PRINTED: 03/18/2024 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G175			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/05/2024
	PROVIDER OR SUPPLIE	LTERNATIVES SE IN	3607 M	ADDRESS, CITY, STATE, ZIP COD IIDDLE RD RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	(X5) COMPLETION DATE
W 0000	REGELITORI	RESCRIPENTIAL TRANSPORTER	Ind		BITE
Bldg. 00	recertification and visit included the in #IN00425498 and in Complaint #IN0042	pre-determined full annual state licensure survey. This avestigation of complaints #IN00426041.	W 0000		
	at: W186 and W214 Complaint #IN004 deficiencies related at: W186 and W214 Survey dates: 1/29/ 2/2/24 and 2/5/24. Facility Number: 0 Provider Number:	0. 26041: Federal and state to the allegation(s) are cited 0. 24, 1/30/24, 1/31/24, 2/1/24, 00709 15G175			
W 0126 Bldg. 00	accordance with 46 Quality Review of on 2/19/24. 483.420(a)(4) PROTECTION Of The facility must eclients. Therefore individual clients that affairs and teach of their capabilities.	also reflect state findings in to IAC 9. this report completed by #15068 F CLIENTS RIGHTS ensure the rights of all e, the facility must allow to manage their financial them to do so to the extent s.			
	Based on record resampled clients (A. clients (D, E and F. clients A, B, C, D,	wiew and interview for 3 of 3 B and C) and 3 additional b, the facility failed to ensure E and F had the opportunity to ds during their community	W 0126	The facility will ensure individual clients to the right to manage their financial affairs teach them to do so to the ext of their capabilities.	and

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

TITLE (X6) DATE

Mark Slaughter AED 03/04/2024

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.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) Da			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPI			ETED	
		15G175	B. W	ING		02/05/	/2024
		l .	<u> </u>	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			IDDLE RD		
RES CAE	RE COMMINITY A	LTERNATIVES SE IN			RSONVILLE, IN 47130		
INLO OAI	L COMMONTT A	ETERMATIVES SE IIV		JEI I EI	TOOMVILLE, IN 47 100		
(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	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	outings.				The QIPD will update CI	FA	
					and develop a formal money		
	Findings include:				management goal to teach cli	ents	
					in the facility to manage their		
		PM, a review of clients A, B, C,			finances to the best of their		
		on hand personal finances was			capabilities.		
		iew indicated clients A, B, C,	1		Goals will be updated ba	ased	
		a zero balance for their January			on the QIDP assessment		
	_	ers and none of the clients had	1		developing a formal money		
		counting. At 4:34 PM, the			management goal to teach cli	ents	
Qualified Intellectual Disabilities Professional				in the facility to manage their			
(QIDP) was asked when was the last time clients					finances.		
A, B, C, D, E and F had gone to the community to				The QIDP will review all			
		l funds. The QIDP indicated			Clients CFAs and make updat	tes	
		nt spend downs from their			to the ISP based on		
	· ·	Fund Management System)			recommendations from the ID		
	-	P was asked about the clients'		comprised of para-professionals.			
	_	rs and when those ledgers			QIDP will update The IS		
		ty to spend personal funds in			(Individual Support Plan) base	ed on	
	I -	e QIDP stated, "September of			assessment.		
	last year (2023)".				The QIDP will retrain all	staff	
					in the facility on updated ISP.		
		AM, a review of the clients A,			A member of the		
		RFMS accounting was			Administrative team will condu		
		iew indicated the following			monthly site reviews for all clie		
		mmunity outings with			in facility and the administrato	r will	
	opportunity for spe	nding personal finances:			hold a weekly ICF meeting to		
		unct the color of the color			discuss issues that arise in the	е	
		"Christmas Shopping" with a			facility.		
	debit of \$135.63.						
		'Winter Clothes" with a debit of					
		23 "Christmas Shopping" with a			Persons Responsible: AED,	~ *	
	debit of \$201.93.				Quality Assurance Manager, (JA	
		transactions from his RFMS			Coordinator/QIDP Manager,		
	account.	unct the left to the test			Program Manager, Area		
		"Christmas Shopping" with a			Supervisor, QIDP, Direct Supp	port	
	debit of \$171.40.	ng 15 n vi 11 o			Lead, and DSP.		
		"Spend Down" with a debit of					
		3 "[Online Retailer] Clothes"	1				
	with a debit of \$314	4.19, 12/26/23 "Christmas	1				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETE			LETED
		15G175	B. WI	NG		02/05/2024	
				CED FEET	ADDRESS STEV STATE TIP SOD		
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
DE0 045	DE OOMAN IN INT. / A	1 TEDNIA TIV (EQ. QE IN			IDDLE RD		
RES CAR	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Shopping" with a d	ebit of \$170.85 and 1/29/24					
	"Spend Down" with	h a debit of \$1,000.00.					
	Client F - 10/30/23	"[Online Retailer] Shopping"					
	with a debit of \$447	7.95 and 12/26/23 "Christmas					
	Shopping" with a d	ebit of \$157.74.					
		PM, the QIDP was interviewed.					
	-	ed about clients A, B, C, D, E					
		ts and if any of the indicated					
		participation of the clients with					
		funds in the community. The					
	-	personal funds for the spend					
		ot cash on hand sent to the					
		ccounted within the cash on					
	_	ers and client personal use.					
	1	d a list of items to purchase					
		ith the staff for client needs.					
	The QIDP was aske						
		accounting of their receipts of					
		ses was available for review.					
	1	No. [Client D] is the only one					
		the community. He'll go into					
	· ·	ou what he wants. I'm not sure					
		ularity. He has in the past".					
	-	ed about the development of					
	1	ases for the clients were all					
		OIDP indicated the clients					
		e team leader to include input					
		the development of the list and					
	1	ot go shopping for their					
		here is concern for taking					
		nt C] in the community because					
		The QIDP indicated clients B					
		rch activities on the weekend					
		er but based upon the cash on					
		ers and the debit accounting					
		counts, opportunities to spend					
	l -	not occurred since September					
		indicated clients A, B, C, D, E					
	and F did not have:	money management objectives					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED			
		15G175	B. WING		02/05/2024
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD JEFFERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPROPR	
W 0186 Bldg. 00	for participation and personal funds. The had a basic money ridentifying coins. The was needed to ensure program plans had opersonal funds in the 9-3-2(a) 483.430(d)(1-2) DIRECT CARE STATE The facility must personal funds in the second control of the personal funds in the second control of the facility must personal funds in the second control of the facility must personal funds in the second control of the facility must personal funds in the second control of the facility must personal funds in the second control of the facility must personal funds in the facil	d opportunity to spend QIDP indicated only client A management objective for he QIDP indicated follow up re clients A, B, C, D, E and F's opportunities for spending e community.			
	accordance with the plans. Direct care staff and on-duty staff calculars. 24-hour period for living unit. Based on record revisampled clients (A and (D), the facility failuresources were depleted in an incident of client requiring medical and had not occurred, 20 unattended while in client-to-client aggrep. Findings include: On 1/30/24 at 9:16 and Bureau of Disabilities accompanying investigations.	re defined as the present plated over all shifts in a each defined residential riew and interview for 2 of 3 and C) and 1 additional client ed to ensure sufficient staffing oyed appropriately to prevent: ent A obtaining leftover foods attention to ensure aspiration of client D's fall while being left the bathroom, and 3) a ression between clients C and AM, a review of the facility's es Services (BDS) reports and stigation summaries was ew indicated the following	W 0186	The facility will provide sufficient direct care staff to manage and supervise clien accordance with their individe program plans. The Operations Team conduct a weekly meeting to project needs and plan cover for open shifts with Human Resources until proper staffications are maintainable. Human Resources has made filling Middle Road ICI shifts a priority, this will contruct until vacancies are filled. The Area Supervisor was coordinate with Direct Support Leads to ensure shift coverage.	ts in ual will rage ng F open inue vill ort ge. All

