PRINTED:	04/13/2017
FORM AP	PROVED

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

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		15G247	B. WING		11/30/2016
NAME OF I	DROVIDER OR SUBDLIE	D	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF 1	PROVIDER OR SUPPLIE	ĸ	2401 C	ORNWALL DR	
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN	JEFFE	RSONVILLE, IN 47130	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
W 0000					
Bldg. 00					
	This visit was f	or a pre-determined full	W 0000		
	recertification a	nd state licensure survey.			
		-			
	This survey was	s conducted in			
	conjunction wit	h a post certification visit			
	for the investiga	ation of complaint			
	#IN00199703.	-			
	Survey Dates:	November 28, 29, and 30,			
	2016.				
	Facility Numbe	r: 000769			
	Provider Numb	er: 15G247			
	AIM Number:	100248810			
	These deficienc	ies reflect state findings			
	in accordance w	vith 460 IAC 9.			
	Quality Review	of this report completed			
	by #15068 on 1	2/14/16.			
	-				
W 0104	483.410(a)(1)				
	GOVERNING BC	DDY			
Bldg. 00		ody must exercise general			
		nd operating direction over			
	the facility.	notion and interview for A	W 0104	W104: The governing body m	nuet 10/20/2016
		vation and interview for 4	W 0104	exercise general policy, budge	
	-	ients (A, B, C, and D),		and operating direction over the	
		l clients, (E, F and G), the		facility.	
	facility's govern	ing body failed to ensure			
LABORATOR	AY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	T OF HEALTH AND HU R MEDICARE & MEDIC						ORM APPROVED MB NO. 0938-0391
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COME	PLETED
		15G247	B. WIN	G		11/3	0/2016
JAME OF	PROVIDER OR SUPPLIEI	3	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
		LTERNATIVES SE IN		JEFFEI	RSONVILLE, IN 47130		
X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL	Р	REFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	^{BE} RIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		vsical environment was			Corrective Action: (Specif		
	maintained in go	ood repair.			The large bathroom will have		
					quarter round, baseboard a caulking replaced around th		
	Findings include	2			shower area. The small	C	
	0				bathroom shower will be		
	Observations at	the facility where clients			re-caulked and thoroughly		
		-			cleaned. The furniture in the	9	
		, and G lived were			home will be cleaned and/o		
		/28/16 from 4:00 PM			replaced and the air condition		
		nd on 11/29/16 from 6:00			vent in the living room will b		
	AM until 10:30	AM.			replaced. The dresser in the		
					bedroom hallway will be ren and the deck will have lighti		
	The large bathro	oom had discolored and			added. The Site Supervisor		
	-	und on the wall's			be re-trained on the timely		
		d the shower area. The			completion of maintenance		
		s missing caulking. The			requests for items that need	l	
					repaired in the home.		
		s shower was discolored					
	-	caulking. The chair and					
	love seat in the	iving room had a strong				l.	
	odor. The air co	nditioning vent in the			How others will be identified (Systemic): The maintenant		
	living room was	rusted and had a strong			coordinator will visit the hon		
	-	bedroom hallway which			least weekly and complete a		
		had a 3 drawer dresser in			environmental inspection		
		belonging to client B.			checklist and turn it into the		
		a deck on the rear of the			Program Manager each we		
	-	via a door from the			any areas are noted as nee	ding	
					repair the maintenance	_	
	-	s was a fire exit. The			coordinator will schedule the repairs immediately. The	5	
	deck had no ligh	nt fixture.			Program Manager will visit f	he	
					home at least every other w	eek to	
		House Manager staff #1			complete and environmenta		
	on 11/30/16 at 1	0:30 AM indicated the			inspection checklist and foll		
	doors leading fr	om the back bedroom			on all repairs completed by	the	
	-	he deck were fire exit			maintenance coordinator.		
	-	by the clients during			Monsures to be put in place	· • ·	
		5. The interview indicated			Measures to be put in place The large bathroom will have		

Event ID:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/30/2016	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	2401 0	ADDRESS, CITY, STATE, ZIP (CORNWALL DR RSONVILLE, IN 47130	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	RRECTION SHOULD BE APPROPRIATE	(X5) COMPLETIC DATE	
TAG REGULATORY OR LSC IDENTI the strong odor emanating furniture and heating vent 9-3-1(a)	-		quarter round, basebo caulking replaced arous shower area. The sma bathroom shower will re-caulked and thorous cleaned. The furniture home will be cleaned a replaced and the air or vent in the living room replaced. and the air or vent in the living room replaced. The dresser bedroom hallway will b and the deck will have added.	und the all be ghly in the and/or onditioning will be conditioning will be in the back be removed			
				Monitoring of Correct Action: The maintena coordinator will visit th least weekly and comp environmental inspect checklist and turn it int Program Manager ead any areas are noted a repair the maintenance coordinator will schedu repairs immediately. T Program Manager will home at least every of complete and environment inspection checklist are on all repairs complete maintenance coordination	ance le home at plete an ion to the ch week. If s needing e ule the The visit the ther week to mental nd follow up ed by the		
				Completion date: 12/	/30/2016		

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CENTERS FOR MEDICARE & MEDICAID SERVICES	

