24

			PRINTED:	07/05/20
ARTMENT OF HEALTH AND HUM	MAN SERVICES		FORM API	PROVED
TERS FOR MEDICARE & MEDICA	AID SERVICES		OMB NO. (0938-039
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVE	Y

	MENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AN OF CORRECTION IDENTIFICATION NUMBER 15G442		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/10/2024	
RES CAR	ROVIDER OR SUPPLIER	R LTERNATIVES SE IN	402 EWING LN		DDRESS, CITY, STATE, ZIP COD ING LN RSONVILLE, IN 47130			
(X4) ID PREFIX TAG W 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE	
Bldg. 00	(PCR) to the PCR of pre-determined full licensure survey an complaint #IN0040 Complaint #IN0040 This survey was in investigation of corresponding to the survey was in investigation of corresponding to the survey dates: 6/5/2 Facility Number: 00 Provider Number: 1002 These deficiencies: accordance with 46	conjunction with a PCR to the inplaint #IN00426049. conjunction with a PCR to the inplaint #IN00426636. 4, 6/6/24, 6/7/24 and 6/10/24. 00956 15G442 244760 also reflect state findings in 0 IAC 9. this report completed by #15068	W 00	00				
W 0149 Bldg. 00	The facility must of written policies and mistreatment, negrous Based on observation interview for 2 of 3 facility failed to improve Exploitation, Mistre Individual's Rights of falls resulting in	ENT OF CLIENTS develop and implement ad procedures that prohibit glect or abuse of the client. on, record review and sampled clients (A and B), the plement the Abuse, Neglect, eatment and/or Violation of policy to prevent: 1) a pattern injury to client A, and 2) a unknown injuries to client B.	W 01	49	The Facility will ensure the Nurse will review all HRF with focus on Client A's fall F Syncope will be added to the risk plan and then nurse will retrain the staff on all HRPs. The Facility will add no	Ps, IRP. · fall	07/01/2024	
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE		TITLE		(X6) DATE	

Tracy Callahan Program Manager 07/01/2024

Any defiencystatement 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7FKA13 Facility ID: 000956 If continuation sheet Page 1 of 29

07/05/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/10/2024 15G442 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 402 EWING LN RES CARE COMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE treads to the van steps and the Findings include: interior floor of the van to help with client stability. 1) An observation was conducted on 6/5/24 from The Facility staff will be 3:32 PM to 4:43 PM. During the observation, client retrained on assisting clients 1 by A wore a hard plastic boot on her right foot. Upon 1 especially those at risk for falls entering the home, client A was seated at the when entering and exiting the van. dining room table with her leg elevated in a chair The Facility will ensure that while wearing the boot around her ankle. At 4:23 staff are retrained on giving verbal PM, client A participated in the evening meal and prompts to Client A on ensuring continued to wear the boot on her right foot. she has gained her balance before Client A wore the hard plastic boot throughout trying to ambulate. the observation period. During this observation, The Facility will ensure new flooring was observed throughout the follow up appointment with a kitchen and dining room. Neurologist to rule out seizure activity. On 6/6/24 at 10:21 AM, a review of the facility's The Facility will ensure that Bureau of Disabilities Services (BDS) reports was the staff are trained on notifying conducted. The review indicated the following the nurse immediately of all affecting client A: incidents regarding falls. The Facility will ensure that -BDS incident report dated 3/24/24 indicated, "It the Nurse will review all HRPs. was reported [client A] went to sit down in a chair with focus on Client A's fall HRP. at the kitchen table and missed the chair causing Syncope will be added to the fall her to fall onto her bottom. [Client A] was able to risk plan and then nurse will get up on her own. [client A] then went to get her retrain the staff on all HRPs. bread and condiments and fell a second time onto The Facility will add nonslip her bottom. [Client A] again was able to get up on treads to the van steps and the her own. Staff notified the nurse and assessed interior floor of the van to help with [client A] for injuries noting no visible signs of client stability. redness or injuries, but [client A] stated her The Facility staff will be buttock was sore. A couple of hours later in the retrained on assisting clients 1 by day, [client A] fell and immediately got herself 1 especially those at risk for falls back up when called to come take her medicine.

[Client A] had no complaints of pain or

discomfort. Staff notified the nurse who requested

room) for evaluation. Plan to Resolve: [Client A]

[client A] be transported to the ER (emergency

was evaluated in the ER and discharged to her

home. Discharge diagnosis: Lisfranc (bones in

trying to ambulate.

when entering and exiting the van.

staff are retrained on giving verbal

she has gained her balance before

The Facility will ensure

prompts to Client A on ensuring

The Facility will ensure that

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

	OF CORRECTION	IDENTIFICATION NUMBER 15G442	A. BUILDING B. WING	00	COM	PLETED 0/2024
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP COD VING LN RSONVILLE, IN 47130)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	midfoot) fracture riginstructions: Referrations: Referrations within 1 week. Non wheelchair. Follow-discharge for visit to on discharge instructions attends and will notify the resultance of the Elevaluation. The nur Resolve: [Client A] discharged to the Elevaluation. The nur Resolve: [Client A] discharged to her he Syncope (loss of colightheadedness. La Instructions: Conting prescribed medication positions slowly and feeling dizzy. Use a walker. Get plenty of neurologist for furth management of light syncope. Follow-up physician) as needed worsening sympton the discharge instrumonitor [client A],	ght foot Discharge al to [Medical Provider Name] -weight bearing in boot and -up primary care upon oday. Staff have been trained ctions. Staff will continue to ensure she follows all sall follow-up appointments, nurse of any changes". rt dated 5/17/24 indicated, "It s A] had her head down and to staff when they called her 111 and [client A] was R (emergency room) for se was notified. Plan to was evaluated in the ER and ome. Discharge diagnosis: nsciousness), albs completed Discharge tue taking previously ons as directed. Change d call for help if you begin mbulatory aid such as cane or of fluids. Follow-up with her evaluation and otheadedness and near with PCP (primary care d. Return to the ER for new or hs. Staff have been trained on ctions. Staff will continue to follow her plans in place, and any changes. No further		follow up appointment win Neurologist to rule out set activity. The Facility will ensithe staff are trained on not the nurse immediately of incidents regarding falls. PERSONS RESPONSIBIN Nurse, Director of Nursin Assurance Manager, QA Coordinator/QIDP Manager Program Manager, Area Supervisor, QIDP, Direct Lead, DSP	th a eizure sure that otifying all LE: AED, g, Quality	
	was reported [client kitchen and reported restroom. Staff note	rt dated 5/24/24 indicated, "It a A] wheeled herself into the d to staff she fell while in the ad a knot on [client A's] er eyes at the top of her nose.				