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00		COMPLETED	
		15G175	B. WI	NG		02/05/	2024
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		3607 M	ADDRESS, CITY, STATE, ZIP COD IDDLE RD RSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	<u> </u>	ID			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1) BDS incident rep	port dated 9/1/23 indicated, "It			Program Manager.		
		vas getting [client A] to come			A weekly report is being		
		tion when she found [client A]			provided to the hiring manage	r that	
	_	eftover food. [Client A] is on a			will identify open positions and	t	
	1 ~	as able to get [client A] to spit			forecast staff gains and losses	S.	
		nes. [Client A] started to vomit			A member of the		
		ting finger sweeps. The nurse			Administrative Team will cond		
		dvised staff to transport			monthly site reviews for all clie		
		(emergency room) for			in facility and the administrato	r will	
		Resolve: [Client A] was			hold a weekly ICF meeting to		
	evaluated and released with discharge paperwork				discuss issues that arise in the	Э	
	for Aspiration Precautions, Adult. Staff will				facility		
		[client A] for signs of					
		t all signs and symptoms to					
	the nurse".						
					Persons Responsible: Program	n	
	1	ary dated 9/1/23 indicated,		Manager, Human Resources,			
		dent: Staff went to find [client		Quality Assurance, Area			
		e kitchen eating the leftover			Supervisor, QIPD, DSL,		
		. [Client A] started to cough.			Residential Manager, Human		
		food out of his mouth. He			Resource Assistant, and DSP		
		he staff weren't sure all the					
	~	mouth. The nurse indicated to					
		(emergency room) to check for					
		Witness Statements					
	`	olved in the incident and list their name(s) and include their					
	_	eader] 9/1/23 Where were					
		was in the kitchen? I was to find him and he was in the					
	_	ing out of the pans/bowls of					
		clusion: The client choked and					
		esent due to not putting					
		re starting med (medication)					
		tions: The staff will be					
	1 ^	Food away after the meal to					
	_	ient access and choking					
	possibilities".	tont access and choking					
	Possionnies .						
	On 2/1/24 at 3:45 P	M. the Oualified Intellectual					

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 15G175	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/05/2024
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	3607 M	ADDRESS, CITY, STATE, ZIP COD IIDDLE RD RSONVILLE, IN 47130	į.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Disabilities Professional (QIDP) was interviewed. The QIDP was asked about staff deployment during client A's incident of obtained leftover food items which required medical attention to ensure client A had not aspirated. The QIDP indicated deployment of staffing was a recommended area of review for training from the investigation. The QIDP stated, "Yeah, that should be reviewed as to where they are in the home". The QIDP was asked how staff should be deployed. The QIDP stated, "Checking on them and nearby frequently checking". 2A) BDS incident report dated 10/16/23 indicated, "It was reported [client D] was on his way to the laundry room when he fell to the floor. Staff completed skin assessment and found a ½ inch abrasion on his left knee. Staff assisted [client D] from the floor. A little later [client D] went to his bedroom when he fell to the floor. Staff completed skin assessment and found no new injuries. Staff contacted the nurse and was instructed to transport [client D] to the ER for evaluation. Plan to Resolve: [Client D] was evaluated and had labs and urinalysis completed with normal results. X-ray of left knee was completed with no sign of fracture [Client D] was advised to take Tylenol as needed for pain. [Client D] was released to return to the group home". 2B) BDS incident report dated 10/18/23 indicated, "It was reported staff heard a noise in the bathroom and went to see what had happened. Staff found [client D] sitting on the floor and he told staff he had fallen off the toilet. Staff assisted [client D] from the floor and completed skin assessment. [Client D] sustained a 1-inch bruise and a 3/8-inch abrasion on his right hip. Nurse was contacted and instructed staff to take [client D] to the ER (emergency room) for evaluation.			

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER 15G175		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/05/2024	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	3607 N	ADDRESS, CITY, STATE, ZIP COD MIDDLE RD 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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	D BE COMPLETION	
	Plan to Resolve: and Flu A/B PCR (1 [Client D] tested por generalized weakness with prescriptions of and Acetaminopher D] will isolate in his Disease Control and followed. ResCare in needed supports". Investigation summation 10/17/23 indicated, falls within a 48-ho at 7AM, he fell on the and got a small scramothing in his path. D] had a fall in his sway. He was taken 10/17/23, [client D] hands on his head a had a small scramp (some the tested Conclusion: The some clients in the bata are on the toilet. Durupdate his risk plant be retrained to check in the restroom". On 2/1/24 at 3:45 P Disabilities Profess The QIDP was asked during client D's indicated client D in following three fall: 10/17/23. The QIDI reviewed as to when	[Client D] also had Covid-19 test for virus) swab completed. sitive for Covid-19 and has ass. [Client D] was released for Ibuprofen (pain reliever) a (pain and fever relief). [Client as room. All CDC (Center for a Prevention) guidelines will be management will provide all ary dated 10/15/23 through "Introduction: [Client D] had 3 tur period of time. On 10/15/23 the way to the laundry room the on his knee. There was On 10/15/23 at 8:30AM, [client troom. There was nothing in his to the Urgent Care On fell off the toilet. He put his and indicated he felt dizzy. He ic) and bleeding on his left hip. To check for neurology positive for Covid staff will be retrained to check throom frequently when they the to these falls, the nurse will a Recommendations: Staff will be not he clients while they are M, the Qualified Intellectual tional (QIDP) was interviewed. The dabout staff deployment be deducted positive for Covid-19 as between 10/15/23 through the staff should be deployed.				