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G247	15G247 B. WING			(X3) DATE SURVEY COMPLETED 11/30/2016	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		2401 C	ADDRESS, CITY, STATE, ZIP CODE ORNWALL DR RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
W 0137 Bldg. 00	The facility must clients. Therefor that clients have appropriate perso clothing. Based on obser of 4 sampled cl failed to ensure	F CLIENTS RIGHTS ensure the rights of all e, the facility must ensure the right to retain and use onal possessions and vation and interview for 1 tents (A), the facility client A's right to retain a to his personal clothing. e:	wo	0137	W137: The facility must ensut the rights of all clients. Therefore, the facility must ensure that clients have the to retain and use appropriate personal possessions and clothing.	right	12/30/2016
	conducted on 1 Client A's room a locked door. (and contained a	client A's bedroom was 1/29/16 at 6:00 AM. had two closets. One had One closet was unlocked n air freshener, a plastic bedroom slipper. The othing.			Corrective Action: (Specifi All staff at the home will be re-trained on client rights. Cl #1 no longer lives in the hom	ient ie.	
	on 11/29/16 at A's clothing wa because it woul	House Manager staff #1 10:00 AM indicated client s not kept in his bedroom d become soiled. The ontained clothing that did			How others will be identifie (Systemic): The Area Super and the QIDP will be at the h at least weekly to ensure tha clients in the home have acc to their clothing items at all ti	visor iome t all ess	
	Interview with Administrative staff #2 on 11/30/16 at 2:45 PM indicated client A was supposed to have clean clothing outfits in his bedroom.				Measures to be put in place staff at the home will be re-tr on client rights. Client #1 no longer lives in the home.		

	R MEDICARE & MEDIO	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247			A. BUILDING B. WING	<u>00</u>	COMPLETED 11/30/2016
	PROVIDER OR SUPPLIE	ALTERNATIVES SE IN	2401 0	ADDRESS, CITY, STATE, ZIP CODE CORNWALL DR ERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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
	9-3-2(a)			Monitoring of Corrective Action: The Area Supervisor ar the QIDP will be at the home at least weekly to ensure that all clients in the home have access to their clothing items at all time Completion date: 12.30.2010	S S.
W 0149 Bldg. 00	The facility must written policies a mistreatment, ne Based on obser interview for 8 incidents/invest affecting 4 of 4 C and D), and 3 and G), the faci policies and pro neglect (failure programming) a	and abuse (peer to peer clients were implemented.	W 0149	W149: The facility must develop and implement writte procedures that prohibit mistreatment, neglect or abuse of the client. Corrective Action: (Specific): All staff in the home will be re-trained on th operation standard for reporting and investigating abuse neglect exploitation mistreatment or violation of a individual's rights. Client A	e
	_	cident reports, BDDS		individual's rights. Client A received a CIH waiver and n longer resides in the home.	0

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BU	JILDING	00	COMPLETED		
		15G247	B. W.	ING		11/3	0/2016
NAME OF	PROVIDER OR SUPPLIE	P		STREET	ADDRESS, CITY, STATE, ZIP CODE		
					ORNWALL DR		
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN		JEFFE	RSONVILLE, IN 47130		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		elopmental Disabilities					
	· ·	s and investigations were					
		/28/16 at 1:00 PM and on			How others will be		
	11/30/16 at 1:24	4 PM and indicated the			identified: (Systemic):		
	following:				Quality Assurance will rev	iew	
					all incidents daily to ensur		1
	1. An investiga	tion dated 8/02-04/16			that incidents of peer to pe		
	-	y staff hid food from			aggression are addressed		
		ffort to control his food			have preventative measur		
		or. The hiding of food			put in place. The Program		
	was substantiate	•			Manager will meet with Q	A at	
	was substantiat				least weekly to ensure that	t all	
	2 A DDDS ror	oort dated 11/05/16			incidents of peer to peer		
	-	A wanted more snack			aggression are addressed		
					have preventative measur	es	
		ed staff' three times,			implemented.		
	-	othing. Staff employed			Maaauraa ta ba mutin		
		afe, I'm Safe/restraint			Measures to be put in	-	
	· ·	anaging behavior). The			place: All staff in the home will be re-trained on the	e	
	staff called 911	for assistance.			operation standard for		
					reporting and investigating	r	
	3. A BDDS rep	port dated 9/24/16			abuse neglect exploitation	-	
	indicated on 9/2	24/16 at 4:30 PM, client A			mistreatment or violation		
	wanted more fo	od after dinner. He			individual's rights. Client		
	attacked client	C causing bleeding to his			received a CIH waiver and		
	arm (he was on	a blood thinning			longer resides in the home	Э.	
		ient A "cornered"			-		
	· · · ·	ent F. Client A physically					
	. , , , , , , , , , , , , , , , , , , ,	ipping off her blouse and					1
		Staff called 911 and client			Monitoring of Corrective		1
		ted to a hospital for			Action: Quality Assuranc		
		•			will review all incidents da		
		(Emergency Medical			ensure that incidents of pe	er	
		nnel treated client F's			to peer aggression are		
	5	rm. Staff treated staff's			addressed and have	4 i.a	
	injuries.				preventative measures pu	t IN	