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

Event ID:

7FKA13

Facility ID: 000956

If continuation sheet

Page 3 of 29

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPI	
		15G442	B. W	'ING		06/10	/2024
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ΔTF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		l [client A] was transported to					
		on. The nurse was notified.					
	Plan to Resolve: [Client A] was evaluated in the						
	_	to her home. Discharge					
		ury, adult. No signs of					
		ad injury information sheets					
	_	charge instructions: Follow-up					
		care physician) in 2 to 3 days.					
		ned on the head injury					
	information sheets and discharge instructions. Staff will continue to monitor [client A] and notify						
	the nurse of any changes. The ID						
	(interdisciplinary) team will meet to discuss						
	additional measures needed to better assist [client						
	A]. No further incidents have been reported".						
	No investigation was available for review.						
	On 6/6/24 at 11:49	AM, a focused review of client					
		ducted. The review indicated					
	the following:						
	_	d 6/5/24 indicated, "Problem					
	Risk of Falls Goa	al: Will have no injury related to					
		2025 Approach: 1. Staff will					
		sistance with helping [client					
	-	Staff will keep the environment					
		es to prevent falls. 3. Staff will					
	encourage client to						
	_	ring. 4. Staff will ensure that					
		lking boot while ambulating as					
	notify nurse of any	opedic specialist. 5. Staff will					
	nonly nurse of any	14115					
	-No syncope health	risk plan was available for					
	review.	•					
	On 6/6/24 at 12:18	PM, the Quality Assurance					
	Manager (QAM) w	as interviewed. The QAM was					
	asked about client A	A's falls with injuries. The					

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

Event ID:

7FKA13 Facility ID: 000956

If continuation sheet Page 4 of 29

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL		
		15G442	B. W	/ING		06/10/	2024	
NAME OF P	DOMDED OF CHIPPLYEE		-	STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
NAME OF P	PROVIDER OR SUPPLIEF			402 EW				
	RE COMMUNITY A	LTERNATIVES SE IN		JEFFERSONVILLE, IN 47130				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION net and did a trend analysis.	+	TAG	DEFICIENCE		DATE	
		ou're seeing. [Qualified						
	Intellectual Disabilities Professional/QIDP] did							
		with staff. [Nurse] is doing						
	more follow-up wit	h OT/PT (Occupational						
		herapy)". The QAM						
		lid not find any one particular						
	_	to the falls. The QAM						
	indicated she would provide additional follow-up for: A) investigations for client A's falls, B)							
	, ,							
	medical discharge paperwork for the diagnosis of syncope and C) the interdisciplinary teams (IDTs)							
	meeting minutes.							
	On 6/6/24 at 1:52 PM, the QAM provided							
		p documentation for review.						
		l more follow-up was being						
		IDP to obtain the investigation						
		dent of client A reporting a fall						
		The QAM indicated the QIDP						
		r the week but would provide on once obtained for review.						
	requested informati	on once obtained for review.						
		M, a review was conducted of						
		for client A's 3/24/24 fall with						
	· ·	l discharge paperwork for the						
		ne and C) the interdisciplinary						
	` ,	group home. The review						
	indicated the follow							
	Interest in tonow							
	A) Investigation Su	mmary dated 3/29/24						
		etion: On 3/23/24, [client A]						
		a chair at the kitchen table and						
		using her to fall onto her						
	bottom. [Client A] was able to get up on her own.							
	[Client A] then went to get her bread and							
		a second time onto her						
		again was able to get up on her						
	own. Stall notified	the nurse and assessed [client						

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

Event ID:

7FKA13 Facility ID: 000956

If continuation sheet Page 5 of 29

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	ESURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMP	LETED	
		15G442	B. WING		06/10	0/2024	
		1	STDEE	ET ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	2		EWING LN			
RES CAR	RE COMMUNITY A	LTERNATIVES SE IN		ERSONVILLE, IN 47130			
INLO OAI	L COMMONTT A	ETERMATIVEO OL IIV	, I JEFF	LINGUINVILLE, IIN 47 100		_	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
		ng no visible signs of redness					
	_	ent A] stated her buttock was					
	_	ours later in the day, [client A]					
		y got herself back up when					
		her medicine. [Client A] had					
	no complaints of pa	mi of discomfort					
	Factual Findings: T	he first fall occurred when					
	1	it down in a chair at the kitchen					
		e chair causing her to fall onto					
		A] was able to get up on her					
		ll occurred when [client A]					
	went to get her bread and condiments and onto						
	her bottom. [Client A] again was able to get up on						
	_	ned the nurse and assessed					
	[client A] for injuri	es noting no visible signs of					
	redness or injuries,	but [client A] stated her					
	buttock was sore. A	couple of hours later in the					
	day, [client A] fell a	and immediately got herself					
	_	d to come take her medicine.					
		omplaints of pain or					
		f reported assisting [client A]					
	prior to the falls						
	Fa. 00 1157						
		e was in the med (medication					
		m each time [client A] fell.					
		e was (sic) the restroom when					
		rst two times and had just came					
		[client A] fell the third time.					
		f #6] both stated they assisted					
	ner after the falls ar	nd checked her for injuries					
	[Client A's] 12/202	3 fall risk plan has the following					
	approach:	Jan risk plan has the following					
	* *	stand-by assistance with					
	helping [client A] onto the van Staff will keep the environment free of any						
	obstacles to prevent falls						
	_	e client to wear shoes while					
	ambulating/transfer						
		-	1	Í.		1	

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

Event ID:

7FKA13 Facility ID: 000956

If continuation sheet Page 6 of 29

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/10/2024		
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CO /ING LN	D	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)		COMPLETION DATE
	Staff will ensure that	at [client A] wears walking boot s prescribed by Orthopedic				
	[Client A] attended 3/28/24. Physician/02nd/3rd Metatarsal boney Lisfranc (broweight bearing in becannot walk withou repeat x-rays. If staffractures move, will Staff need to monite ambulating and give stands and gains her Conclusion: It is suffice are risk plans address falls and mesubstantiated [client implemented at the Recommendation: She is ambulating and ensure she stands and ambulating".	Staff to monitor [client A] when and give verbal prompts to and gains her balance before the factual findings, the				
	investigation indica close proximity to c ambulate prior to he indicated staff #5 w	ted staff members were not in client A when she attempted to er falls. The investigation as in the medication				
	staff #6 stated she v client A fell the firs back into the kitche time. Both staff #5	n each time client A fell and was in the restroom when t two times and had just come n when client A fell the third and staff #6 stated they er each of the falls had				

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

Event ID:

 $7 FKA 13 \qquad {\tt Facility \, ID:} \quad 000956$

If continuation sheet

Page 7 of 29

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMP	LETED
		15G442	B. WING		06/10)/2024
			CTDE	ET ADDRESS, CITY, STATE, ZIP CO	<u>-</u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			עכ	
DEC CAE		LTERNATIVES OF IN		EWING LN		
RES CAR	RE COMMUNITY A	LTERNATIVES SE IN	JEFF	ERSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	OULD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	B) Medical Dischar	rge dated 5/16/24 indicated,				
	"Instructions: Change positions slowly and call for help if you begin feeling dizzy. Use ambulatory					
	aids such as cane or	r walker. Get plenty of fluids.				
	Follow-up with new	rologist for further evaluation				
	and management of	f lightheadedness and near				
	syncope. Follow-up	with primary care provider as				
	needed".					
		24 indicated, "Meeting				
		to discuss falls and a potential				
	trend as it relates to the [group home], for					
		ent reports reviewed showed:				
	_	/23 (2024) resulting in a fracture.				
	_	l with follow up recommended,				
	_	aring in a boot and wheelchair.				
		been cleared to ambulate, w/				
		was discussed, she will not be				
		she is released from Ortho				
	_	r). [Client A] had another fall				
	· · ·	which she was wheeling herself,				
	· ·	o the kitchen and told staff she				
		troom. She was transported to				
	the ER					
		taff will have a refresher on				
	` *	plans), specifically as it relates				
	•	nd assisting clients when				
		Iful of environment, such as				
		ning, steps on vans/uneven				
	surfaces, keeping w	valkways cleared, etc				
	The fleesing in the	home was in the mar				
		home was in the process of				
		m Manager) to follow up and areas of the floor that could				
	pose as a potential trip hazard					
	Nouvo (Nouvolo - :	al) consult is set up to sheet				
	,	al) consult is set up to check				
	[chent A's] neurolo	gical status due to periods of				

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

Event ID:

7FKA13 Facility ID: 000956

If continuation sheet Page 8 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		r í	UILDING	instruction 00	(X3) DATE COMPL 06/10 /	ETED	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		402 EW	NDDRESS, CITY, STATE, ZIP COD I'ING LN RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY 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 APPROPRIA DEFICIENCY)	ΤΕ	(X5) COMPLETION DATE
	not responding to staff Ortho was consulted regarding Dexa Scans (bone density) and they stated they didn't feel it was warranted at this time						
	The team agrees to continue OT/PT once released for [client A]						
	AS (Area Supervisor) is checking to ensure all clients have proper fitting shoes and staff are checking shoes to ensure they are being worn properly						
	Nonslip tape/surface will be purchased and placed on the van steps in order to provide extra grip if it's raining or slick. Staff will attempt to get clients off the van 1 by 1, assisting individuals who are a falls risk first".						
	On 6/6/24 at 3:28 PM, the Nurse was interviewed. The Nurse was asked about client A's incident history for falls with injury and her diagnosis of syncope. The Nurse indicated client A was currently in a walking boot and a hard cast had been removed the week prior. The Nurse stated, "They're in hope to put her in a normal shoe. She						
	will not start PT un Physician] did not of Scan". The Nurse in for bone health and (weak bones) had b the year with negati	til released. [Primary Care order a report on the Dexa ndicated a Dexa Scan to review to rule out Osteoporosis een completed previously in ive findings to indicate client					
	client A's diagnosis indicated a referral physician to a neuro process. The Nurse neuro (neurological	s. The Nurse was asked about of syncope. The Nurse from client A's primary care plogist had been made and in stated, "I just want to rule out or seizure activity. Once ary care will send it to us to go					

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

Event ID:

7FKA13

Facility ID: 000956

If continuation sheet

Page 9 of 29

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		15G442	B. W	ING		06/10/	2024
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DES CVE		I TEDNIATIVES SE INI		402 EW	'ING LN RSONVILLE, IN 47130		
	COMMUNITY A	LTERNATIVES SE IN		JEFFER	NOONVILLE, IIN 41 130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		". The Nurse was asked about		TAG	DEFICIENC!)		DATE
	client A's fall risk plan not indicating a risk of syncope to contribute to falls or a syncope risk						
	1	eview. The Nurse indicated a					
	1 ~	ad been developed and would					
	provide a copy for review.						
		ed how the hospital discharge					
	instructions from a syncope diagnosis had been						
	incorporated into client A's fall risk plan. The						
	Nurse stated, "The only difference with (sic)						
	syncope and fall risk is complaints of light headedness or dizzy (sic). I could combine them. It						
	really could have been combined with that. The						
	only thing I see different is the client could report						
		lightheaded". The Nurse was					
	1	ed ambulatory aids. The Nurse					
		ot". The Nurse was asked if					
	other discharge inst	ructions needed incorporated					
		isk plan beside client A's					
		dizzy or lightheaded and need					
		The Nurse stated, "Getting					
		th that's on here (syncope risk					
	1 * /	ater intake. I guess that should					
		ess I should split that (fluid water daily and encourage her					
		4 ounces of water at med					
		istration. I may need to have					
	· ′	ne Fall Risk plan is more along					
		, wearing the boot, assistance					
	_	I could incorporate more of the					
	syncope for dizzy o	r lightheadedness (requesting					
	staff assistance) into	o the falls plan".					
	0 (((04 : 400)	MA C 1 ' C1'					
		PM, a focused review of client					
		e risk plan was conducted. The Friggers to Notify Nurse:					
		ness or lightheaded Expected					
	_] will have no injuries related to					
	_	thru May 2025 Actions: 1)					

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

Event ID:

7FKA13 Facility ID: 000956

If continuation sheet Page 10 of 29

PRINTED: 07/05/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		15G442	B. WING		06/10/2024
NAME OF I	PROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD	
				VING LN	
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN	JEFFE	RSONVILLE, IN 47130	<u> </u>
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		ered, 2) Encourage water			
		medication administration, 3)			
		owly, 4) Staff will encourage if she is feeling dizzy or			
		If will assist as needed when			
		he van, 6) Staff will keep			
		f obstacles that may cause a			
	fall".	obstacles that may cause a			
	1411				
	Based on review of	client A's fall risk plan,			
		nd interview with the Nurse,			
		for the prevention of falls did			
	_	ts of the medical discharge			
		at A to ask for help when			
		ntheaded. The Nurse indicated			
		ient A's fall risk plan and			
	syncope risk plan to	determine if fall prevention			
	should be incorpora	ated as one plan or maintained			
	as two separate plan	ns was needed. The Nurse			
	indicated more deta	il could be developed and			
	added to client A's	risk plan for the prevention of			
	syncope and falls. T	The Nurse indicated more			
	follow-up was being	g pursued to obtain a			
	neurological consul	t to rule out the potential for			
	seizure activity and	any neurological factors that			
	might contribute to	falls and if necessary, revision			
	would be made for	client A's health risk plans.			
	2) On 6/6/24 at 10-2	21 AM, a review of the facility's			
	1 '	ies Services (BDS) reports was			
		iew indicated the following			
	affecting client B:	iew indicated the following			
	arreading entent B.				
	-BDS incident repo	rt dated 4/12/24 indicated,			
	"Staff reported while	le she was preparing meds,			
	_	and reported [client B] had			
		taff went to check on [client B]			
		e floor trying to get up. Staff			
		ay where she was while staff			