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	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	3607 M	ADDRESS, CITY, STATE, ZIP COI IDDLE RD RSONVILLE, IN 47130)	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREGEACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
		Checking on them and nearby				
	"[Client C] came of on the right bicep. So for injuries. Plan to redness, the size of bite did not break the follow plans in place. Investigation Summer "Introduction: It was assurance) on 11/2 [team leader] to let come into the living bicep. [Team leader] (medications) ready. The skin on [client nurse was notified, to his room after the further issues Coanother staff in the doing meds, this ince the doing meds, this ince the doing meds, this ince the doing meds and mealt support". On 2/1/24 at 3:45 P Disabilities Profess: The QIDP was asked during clients C and aggression. The QII should be deployed on them and nearby QIDP indicated dep	hary dated 12/1/23 indicated, is reported to QA (Quality 4/23, [client D] came to staff ther know that [client C] had groom and bit him on the right of had been getting meds in the med room for med pass. D's] arm was not broken. The and [client C] had gone back incident. There were no inclusion: If there had been thome while [team leader] was eident may have been avoided. Two staff be available during times to provide necessary M, the Qualified Intellectual fonal (QIDP) was interviewed. In D's incident of client-to-client DP was asked how staff. The QIDP stated, "Checking frequently checking". The cloyment of staffing should be ment program plans to prevent				
	This federal tag rela	ites to complaint #IN00426041				

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AND PLAN OF CORRECTION DENTIFICATION NUMBER 1, WIND COMPLETED 02/05/2024	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVI					
RES CARE COMMUNITY ALTERNATIVES SE IN ONLY ID SUMMARY STATEMENT OF DEFICIENCIE PREITY (HACH DEPICIENCY MUST BE PRECEDED BY PULL TAG REGULATORY OF DESCRIBINITY VING INFORMATION And #IN00425498. 9-3-3(a) W 0210 483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments are assessments as needed to supplement the preliminary evaluation. Conducted prior to admission. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A was reassessed for environmental supports to ensure his health and safety with access to unsecured cleaning products. Findings include: Observations were conducted on 1/29/24 from 3:12 PM to 6:03 PM, on 1/30/24 from 5/29 M to 6:48 PM. During observations, Client A was not in the home on 1/29/24 daring observations. Client A had been admitted to the hospital due to being pate in color and unresponsive with the musing staff over the previous weekend. On 1/29/24 at 3:44 PM, the Qualified intellectual Disabilities Professional (QIDP) was asked about client A's admission to the hospital. The QIDP indicated further testing was beging completed and all results had been negative findings, but client A was going to stay in the hospital of ma additional day for further observation and testing. The QIDP indicated the interdisciplinary team had discussed the possibility of a move to another residential setting with less housemates and more one to one staffing due to client A's recent decline in health	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G175					
RES CARE COMMUNITY ALTERNATIVES E IN IXA D SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION AS 3.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A was reassessed for environmental supports to ensure his health and safety with access to unsecured cleaning chemicals and/or cleaning products. Findings include: Observations were conducted on 1/29/24 from 3:12 PM to 6:35 PM, on 1/30/24 from 7:40 Z AM to 8:05 AM, and on 1/31/24 from 5:47 PM to 6:48 PM. During observations, client A was not in the home on 1/29/24 and 1/30/24 during observations. Client A had been admitted to the hospital due to being pale in color and unresponsive with the unusing staff over the previous weekend. On 1/29/24 at 3-34 I PM, the Qualified intellectual Disabilities professional (QIDP) was asked about client A's admission to the hospital. The QIDP indicated the interdisciplinary team additional day for further observation and testing. The QIDP indicated the interdisciplinary team additional day for further observation and testing. The QIDP indicated the interdisciplinary team additional day for further observation and testing. The QIDP indicated the interdisciplinary team additional day for further observation and testing. The QIDP indicated the interdisciplinary team additional day for further observation and distinguished to ever the observation and testing. The QIDP indicated the interdisciplinary team additional day for further observation and testing. The QIDP indicated the interdisciplinary team additional day for further observation and testing. The QIDP indicated the interdisciplinary team additional day for further observation and testing. The QIDP indicated the interdiscipli			100170	B. W			02/03	12024
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indicated the interdisciplinary team had discussed the possibility of a move to another residential setting with less housemates and more one to one staffing due to client A's recent decline in health discuss issues that arise in the facility							r WIII	
the possibility of a move to another residential setting with less housemates and more one to one staffing due to client A's recent decline in health			- ·			,	•	
setting with less housemates and more one to one staffing due to client A's recent decline in health							=	
staffing due to client A's recent decline in health						lacility		
		-						
L DEREVEG TO DE LETATEU TO HIS GENERITA. CHERLA		_						

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

PRINTED: 03/18/2024 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G175	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/05/2024	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		3607 M	ADDRESS, CITY, STATE, ZIP COD IDDLE RD RSONVILLE, IN 47130		
				<u> </u>			
(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		R LSC IDENTIFYING INFORMATION		TAG			DATE
	was discharged and returned to the group home during the afternoon hours on 1/30/24.				Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Nurse,	im	
	On 1/31/24 from 5:	47 PM to 6:48 PM, client A was			DSP.		
		home. The cabinets above					
		er were unlocked and					
	-	aning chemicals and/or					
		These cabinets with cleaning					
	chemicals and/or cl	eaning products remained					
	unlocked and unsec	cured throughout all					
	observation periods during the week. At 6:00 PM,						
	staff #10 was asked how client A was doing since						
	his discharge from the hospital. Staff #10 stated,						
	"Better. He does love to eat". Staff #10 prepared						
	client A's food in a	processor and stated, "He's a					
	_	what this machine is. It helps					
	_	Staff #10 was asked about					
	-	to prevent him from eating					
		according to his dining plan					
		to consume. Staff #10					
	_	erator had an audible alarm and					
	-	n it. It will tell you. It's loud					
	-	". Staff #10 indicated client A					
		g to ensure his health and					
		od and beverage consumption.					
		DP was asked about the					
		cured cabinets above the					
		rith cleaning chemicals, client					
	-	zation and the indication of a					
		is dementia, and the overall					
		rith having access to chemicals arm system had been installed					
		door to alert staff when					
		indicated no approval had					
		ck and secure cleaning					
		e had been for the installation					
		on the refrigerator. The QIDP					
		sessment of client A's health					
		ng access to chemicals and/or					
	cleaning products v						
	Products v						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G175	A. BUILDING B. WING	00	COMPLETED 02/05/2024	
			STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIEF			IDDLE RD		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	JEFFE	RSONVILLE, IN 47130	•	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E		
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE COMPLETION DATE	
	Bureau of Disabiliti accompanying inveconducted. The revaffecting client A: -BDS incident repowas reported staff vand take his medicate the stove eating I pureed diet. Staff wout food several times staff was complewas contacted and a [client A] to the ER evaluation. Plan to evaluated and releasor for Aspiration Precontinue to monitor aspiration and report the nurse". Investigation summers "Staff went to find kitchen eating the Ic [Client A] started to food out of his moustaff weren't sure al mouth. The nurse in (emergency room) Conclusion: The not present due to no before starting med Recommendations: put all food away a potential client acce.	AM, a review of the facility's ies Services (BDS) reports and stigation summaries was iew indicated the following In the dated 9/1/23 indicated, "It was getting [client A] to come attion when she found [client A] eftover food. [Client A] is on a was able to get [client A] to spit where. [Client A] started to vomit thing finger sweeps. The nurse advised staff to transport. (emergency room) for Resolve: [Client A] was seed with discharge paperwork autions, Adult. Staff will was seed with discharge paperwork autions, Adult. Staff will was seed with discharge paperwork autions, Adult. Staff will was seed with discharge paperwork autions, Adult. Staff will was seed with discharge paperwork autions, Adult. Staff will was seed with discharge paperwork autions, Adult. Staff will be felious for the staff got lots of the staff of the staff got lots of the staff got lots of the staff got lots of the staff got out of his dicated to take him to the ER to check for possible aspiration client choked and the staff was not putting leftovers away (medication) pass. The staff will be retrained to fter the meal to prevent was and choking possibilities". PM, the Nurse was interviewed. and about client A's recent				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G175		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/05/2024	
	RE COMMUNITY A	TERNATIVES SE IN	3607 M	ADDRESS, CITY, STATE, ZIP COD IIDDLE RD RSONVILLE, IN 47130	•
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFECTION OF THE APPROPRIED OF THE	LD BE COMPLETION COMPLETION
TAG	hospitalization and related to his demer PCP (primary care per (psychiatrist) said hospitalization other appointments with leading of the property of the prop	the indication of a decline tia. The Nurse stated, "The ohysician) and psych is dementia is progressing and d do a med (medication) ne changing his medications he decline. They said it was Nurse indicated no new orders re client A's recent or than further follow up his primary care, Pulmonary curology (brain/nervous) PM, a review of client A's red. The review indicated the Plan (ISP) dated 7/16/23 al Profile: He (client A) has dealing with issues related to redisciplinary team has rehensive assessments and his time, due to the level of required and his inability to to other environments or s in need of continued re treatment services. The was discussed with [client resed other placement, waiver	TAG	DEFICIENCY	DATE
	List/Plan: CT (comp	outerized scan) and MRI Neurology consulted			