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	R MEDICARE & MEDIC				OMB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· · ·	CONSTRUCTION	(X3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED
		15G247	-		11/30/2016
JAME OF F	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP C	CODE
				CORNWALL DR	
RES CAP		LTERNATIVES SE IN	JEFF	ERSONVILLE, IN 47130	
X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	
REFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	APPROPRIATE
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	~			place. The Program	-
	-	ort indicated on 9/23/16		will meet with QA at	
	at 8:00 PM, clie	nt A attacked staff and		weekly to ensure the	
	threatened his h	ousemates (clients B, C,		incidents of peer to p aggression are addre	
	D, E, F, and G).	Housemates went to		have preventative m	
	their bedrooms	and 911 was called.		implemented.	
	Client A went to	o a local hospital and was			
		octors began haloperidol			
		2 milligrams three times			
	daily for behavi	-			
	5 A BDDS ren	ort dated 9/23/16			
	-	A scratched client E.			
	indicated cheft	A seratened cheft E.			
	6 A DDDS rom	art datad 0/10/16		Completion date:	
	-	ort dated 9/10/16		12/30/2016	
		A went into the kitchen		12/00/2010	
	-	cool aid and client F tried			
	-	ff got between the clients.			
	-	d client F's arm leaving 3			
	scratches.				
	-	ort dated 7/20/16			
		ident on 7/19/16 at 12:00			
		ent A tried to take client			
		fell onto the floor. Client			
	E hit client A w	ith the palm of his hand.			
		art data d (/10/16			
	8. A BDDS report dated 6/19/16				
		ident on 6/18/16 at 7:00			
	-	t indicated client G was			
	-	vior" and client A reached			
	out and grabbed	his arm as he was			
	walking by. Clie	ent G received two 1 inch			
	scratches to his	left forearm.			

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 15G247 B. WING 11/30/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2401 CORNWALL DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG Observations at the facility where clients A, B, C, D, E, F, and G lived were conducted on 11/28/16 from 4:00 PM until 6:30 PM, on 11/29/16 from 6:00 AM until 10:30 AM, and 11/30/16 from 11:15 AM until 12:00 PM. Client A was home with clients E and C on 11/29/16 with House Manager #1 while staff #3 took the other clients to workshop (7:45 AM to 9:00 AM). On 11/30/16, clients A and C were at home with HM #1 at 11:15 AM. Staff #2 had taken clients to work at 8:00 AM, then had taken client F to a medical appointment and back to workshop. Staff #2 returned to the facility at 11:35 AM. During these observation periods, client A was not on a true one on one staffing ratio. Interview with House Manager staff #1 on 11/28/16 at 4:45 PM indicated client A was a one on one (one staff to one client ratio) due to his physically aggressive behaviors toward peers and staff. Client A was to be in staff's line of sight when he was awake unless he was in his bedroom. Confidential interview #1 indicated client A "targeted" client C physically. During a recent incident, client C had held up his

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cane as a barrier when client A came

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

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number: 15G247	A. BUILDING B. WING	CONSTRUCTION 00	CO	ate survey mpleted /30/2016
	PROVIDER OR SUPPLI	ER ALTERNATIVES SE IN	2401	T ADDRESS, CITY, STATE, ZIF CORNWALL DR ERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
	toward him in	a threatening manner as h his feet elevated so he				
	was not always had to take clie the community to workshop, th	terview #2 indicated there is a second staff when staff ent A on appointments in a. When clients were taken that left client A in the or 2 other clients and one				
	at 2:25 PM ind Team Meeting IDT indicated a (one staff for c implemented w meeting today him (client A) (clients B, C, I housemates ha him and the tea him on a one to of him and all I one will be dur the staff (one to	nt A's record on 11/30/16 icated an Interdisciplinary /IDT dated 11/07/16. The a one on one staffing ratio lient A) would be with client A: "The team is to discuss the safety of and the housemates D, E, F, and G). The we stated they are scared of any has decided to place to one to ensure the safety housemates. The one to ring all waking hours and to one) will remain within him (client A)"				
	"Reporting and Neglect, Explo Violation of an	Derational Standard I Investigating Abuse, itation, Mistreatment or Individual's Rights" f 1/2016 was reviewed on				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 15G247 B. WING 11/30/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2401 CORNWALL DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG 11/28/16 at 3:00 PM. The review indicated the agency prohibited staff neglect/abuse/exploitation of clients. The policy indicated all allegations would be investigated and addressed. The Operation's Standard included, in part, the following: "[The agency] strictly prohibits abuse, neglect exploitation, mistreatment, or violation of an Individual's rights. These include and are defined as any of the following:...hitting...the infliction of physical pain...verbal abuse including screaming, swearing, name-calling, belittling, damaging an individual's self-respect or dignity...Medical treatment or care " 9-3-2(a) W 0159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Bldg. 00 Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. W 0159 W159: Each client's active 12/30/2016 Based on record review and interview for treatment program must be 4 of 4 sampled clients (A, B, C and D), integrated, coordinated and the facility's Qualified Intellectual monitored by a qualified Disabilities Professional/QIDP) failed to intellectual disability professional. monitor clients' programs and ensure data was collected. Findings include:

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247					(X3) DATE SURVEY COMPLETED 11/30/2016	
	PROVIDER OR SUPPLIE	R R ALTERNATIVES SE IN		2401 0	ADDRESS, CITY, STATE, ZIP CODE CORNWALL DR RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERNCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Client A's recor 11/29/16 at 9:22 Client A's mont	d was reviewed on 5 AM and 1:30 PM. hly reviews had not been d by the QIDP for August,			Corrective Action: (Specific The QIDP will be re-trained o the completion of quarterly reviews for all clients programming.	-	
	11/29/16 at 8:4 Client B's mont signed/reviewed September or C	d was reviewed on 5 AM and 12:10 PM. hly reviews had not been d by the QIDP for August, october 2016. d was reviewed on			How others will be identified (Systemic): The Program Manager will review all client plans during site visits at leas monthly to ensure that all clien have quarterly reviews of the program data completed time	st ents ir	
	reviews had not the QIDP for A October 2016.	0 AM. Client C's monthly t been signed/reviewed by ugust, September or d was reviewed on			Measures to be put in place The QIDP will be re-trained o the completion of quarterly reviews for all clients programming.		
	Client D's mont signed/reviewed September or C program book h the month of Ne	5 AM and 2:08 PM. thly reviews had not been d by the QIDP for August, betober 2016. C client D's had no data collection for by been 2016 for his Support Plan dated			Monitoring of Corrective Action: The Program Manag will review all client plans dur site visits at least monthly to ensure that all clients have quarterly reviews of their prog data completed timely.	ing	
	11/29/16 at 2:20 data should be on No further information	rmation was available in PIDP's lack of monitoring			Completion date: 12/30.201	6	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	
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	IT OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: A.		JILDING NG	<u>00</u>	COMPLI 11/30/2	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		2401 C	ADDRESS, CITY, STATE, ZIP CODE CORNWALL DR RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R 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 0240 Bldg. 00	relevant interven individual toward Based on record 2 of 4 sampled facility failed to address client A appointments (a programming) issues. Findings includ Client A's record 11/29/16 at 9:2 Client A had no 2/4/15. He had Nose, and Thro and was suppos There was no e assessment in h was scheduled on 12/15/16. Th contained an IS dated 8/25/16 a Support Plan da record had no r	ogram plan must describe tions to support the independence. d review and interview for clients, (A and C), the o add methodology to A's refusals for medical desensitization and client C's heart/lung	w	9240	W240: The individual program plan must describe relevant interventions to support the individual towards independence Corrective Action: (Specific): Client A received a CIH waiver and no longer resides in the home. The nurse will be re-trained on ensuring that all clients are up to date on all medical appointments. The QIE will be re-trained on ensuring th clients who are refusing to atter medical appointments have pla developed with methodologies and desentization techniques to assist them toward independence. The nurse will b re-trained on the development and implementation of risk plan for related diagnosis for all clients. Client C will have a risk plan developed for the oxygen use, Coumadin therapy and heart/respiratory issues if it is si required. How others will be identified:	oP at nd ns o e s	12/30/2010

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G247	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 11/30/2016	
				ADDRESS, CITY, STATE, ZIP CODE	11/00	2010
NAME OF	PROVIDER OR SUPPLIE	ER	2401 0	CORNWALL DR		
RES CA	RE COMMUNITY	ALTERNATIVES SE IN	JEFFE	RSONVILLE, IN 47130		
X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	appointments. Interview with on 11/29/16 at A was resistive medical appoin gone to the gas would not rema the office and t facility van, the and refused to g transported him House Manage facility van to t Client C's recon 11/29/16 at 9:5 indicated client with pneumonic had been treate signs/symptom hospital. Client for cardiac prob 8/13/16. The cl diagnoses inclu to, COPD (Chr- Pulmonary Disc CHF/congestiva atrial fibrillatio response (irregu	House Manager staff #1 11:30 AM indicated client to going into offices for tments. The client had troenterologist's office but ain in the office. He left ried to get into the locked en got into his mother's car get out. His mother had a to the appointment and r #1 had to drive the he appointment. rd was reviewed on 0 AM. The record review C had been hospitalized a on 10/20/16. Client C d on 8/10/16 for s of a stroke in the C had also been treated blems in the hospital on ient's record indicated his ided, but were not limited onic Obstructive ease), acute e heart failure, and chronic n with rapid ventricular ular heartbeat). The client blood thinning drug, oxygen when in bed. The rd health risk plans dated		 (Systemic): The Nursing Manager will review all client medical files at least monthly ensure that all clients are up date on all medical appointme and have risk plans in place t address all medical diagnosis needs. All client plans will be reviewed at least quarterly by team. Measures to be put in place Corrective Action: (Specifi Client A received a CIH waiv and no longer resides in the home. The nurse will be re-trained on ensuring that al clients are up to date on all medical appointments. The C will be re-trained on ensuring clients who are refusing to att medical appointments have p developed with methodologie and desentization techniques assist them toward independence. The nurse wil re-trained on the developmer and implementation of risk pla for related diagnosis for all clients. Client C will have a r plan developed for the oxyge use, Coumadin therapy and heart/respiratory issues if it is required. Monitoring of Corrective Action: The Nursing Manag will review all client medical fi at least monthly to ensure that clients are up to date on all medical appointments and hat risk plans in place to address 	to to ents o s and e the the the that dans s to l be that dans s to l be that dans s s to l be that dans s s to l be ans s to l be that ans s to l be that ans s to l be that dans s s to l be that dans s s to l be that dans s s to l be that dans s s to l be that dans s s to l be dans s s to l be that dans s s to l be dans s s to l be dans s s to l be that dans s s to l be that dans s s to l be dans s s to l be dans s s to l be that dans s s to l be that dans s s to l be that dans s s to l be that dans s s to l be that dans s s to l be that dans s s to l be dans s s to l be that dans s s to l be that dans s s to l be dans s to l be dans s s to l be dans s to l be dans s to l be dans s to l be dans s to l b dans s to l b dans s to l b dans s to l b dans s to l b dans s to l b dans dans dans dans dans dans dans dans	DATE

