CENTERS FOR	MEDICARE & MEDIC	AID SERVICES	OMB NO. 0938-039						
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY					
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED				
		15G442	B. WING		03/12/2024				
			<u> </u>		I				
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD					
				VING LN					
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	JEFFE	JEFFERSONVILLE, IN 47130					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5	5)			
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLE				
TAG	•	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATI				
W 0000									
Bldg. 00									
g. 00	This visit was for th	ne investigation of complaint	W 0000						
	#IN00426636.		** 0000						
	######################################								
	Complaint #INO042	26636: Federal and state							
	_	to the allegation(s) are cited at							
	W159, W164 and W	9 ()							
	w 133, w 104 and w	v 47.							
	Date of Survey: 3/1	2/24							
	Date of Survey. 3/1	2/24.							
	Facility Number: 00	00056							
	_								
Provider Number: 15G442 AIMS Number: 100244760									
	Alivis Nulliber. 100	0244700							
	These federal deficiencies also reflect state								
	findings in accordar								
	_	his report completed by #15068							
	on 3/26/24.	ms report completed by #15008							
	011 3/20/24.								
W 0159	483.430(a)								
11 0 100	465.450(a) QIDP								
Bldg. 00		e treatment program must							
Diag. 00									
	be integrated, coordinated and monitored by a qualified intellectual disability professional who- Based on record review and interview for 1 of 3								
			W 0159	The Facility will ensure e	each 04/11/	2024			
		, the QIDP (Qualified	W 0139	client's active treatment progra		∠∪∠4			
		ties Professional) failed to		is integrated, coordinated and	3111				
				monitored by a qualified					
	_	ntegrate, coordinate and monitor client A's active reatment program regarding client A's substance		intellectual disability profession					
	abuse support needs			An IDT was held to inclu					
	abuse support needs			a Behaviorist and additional	u c				
	Findings include:								
	i maniga metude.			members of the support team					
	1 The OIDD foiled	to ensure client A's IDT		regarding client A substance					
		eam) consulted with a		abuse support needs.	_{DB}				
		or other professional regarding		Based on the IDT the QI					
		abuse support needs. Please		updated client A's ISP and BS					
	chem A s substance	abuse support ficeus. Flease		include supports for substance	·				
				1					

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

(X6) DATE

TITLE

Mark Slaughter AED 04/11/2024

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

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CENTERS FOR	WIEDICARE & WIEDIC				ONIB NO. 0938-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING 00		COMPLETED		
		15G442	B. WING		03/12/2024		
			CTREET	ADDRESS CITY STATE ZIR COD			
NAME OF I	PROVIDER OR SUPPLIEF	R		ADDRESS, CITY, STATE, ZIP COD WING LN			
DECCAR		LTERNATIVES SE IN		RSONVILLE, IN 47130			
NEO CAI	· COMMONITY A	LILINATIVES SE IIV	JEFFE	.NOONVILLE, IN 47 13U			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX (EACH DEFICIENCY MUST BE PREC		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	see W164.			abuse.			
				The QIDP will retrain all	staff		
	2. The QIDP failed	to ensure client A's ISP		in the facility on updated ISP a	nd		
	(Individual Support	t Plan) and BSP (Behavior		BSP.			
	Support Plan) were	implemented regarding her		A member of the			
	substance abuse sup	pport needs. Please see W249.		administrative team will conduc	ct a		
				monthly site reviews for all clie	nts		
	This federal tag rela	ates to complaint #IN00426636.		in facility and the administrator			
		-		hold a weekly ICF meeting to			
	9-3-3(a)			discuss issues that arise in the			
				facility.			
				Persons Responsible: AED,			
			Nurse, Director of Nursing, Qu	ality			
				Assurance Manager, QA			
			Coordinator/QIDP Manager,				
				Program Manager, Area			
			Supervisor, QIDP, Direct Supp	ort			
				Lead, and DSP.			
				,			
W 0164	483.430(b)(1)						
	PROFESSIONAL	PROGRAM SERVICES					
Bldg. 00		receive the professional					
	program services needed to implement the active treatment program defined by each client's individual program plan.						
		view and interview for 1 of 3	W 0164	The Facility will ensure a	II 04/11/2024		
	sampled clients (A), the facility failed to ensure		1,, 010,	clients in the facility will receive			
		erdisciplinary Team) consulted		the professional program servi			
	,	erapist or other professional		needed to implement the active			
		s substance abuse support		treatment program defined by			
	needs.	11		each client's individual program	n.		
				An IDT was held to include			
	Findings include:			a Behaviorist and additional			
	<i>5</i>			members of the support team			
	Client A's record w	ras reviewed on 3/12/24 at 12:21		regarding client A substance			
		dated 10/16/23 indicated the		abuse support needs.			
	following:			The QIDP setup treatment	nt		
				options with a therapist to inclu			
	-"[Client Al has liv	red on her own for a while and it		AA support that best provides	140		
	Lenent II has hv	ca on not own for a winte and it	Ī	1 / v / aubbour mar near brownes	ı		