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE O		(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G175	A. BUILDING B. WING	00	COMPLETED 02/05/2024
		100170	_		02/03/2024
NAME OF F	PROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP COD	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		ERSONVILLE, IN 47130	
(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)	
TAG	Dementia".	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
	Dementia				
	No assessment for o	client A concerning his access			
	to chemicals and/or	cleaning products was			
	available for review	<i>I</i> .			
	On 2/1/24 at 3:45 PM, the QIDP was interviewed.				
		ed about the lack of assessment			
		and safety concerning			
		cured cleaning chemicals			
	and/or cleaning pro	ducts. The QIDP stated, "Yes.			
		The QIDP indicated further			
	review and follow up was needed to assess client A's health and safety concerning access to cleaning chemicals and/or cleaning products.				
	On 2/2/24 at 3:48 P	M, the Nurse was interviewed.			
		rse was the observation on			
	1/31/24 from 5:47 I	PM to 6:48 PM where the			
	_	and/or cleaning products were			
		nsecured. The Nurse was			
		of an assessment available for			
		client A's health and safety for cured chemicals in the cabinets			
		nd dryer. The Nurse indicated			
		as needed and stated, "I agree,			
	I do think they shou	_			
	_	ates to complaint #IN00426041			
	and #IN00425498.				
	9-3-4(a)				
	,				
W 0217	483.440(c)(3)(v)				
DL-J CC	INDIVIDUAL PRO				
Bldg. 00	•	ve functional assessment			
	must include nutri	tional status. on, record review and	W 0217	1.The Facility will ensure the	02/05/2024
		sampled clients (B), the facility	W 021/	comprehensive functional	e 03/05/2024
		nt B's nutritional status to		assessment included nutrition	ial