Event ID:

1MMD11 Facility ID: 000769

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	VTERS FOR MEDICARE & MEDICAID SERVICES				OME	3 NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLE	ETED
		15G247	B. WING		11/30/2	2016
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN		CORNWALL DR RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	Ξ	COMPLETIO
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	plans/methodolo	ogy for the oxygen,		medical diagnosis and needs.	All	
	Coumadin thera	py or his heart/respiratory		client plans will be reviewed at least quarterly by the team.		
	issues.					
	Interview with I	LPN #1 on 11/30/16 at				
		ted a health risk plan for				
		he interview indicated		Completion date: 12/30/2016		
		ll not released by his				
		1				
		urn to work and portable				
		ng pursued. The interview				
		k plans would be				
	updated.					
	9-3-4(a)					
V 0249	483.440(d)(1) PROGRAM IMPL	.EMENTATION				
Bldg. 00		terdisciplinary team has				
-		nt's individual program plan,				
		receive a continuous active				
		m consisting of needed services in sufficient				
			1			
		lency to support the				
	number and frequ	uency to support the ne objectives identified in				
	number and frequ	ne objectives identified in				
	number and frequ achievement of the the individual pro-	ne objectives identified in	W 0249			12/30/20
	number and frequ achievement of the the individual prog Based on observ	ne objectives identified in gram plan.	W 0249			12/30/20
	number and frequ achievement of the the individual pro- Based on observ interview for 1 of	ne objectives identified in gram plan. vation, record review and	W 0249	W249: As soon as the interdisciplinary team has		12/30/20
	number and frequ achievement of the the individual pro- Based on observ- interview for 1 of the facility faile	ne objectives identified in gram plan. vation, record review and of 4 sampled clients, (A),	W 0249	W249: As soon as the interdisciplinary team has formulated a clients' individual		12/30/20
	number and frequ achievement of the the individual pro- Based on observ- interview for 1 of the facility faile	ne objectives identified in gram plan. vation, record review and of 4 sampled clients, (A), d to implement client A's	W 0249	interdisciplinary team has formulated a clients' individual program plan, each client must		12/30/20
	number and frequ achievement of the the individual prog- Based on observ- interview for 1 of the facility faile behavioral prog-	ne objectives identified in gram plan. vation, record review and of 4 sampled clients, (A), d to implement client A's ramming (one on one	W 0249	interdisciplinary team has formulated a clients' individual	f	12/30/20

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	COMP	e survey leted)/2016
	VIDER OR SUPPLIEF	LTERNATIVES SE IN	2401 C	ADDRESS, CITY, STATE, ZIP CODE CORNWALL DR RSONVILLE, IN 47130		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIEVING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DN BE PRIATE	(X5) COMPLETION
C U A I I h W U A A A A A A A A A A A A A A A A A A	A, B, C, D, E, F onducted on 11 ntil 6:30 PM, o M until 10:30 1:15 AM until ome with clien with House Mar ook the other cl M to 9:00 AM nd C were at ho M. Staff #2 ha :00 AM, then h nedical appoint vorkshop. Staff t 11:35 AM. During these ob was not on a t atio. nterview with F n 11/28/16 at 4 was a one on lient ratio) due ggressive behav taff. Client A w ight when he w n his bedroom.	LSC IDENTIFYING INFORMATION) , and G lived were /28/16 from 4:00 PM n 11/29/16 from 6:00 AM, and 11/30/16 from 12:00 PM. Client A was its E and C on 11/29/16 ager #1 while staff #3 ients to workshop (7:45). On 11/30/16, clients A ome with HM #1 at 11:15 d taken clients to work at ad taken client F to a ment and back to #2 returned to the facility servation periods, client rue one on one staffing House Manager staff #1 :45 PM indicated client one (one staff to one to his physically viors toward peers and vas to be in staff's line of as awake unless he was	TAG	DEFICIENCY) achievement of the objective identified in the individual program plan. Corrective Action: (Spect All staff at the home will be in-serviced on all client pro- plans and the implementat all program objectives and for all clients. All staff at the home will be in-serviced or treatment. Client A receive CIH waiver and is no longe home. How others will be identii (Systemic): The QIDP will the home at least twice we for 30 days and weekly the to ensure that all clients' pr plans are being implement written and that active treat plans are being followed. Program Manager will be at home at least weekly to en- that all clients' program plat being implemented as writt that active treatment plans being followed. Measures to be put in plat Corrective Action: (Spect All staff at the home will be in-serviced on all client pro- plans and the implementat all program objectives and for all clients. All staff at the	ves fic): e gram ion of goals e n active ed a rr in the fied: l be at ekly reafter ogram ed as tment The t the sure ns are en and are fic): e gram ion of goals e treafter ogram ed as tment The t the sure ns are en and are	DATE

cane as a barrier when client A came toward him in a threatening manner as client C sat with his feet elevated so he

FORM CMS-2567(02-99) Previous Versions Obsolete

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home.

