STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G175	A. BUILDING 00 B. WING	04/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	3607 MIDDLE RD JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a Post Certification Revisit (PCR) to the pre-determined full annual recertification and state licensure survey and the investigation of complaints #IN00425498 and #IN00426041 conducted on 2/5/24. This survey was in conjunction with the investigation of complaint #IN00431254. Complaint #IN00425498: Corrected. Complaint #IN00426041: Corrected. Survey dates: 4/22/24, 4/23/24, 4/24/24 and 4/25/24. Facility Number: 000709 Provider Number: 15G175 AIM Number: 100243190 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #27547 on 5/1/24.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation and interview for 3 of 3 sampled clients (A, B and C) and 4 additional clients (D, E, F and G), the facility's governing body failed to exercise operating direction over the facility to ensure the bathroom adjacent to medication room and the flooring in front of the	W 0104	Construction on both facility bathrooms will be complete by C&S Construction by 15May2024 ResCare Maintenance Manager will inspect completed work and report any issues	05/15/2024

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

Mark Slaughter | AED | 05/17/2024

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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	medication room were in good repair. Findings include: An observation was conducted at the group home on 4/22/24 from 3:38 PM through 7:01 PM. The home's floor covering located in front of the medication administration room entry was damaged. The area had a tear in the vinyl flooring with a section missing. The area was shaped like an almond extending 12 inches in length with the thickest middle portion 3.5 inches wide. The edges of the damaged area were rough and raised (not level) with the surrounding floor area. This affected clients A, B, C, D, E, F and G. DSL (Direct Support Lead) was interviewed on 4/22/24 at 4:11 PM. DSL indicated the flooring in front of the medication room door was damaged. DSL was interviewed on 4/22/24 at 5:05 PM. DSL indicated the home's bathroom next to the home's medication administration room was actively being renovated. DSL indicated the shower and floor were being replaced with tiles. DSL indicated the shower and floor repairs were not complete with unfinished surfaces present. DSL indicated clients A, B, C, D, E, F and G continued to have access and utilize the restroom during the repair process. At 3:49 PM, client F entered the bathroom adjacent to the medication administration room to use the restroom. The bathroom was under construction and missing the shower insert. On the floor was a two inch by four inch piece of lumber which spanned the width of the bathroom floor near the toilet. At 3:50 PM, client C entered the bathroom to use the restroom.		A member of the administrative team will conduct a monthly site review for all clients in facility and the administrator will hold a weekly ICF meeting to discuss issues that arise in the facility. **Persons Responsible**: QA Manager, QA Coordinator, QIDP, Residential Manager, Area Supervisor, DSP and Program Manager Maintenance Manager	

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	At 3:52 PM, client A entered the bathroom and used the sink. Client A splashed water on the floor below the sink. The bathroom floor was partially tiled with an exposed wood subfloor adjacent to the toilet. At 4:00 PM, both the Direct Support Lead (DSL) and Area Supervisor (AS) redirected client A from the bathroom. The AS used a mop due to the excessive amount of water on the partially tiled floor and the exposed wood subfloor. At 4:04 PM, the DSL used a verbal prompt to indicate to client B it was time for his medication administration routine. The laminate flooring in front of the medication administration room had a 12-inch long by 3 and half inch wide section torn which curled upward. At 4:55 PM, client A entered the bathroom and splashed more water from the sink onto the partially tiled bathroom floor. On 4/22/24 at 5:04 PM, the Direct Support Lead (DSL) was interviewed. The DSL was asked about the environmental condition of the bathroom and completion of the work project. The DSL indicated the remodeling of the bathroom began at the end of February 2024. The DSL indicated maintenance would work on the bathroom from 8 AM to 12 PM and stated, "If the guys (clients) don't have day program he stops and has to let them use the bathroom". On 4/23/24 at 2:03 PM, the Program Manager (PM) and Quality Assurance Manager (QAM) were interviewed. The PM and QAM were asked about the environmental repairs for the bathroom and the torn laminate flooring in front of the medication administration room. The PM stated,			