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

went and got the phone. When staff returned to

Event ID:

7FKA13 Facility ID: 000956

If continuation sheet Page 11 of 29

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	
		15G442	B. W	VING		06/10/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8		402 EW			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		bhone, [client B] was sitting on					
		ed the nurse and requested					
	she be transported to the urgent care. Plan to						
		was evaluated at the urgent					
	_	to her home. Discharge					
	-	st fall normal exam. Discharge					
	instructions: Fall prevention in the home. [Client B] has a fall risk plan in place that staff are trained						
	-	•					
	on. Staff will remind and encourage [client B] to utilize her call button when she is ready to get up						
		, , ,					
	so staff may assist. [Client B] denies complaints of pain or discomfort. Staff will continue to monitor						
	[client B] and notify the nurse of any changes".						
	[chefit b] and notify the hurse of any changes.						
	No investigation was available for review.						
	-BDS incident repo	rt dated 4/23/24 indicated, "It					
	-	1/24, [client B's] left hand					
	-	[client B] awoke on 4/22/24,					
	her left hand appear	red swollen, and the redness					
	developed into a bri	uise. [Client B] could not say					
	how she injured her	hand. The nurse was notified					
	and requested [clier	nt B] be transported to the					
	urgent care for eval	uation. Plan to Resolve: [Client					
	_	urgent care and discharged to					
	_	e diagnosis: Contusion					
		l, initial encounter, localized					
	_	d, contusion of wrist x-rays					
	_	e. Discharge instructions: Ace					
	*	on and off to help with pain					
		ol as needed for pain, swelling.					
	-	P (primary care physician) in 1					
		en trained on the discharge					
	_	t B] denies complaints of pain					
		will continue to monitor [client					
	B and notify the nu	arse of any changes".					
	No investigation wa	as available for review.					
	-BDS incident repo	rt dated 5/15/24 indicated, "It					

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

Event ID:

7FKA13 Facility ID: 000956

If continuation sheet Page 12 of 29

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	00	COMPL	
		15G442	B. WING			06/10/	2024
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	40	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		DROVINED'S BLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREI	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TA	G	DEFICIENCY)		DATE
	•	side of [client B's] left ankle					
		oruised. [Client B] had not					
	1 -	idents that could result in					
	injuries. The nurse was notified and requested						
	[client B] be transported to the urgent care for						
	evaluation. Plan to Resolve: [Client B] was						
		gent care and discharged to her					
	home. Discharge diagnosis: left foot pain. Imaging						
		findings. Discharge					
		v-up with PCP for further					
	evaluation and treat						
	Tylenol/Motrin as needed for pain/fevers. Make						
	sure patient is drinking plenty of fluids. Return for						
	any new or worsening symptoms. Staff have been trained on the discharge instructions. [Client B]						
		-					
	_	of pain or discomfort. Staff will					
		[client B], follow her plans in					
	prace, and notify th	e nurse of any changes".					
	No investigation wa	as available for review.					
	-BDS incident repo	rt dated 5/16/24 indicated, "It					
	_	neard a noise from [client B's]					
	_	heck and found [client B] on					
		sted [client B] up and into her					
		ited she was not sure why she					
		esting staff assistance. Staff					
	assessed [client B]	for signs of injury noting a					
	small scratch on he	r left knee. The nurse was					
	notified. Plan to Re	solve: Staff assisted [client B]					
		eratch with an alcohol pad and					
		l. [Client B] denied complaints					
	_	ort. Staff will continue to					
		follow her plans in place, and					
	notify the nurse of a	any changes".					
	No investigation wa	as available for review.					
	On 6/6/24 at 11:57	AM, a focused review of client					
		ducted. The review indicated					

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

Event ID:

7FKA13 Facility ID: 000956

If continuation sheet Page 13 of 29

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. WI	ILDING NG	00	COMPL 06/10	
		15G442	B. WI		_	06/10/	2024
NAME OF F	PROVIDER OR SUPPLIEF	8		STREET A	ADDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	the following:	R LSC IDENTIFYING INFORMATION		TAG	DEI ICIENCI I		DATE
	une rone wing.						
	Fall Risk Plan dated	d 5/14/24 indicated, "Problem:					
		Vill have no injuries r/t (related					
		gh) May 2025 Approach: 1.					
		ithin arm's reach of [client B]					
		ensure safety and help prevent					
	falls. 2. Staff will ensure [client B] wears appropriate shoes, tennis shoes, soled shoes or						
	* * *	Staff will ensure [client B] uses					
		staff will remain in the					
		ssistance is needed/requested.					
	4. Staff will keep th	ne environment free of any					
	obstacles to prevent	t falls".					
	Manager (QAM) w asked about client I unknown origin. The did a trend analysis seeing. [Qualified I Professional/QIDP] staff. [Nurse] is doi (Occupational Ther QAM indicated the particular contribute injuries of unknown she would provide to meeting minutes an	PM, the Quality Assurance as interviewed. The QAM was B's falls and injuries of the QAM stated, "We met and and additional training with the proof of the PAM was been what you're the proof of the QAM stated, "We met and additional training with the proof of the proof of the proof of the proof of the falls or the origin. The QAM indicated the interdisciplinary team (IDT) and injuries of unknown					
	additional follow-up The QAM indicated pursued with the Ql investigations into ounknown origin. The	client B's falls and injuries of ne QAM indicated the QIDP r the week and would provide					

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

Event ID:

7FKA13 Facility ID: 000956

If continuation sheet Page 14 of 29

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G442	B. W	NG		06/10/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			/ING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
			<u> </u>		, , , , , , , , , , , , , , , , , , , ,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAU	REGULATORT OF	CESC IDENTIFTING INFORMATION		IAU			DATE
	On 6/6/24 at 1:55 F	PM, a review of the					
		ams (IDTs) meeting minutes for					
	the trend of falls and injuries of unknown origin at						
		s conducted. The review					
	indicated the following:						
	IDT dated 5/31/24 indicated, "Meeting Minutes:						
		falls and a potential trend as it					
		p home], for falls/injuries.					
	-	riewed showed: [Client B]					
	· ·	nout) injury on 4/12 (2024), she					
	~	seat, another slide from the					
		nto staff foot on 4/19 (2024) w/o					
		she fell getting up from her bed.					
	_	ollowed at the time, [client B]					
		ssist when ambulating and she					
	_	which are checked and					
	confirmed to be in	working order					
	Plan of Action: T	he team identified that [client					
		e mattress protector, due to					
		, which may cause the surface					
		tempting to stand from a seated					
		otector will be purchased, of a					
	cloth material, in at	-					
	falls/stumbles/slide	• •					
	Staff will have a re	fresher on HRPs (health risk					
	plans), specifically	as it relates to falls risk plans					
	and assisting client	s when needed, being mindful					
	of environment, suc	ch as slick surfaces if raining,					
	steps on vans/uneve	en surfaces, keeping					
	walkways cleared,	etc					
		home was in the process of					
		m Manager) to follow up and					
		areas of the floor that could					
	pose as a potential	trıp hazard					

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

Event ID:

7FKA13

Facility ID: 000956

If continuation sheet Page 15 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPLETED	
		15G442	B. WING	G		06/10/2024	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 402 EWING LN JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	<u>-</u> _	ID		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PI	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	[Client B] has OT/I	PT and call out to [Physical					
	Therapy Provider]	to set up going forward					
	AS (Area Superviso	or) is checking to ensure all					
	clients have proper fitting shoes and staff are						
		ensure they are being worn					
	properly						
	Nonslip tape/surface will be purchased and placed						
	on the van steps in order to provide extra grip if						
	_	Staff will attempt to get clients					
	_	assisting individuals who are a					
	falls risk first".						
	On 6/6/24 at 3:28 PM, the Nurse was interviewed.						
		ed about client B's incident of					
		ınknown origin. The Nurse					
	1	s a stand-by assist with					
		#5] said [Physical Therapy					
	Provider] is coming	g in the morning to do their					
	initial assessment for	or both [client B] and". The					
	Nurse was asked if	client B was utilizing an alarm					
	to alert staff when a	attempting to ambulate. The					
	Nurse stated, "She	is. She uses it in the bed and					
	they (staff) transfer	it to the chair. She (client B)					
		where she can alert they're					
	needed".						
	Based on review of	the incident history, client B's					
		staff or reported by another					
	· ·	indicates implementation of a					
		client B during ambulation					
	did not occur. The p	pattern of falls and injuries of					
	unknown origin ind	licated the audible alarm/call					
	_	sistance were not effective					
	intervention strateg	ies to prevent fall/injuries.					
	On 6/6/24 at 12:27	PM, the QAM was asked about					
		the abuse, neglect, exploitation,					
	_	r violation of an individual's					

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

Event ID:

7FKA13

Facility ID: 000956

If continuation sheet

Page 16 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE C A. BUILDING B. WING	X3) DATE SURVEY COMPLETED 06/10/2024		
	PROVIDER OR SUPPLIER		402 E\	ADDRESS, CITY, STATE, ZIP COD WING LN	
KES CAI	RE COMMUNITY A	LTERNATIVES SE IN	JEFFE	RSONVILLE, IN 47130	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	falls and injuries of clients A and B. Th of falls and/or injuritrend at the group h 5/31/24 IDT meetin The QAM indicated implemented at all to On 6/10/24 at 10:53 Manager (QAM) wasked about the involved	r as it related to the pattern of unknown origin for both e QAM indicated the pattern des had been identified as a some and the purpose for the g to establish a plan of action. If the ANE policy should be times and stated, "Yes". 6 AM, the Quality Assurance as interviewed. The QAM was estigations for client B's d/or injuries of unknown			
	QAM indicated no	ere available for review. The investigations could not be and stated, "[QIDP] could not			
	ANE policy was co the following: "Res the rights and safety strictly prohibits ab	AM, a review of the 11/10/23 inducted. The review indicated Care staff actively advocate for of all individuals ResCare use, neglect, exploitation, plation of an Individual's			
	9-3-2(a)				
W 0154 Bldg. 00	alleged violations	ave evidence that all are thoroughly investigated.			
	interview for 2 of 3 facility failed to tho	on, record review and sampled clients (A and B), the roughly investigate incidents of unknown origin for clients	W 0154	The Facility will ensure to the QIDP is retrained on thoro completion of investigations at follow ups for all incidents. The Facility will ensure to the area supervisor will retrain staff on the proper implements of the ANE policy to	ugh nd hat all

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

Event ID:

 $7 FKA 13 \qquad {\tt Facility \, ID:} \quad 000956$

If continuation sheet

Page 17 of 29

07/05/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 06/10/2024 15G442 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 402 EWING LN RES CARE COMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 1) An observation was conducted on 6/5/24 from prevent/address the reoccurring 3:32 PM to 4:43 PM. During the observation, client patterns of trends. A wore a hard plastic boot on her right foot. Upon The Facility will ensure that entering the home, client A was seated at the the Nurse will review all HRPs, dining room table with her leg elevated in a chair with focus on Client A's fall HRP. while wearing the boot around her ankle. At 4:23 Syncope will be added to the fall PM, client A participated in the evening meal and risk plan and then nurse will continued to wear the boot on her right foot. retrain the staff on all HRPs. Client A wore the hard plastic boot throughout The Facility will add nonslip the observation period. During this observation, treads to the van steps and the new flooring was observed throughout the interior floor of the van to help with kitchen and dining room. client stability. The Facility staff will be On 6/6/24 at 10:21 AM, a review of the facility's retrained on assisting clients 1 by Bureau of Disabilities Services (BDS) reports was 1 especially those at risk for falls conducted. The review indicated the following when entering and exiting the van. affecting clients A: The Facility will ensure that staff are retrained on giving verbal -BDS incident report dated 5/24/24 indicated, "It prompts to Client A on ensuring was reported [client A] wheeled herself into the she has gained her balance before kitchen and reported to staff she fell while in the trying to ambulate. restroom. Staff noted a knot on [client A's] The Facility will ensure forehead between her eyes at the top of her nose. follow up appointment with a Staff called 911 and [client A] was transported to Neurologist to rule out seizure the ER (emergency room) for evaluation. The activity. nurse was notified. Plan to Resolve: [Client A] The Facility will ensure that was evaluated in the ER and discharged to her the staff are trained on notifying home. Discharge diagnosis: Head injury, adult. No the nurse immediately of all signs of fractures noted. Head injury information incidents regarding falls. sheets were provided. Discharge instructions: Follow-up with PCP (primary care physician) in 2 PERSONS RESPONSIBLE: AED, to 3 days. Staff have been trained on the head Nurse, Director of Nursing, Quality injury information sheets and discharge Assurance Manager, QA instructions. Staff will continue to monitor [client Coordinator/QIDP Manager, A] and notify the nurse of any changes. The ID Program Manager, Area (interdisciplinary) team will meet to discuss Supervisor, QIDP, Direct Support additional measures needed to better assist [client Lead, DSP A]. No further incidents have been reported".