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treatment. Client A received a

CIH waiver and is no longer in the

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PRINTED:

04/13/2017

NT OF DEFICIENCIES	W1) DDOLUDED (CLIDDLIED /CLIA					
		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPLETED	
	15G247	B. WING	i		11/30/2016	
PROVIDER OR SUPPLIEI	2					
	LTERNATIVES SE IN			RSONVILLE, IN 47 130		
				PROVIDER'S PLAN OF CORRECTION	(X5)	
				CROSS-REFERENCED TO THE APPROPRIAT	E COMPLETIC DATE	
	,		IAU		DATE	
Confidential interview #2 indicated there				-	he	
				home at least twice weekly for		
				days and weekly thereafter to		
-				ensure that all clients' program		
-						
1,				Program Manager will be at the	e	
-	r 2 other clients and one			home at least weekly to ensure	e	
staff.				that all clients' program plans a		
Review of client	t A's record on 11/29/16					
at 9:25 AM and	1:30 PM, indicated					
progress notes for	or November of 2016.					
The progress no	tes indicated client A did					
not always sleep	through the night.			Completion date: 12/30/2016		
Sometimes he w	vas up when only one					
	1 P					
6:00 AM:						
11/08/16. awake	e from 2:00 AM until					
	e from 10.00 PM until					
-						
-						
-						
	\sim from 4.00 AM to 8.00					
	- 110111 - 1.00 ANI 10 0.00					
	from 11.00 DM to 2.00					
-						
-	e from 3:00 AM until					
	from 10:00 PM until					
	RE COMMUNITY A SUMMARY S (EACH DEFICIEN REGULATORY OF was unable to m Confidential inter was not always 3 had to take client the community. to workshop, that facility with 1 or staff. Review of client at 9:25 AM and progress notes for The progress no not always sleep Sometimes he w staff was on dut 6:00 AM: 11/08/16, awake 8:00 AM. 11/09/16, awake 8:00 AM and 5: 11/17/16, awake 8:00 AM. 11/18/16, awake 8:00 AM. 11/18/16, awake 8:00 AM. 11/19/16, awake 8:00 AM. 11/19/16, awake 8:00 AM. 11/19/16, awake 8:00 AM. 11/19/16, awake 8:00 AM. 11/20/16, awake 9:00 AM.	 was not always second staff when staff had to take client A on appointments in the community. When clients were taken to workshop, that left client A in the facility with 1 or 2 other clients and one staff. Review of client A's record on 11/29/16 at 9:25 AM and 1:30 PM, indicated progress notes for November of 2016. The progress notes indicated client A did not always sleep through the night. Sometimes he was up when only one staff was on duty from 10:00 PM until 6:00 AM: 11/08/16, awake from 2:00 AM until 8:00 AM. 11/09/16, awake from 10:00 PM until 12:00 AM and 2:00 AM until 10:00 AM. 11/14/16, awake from 2:00 AM until 3:00 AM and 5:00 AM until 11:00 AM. 11/17/16, awake from 4:00 AM to 8:00 AM. 11/18/16, awake from 11:00 PM to 2:00 AM and 6:00 AM to 9:00 AM. 11/20/16, awake from 3:00 AM until 9:00 AM. 11/20/16, awake from 10:00 PM until 	PROVIDER OR SUPPLIER S RE COMMUNITY ALTERNATIVES SE IN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) T was unable to move quickly. Confidential interview #2 indicated there was not always second staff when staff had to take client A on appointments in the community. When clients were taken to workshop, that left client A in the facility with 1 or 2 other clients and one staff. Review of client A's record on 11/29/16 at 9:25 AM and 1:30 PM, indicated progress notes for November of 2016. The progress notes indicated client A did not always sleep through the night. Sometimes he was up when only one staff was on duty from 10:00 PM until 6:00 AM. 11/08/16, awake from 2:00 AM until 10:00 AM. 11/14/16, awake from 2:00 AM until 1:00 AM and 5:00 AM until 11:00 AM. 11/17/16, awake from 2:00 AM until 1:00 AM. 11/19/16, awake from 11:00 PM to 2:00 AM. 11/19/16, awake from 3:00 AM. 11/120/16, awake from 3:00 AM. 11/20/16, awake from 3:00 AM. 11/20/16, awake from 11:00 PM to 2:00 AM. 11/20/16, awake from 3:00 AM. 11/20/16, awake from 10:00 PM until <td>ROVIDER OR SUPPLIER STREET./ RE COMMUNITY ALTERNATIVES SE IN JEFFEI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Was unable to move quickly. Confidential interview #2 indicated there was not always second staff when staff had to take client A on appointments in the community. When clients were taken to workshop, that left client A in the facility with 1 or 2 other clients and one staff. Review of client A's record on 11/29/16 at 9:25 AM and 1:30 PM, indicated progress notes for November of 2016. The progress notes indicated client A did not always sleep through the night. Sometimes he was up when only one staff was on duty from 10:00 PM until 6:00 AM: 11/08/16, awake from 2:00 AM until 8:00 AM. 11/08/16, awake from 10:00 PM until 12:00 AM and 2:00 AM until 11:00 AM. 11/17/16, awake from 2:00 AM until 8:00 AM. 11/17/16, awake from 10:00 PM to 2:00 AM. AM. 11/19/16, awake from 11:00 PM to 2:00 AM and 6:00 AM to 9:00 AM. AM. 11/120/16, awake from 11:00 PM to 2:00 AM and 6:00 AM. AM. 11/120/16, awake from 11:00 PM to 2:00 AM. AM. 11/120/16, awake from 11:00 PM until 9:00 AM. 11/120/16, awake from 10:00 PM until 9:00 AM.</td> <td>ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE RECOMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST RE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION) D Was unable to move quickly. D Confidential interview #2 indicated there was not always second staff when staff had to take client A on appointments in the community. When clients were taken to workshop, that left client A in the facility with 1 or 2 other clients and one staff. Monitoring of Corrective Actions: The CIDP will be at the home at least twice weekly for days and weekly thereafter to ensure that all clients' program plans are being followed. The Program Manager will be at the home at least weekly to ensure that all clients' program plans are being followed. The Program plans are being followed. The Program pla</td>	ROVIDER OR SUPPLIER STREET./ RE COMMUNITY ALTERNATIVES SE IN JEFFEI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Was unable to move quickly. Confidential interview #2 indicated there was not always second staff when staff had to take client A on appointments in the community. When clients were taken to workshop, that left client A in the facility with 1 or 2 other clients and one staff. Review of client A's record on 11/29/16 at 9:25 AM and 1:30 PM, indicated progress notes for November of 2016. The progress notes indicated client A did not always sleep through the night. Sometimes he was up when only one staff was on duty from 10:00 PM until 6:00 AM: 11/08/16, awake from 2:00 AM until 8:00 AM. 11/08/16, awake from 10:00 PM until 12:00 AM and 2:00 AM until 11:00 AM. 11/17/16, awake from 2:00 AM until 8:00 AM. 11/17/16, awake from 10:00 PM to 2:00 AM. AM. 11/19/16, awake from 11:00 PM to 2:00 AM and 6:00 AM to 9:00 AM. AM. 11/120/16, awake from 11:00 PM to 2:00 AM and 6:00 AM. AM. 11/120/16, awake from 11:00 PM to 2:00 AM. AM. 11/120/16, awake from 11:00 PM until 9:00 AM. 11/120/16, awake from 10:00 PM until 9:00 AM.	ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE RECOMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MUST RE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION) D Was unable to move quickly. D Confidential interview #2 indicated there was not always second staff when staff had to take client A on appointments in the community. When clients were taken to workshop, that left client A in the facility with 1 or 2 other clients and one staff. Monitoring of Corrective Actions: The CIDP will be at the home at least twice weekly for days and weekly thereafter to ensure that all clients' program plans are being followed. The Program Manager will be at the home at least weekly to ensure that all clients' program plans are being followed. The Program plans are being followed. The Program pla	