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Event ID:

03MP11

Facility ID: 000956

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STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
15G442		B. W	B. WING 03/12/2024			/2024	
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER					/ING LN		
RES CARE COMMUNITY ALTERNATIVES SE IN					RSONVILLE, IN 47130		
KES C	ARE COMMONT I A	ALTERNATIVES SE IN		JEFFER	NSONVILLE, IN 47 130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			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 APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
		ed she is need of more			support for client A based on	the	
	^	learn Independent Living			IDT.		
		s an alcoholic and needs to have			Based on the IDT the Q	IDP	
	-	continues to attend AA			updated client A's ISP and BS	SP to	
		mous) meetings as well as			include supports for substance	е	
	taking necessary m	edication."			abuse.		
					The QIDP will retrain all		
	-"Priority Objective				in the facility on updated ISP a	and	
	-	mmunity skills			BSP.		
	2. Money manag	gement			A member of the		
	3. Hygiene				administrative team will condu		
	4. Attending AA				monthly site reviews for all clie		
	5. Personal Relationships				in facility and the administrato	r will	
	6. Oral Hygiene				hold a weekly ICF meeting to		
	7. Healthy Eating."				discuss issues that arise in the	е	
					facility.		
		-The 10/16/23 ISP did not indicate documentation					
		arding AA attendance or					
	participation.				Persons Responsible: AED,		
					Nurse, Director of Nursing, Qu	uality	
		ed 10/16/23 indicated the			Assurance Manager, QA		
	following:				Coordinator/QIDP Manager,		
					Program Manager, Area		
		h Alcohol addiction and			Supervisor, QIDP, Direct Sup	port	
	attends AA weekly	·.''			Lead, and DSP.		
	WA11 1 11' '	a maladad babasada mar 1 1					
		n related behaviors: when she					
		ore to purchase alcohol, when					
		when she is arrested for					
	drunken disorderly						
		ll have 3 or fewer episodes of					
	Alcohol addiction concerns for three consecutive months by 10/24." -"If she engages in Alcohol addiction related behaviors:						
		ing go to purchase alashal					
	-	ing go to purchase alcohol,					
		ohol, or gets arrested for					1
		to attempt to do the above					
things remind her of her recovery remind her of				•		•	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442 A. BUILDING 00 03/12/2024 STREET ADDRESS, CITY, STATE, ZIP COD	
15G442 B. WING STREET ADDRESS, CITY, STATE, ZIP COD STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OF SUPPLIER	
NAME OF PROVIDER OF SUPPLIER	
402 EWING LN	
RES CARE COMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION (X5)	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX GEACH CORRECTIVE ACTION SHOULD BE COMPLETION	N
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE	
AA, encourage her to discuss how and why she	
is feeling that way.	
i. If she complies provide abundant praise and	
work with her on what is bothering her.	
j. Praise her for positive choices and changes in	
mindset towards alcohol use."	
Client A's record did not indicate documentation	
of AA attendance.	
of 71/1 auchdance.	
QIDP (Qualified Intellectual Disabilities	
Professional) and PM (Program Manager) were	
interviewed on 3/12/24 at 10:26 AM. QIDP	
indicated client A was an alcoholic. QIDP	
indicated client A would not go or attend AA.	
QIDP indicated client A had not attended AA	
since she moved to the group home on 4/14/22.	
QIDP indicated she had not reviewed client A's	
AA attendance in IDT (Interdisciplinary Team)	
meetings but had informal conversations with	
client A about AA. QIDP indicated she had	
recently started attempting to locate a counselor	
or therapist instead of AA for client A's	
substance abuse needs. QIDP indicated she had	
not consulted with a Behavior Therapist or other	
professional staff regarding client A's substance	
abuse support needs and her refusals to attend	
AA.	
Client A's record did not indicate documentation	
of IDT review, discussion or recommendations	
regarding client A's refusals to participate in AA. The review did not indicate documentation of	
consultation with a behavior therapist or other	
professional staff regarding client A's substance abuse needs.	
avuse necus.	
Client A and QIDP were interviewed together on	
3/12/24 at 2:07 PM. When asked if she would like	
to attend AA meetings, client A stated, "Yes,"	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2024			
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	Client A indicated she had ongoing thoughts about alcohol use and would like help in managing her addiction. Client A's guardian and QIDP were interviewed on 3/12/24 at 2:25 PM. Client A's guardian indicated client A had attended AA prior to moving to the group home. Client A's guardian stated, "[Client A] mentions it when we chat on the phone. She'll bring it up that she's still thinking about alcohol." Client A's guardian stated, "She has said not to let her near it (alcohol) because she'd drink it if she found it." Client A's guardian indicated client A would benefit from attending AA or participation in other alcohol addiction support. This federal tag relates to complaint #IN00426636.						
W 0249 Bldg. 00	formulated a client each client must retreatment program interventions and a number and frequenchievement of the individual program Based on record revisampled clients (A) client A's Individual Behavior Support Pregarding client A's	erdisciplinary team has t's individual program plan, eceive a continuous active n consisting of needed services in sufficient ency to support the e objectives identified in the	W 0249	The Facility will ensure a soon as the interdisciplinary to has formulated a client's indiviprogram plan, each client will receive a continuous active treatment program consisting	eam dual of		
		as reviewed on 3/12/24 at 12:21 dated 10/16/23 indicated the		needed interventions and serv in sufficient number and frequent to support the achievement of objectives identified in the	ency		