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	"We had him do the toilet and sink part first, so we would be able to use the bathroom. It's in process". The PM was asked about the damaged laminate floor. The PM stated, "All of that (flooring) will be replaced once the bathroom is done". The PM was asked about the risk of tripping hazards from the damaged flooring. The PM stated, "I need to get something to put over that". The PM and QAM indicated more follow-up was needed to ensure all environmental repairs were completed. The PM and QAM indicated the home should be maintained and in good repair. 9-3-1(a)			
W 0130 Bldg. 00	483.420(a)(7) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. Based on observation and interview for 1 of 3 sampled clients (C) and 1 additional client (F), the facility failed to ensure the privacy of clients C and F was maintained while they used the restroom. Findings include:At 3:49 PM, client F exited the dining room and entered the bathroom adjacent to the medication administration room. Client F stood at the toilet and urinated with the bathroom door open. Upon exiting the bathroom, client F went to the laundry area and obtained a towel to wipe his hands and placed it in a soiled laundry basket. At 3:50 PM, client C exited the dining room and entered the bathroom. Client C stood at the toilet and urinated with the bathroom door open. Clients C and F were not prompted by staff to close the bathroom door to ensure their privacy. The Direct	W 0130	The facility will ensure the rights of privacy during treatment and care of personal needs. The Area Supervisor will retrain all staff in facility on maintaining client privacy. A member of the administrative team will conduct a monthly site review for all clients in facility and the administrator will hold a weekly ICF meeting to discuss issues that arise in the facility. **Persons Responsible**: QA Manager, QA Coordinator, QIDP, Residential Manager, Area Supervisor, DSP and Program Manager.	05/15/2024

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	Support Lead (DSL) was assisting client G in the medication administration room adjacent to the bathroom when clients C and F used the restroom. The Area Supervisor (AS) was in the dining room adjacent to the bathroom when clients C and F used the restroom. Clients C and F were not prompted to shut the bathroom door to ensure their privacy when they used the restroom. On 4/23/24 at 1:56 PM, the Program Manager (PM) and Quality Assurance Manager (QAM) were interviewed. The PM and QAM were asked about ensuring clients C and F's privacy while they used the restroom when the bathroom door had been left opened. The PM stated, "They (staff) should be prompting to close the door". Both the PM and QAM indicated more follow-up was needed to ensure staff prompted clients C and F to close the bathroom door to ensure their privacy when they used the restroom. 9-3-2(a)			
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation and interview for 1 additional client (E), the facility failed to ensure staff working with client E were competent regarding the reporting of his fall risk needs to the facility nurse. Findings include: An observation was completed at the group home on 4/22/24 from 3:38 PM through 7:01 PM. Client E was in the home throughout the observation period. At 3:38 PM, client E gestured for the	W 0192	The facility will ensure all employees who work with clients will be trained on skills and competencies directed toward clients' health needs. The area supervisor will in-service staff on contacting the nurse with any client health concerns. Staff will be retrained by the nurse on fall risk. A member of the	05/15/2024

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	surveyor to look at his left leg. Client E pulled his pant leg up and showed a 1 inch abrasion with red and dark red coloring on his shin. Throughout the observation period client E walked with an unsteady gait. He put his hands on the walls or furniture to support himself while walking. Multiple times, client E picked up a standing dust pan (dust pan with a long plastic handle) and attempted to use it as a cane while walking. He was redirected not to use the dust pan for support by the DSL (Direct Support Lead). Client E went inside of his bedroom and was attempting to retrieve an item from a box on the floor in front of him. Client E began to lose his balance and stumbled forward (did not fall) while leaning over to access the box. The DSL was interviewed on 4/22/24 at 5:05 PM. The DSL indicated client E fell during the morning of 4/22/24 while attempting to load the group home van. The group home van was present in the driveway and DSL demonstrated where and how client E fell. Client E was attempting to lift his left leg up to step onto the running metal step on the side of the van. Client E was not able to hold himself up and he hit his left shin as he fell downward and forward. The DSL indicated client E did not hit his head or another areas of his body and had not expressed issues prior to the fall. The DSL indicated staff were not able to get client E up from the ground, called the group home nurse and then called EMS (Emergency Medical Services). The DSL indicated client E was taken to a local hospital and evaluated with no new orders. The DSL indicated client E's shin was the only injury. The DSL indicated client E had previously been diagnosed with a UTI (Urinary Tract Infection) and had completed an order for antibiotics. DSL indicated client E returned to the group home after being discharged from the		administrative team will conduct a monthly site review for all clients in facility and the administrator will hold a weekly ICF meeting to discuss issues that arise in the facility. **Persons Responsible**: QA Manager, QA Coordinator, QIDP, Residential Manager, Area Supervisor, DSP and Program Manager.	