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

No investigation was available for review.

Event ID:

7FKA13

Facility ID: 000956

If continuation sheet

Page 18 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/10/2024		
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP CO VING LN RSONVILLE, IN 47130	D .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	On 6/6/24 at 11:49 A's record was condithe following: Fall Risk Plan dated Risk of Falls Goa falls through June 2 provide stand-by as A] onto the van. 2.5 free of any obstacle encourage the client ambulating/transfer [client A] wears wa prescribed by Orthonotify the nurse of a On 6/6/24 at 12:18 Manager (QAM) wasked if an investigation and injury was avaindicated she would Qualified Intellectus (QIDP) who was out The QAM indicated provided. On 6/10/24 at 10:53 Manager (QAM) wasked about the investigation could and stated, "[QIDP]	AM, a focused review of client ducted. The review indicated 1 6/5/24 indicated, "Problem al: Will have no injury related to 025 Approach: 1. Staff will sistance with helping [client Staff will keep the environment is to prevent falls. 3. Staff will it to wear shoes while ring. 4. Staff will ensure that liking boot while ambulating as opedic specialist. 5. Staff will may falls". PM, the Quality Assurance as interviewed. The QAM was ation into client A's fall with inable for review. The QAM aneed to follow up with the al Disabilities Professional at of the office for the week. It more follow up would be 6 AM, the Quality Assurance as interviewed. The QAM was estigation for client A's fall the QAM indicated an not be provided for review could not find those".			PROPRIATE	
	Bureau of Disabiliti conducted. The revi affecting clients B:	21 AM, a review of the facility's es Services (BDS) reports was ew indicated the following rt dated 4/12/24 indicated,				

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

Event ID:

7FKA13

Facility ID: 000956

If continuation sheet

Page 19 of 29

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		15G442	B. W	ING		06/10	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			/ING LN		
RES CAR		LTERNATIVES SE IN			RSONVILLE, IN 47130		
	TE COMMONTT A	ETERMATIVEO DE IN		JEI I EF	TOOMVILLE, IN 47 100		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	_	le she was preparing meds,					
		and reported [client B] had					
		taff went to check on [client B]					
		e floor trying to get up. Staff					
		ny where she was while staff					
		one. When staff returned to					
		phone, [client B] was sitting on					
	her bed. Staff notified the nurse and requested she be transported to the urgent care. Plan to						
		was evaluated at the urgent					
		to her home. Discharge					
	_	st fall normal exam. Discharge					
		revention in the home. [Client					
	B] has a fall risk plan in place that staff are trained						
	on. Staff will remind and encourage [client B] to						
		on when she is ready to get up					
		[Client B] denies complaints of					
	-	Staff will continue to monitor					
	_	y the nurse of any changes".					
		, ,					
	No investigation wa	as available for review.					
	-BDS incident repo	rt dated 4/23/24 indicated, "It					
	_	21/24, [client B's] left hand					
	_	[client B] awoke on 4/22/24,					
		red swollen, and the redness					
		uise. [Client B] could not say					
	_	hand. The nurse was notified					
	and requested [clien	nt B] be transported to the					
	urgent care for eval	uation. Plan to Resolve: [Client					
	B] was evaluated at	urgent care and discharged to					
	her home. Discharg	e diagnosis: Contusion					
	1 1	l, initial encounter, localized					
		d, contusion of wrist x-rays					
	negative for fracture	e. Discharge instructions: Ace					
	_	on and off to help with pain					
		ol as needed for pain, swelling.					
	_	P (primary care physician) in 1					
	week. Staff have be	en trained on the discharge					
	instructions. [Client	t B] denies complaints of pain					

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

Event ID:

7FKA13 Facility ID: 000956

If continuation sheet Page 20 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPI	LETED
		15G442	B. WI	NG		06/10	/2024
			<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	R			/ING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(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 B CROSS-REFERENCED TO THE APPROPI		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		f will continue to monitor [client					
	B] and notify the n	urse of any changes".					
	No investigation was available for review.						
	-BDS incident report dated 5/15/24 indicated, "It						
	-	side of [client B's] left ankle					
	and foot appeared bruised. [Client B] had not						
	reported falls or incidents that could result in						
	injuries. The nurse was notified and requested						
	[client B] be transp	orted to the urgent care for					
	evaluation. Plan to Resolve: [Client B] was						
	evaluated in the urgent care and discharged to her						
	home. Discharge diagnosis: left foot pain. Imaging						
	_	o findings. Discharge					
		w-up with PCP for further					
	evaluation and trea						
		needed for pain/fevers. Make					
	-	king plenty of fluids. Return for					
	-	ing symptoms. Staff have been					
		narge instructions. [Client B]					
	_	of pain or discomfort. Staff will					
		r [client B], follow her plans in					
	place, and notify th	ne nurse of any changes".					
	No investigation w	as available for review.					
	_	ort dated 5/16/24 indicated, "It					
	•	heard a noise from [client B's]					
		check and found [client B] on					
		sted [client B] up and into her					
		ated she was not sure why she					
		uesting staff assistance. Staff					
		for signs of injury noting a					
		er left knee. The nurse was					
		esolve: Staff assisted [client B]					
	_	cratch with an alcohol pad and					
		d. [Client B] denied complaints					
	-	ort. Staff will continue to					
	monitor [client B],	follow her plans in place, and					

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

Event ID:

7FKA13

Facility ID: 000956

If continuation sheet

Page 21 of 29

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G442	B. WI	NG		06/10/	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	₹			ING LN		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	notify the nurse of	any changes".					
	No investigation wa	as available for review.					
	On 6/6/24 at 11:57	AM, a focused review of client					
		ducted. The review indicated					
	the following:						
		d 5/14/24 indicated, "Problem:					
		Will have no injuries r/t (related gh) May 2025 Approach: 1.					
		ithin arm's reach of [client B]					
		ensure safety and help prevent					
		nsure [client B] wears					
		ennis shoes, soled shoes or					
		Staff will ensure [client B] uses					
		staff will remain in the					
		ssistance is needed/requested.					
		ne environment free of any					
	obstacles to preven	t falls".					
	On 6/6/24 at 12:18	PM, the Quality Assurance					
		as interviewed. The QAM was					
		ons for client B's incidents of					
	_	of unknown origin were					
	available for review	v. The QAM indicated she					
		w up with the Qualified					
	Intellectual Disabil	ities Professional (QIDP) who					
	was out of the offic	e for the week. The QAM					
	indicated more follo	ow up would be provided.					
	On 6/10/24 at 10:53	3 AM, the Quality Assurance					
		as interviewed. The QAM was					
		estigations for client B's					
		nd/or injuries of unknown					
		vere available for review. The					
		investigations could not be					
		and stated, "[QIDP] could not					
	find those".						