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLE	TED
		15G175	B. W	ING	_	02/05/2	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L.			IDDLE RD		
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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ate diet texture for meats was			status for Client B includes the		
		porated into his health risk and			appropriate diet texture for me		
	dining plans.				are identified and incorporated		
					his heath risk plan and dinning]	
	Findings include:				plan.		
		1 4 1 2 12 72 5 4 6 22			2.The nurse updated the HR		
	Observations were conducted on 3:12 PM to 6:03 PM and on 1/31/24 from 5:47 PM to 6:48 PM. At 5:37 PM, client B joined his peers for the evening				and Dinning plan to include th		
					appropriate diet texture for me	eats	
	-	-			and retrained all staff in the		
	meal. Client B was served chicken and rice. At 5:39				Facility on updated plans. 3 A member of the		
	PM, staff #11 assisted client B by cutting his chicken breast into small pieces and placed a				Administrative Team will cond	uct a	
	clothing protector around him. Staff #11 then used				monthly site reviews for all clie		
	hand over hand assistance with client B to put				in facility and the administrato		
	some peas onto his plate. At 5:47 PM, staff #11				hold a weekly ICF meeting to	· **	
	assisted client B by cutting more pieces of				discuss issues that arise in the	e l	
		serving. At 5:53 PM, client B			facility		
		ng of chicken breast. Client B					
	held the whole piec	e of chicken breast in his hand					
	and took bites from	the whole fillet of chicken					
	breast until he finisl	ned eating the third piece of			Persons Responsible: Progra	am	
	chicken.		Manager, Area Supervisor,				
					Residential Manager, Nurse,		
		PM, staff #10 was near the			DSP.		
		evening meal and staff #1 was					
		peers. Staff #10 was asked					
		pared for the evening meal.					
		the evening meal was going to					
		ootatoes with broccoli as					
		at 6:10 PM, client B and his					
		nd the dining room table for					
	_	Client B was provided oork chop. At 6:13 PM, the					
		B placed more chopped pieces					
	_	ent B's plate. At 6:16 PM, client					
		l pieces of the chopped pork					
	chop.	i proces of the enopped pork					
	Shop.						
	On 1/31/24 at 3:30	PM, a review of client B's record					
		review indicated the					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G175 B. WING COMPLETED 02/05/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG DIning Plan 8/1/23 indicated, "Behavior Concerns: [Client B] has risk of choking at mealtimes Food Texture: Soft diet Dietary Restrictions or Supplements: Cut veggies and fruit into bite size pieces". Health Risk Plan for Choking dated 8/14/23 indicated, "Approach: 1. Staff will assist with eating and cut breads (sandwiches) into 16 pieces".			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN (X4) ID PREFIX TAG Tollowing: Dining Plan 8/1/23 indicated, "Behavior Concerns: [Client B] has risk of choking at mealtimes Food Texture: Soft diet Dietary Restrictions or Supplements: Cut veggies and fruit into bite size pieces". Health Risk Plan for Choking dated 8/14/23 indicated, "Approach: 1. Staff will assist with eating and cut breads (sandwiches) STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD 3607 MIDLE RD 3607 MIDLE RD 3607 MI							OF CORRECTION	AND PLAN
RES CARE COMMUNITY ALTERNATIVES SE IN (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG following: Dining Plan 8/1/23 indicated, "Behavior Concerns: Client B has risk of choking at mealtimes Food Texture: Soft diet Dietary Restrictions or Supplements: Cut veggies and fruit into bite size pieces". Health Risk Plan for Choking dated 8/14/23 indicated, "Approach: 1. Staff will administer meals per diet as ordered by physician. Staff will assist with eating and cut breads (sandwiches)		:/05/2024	02/08	/ING		15G175		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Following: Dining Plan 8/1/23 indicated, "Behavior Concerns: [Client B] has risk of choking at mealtimes Food Texture: Soft diet Dietary Restrictions or Supplements: Cut veggies and fruit into bite size pieces". Health Risk Plan for Choking dated 8/14/23 indicated, "Approach: 1. Staff will administer meals per diet as ordered by physician. Staff will assist with eating and cut breads (sandwiches)			IDDLE RD	3607 M				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Following: Dining Plan 8/1/23 indicated, "Behavior Concerns: [Client B] has risk of choking at mealtimes Food Texture: Soft diet Dietary Restrictions or Supplements: Cut veggies and fruit into bite size pieces". Health Risk Plan for Choking dated 8/14/23 indicated, "Approach: 1. Staff will administer meals per diet as ordered by physician. Staff will assist with eating and cut breads (sandwiches)		(X5)	DE CUIDED ON AN AN AND DOWN	ID		STATEMENT OF DEFICIENCIE	SUMMARY S	(X4) ID
TAG REGULATORY OR LSC IDENTIFYING INFORMATION following: Dining Plan 8/1/23 indicated, "Behavior Concerns: [Client B] has risk of choking at mealtimes Food Texture: Soft diet Dietary Restrictions or Supplements: Cut veggies and fruit into bite size pieces". Health Risk Plan for Choking dated 8/14/23 indicated, "Approach: 1. Staff will administer meals per diet as ordered by physician. Staff will assist with eating and cut breads (sandwiches)	N		(EACH CORRECTIVE ACTION SHOULD BE	PREFIX		ICY MUST BE PRECEDED BY FULL	(EACH DEFICIEN	
Dining Plan 8/1/23 indicated, "Behavior Concerns: [Client B] has risk of choking at mealtimes Food Texture: Soft diet Dietary Restrictions or Supplements: Cut veggies and fruit into bite size pieces". Health Risk Plan for Choking dated 8/14/23 indicated, "Approach: 1. Staff will administer meals per diet as ordered by physician. Staff will assist with eating and cut breads (sandwiches)		DATE	DEFICIENCY)	TAG		R LSC IDENTIFYING INFORMATION	REGULATORY OR	TAG
[Client B] has risk of choking at mealtimes Food Texture: Soft diet Dietary Restrictions or Supplements: Cut veggies and fruit into bite size pieces". Health Risk Plan for Choking dated 8/14/23 indicated, "Approach: 1. Staff will administer meals per diet as ordered by physician. Staff will assist with eating and cut breads (sandwiches)							following:	
meals per diet as ordered by physician. Staff will assist with eating and cut breads (sandwiches)						of choking at mealtimes Food Dietary Restrictions or weggies and fruit into bite size or Choking dated 8/14/23	[Client B] has risk of Texture: Soft diet Supplements: Cut v pieces".	
assist with eating and cut breads (sandwiches)								
							_	
into 16 pieces".								
						into 16 pieces".		
Health Risk Plan for Dysphagia (swallowing difficulties) dated 8/14/23 indicated, "Approach: 1. Staff will administer meals according to physician orders. 2. Staff will monitor all food intake by having a staff member monitoring client during meals to watch for signs of choking".						8/14/23 indicated, "Approach: 1. er meals according to physician I monitor all food intake by the monitoring client during	difficulties) dated 8, Staff will administe orders. 2. Staff will having a staff memb	
Physician Order dated 12/13/23 indicated, "Diet: Soft".						ted 12/13/23 indicated, "Diet:		
On 1/31/24 at 3:52 PM, the Nurse was interviewed. The Nurse was asked about client B's dietary restriction for meat food items, the physician order indicating a soft diet order and observation of client B consuming pieces of meat with the third helping of chicken being whole with client B taking bites from it. The Nurse stated, "I need to get clarification on his meats. On a soft diet, I want to run that past his PCP (primary care physician)". The Nurse was asked about client B eating from a whole piece of chicken taking bites from holding it in his hand. The Nurse stated, "I don't think that is appropriate. We need to see if it should be chopped and with some liquids". The						ed about client B's dietary food items, the physician order et order and observation of g pieces of meat with the third being whole with client B The Nurse stated, "I need to his meats. On a soft diet, I st his PCP (primary care urse was asked about client B e piece of chicken taking bites his hand. The Nurse stated, "I ppropriate. We need to see if it	The Nurse was asker restriction for meat indicating a soft die client B consuming helping of chicken be taking bites from it. get clarification on want to run that pas physician)". The Nue ating from a whole from holding it in helping it in	
Nurse indicated further follow up with client B's primary care physician to assess and ensure client								

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G175		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 02/05/2024		
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	3607 M	ADDRESS, CITY, STATE, ZIP COD IIDDLE RD RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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 APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
TAG W 0227 Bldg. 00	B's appropriate diet 9-3-4(a) 483.440(c)(4) INDIVIDUAL PRO The individual pro specific objectives client's needs, as comprehensive as paragraph (c)(3) of Based on observation interview for 1 of 3 failed to ensure clie healthy food alternathis preferences with foods. Findings include: Observations were 3:12 PM to 6:03 PM 8:05 AM, and on 1/ PM at the day servi 5:47 PM to 6:48 PM client C consumed evening meal consi rice, and peas. At 5 the table with his pe the serving bowls a assistance with the	OGRAM PLAN gram plan states the senecessary to meet the identified by the sessessment required by	W 0227	1 The facility will ensure that the individual program plan star specific objectives necessary to meet clients' needs identified in their comprehensive assessme 2 The Nurse will contact the dietician to identify health food choices based on Client C's preference. 3 The QIDP will update Clie C ISP to include objectives to address healthy food choices based on his preferred food choices. 4 The QIDP will train Facilit Staff on the updated ISP for Cli C. 5 A member of the Administrative Team will condumonthly site reviews for all clier in facility and the administrator hold a weekly ICF meeting to	at tes on ent. e
	encourage client C breast prepared for made a vocalization chicken breast. At 5 verbal prompt with	to try some of the chicken the evening meal. Client C in indicating he did not want the 5:41 PM, staff #11 used a client C to encourage him to the serving bowl. Client C		discuss issues that arise in the facility Persons Responsible: QA Manager, QA Coordinator, QID Residential Manager, Area	

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made a vocalization indicating he did not want the

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Supervisor, DSPs, and Program