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	hospital. The DSL indicated client E had a second fall. The DSL indicated the group home nurse had come to the home to assess client E after his second fall. DSL indicated the group home nurse had not directed any special instructions or additional supports to assist client E's walking. The DSL stated, "It's not like him to have falls. This is not his baseline." When asked if she was concerned if client E was going to fall, DSL stated, "Yes." The DSL indicated client E was utilizing a standing dust pan for support and putting his hand on furniture or the wall to support himself while walking. The DSL indicated she had not contacted the nurse to communicate her concerns regarding client E's ongoing mobility issues. The LPN (Licensed Practical Nurse) was interviewed on 4/22/24 at 6:14 PM. The LPN indicated she was aware client E had fallen two times on 4/22/24. The LPN indicated she had come to the group home and assessed client E after his falls. The LPN indicated she was not aware of additional or ongoing concerns regarding client E's ambulation. The LPN indicated if staff had reported concerns to her regarding client E's unsteady gait and attempts to support himself while walking she would have directed client E be sent to a different ER (Emergency Room) for additional evaluation. The LPN indicated she would direct DSL to take client E to the ER. On 4/22/24 at 6:32 PM, the DSL was walking alongside client E from the group home to the group home van parked in the driveway. Client E was attempting to step up into the group home van to go to the ER for evaluation. Client E was not able to bear weight on his legs and fell to the ground while attempting to step up into the front passenger seat of the van. The DSL was supporting client E from behind him and was able			

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	to lower client E to the ground as he fell. Client E did not express pain or injury but was not able to stand back up. The DSL and QIDP (Qualified Intellectual Disabilities Professional) were not able to lift or assist client E up from his seated position on the ground. EMS was called to get client E up from the ground and transport him to a different ER to be evaluated. The Program Director (PD) and the Quality Assurance Manager (QAM) were interviewed on 4/23/24 at 1:39 PM. The PD and the QAM indicated staff should notify the nurse of concerns or changes in client health. The PD and the QAM indicated client E had been admitted to the hospital on 4/22/24 and had not been discharged at the time of the interview. The PD indicated the hospital had not communicated any new diagnoses but client E was admitted for observation. The PD indicated the hospital communication indicated client E had continued ambulation issues and there was discussion of discharging client E from the hospital to a rehabilitation center. 9-3-3(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 1 additional client (D), the facility failed to implement client D's Human Rights	W 0249	The area supervisor will in-service the facility staff on securing and locking of cleaning	05/15/2024

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	Committee (HRC) approval for the restriction to secure and lock cleaning chemicals. Findings include: An observation was conducted on 4/22/24 from 3:38 PM to 7:01 PM. Upon entering the home through the laundry area, two cabinets with pad locks were observed above the washer and dryer. At 4:04 PM, cleaning chemicals were observed in the unlocked and unsecured cabinet below the kitchen sink. At 4:15 PM, a bottle of disinfectant was observed on a shelf in the dining room. At this time, a second bottle of disinfectant could be observed on a desk from the dining room in the small office area between the dining room and garage. Both bottles of disinfectant were left unsecured and unlocked on the shelf in the dining room and on the desk in small office. This affected client D. On 4/23/24 at 1:19 PM, a focused review of client D's record was conducted. The review indicated the following: Human Rights Committee Approval (HRC) dated 4/13/24 indicated, "Clients (client D) at [name of group home] are low functioning and could be put in danger if chemicals are left unlocked. Requesting HRC to lock the chemical cabinet...". The observation indicated cleaning chemicals were kept unsecured under the kitchen sink, and two bottles of disinfectant were accessible in the dining room and the small office. Client D's HRC approval indicated a restriction was required to secure and lock cleaning chemicals in cabinets. From interviews, client D's approved HRC for locking cleaning chemicals should have been implemented.		chemicals. The program manager will in-service the Direct Support Lead on supervision of staff and securing cleaning chemicals, and verify cleaning chemicals are secured after use. The Area Supervisor and QIDP will conduct random weekly observations to ensure cleaning chemicals are properly secured after use. If cleaning chemicals are not secure the cleaning chemicals will be immediately stored and staff retrained. A member of the administrative team will conduct a monthly site review for all clients in facility and the administrator will hold a weekly ICF meeting to discuss issues that arise in the facility **Persons Responsible**: QA Manager, QA Coordinator, QIDP, Residential Manager, Area Supervisor, DSP and Program Manager.	