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

Event ID:

7FKA13

Facility ID: 000956

If continuation sheet Page 22 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		15G442	B. WI	NG		06/10	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD	<u> — </u>	
NAME OF 1	PROVIDER OR SUPPLIE	R			WING LN		
RES CAI	RE COMMUNITY A	ALTERNATIVES SE IN			RSONVILLE, IN 47130		
TILO O/II	TE GOIMMONT 7	CIEINA (TIVEO GE IIV		OLI I L	TOOM TELE, IN 47 100		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	9-3-2(a)						
NV 0040	400 440()(0)(')						
W 0240	483.440(c)(6)(i)						
Dida 00	INDIVIDUAL PRO						
Bldg. 00	1	ogram plan must describe					
		tions to support the individual					
	toward independ	ion, record review and	111.0	240	The Facility will ansure t	hat	07/01/2024
		3 sampled clients (A), the facility	l w c	240	The Facility will ensure t the Nurse will review all HRPs		07/01/2024
		ent A's fall risk plan			with focus on Client A's fall H		
		sk of syncope (loss of			Syncope will be added to the		
	_	d medical discharge			risk plan and then nurse will	ıaıı	
	instructions.	a medicar disenarge			retrain the staff on all HRPs.		
	mor actions.				The Facility will add non	ıslin	
	Findings include:				treads to the van steps and th	-	
					interior floor of the van to help		
	An observation wa	s conducted on 6/5/24 from			client stability.	*******	
		M. During the observation, client			The Facility staff will be		
		stic boot on her right foot. Upon			retrained on assisting clients	1 bv	
	_	client A was seated at the			1 especially those at risk for fa	-	
		with her leg elevated in a chair			when entering and exiting the		
		boot around her ankle. At 4:23			The Facility will ensure t		
		cipated in the evening meal and			staff are retrained on giving ve		
	continued to wear	the boot on her right foot.			prompts to Client A on ensuring		
	Client A wore the	hard plastic boot throughout			she has gained her balance b	efore	
	the observation per	riod. During this observation,			trying to ambulate.		
	new flooring was o	observed throughout the			The Facility will ensure		
	kitchen and dining	room.			follow up appointment with a		
					Neurologist to rule out seizure)	
		AM, a review of the facility's			activity.		
	Bureau of Disabili	ties Services (BDS) reports was			The Facility will ensure t	:hat	
		view indicated the following			the staff are trained on notifyir	ng	
	affecting client A:				the nurse immediately of all		
					incidents regarding falls.		
	_	ort dated 3/24/24 indicated, "It			The Facility will ensure t		
		nt A] went to sit down in a chair			the Nurse will review all HRPs		
		and missed the chair causing			with focus on Client A's fall Hi		
		bottom. [Client A] was able to			Syncope will be added to the	fall	
		[client A] then went to get her			risk plan and then nurse will		
I	bread and condime	ents and fell a second time onto	I		retrain the staff on all HRPs.		

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

Event ID:

7FKA13

Facility ID: 000956

956 If continuation sheet

Page 23 of 29

07/05/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 06/10/2024 15G442 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 402 EWING LN RES CARE COMMUNITY ALTERNATIVES SE IN JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE

her bottom. [Client A] again was able to get up on her own. Staff notified the nurse and assessed [client A] for injuries noting no visible signs of redness or injuries, but [client A] stated her buttock was sore. A couple of hours later in the day, [client A] fell and immediately got herself back up when called to come take her medicine. [Client A] had no complaints of pain or discomfort. Staff notified the nurse who requested [client A] be transported to the ER (emergency room) for evaluation. Plan to Resolve: [Client A] was evaluated in the ER and discharged to her home. Discharge diagnosis: Lisfranc (bones in midfoot) fracture right foot ... Discharge instructions: Referral to [Medical Provider Name] within 1 week. Non-weight bearing in boot and wheelchair. Follow-up primary care upon discharge for visit today. Staff have been trained on discharge instructions. Staff will continue to monitor [client A], ensure she follows all instructions, attends all follow-up appointments, and will notify the nurse of any changes".

-BDS incident report dated 5/17/24 indicated, "It was reported [client A] had her head down and was not responding to staff when they called her name. Staff called 911 and [client A] was transported to the ER (emergency room) for evaluation. The nurse was notified. Plan to Resolve: [Client A] was evaluated in the ER and discharged to her home. Discharge diagnosis: Syncope (loss of consciousness), lightheadedness. Labs completed ... Discharge Instructions: Continue taking previously prescribed medications as directed. Change positions slowly and call for help if you begin feeling dizzy. Use ambulatory aid such as cane or walker. Get plenty of fluids. Follow-up with neurologist for further evaluation and management of lightheadedness and near

The Facility will add nonslip treads to the van steps and the interior floor of the van to help with client stability.

The Facility staff will be retrained on assisting clients 1 by 1 especially those at risk for falls when entering and exiting the van.

The Facility will ensure that staff are retrained on giving verbal prompts to Client A on ensuring she has gained her balance before trying to ambulate.

The Facility will ensure follow up appointment with a Neurologist to rule out seizure activity.

The Facility will ensure that the staff are trained on notifying the nurse immediately of all incidents regarding falls.

PERSONS RESPONSIBLE: AED,

Nurse, Director of Nursing, Quality Assurance Manager, QA Coordinator/QIDP Manager, Program Manager, Area Supervisor, QIDP, Direct Support Lead, DSP

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2024	
NAME OF I	PROVIDER OR SUPPLIE	.		ET ADDRESS, CITY, STATE, ZIP COD EWING LN	•	
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		FERSONVILLE, IN 47130		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO	OBE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	physician) as needed worsening symptor the discharge instru- monitor [client A], notify the nurse of	with PCP (primary care and Return to the ER for new or ans. Staff have been trained on actions. Staff will continue to follow her plans in place, and any changes. No further				
	incidents have been	reported".				
	_	ort dated 5/24/24 indicated, "It t A] wheeled herself into the				
		d to staff she fell while in the				
		ed a knot on [client A's]				
		er eyes at the top of her nose. [client A] was transported to				
	the ER for evaluation. The nurse was notified.					
	Plan to Resolve: [Client A] was evaluated in the					
	ER and discharged	to her home. Discharge				
		ury, adult. No signs of				
		ad injury information sheets				
	_	charge instructions: Follow-up				
		care physician) in 2 to 3 days.				
		ined on the head injury				
		and discharge instructions. to monitor [client A] and notify				
	the nurse of any ch	= = = =				
	I	eam will meet to discuss				
		s needed to better assist [client				
		dents have been reported".				
		AM, a focused review of client				
	A's record was conthe following:	ducted. The review indicated				
		d 6/5/24 indicated, "Problem				
		al: Will have no injury related to				
	_	2025 Approach: 1. Staff will				
		ssistance with helping [client				
	1 -	Staff will keep the environment				
	encourage client to	es to prevent falls. 3. Staff will wear shoes while				