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G175		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/05/2024		
	ROVIDER OR SUPPLIER	LTERNATIVES SE IN	3607 M	ADDRESS, CITY, STATE, ZIP COD MIDDLE RD RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
TAG	peas. At 5:42 PM, the some warmed procedure hashbrown squares, eating his chicken in squares and left the On 1/30/24 at 7:33 dining room table wassisted the clients of placing cream of whom their plates. At 7 did not want raising prompt to encourage raisin toast. Client Client Client C declined to raisin toast and was alternative. On 1/31/24 at 10:45 the day service provisupports and service clients. The Day Program] provides a EJ, [client FJ and [ctwo staff for [client which accompanied location were staff staff #1 and staff #7 encourage all client meal, clean up their hands. At 11:40 AM chips, crackers, Jell chicken nuggets for client C finished ear	he team leader brought client C essed chicken nuggets with At 5:48 PM, client C finished nuggets and hashbrown dining room. AM, client C was seated at the with his peers. The team leader with the serving bowl and neat and cinnamon raisin toast :35 AM, client C indicated he coast. The QIDP used a verbal eclient C to try a bite of the C made a vocalization and want to try the raisin toast. Try to the cream of wheat and provided a pop tart as an	TAG	Manager.	DATE
	indicated pork chop	for the evening meal. Staff #10 s and potatoes with a side 6:08 PM, client C sat down at			

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Event ID:

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STATEMEN	NT 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	
		15G175	B. W	ING		02/05/	/2024
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹		3607 MI	IDDLE RD		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		JEFFEF	RSONVILLE, IN 47130		
(X4) ID	SUMMARY	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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		brought client C a plate with					
	warmed french-fries and chicken nuggets. Client C						
	was seated at the table alone. Client C was not offered the main menu items of pork chops,						
		oli. At 6:10 PM, client C's					
	l -	the dining room for their					
		5:12 PM, client C finished					
	_						
	eating his french-fries and chicken nuggets and returned to his bedroom.						
	On 1/31/24 at 4:16 PM, a review of client C's record						
	was conducted. The review indicated the						
	following:						
		Plan (ISP) dated 1/22/1/25 (sic)					
	· ·	Objectives: 1. Medication					
		Safety Skills. 3. Oral Hygiene					
	•	ılt daily living) skills". Client					
		cate objectives to address					
	·	es based on his preferred food					
	items.						
	Dining Plan dated 8	3/14/23 indicated, "Dietary					
	_	plements: Lactose Intolerant.					
	Strict low fat diet	-					
	Maintain/Acquire:	The ability to eat safely which					
	has been done in th	e past and follow the menu".					
	Dhygiaian Ondar 1-	ted 12/12/22 indicated "Dist					
	1	ted 12/13/23 indicated, "Diet: (non-concentrated sweets),					
	Diabetic diet".	(non-concentrated sweets),					
	Diauctic dict						
	On 1/31/24 at 3:59	PM, the Nurse was interviewed.					
		ed about client C's dining					
		healthy food choices to					
	_	mption of warmed up					
	processed foods. Th	ne Nurse indicated a formal					
	plan to offer client	C healthy food choices based					
	_	as not available for review and					
	stated, "I don't know	w if there are low fat chicken					

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

PRINTED: 03/18/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15G175		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/05/2024	
	ROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET A 3607 M JEFFER		
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	breast to make nugg (something client C other things he likes Maybe we make it i indicated further rev plan to encourage h client C's preference	Ethey had made them (chicken gets), if it would be better would have eaten). He has so we can't make him change. In an air fryer. The Nurse view and development of a ealthy food choices based on the was needed.			
	The QIDP was asket habits and offering in promote less consurprocessed foods. The needed to be developed had spoken with the and identifying preferoption when he does from the menu. The offer him the food be nuggets. We talked him to new foods. It QIDP indicated the	d about client C's dining healthy food choices to inption of warmed up he QIDP indicated a plan ped. The QIDP indicated she hurse about food options ferred healthy choices as so not want what was prepared QIDP stated, "The plan is to before making the chicken yesterday about introducing it's all about looks for him". The development of a plan to offered healthy food choices			
W 0252	483.440(e)(1) PROGRAM DOCU				
Bldg. 00	criteria specified in plan objectives mu measurable terms Based on record rev sampled clients (B), client B's behavior to	complishment of the a client individual program ust be documented in . view and interview for 1 of 3 , the facility failed to ensure racking was maintained for his happropriate sexual behavior.	W 0252	1 The Facility will ensure relative to accomplishment of criteria specified in client indiversity program plan objectives must documented in measurable to the QIDP retrained states.	the vidual be erms.

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Event ID:

B2XN11

Facility ID: 000709

If continuation sheet

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DENTIFICATION NUMBER 15G175 NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN O(4) ID SUMMARY STATEMENT OF DEFICIENCE PRIFIX GLACH DEPTIFIX OF ALTERNATIVES SE IN O(5) ID REGULATORY OR LSC DIDENTIFYING INFORMATION On 1/31/24 at 3:30 PM, client B's record was reviewed. The review indicated the following: -Individual Support Plan (ISP) dated 4/14/23 indicated, "Behavior History [Client B] lbs trouble with public musturbation and will attempt to massage various items on his supper seg and can be verbally redirected when this happens Target Behavior and Goals: When [client B] rubs himself in public with various objects or openly musturbates. Goal: [Client B] will have five or fewer occurrences of inappropriate sexual behavior for three consecutive months 4.14.24 behavior for three consecutive months 4.14.24 Data Collection sheat across all shifts. Instruction to fill out the data sheets are provided on the data sheets are provided on the data sheets are provided on the data sheets are provided for review. On 2/1/24 at 3:45 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the behavior tracking for relent B. The QIDP was asked about the behavior tracking for eignt B. The QIDP was asked about the behavior tracking inappropriate sexual behavior; The QIDP was asked about the behavior tracking in propriate sexual behavior. The QIDP stated, "Yes, they need to do it (ABC behavior tracking)".	STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
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9-3-4(a)		9-3-4(a)						
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Event ID:

B2XN11 Facility ID: 000709

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		15G175	B. WI	NG		02/05/	2024
	PROVIDER OR SUPPLIEI	R LTERNATIVES SE IN	•	3607 M	ADDRESS, CITY, STATE, ZIP COD IIDDLE RD 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 BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
Bldg. 00	483.470(i)(1) EVACUATION DI at least quarterly Based on record resampled clients (A, clients (D, E and F) quarterly evacuation personnel. Findings include: On 1/31/24 at 1:15 evacuation drills with the evacuation drills with ev	PM, a review of the group home as conducted. The review of sincluded the following B, C, D, E and F: ht shift (8 PM - 8 AM), there ion of evacuation drills for each shift of sincluded the following B, C, D, E and F: ht shift (8 PM - 8 AM), there ion of evacuation drills /1/23 through 12/31/23. PM, the Qualified Intellectual ional (QIDP) was interviewed. ed about the missing cumentation between 10/1/23 or the twelve hour second shift. d no further documentation was w. The QIDP was asked how ould be conducted. The QIDP	W	1440	·All staff at the home will be re-trained on conducting evacuation drills quarterly on a shifts. The Residential Managwill review all drills to ensure a required drills area conducted The Program Manager will traithe Area Supervisor and the A Supervisor will train all facility staff. ·The Area Supervisor will vist the home at least monthly to ensure the drills are in the hor and up to date. ·Direct Supper Lead will submonthly drills to the QA Department upon completion. QA Department will notify the Manager and Program managthe facility has not performed monthly drills as required. ·The Area supervisor will endrills are completed as required. ·The program manager will conduct random monthly inspections to ensure drills are being completed as required. A member of the Administrative team will condumonthly site reviews for all clie in facility and the administrato hold a weekly ICF meeting to discuss issues that arise in the facility.	all ger all in trea sit The Area ger if sure ed. e	03/05/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G175		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI A. BUILDING 00 COMPLETED B. WING 02/05/2024			LETED		
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD JEFFERSONVILLE, IN 47130			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	Manager, Area Supervisor, Residential Manager, Direct Support Lead, DSP, QA		DATE
W 0448	483.470(i)(2)(iv) EVACUATION DI	RILLS					
Bldg. 00	The facility must in evacuation drills, Based on record re-	investigate all problems with including accidents. view and interview for 3 of 3	W 0	448	1 All staff at the Facility wi		03/05/2024
	clients (D, E and F evacuation drills w	, B and C) and 3 additional), the facility failed to ensure vere documented with accurate ues and concerns to prevent e.			be re-trained on conducting fir drills quarterly on all shifts. The Area Supervisor will review all to ensure all required drills are conducted. The Program Mar will train the Area Supervisor a	ne drills ea nager	
	Findings include:				the Area Supervisor will train a facility staff.		
	evacuation drills we the evacuation drills affecting clients A, -12/21/22 at 3:30 A seconds. No issues documented1/1/23 at 10:04 AI issues and/or concers we -3/23/23 at 5:45 AI issues and/or concerns we -4/30/23 at 6:00 AM and/or concerns we -4/30/23 at 9:20 PN inaccurate duration concerns being documents.	AM, duration 16 minutes and 3 and/or concerns were M, duration 26 minutes. No terns were documented. I, duration 15 minutes. No issues the documented. M, duration 10 minutes. No terns were documented. I, duration 10 minutes. No issues the documented. M, duration 10 minutes. No issues the documented. M, duration 0 minutes. An in with no issues and/or terms were documented. M, duration 6 minutes. No issues			the home at least monthly to ensure the drills are in the hor and up to date. Staff will be in serviced to the Program Manager on conducting evacuation drills, of collection, and determine if a solution to reduce the length of duration for evacuation drills a needed. The Direct Support Lead submit monthly drills to the QAD Department upon completion. QA Department will notify the Manager and Program manage the facility has not performed monthly drills as required. The Area supervisor will ensure drills are completed as required.	ne Dy data of s will A The Area ler if	
	On 1/31/24 at 1:40	PM, the Qualified Intellectual			6 The program manager w conduct random monthly	/III	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G175		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 02/05/2024		
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	3607 M	ADDRESS, CITY, STATE, ZIP COD IIDDLE RD RSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	(X5) COMPLETION DATE
W 0455 Bldg. 00	The QIDP was asked and a lack of docum difficulties to ensur to prevent reoccurre QIDP indicated more ensure staff accurated duration and if difficulties are to 5 minutes long". 9-3-7(a) 483.470(l)(1) INFECTION CON There must be an prevention, control infection and com Based on observations ampled clients (B) infection control produring client B's more evening meal. Findings include: Observations were 3:12 PM to 6:03 PM to 6:48 PM. At 4:01 cleaning wipes to the room and prepared administration routile leader washed her had assist her by bringing assist her by bringing to the room and prepared assist her by bringing assist her by bringing and prevention was assist her by bringing and preventions were successful to the product of	active program for the ol, and investigation of municable diseases. On and interview for 1 of 3, the facility failed to ensure actices were implemented edication administration and conducted on 1/29/24 from M and on 1/31/24 from 5:47 PM I PM, the team leader brought the medication administration for the evening medication ine. At 4:02 PM, the team	W 0455	inspections to ensure drills are being completed as required. 7 A member of the Administrative team will condumonthly site reviews for all clic in facility and the administration hold a weekly ICF meeting to discuss issues that arise in the facility. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP The facility will ensure that an active program for the prevention, and control of infeand communicable diseases it ongoing. The Facility Staff will be in-serviced by the QIDP on ensuring all staff in the facility sanitize their hands during mepass and proper use of PPE. The Direct Support Lead and Direct Care Professionals will ensure all Company and State PPE guidelines are followed for visitors, staff and clients. The Area Supervisor and Program Manager will perform random checks to ensure the active program for the preventant control of infection and control of infection an	auct a ents or will lee am 03/05/2024 ection is leed and lee or all lee and lee or all lee and

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administration room.

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Facility ID: 000709

communicable diseases is

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ПП ТІРІ Е СС	ONSTRUCTION	(X3) DATE	SURVEY
		, '		UILDING		COMPL	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00		
		15G175	B. W	ING		02/05	12024
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					IDDLE RD		
KES CAF	≺E COMMUNITY A ———	LTERNATIVES SE IN		JEFFEF	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 BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					ongoing.		
	· ·	am leader mixed the thickener in			·The QIDP will in-service Fa	acility	
		nistered client E his medication.			Staff on ensuring client hand		
	After client E's medication administration routine,				washing prior to all meals and	l food	
	the team leader did not wash or sanitize her hands				saftey.		
	again.				A member of the		
					Administrative team will cond		
	At 4:14 PM, the team leader verbally prompted for				monthly site reviews for all cli		
	client D to come to the medication administration				in facility and the administrate	r will	
	room as she prepared his medication. At 4:16 PM,				hold a weekly ICF meeting to		
		ninistered client D his			discuss issues that arise in th	е	
		eam leader did not wash or			facility.		
	sanitize her hands.						
	At 4:19 PM, the team leader used a verbal prompt				Persons Responsible: QA		
		to wash his hands and prepare			Manager, QA Coordinator, QI	ΠP	
		administration routine. The			Residential Manager, Area	, וט	
		wash or sanitize her hands.			Supervisor, DSP and Program	n	
	team reader and not	wash of samuze her hamas.			Manager.		
	At 4:20 PM, client	B obtained water and took a					
	drink, followed by	an attempt to take his					
	medications the tea	m leader had prepared. One					
	tablet remained in t	the small plastic cup. The team					
	leader used her bare	e hand and fingers to retrieve					
		he cup and placed it in client					
	B's hand. Client B t	then administered the tablet to					
	himself.						
	A4 4.24 DN 4 41 4	1 - 4					
	· ·	am leader was asked if client B					
	I	taking his medication. The team					
	·	He took a drink of water, then					
		ds (medications)". The team					
		the tablet she had retrieved					
	team leader stated,	ers had stuck in the cup. The					1
	team leader stated,	ı cail .					
	On 1/31/24 at 5:55	PM, staff #10 was preparing the					
		taff #1 assisted other					
	_ ~	nt B in the home. Staff #10 was					
		ing prepared for the evening					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	A. BUILDING <u>00</u>		COMPLETED		
		15G175	B. W	B. WING		02/05/2024		
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIEF	R			IDDLE RD			
RES CARE COMMUNITY ALTERNATIVES SE IN					RSONVILLE, IN 47130			
	I COMMONT A	E. E. GOVIIVEO OF IIV					1	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPR			
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		icated the evening meal was						
	1 ~ ~ .	ops and potatoes with						
	broccoli as another side dish.							
	A4 (.10 DM -1:	D 4 h :- h 4 h 4						
		B and his housemates gathered oom table for their evening						
		vere not prompted to wash their						
	hands prior to the e	vening mear.						
	At 6:13 PM_client	F was seated next to client B						
		g up his pork chop pieces from						
		F scooped up his pork chop,						
		both staff #10 and staff #1,						
		t want his pork chop". The						
		leave the dining room to find						
		rening meal. Client F proceeded						
		k chop and began placing						
	those pieces on client B's plate. Staff #10 and staff							
		the dining room. No verbal						
	_	client F from placing his pork						
		plate were provided. Client B						
		eces of pork chop from his						
	plate.	F F						
	r							
	At 6:16 PM, client	B finished eating all pieces of						
	pork chop from his							
	On 2/1/24 at 3:45 PM, the QIDP was interviewed.							
	The QIDP was asked about the infection control							
	practices during client B's medication							
	administration and mealtime where people							
	touched and used their bare hand for the							
	medication and food items he had consumed. The							
	QIDP indicated client B should have been							
	prompted to retrieve his medication when stuck in							
	the cup, that staff co	ould have used a gloved hand,						
	and staff should hav	ve intervened to prevent client						
	B from eating the p	ork chop. The QIDP indicated						
	hand washing should have been prompted prior							
to this evening meal. The QIDP stated, "We'll								