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

AND PLAN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G247	(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/30/2016
	PROVIDER OR SUPPLIE	ALTERNATIVES SE IN	2401	T ADDRESS, CITY, STATE, ZIP CODE CORNWALL DR ERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	 9:00 AM. 11/27/16, awak 8:00 AM. 11/28/16, awak AM. Review of clier at 2:25 PM indi Team Meeting/ IDT indicated at (one staff for clients and the teat) him (client A) at (clients B, C, D) housemates have him and the teat him on a one too of him and all hone will be durit the staff (one to the staff	e from 12:00 AM until e from 2:00 AM until e from 10:00 PM to 12:00 at A's record on 11/30/16 icated an Interdisciplinary IDT dated 11/07/16. The a one on one staffing ratio ient A) would be ith client A: "The team is to discuss the safety of and the housemates b, E, F, and G). The ve stated they are scared of m has decided to place o one to ensure the safety housemates. The one to ing all waking hours and b one) will remain within him (client A)"			
W 0331 Bldg. 00	services in accor Based on record	/ICES provide clients with nursing dance with their needs. d review and interview for clients, (A and C), the	W 0331	W331: The facility must provid clients with nursing services in	

PARTMENT OF HEALTH AND HUMAN SERVICES NTERS FOR MEDICARE & MEDICAID SERVICES							XM APPROVED B NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CON	NSTRUCTION	X3) DATE S	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	00	COMPL	ETED
		15G247	B. WING			11/30/	2016
	PROVIDER OR SUPPLIE	2	ST	REET A	DDRESS, CITY, STATE, ZIP CODE		
					ORNWALL DR		
RES CA	RE COMMUNITY A	LTERNATIVES SE IN	JE	FFER	SONVILLE, IN 47130		
X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TA	G			DATE
	methodology to	address client A's			Corrective Action: (Specific):		
	refusals for med	ical appointments			Client A received a CIH waive	r	
	(desensitization	programming) and client			and no longer resides in the		
	C's heart/lung is				home. The nurse will be re-trained on ensuring that all		
					clients are up to date on all		
	Findings include	- .			medical appointments. The QII)P	
	r manigs menua			will be re-trained on ensuring th			
					clients who are refusing to atte	nd	
		d was reviewed on			medical appointments have pla	ins	
	11/29/16 at 9:25	5 AM and 1:30 PM.			developed with methodologies		
	Client A had no	t been to the dentist since			and desentization techniques to	0	
2	2/4/15. He had b	been to the ENT (Ear,			assist them toward independence. The nurse will b	20	
	Nose, and Throa	at) physician on 3/18/15			re-trained on the development		
		ed to return in one year.			and implementation of risk plar	าร	
		vidence of a hearing			for related diagnosis for all		
		s record. An appointment			clients. Client C will have a ris	k	
		**			plan developed for the oxygen		
		or a hearing evaluation			use, Coumadin therapy and		
	on 12/15/16. Th				heart/respiratory issues if it is s required.	TIII	
		P/Individual Support Plan			Tequired.		
	dated 8/25/16 ar	nd a BSP/Behavior			How others will be identified:		
	Support Plan da	ted 1/25/16. The client's			(Systemic): The Nursing		
	record had no m	ethodology which			Manager will review all client		
	addressed being	compliant with medical			medical files at least monthly to		
	appointments.	*			ensure that all clients are up to		
	11				date on all medical appointmen	nts	
	Interview with I	House Manager staff #1			and have risk plans in place to	and	
		1:30 AM indicated client			address all medical diagnosis a needs. All client plans will be	ai IU	
					reviewed at least quarterly by t	he	
		to going into offices for			team.	-	
		ments. The client had					
		roenterologist's office but			Measures to be put in place:		
	would not remain	in in the office he left the			Corrective Action: (Specific)		
	office and tried	to get into the locked			Client A received a CIH waive	r	
		n got into his mother's car			and no longer resides in the		
	-	et out. His mother had			home. The nurse will be		
		to the appointment and			re-trained on ensuring that all clients are up to date on all		
	a ansported min	to the appointment and			circlits are up to date of all		

