doors and client #1's closet door being locked. The AS indicated she was not aware of the staff restricting client #1's and client #6's access to the clothes. On 10/20/21 at 1:01 PM, the AED (the interim Qualified Intellectual Disabilities Professional) indicated restricting client #1's and client #6's access to their clothing was not part of a plan. The AED stated, "Not alright. Shouldn't be like that. Closet shouldn't be locked." On 10/20/21 at 1:02 PM, the Residential Manager		The QIDP will adjust the plans per IDT recommendations and if needed seek HRC approval. To ensure no others were affected the QIDP will review all plans for current restrictions and inspect the home for any unapproved restrictions. Additional monitoring will be achieved through weekly supervisory staff observations. Ongoing monitoring will be achieved through monthly site reviews conducted by administrative staff.	

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	(RM) indicated the closet door was locked to keep client #6 out of client #1's closet. The RM indicated there was no plan for the lock. The RM indicated the key was kept in a drawer in the kitchen. The RM indicated there were no plans addressing client #1's and client #6's dressers being turned around restricting access to the drawers and the closets. This deficiency was cited on 9/3/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview for 1 of 3 clients in the sample (#6), the facility failed to ensure client #6 used a long handled, small spoon during lunch. Findings include: On 10/20/21 from 12:00 PM to 2:40 PM, an observation was conducted at the group home. At 12:19 PM, lunch started. Throughout lunch, client #6 did not use and was not provided a long handled, small spoon or special eating utensils. On 10/20/21 at 1:39 PM, a focused review of client #6's record was conducted. Client #6's 3/11/21 Individual Support Plan indicated in the Adaptive	W 0436	To correct the deficient practice site staff have received competency-based training on all client's meal plans and adaptive equipment by the nursing staff. To ensure no others were affected the nursing staff will review all dining plans and ensure staff have the appropriate items needed. Additional monitoring will be achieved through weekly supervisory staff meal observations. Ongoing monitoring will be achieved through monthly site reviews conducted by administrative staff.	11/20/2021

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	Equipment section, "small spoon." Client #6's 9/13/21 Choking risk plan indicated, "...Staff will ensure the use of a divided high-sided plate with special eating utensils...." On 10/20/21 at 1:35 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client #6 should have used a long handled, small spoon during lunch. On 10/20/21 at 1:47 PM, staff #3 indicated client #6 did not use his special spoon during lunch. Staff #3 stated, "It was negligence on my part." Staff #3 showed the surveyor client #6's spoon was in the home and available in a drawer in the kitchen. This deficiency was cited on 9/3/21. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-7(a)			