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Event ID:

03MP11

Facility ID: 000956

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER.		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00		COMPLETED		
150		15G442	B. W	ING		03/12	/2024		
				CTREET	A DDDEGG GITY GTATE ZID GOD				
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD				
RES CARE COMMUNITY ALTERNATIVES SE IN				402 EWING LN					
RES CAI	RE COMMUNITY A	ALTERNATIVES SE IN		JEFFE	RSONVILLE, IN 47130				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE		
	following:				individual program plan.				
					An IDT was held to incl	ude			
	-"[Client A] has liv	ed on her own for a while and it			a Behaviorist and additional				
	has been determine	ed she is need of more			members of the support tean	า			
	supervision and to	learn Independent Living			regarding client A substance				
		s an alcoholic and needs to have			abuse support needs.				
	•	continues to attend AA			The QIDP setup treatm	ent			
	(Alcoholics Anony	mous) meetings as well as			options with a therapist to inc	clude			
	taking necessary m	edication."			AA support that best provide:	S			
					support for client A based on	the			
	-"Priority Objective				IDT.				
	 Safety and community skills Money management 				Based on the IDT the C	QIDP			
					updated client A's ISP and B	SP to			
	3. Hygiene				include supports for substance	ce			
	4. Attending AA				abuse.				
	5. Personal Relationships				The QIDP will retrain al	l staff			
	6. Oral Hygiene				in the facility on updated ISP	and			
	7. Healthy Eating."				BSP.				
					A member of the				
		did not indicate documentation			administrative team will cond	uct a			
		arding AA attendance or			monthly site reviews for all cl				
	participation.				in facility and the administrate				
					hold a weekly ICF meeting to				
		ed 10/16/23 indicated the			discuss issues that arise in the	ne			
	following:				facility				
		th Alcohol addiction and							
	attends AA weekly	·."			Persons Responsible: AED				
		1 . 11 1			Nurse, Director of Nursing, C	uality			
		n related behaviors: when she			Assurance Manager, QA				
	asks to go to the store to purchase alcohol, when she uses alcohol, when she is arrested for drunken disorderly (sic). Goal: [client A] will have 3 or fewer episodes of				Coordinator/QIDP Manager,				
					Program Manager, Area	4			
					Supervisor, QIDP, Direct Sup	oport			
		-			Lead, and DSP.				
		concerns for three consecutive							
	months by 10.24"								
	"If ak	Alachal addition wiles 1							
		Alcohol addiction related							
	behaviors:	4							
g. If she is attempting go to purchase alcohol,				1		1			

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

PRINTED: 04/23/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	` ′	JILDING	onstruction 00	(X3) DATE COMPI 03/12	LETED
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN 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 B: CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	ACTION SHOULD BE COMP O TO THE APPROPRIATE	
	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION threatens to use alcohol, or gets arrested for h. If she continues to attempt to do the above things, remind her of her recovery, remind her of AA, encourage her to discuss how and why she is feeling that way. i. If she complies provide abundant praise and work with her on what is bothering her. j. Praise her for positive choices and changes in mindset towards alcohol use." Client A's record did not indicate documentation of AA attendance. QIDP (Qualified Intellectual Disabilities Professional) and PM (Program Manager) were interviewed on 3/12/24 at 10:26 AM. QIDP indicated client A was an alcoholic. QIDP indicated client A would not go or attend AA. QIDP indicated client A had not attended AA since she moved to the group home on 4/14/22. This federal tag relates to complaint #IN00426636.						

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