Event ID:

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ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G247			WING		11/3	(X3) DATE SURVEY COMPLETED 11/30/2016	
ROVIDER OR SUPPLIE			2401 C				
SUMMARY (EACH DEFICIE REGULATORY O House Manager van to the appo Client C's recor 11/29/16 at 9:50 indicated client with pneumonia had been treated signs/symptoms hospital. Client for cardiac prob 8/13/16. The cli diagnoses inclu to, COPD (Chro Pulmonary Dise CHF/congestive atrial fibrillation response (irregu was receiving a Coumadin and o record containe 11/04/16 but no plans/methodol Coumadin thera issues.	statement of DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) : #1 had driven the facility intment. d was reviewed on 0 AM. The record review C had been hospitalized a on 10/20/16. Client C d on 8/10/16 for s of a stroke in the C had also been treated olems in the hospital on ient's record indicated his ded, but were not limited onic Obstructive ease), acute e heart failure, and chronic n with rapid ventricular ilar heartbeat). The client blood thinning drug, oxygen when in bed. The d health risk plans dated o health risk ogy for the oxygen, apy or his heart/respiratory		JEFFE ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROD DEFICIENCY) medical appointments. The will be re-trained on ensurin clients who are refusing to medical appointments have developed with methodolog and desentization technique assist them toward independence. The nurse w re-trained on the developm and implementation of risk for related diagnosis for all clients. Client C will have a plan developed for the oxyg use, Coumadin therapy and heart/respiratory issues if it required. Monitoring of Corrective Action: The Nursing Mana will review all client medica at least monthly to ensure t clients are up to date on all medical appointments and risk plans in place to addre medical diagnosis and need client plans will be reviewed least quarterly by the team.	BE PRIATE QIDP ng that attend e plans gies es to will be ent plans a risk gen d is still ager I files that all have ss all d at	(X5) COMPLETION DATE	
	RE COMMUNITY A SUMMARY (EACH DEFICIE REGULATORY O House Manager van to the appo Client C's recor 11/29/16 at 9:50 indicated client with pneumonia had been treated signs/symptoms hospital. Client for cardiac prob 8/13/16. The cli diagnoses inclu to, COPD (Chro Pulmonary Disc CHF/congestive atrial fibrillation response (irregu was receiving a Coumadin and a record containe 11/04/16 but no plans/methodol Coumadin thera issues.	RE COMMUNITY ALTERNATIVES SE IN SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) House Manager #1 had driven the facility van to the appointment. Client C's record was reviewed on 11/29/16 at 9:50 AM. The record review indicated client C had been hospitalized with pneumonia on 10/20/16. Client C had been treated on 8/10/16 for signs/symptoms of a stroke in the hospital. Client C had also been treated for cardiac problems in the hospital on 8/13/16. 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The interview indicated client C was still not released by hisCompletion date: 12/30/2	LEE COMMUNITY ALTERNATIVES SE IN2401 CORNWALL DR JEFFERSONVILLE, IN 47130SUMMARY STATEMENT OF DEFICIENCTES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)House Manager #1 had driven the facility van to the appointment.TAGDEFICIENCY DEFICIENCYREGULATORY OR LSC IDENTIFYING INFORMATION)House Manager #1 had driven the facility van to the appointment.TAGDEFICIENCYClient C's record was reviewed on 11/29/16 at 9:50 AM. The record review indicated client C had been hospitalized with pneumonia on 10/20/16. Client C had been treated on 8/10/16 for signs/symptoms of a stroke in the hospital. Client C had also been treated for cardiac problems in the hospital on 8/13/16. 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Event ID:

1MMD11 Facility ID: 000769

If continuation sheet Page 19 of 20

	OF HEALTH AND HU! MEDICARE & MEDIC						D: 04/13/2017 APPROVED IO. 0938-0391
STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPL				NSTRUCTION	(X3) DATE SUI	RVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLET	ED
		15G247	B. WING			11/30/20	16
NAME OF P	NAME OF PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
RES CAR	RES CARE COMMUNITY ALTERNATIVES SE IN			JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)

RES CA	RES CARE COMMUNITY ALTERNATIVES SE IN			ORNWALL DR RSONVILLE, IN 47130	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
	9-3-6(a)				