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	On 4/23/24 at 1:39 PM, the Program Manager (PM) and Quality Assurance Manager (QAM) were interviewed. The PM and QAM were asked about the unsecured cleaning chemicals. The PM indicated cleaning chemicals needed to be secured. The PM was asked if cleaning chemicals should be left unsecured in the kitchen cabinets and the bottles of disinfectant left out on shelving and a desk. The PM stated, "It's not supposed to be like that". The PM and QAM indicated cleaning chemicals should be locked and secured as indicated in client D's HRC approval. The PM and QAM indicated more follow-up to ensure staff locked and secured cleaning chemicals when not being used was needed.The DSL (Direct Support Lead) was interviewed on 4/22/24 at 5:05 PM. The DSL indicated chemicals such as cleaning agents should be locked. The DSL indicated the home had a cabinet above the washer and dryer for the storage of chemicals. The DSL indicated the cabinet above the washer and dryer should be locked unless being used by staff. The DSL indicated there were chemicals being stored underneath the kitchen sink in a cabinet. The DSL indicated the kitchen cabinet was not locked. 9-3-4(a)			
W 0455 Bldg. 00	483.470(l)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. Based on observation and interview for 3 of 3 sampled clients (A, B and C) and 4 additional clients (D, E, F and G), the facility failed to ensure infection control practices for hand washing was implemented for clients A, B, E and F and the	W 0455	The facility will ensure that an active program for the prevention, and control of infection and communicable diseases is	05/15/2024

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	storage of clients A, B, C, D, E, F and G's packaged bread and snack crackers were stored in a manner to prevent a pest infestation. Findings include: An observation was conducted at the group home on 4/22/24 from 3:38 PM through 7:01 PM. The DSL (Direct Support Lead) completed clients A, B, E and F's evening medication pass from 4:01 PM through 4:10 PM. The DSL did not encourage clients A, B, E or F to wash or sanitize their hands prior to participation in the administration of their oral medications. The home had a pantry/storage closet located inside of the garage. This was located near the exterior garage door entry. The pantry/closet door was locked. The pantry contained numerous loaves of bread stored on a shelf near the floor. There were boxes of snack crackers with the packages open with exposed food and numerous food items. There were no rodent or infestation control devices or deterrents visibly present in the area. This affected clients A, B, C, D, E, F and G. The DSL was interviewed on 4/22/24 at 5:05 PM. The DSL indicated clients A, B, E and F should be encouraged to wash or sanitize their hands prior to participating in the administration of their medications. The DSL indicated the home had a pantry located in the garage. The DSL indicated the pantry was locked and was utilized to store food, snacks and cleaning supplies. On 4/22/24 at 3:49 PM, client F exited the dining room and entered the bathroom adjacent to the medication administration room. Client F stood at the toilet and urinated with the bathroom door open. Upon exiting the bathroom, client F went to the laundry area and obtained a towel to wipe his hands and placed it in a soiled laundry basket.		ongoing. The Facility Staff will be in-serviced by the QIDP on ensuring all staff in the facility sanitize their hands during med pass and proper use of PPE. ·The Direct Support Lead and Direct Care Professionals will ensure all Company and State PPE guidelines are followed for all visitors, staff and clients. ·The Area Supervisor and Program Manager will perform random checks to ensure the active program for the prevention, and control of infection and communicable diseases is ongoing. ·The QIDP will in-service Facility Staff on ensuring client hand washing prior to all meals and food safety. The facility installed permanent mount soap dispenser to ensure proper hand washing supplies are made safely available for staff and clients. The facility is treated monthly by professional pest control to deter rodent and insect infestation. The Program Manager will purchase storage boxes and the area supervisor will in-service staff on proper storage of open snacks and bread to prevent rodent and insect infestation. A member of the administrative team will conduct a monthly site review for all clients	

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	At 3:50 PM, client C exited the dining room and entered the bathroom. Client C stood at the toilet and urinated with the bathroom door open. Clients C and F were not prompted by staff to wash their hands after using the restroom. On 4/23/24 at 1:49 PM, the Program Manager (PM) and QAM were interviewed. The PM and QAM were asked about the implementation of infection control practices to prevent a pest infestation of food items stored in the pantry located in the garage. The PM stated, "I'm going to have to come up with a way to keep open stuff (food items). No, it should not be left like that". The PM was asked about infection control practices for hand washing after the clients used the bathroom and were administered their medications. The PM stated, "Yes, they should (be prompted to wash their hands)". The PM and QAM indicated further follow-up to ensure infection control practices for hand washing and the proper storage of food items was needed. This deficiency was cited on 2/5/24. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-7(a)		in facility and the administrator will hold a weekly ICF meeting to discuss issues that arise in the facility. **Persons Responsible**: QA Manager, QA Coordinator, QIDP, Residential Manager, Area Supervisor, DSP and Program Manager.	