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Event ID:

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
		IDENTIFICATION NUMBER		A. BUILDING <u>00</u>			COMPLETED		
15G175		B. WING				02/05/2024			
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD JEFFERSONVILLE, IN 47130					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	ADDOLUBERG N. AN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG				TAG	DEFICIENCY)		DATE		
	follow up with staff".								
	9-3-7(a)								
W 0474	483.480(b)(2)(iii) MEAL SERVICES								
Bldg. 00		ved in a form consistent							
g.	with the developmental level of the client.								
	Based on observation, record review and		\mathbf{w}_0	474	The Facility will ensure all		03/05/2024		
	interview for 1 addi	tional client (E), the facility			food is served in a form consis				
	failed to ensure clie	nt E's diet consistency was			with the developmental level of	of the			
	implemented accord	ding to his dining plan and			client.				
	physician orders for	r nectar thickened liquids and			The Nurse will retrain sta	aff in			
	a pureed (honey thic	ck consistency) food textured			the Facility on all clients the				
	diet.				clients dining plan and followir	ng			
	Findings include:				physicians orders. The Area Supervisor will	I			
	An observation was	s conducted on 1/30/24 from			conduct random weekly observation to ensure staff are	•			
					following client dining plan and				
		7:02 AM to 8:05 AM. At 7:12 AM, staff #8 prepared for client E's morning medication			physicians orders.	J			
	administration routine. At 7:28 AM, client E took				A member of the				
	his morning medications with a cup of water mixed				Administrative Team will cond	uct a			
	with his morning dose of Polyethylene Glycol				monthly site reviews for all clie				
	3350 (constipation) medication. At 7:29 AM, staff				in facility and the administrato				
	#8 filled a second cup of water with the powder				hold a weekly ICF meeting to				
		the additional cup of water and			discuss issues that arise in the	е			
	provided it to client	E. Client E's first cup of water			facility				
	_	nis morning medications did							
	not contain the thicl	kener.			Persons Responsible: Nurse	, QA			
					Manager, QA Coordinator, QII	DP,			
		am leader assisted client E			DSL, Area Supervisor, DSP a	nd			
	using hand over hand assistance to place his				Program Manager.				
	morning meal of cream of wheat and a portion of								
	_	pureed raisin toast on his plate. As the team							
		ound the table assisting client							
		laced a bowl of chopped							
	boiled egg next to client E's plate. Client E did not								
		nopped boiled egg. At 7:41							
AM, client E obtained a second serving of the									

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
		IDENTIFICATION NUMBER		A. BUILDING 00 COMPL					
15G175		B. W	ING		02/05/2	2024			
NAME OF BROWINGS OR CURBULED				STREET A	DDRESS, CITY, STATE, ZIP COD				
NAME OF PROVIDER OR SUPPLIER				3607 MIDDLE RD					
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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
		ond serving of the raisin toast							
		of bread. At 7:42 AM, client E							
		broke the toast into pieces o his mouth to eat. At 7:43							
	1 -								
	AM, client E took his plate and utensils to the kitchen sink ending his morning meal.								
		<u> </u>							
	On 1/31/24 at 3:57	PM, a focused review of client							
		lucted. The review indicated							
	the following:								
	Di Di Li	0/1/00: 1: . 1 117 1 1							
	_	8/1/23 indicated, "Behavioral							
] has a history of choking							
	during mealtimes. Food Textures: Pureed texture Fluid Texture: Nectar thickened liquids".								
	Tidia Texture. Neet	ar unekened riquids							
	-Physician Order da	ated 12/13/23 indicated, "Diet:							
		liquids Thick-it Pow							
	(powder): Use as directed in food or beverages for								
	honey thick consistency".								
	0 1/01/04 : 0.50	Date de la Transitation de la Contraction de la							
		PM, the Nurse was interviewed.							
		vided examples from							
		-							
	observation for thin liquids during medication administration, whole pieces of raisin toast and								
		. The Nurse indicated client							
		a pureed diet with nectar thick							
		ndicated client E's dining plan							
		for his diet consistency							
	should be implemen	nted to ensure client E received							
		and a pureed food textured							
		icated further follow up was							
		aff were retrained on client E's							
	diet textures.								
	On 2/1/24 at 3:45 D	M, the Qualified Intellectual							
	Disabilities Professional (QIDP) was interviewed. The QIDP was asked about client E's diet textures								
		items. The QIDP indicated							
						l			

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

PRINTED: 03/18/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G175	(X2) MULT A. BUILD B. WING		nstruction 00	(X3) DATE COMPL 02/05 /	LETED
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 3607 MIDDLE RD JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		II	D	PROVIDER'S PLAN OF CORRECTION	VIDER'S PLAN OF CORRECTION	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
	client E's diet textur	e for liquids was nectar thick					
	and a pureed diet consistency. Shared with the						
	QIDP were observations where client E's diet						
	textures were not implemented during his meal and						
	medication administration. The QIDP indicated						
	further follow up was needed to ensure staff						
	implemented and followed client E's diet textures						
	according to his din	ing plan and physician orders.					
	9-3-8(a)						

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