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

Event ID:

7FKA13 Facility ID: 000956

If continuation sheet Page 25 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G442		(X2) MULTIPLE CO A. BUILDING B. WING	·			
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	402 EV	ADDRESS, CITY, STATE, ZIP CO VING LN RSONVILLE, IN 47130	D	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
mo	ambulating/transfer [client A] wears wa prescribed by Ortho notify nurse of any -No syncope health	ring. 4. Staff will ensure that lking boot while ambulating as opedic specialist. 5. Staff will	TAG .			DATE
	Manager (QAM) wasked about client AQAM stated, "We're seen what you Intellectual Disability additional training was more follow-up with Therapy/Physical Tindicated the team of contributing factor indicated she would	PM, the Quality Assurance as interviewed. The QAM was a half with injuries. The net and did a trend analysis. But the seeing. [Qualified ties Professional/QIDP] did with staff. [Nurse] is doing the OT/PT (Occupational herapy)". The QAM did not find any one particular to the falls. The QAM a provide additional follow-up ge paperwork for the diagnosis				
	medical discharge p syncope. The review "[Client A's] 12/202 following approach 'Staff will provide s helping [client A] o Staff will keep the cobstacles to prevent Staff will encourage ambulating/transfer Staff will ensure the while ambulating as specialist'	tand-by assistance with nto the van environment free of any falls e client to wear shoes while ring at [client A] wears walking boot s prescribed by Orthopedic				
	[Client A] attended	her follow-up appointment on				

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

Event ID:

7FKA13 Facility ID: 000956

If continuation sheet Page 26 of 29

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
15G442		15G442	B. W	ING		06/10	/2024
),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	NOVEMBER OF STREET			STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF PROVIDER OR SUPPLIER				402 EW	/ING LN		
RES CARE COMMUNITY ALTERNATIVES SE IN				JEFFERSONVILLE, IN 47130			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			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 DEFICIENCY)	ROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEI IOLENOT?		DATE
	3/28/24. Physician/Consultant Orders: Right 2nd/3rd Metatarsal (bones in foot) base fractures -						
	boney Lisfranc (broken foot) injury. Can weight						
		short distances only - cannot					
	walk without boot. Recheck in 2 weeks for repeat						
	x-rays. If stable, the	en no surgery. If fractures					
	move, will need surgery for fractures						
	Staff need to monitor [client A] when she is						
	ambulating and give verbal prompts to ensure she						
	stands and gains her balance before ambulating						
	Conclusion: It is substantiated [client A] fell and						
	there are risk plans in place which appropriately						
	address falls and m	etatarsal fractures. It is					
	substantiated [client A's] fall risk plans were being						
	implemented at the time of each fall						
	Recommendation: Staff to monitor [client A] when						
	she is ambulating a	nd give verbal prompts to					
	ensure she stands a	nd gains her balance before					
	ambulating".						
	_	dated 5/16/24 indicated,					
		ange positions slowly and call					
		n feeling dizzy. Use ambulatory					
		r walker. Get plenty of fluids.					
		prologist for further evaluation					
		f lightheadedness and near with primary care provider as					
		ommendations for changing					
		d to call for help if feeling					
		nbulatory aids, and drinking					
		re not incorporated into client					
	A's fall risk plan.	•					
	On 6/6/24 at 3:28 P	PM, the Nurse was interviewed.					
		ed about client A's fall risk plan					
		k of syncope to contribute to					
		isk plan available for review.					

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

Event ID:

7FKA13 Facility ID: 000956

If continuation sheet Page 27 of 29

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

PRINTED: 07/05/2024 FORM APPROVED OMB NO. 0938-039

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G442	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/10/2024	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	•	
RES CARE COMMUNITY ALTERNATIVES SE IN				WING LN		
	1			ERSONVILLE, IN 47130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRE DD FFIY (EACH CORRECTIVE ACTION SHO		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPR DEFICIENCY)		OMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION The Name indicated a symposic plan had been		TAG	Barrelater		DATE
	The Nurse indicated a syncope risk plan had been developed and would provide a copy for review.					
	as verspea and wes	,				
	The Nurse was ask	ed how the hospital discharge				
	instructions from a	syncope diagnosis had been				
	_	lient A's fall risk plan. The				
		only difference with (sic)				
		sk is complaints of light				
		y. I could combine them. It seen combined with that. The				
		ferent is the client could report				
		r lightheaded". The Nurse was				
	· ·	sed ambulatory aids. The Nurse				
		ot". The Nurse was asked if				
	other discharge ins	tructions needed incorporated				
	into client A's fall 1	risk plan beside client A's				
		g dizzy or lightheaded and need				
		. The Nurse stated, "Getting				
		ah that's on here (syncope risk				
		vater intake. I guess that should				
		ess I should split that (fluid				
		water daily and encourage her 4 ounces of water at med				
		nistration. I may need to have				
	1	The Fall Risk plan is more along				
		g, wearing the boot, assistance				
		I could incorporate more of the				
		or lightheadedness (requesting				
	staff assistance) int	to the falls plan".				
	On 6/6/24 at 4:30	PM, a focused review of client				
		be risk plan was conducted. The				
		Triggers to Notify Nurse:				
		iness or lightheaded Expected				
	•	A] will have no injuries related to				
		thru May 2025 Actions: 1)				
		lered, 2) Encourage water				
		medication administration, 3)				
		lowly, 4) Staff will encourage				
	[client A] to report	if she is feeling dizzy or				

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

Event ID:

7FKA13 Facility ID: 000956

If continuation sheet Page 28 of 29

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
15G442		B. WING		06/10/2024			
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	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		
	getting on and off the environment free of fall". Based on review of syncope risk plan and client A's risk plan and not indicate the medicate that the syncope risk plan and the syncope risk plan a	was being pursued and any would be made for client A's cited on 1/19/24. The facility a systemic plan of correction					
	9-3-4(a)						
)-3 -4 (a)						
W 9999							
Bldg. 00			W 9999	no response required		07/01/2024	

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7FKA13 Facility ID: 000956 If continuation sheet Page 29 of 29