STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 00 B. WING	09/29/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

(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 pre-determined full annual recertification and state licensure survey. Survey dates: 9/26/23, 9/27/23, 9/28/23 and 9/29/23. Facility Number: 004615 Provider Number: 15G723 AIM Number: 200528230 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 10/11/23.	W 0000		
W 0391 Bldg. 00	483.460(m)(2)(ii) DRUG LABELING The facility must remove from use drug containers with worn, illegible, or missing labels. Based on observation, record review and interview for 1 additional client (#4), the facility failed to ensure client #4's Mineral Oil prescription drug labeling was not worn and illegible. Findings include: An observation was conducted on 9/27/23 from 6:45 AM to 9:14 AM. At 7:53 AM, client #4 entered the medication administration room while staff #2 gathered client #4's medication supplies. Staff #2 pulled a small bottle of mineral oil out of a plastic bag with liquid spilled inside. At 7:55 AM, staff #2 administered mineral oil drops into both of client #4's ears. No prescription label was on the outside of the plastic bag and the bottle and label were covered in oil. Staff #2 indicated the label	W 0391	To correct deficient practice, a new legible label was obtained and placed on the outside of the bottle. All staff responsible for administering medications will be retrained on proper storage of medications, proper administration of liquids, and checking medication labels to ensure they are not worn, illegible, torn or that there are missing labels. If labels are found to have any defects, staff will contact the ResCare LPN for guidance and a new label will be placed on the medication. The LPN will be retrained to check on medication labels any time in the	11/24/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lindsay Johnson	QA Manager	10/26/2023

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	would not scan in the electronic system so he manually entered the information to indicate client #4's mineral oil had been administered. Staff #2 stated the label on the bottle was worn and could be "torn apart" if manipulated. Staff #2 was asked if any additional packaging with a prescription label for the mineral oil he had administered to client #4 was available for review. Staff #2 indicated there was no other packaging with prescription labeling available for review. On 9/27/23 at 12:29 PM, staff #2 was interviewed. Staff #2 was asked about client #4's prescription drug labeling for his mineral oil being worn. Staff #2 stated, "It used to be scannable". Staff #2 was asked if the prescription label for client #4's mineral oil came delivered with it on the bottle and if any additional packaging with a prescription label came with it. Staff #2 stated, "Yeah, you would think they would put on a second label. It's not removable". On 9/28/23 at 2:04 PM, a focused review of client #4's record was conducted. The review indicated the following: -Physician Orders dated 9/27/23 indicated, "GNP Mineral Oil: Instill 3 drops in both ears twice daily... Date Written: 22-Jun-2023...". On 9/27/23 at 3:33 PM, the Nurse was interviewed. The Nurse was asked about client #4's mineral oil being maintained in a plastic bag with liquid inside and the prescription drug label being worn and not scannable and could be torn if manipulated. The Nurse indicated the policy was for liquid medication to be maintained in a plastic bag to prevent liquid from getting onto other medication containers. The Nurse stated, "We don't have a policy for keeping a label on the bag". The Nurse		home, twice monthly at a minimum. Ongoing monitoring will be achieved through a monthly medication cabinet check completed by AS, LPN and/or DSL.	

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	was asked if she should be notified if the prescription drug labeling was worn and needed replacement. The Nurse stated, "Yes. I teach that in class. I wrote a note to in-service". The Nurse indicated a paper prescription label for client #4's mineral oil had been created and she was going to go to the home to follow up. 9-3-6(a)			
W 0454 Bldg. 00	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation and interview for 2 of 2 sampled clients (#1 and #2) and 1 additional client (#4), the facility failed to ensure clients #1, #2, and #4's plastic cups and the pitcher of water used during medication administration were sanitary. Findings include: Observations were conducted on 9/26/23 from 12:11 PM to 1:23 PM, on 9/27/23 from 6:45 AM to 9:14 AM and from 11:20 AM to 12:48 PM. The observations indicated the following: At 12:45 PM, client #1 indicated to staff he did not want to join his peers for the noon meal due to an upset stomach. Staff #1 then called the nurse and informed her of client #1's complaint of stomach pain. At 12:48 PM, staff #1 verbally prompted client #1 to come to the medication administration room for a PRN (as needed) medication. At 12:50 PM, client #1 was administered a gas relief medication. Staff #1 used a verbal prompt to have client #1 take a drink of more water with his medication. At 12:52 PM, client #1 drank a second cup of water. Upon client #1 finishing his second	W 0454	To correct deficient practice, the plastic cups were removed from the medication room and replaced with disposable cups. A pitcher with a lid will be used to prevent water from being poured back into the pitcher. Staff will be trained on ensuring any pitcher used for medication pass has a lid on it and that water is not poured back into it, after being poured in a cup. On going monitoring will be achieved by DSL, LPN or AS completing random medication observations in the home at least twice monthly.	11/24/2023

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	cup of water, staff #1 stacked client #1's used cup on top of two other small cups on top of a pitcher of water. Client #1's used plastic cup was not taken to the kitchen sink or dishwasher. At 7:07 AM, staff #2 prepared for the morning medication administration routine. At 7:15 AM, client #1 was administered his morning medications. Client #1 used a plastic cup with water from the file cabinet where a pitcher of water was located with two other small plastic cups. Client #1 used an orange plastic cup and it was placed back on the file cabinet upon finishing. At 7:29 AM, staff #2 used a verbal prompt with client #2 to get a cup from the filing cabinet and poured him some water for his morning medications. At 7:41 AM, client #2 used a red plastic cup with water to take with his morning medications. Upon finishing, client #2 placed his small plastic cup on the file cabinet and left the medication administration room. At 7:53 AM, client #4 entered the medication administration room and poured himself some water in a yellow plastic cup. At 8:13 AM, client #4 took his morning medication using the yellow plastic cup. At 8:14 AM, as client #4 was leaving the medication administration room, staff #2 stacked the three plastic cups together on the filing cabinet with the pitcher of water. Clients #1, #2 and #4 used plastic cups were stacked together and placed on the filing cabinet. At 11:52 AM, staff #2 prepared for the Noon medication administration routine with client #2. At 11:56 AM, client #2 asked staff #2 if he could get himself a cup of water. Staff #2 stated, "Yeah, pick a cup". Client #2 poured water and overfilled his cup. Staff #2 physically assisted client #2 with pouring water from the cup back into the pitcher of water. At 12:01 PM, upon client #2 finishing his			

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	noon medication administration, staff #2 stacked his used cup with the other two on the file cabinet. At 12:06 PM, client #4 entered the medication administration room. Staff #2 verbally prompted client #4 to get himself a cup and pour some water from the pitcher. Client #4 picked the orange cup from the stack and spilled water as he attempted to fill it. Staff #5 indicated to staff #2, he would clean the spilled water as staff #2 assisted client #4 with his noon medication administration. Staff #5 placed the yellow and red plastic cups stacked together on an adjacent desk. At 12:11 PM, client #4 took his noon medications with water poured from the pitcher where client #2's water had been poured back into from his cup. Upon clients #1, #2 and #4's finishing their medication administration routine, the used plastic cups were not taken to the kitchen sink or dishwasher. Client #1, #2 and #4's used plastic cups were stacked together and placed on the filing cabinet. On 9/27/23 at 12:09 PM, staff #2 was interviewed. Staff #2 was asked about the practice of reusing cups for clients #1, #2 and #4 and pouring client #2's water back into the pitcher during the medication administration observations. Staff #2 indicated he had assisted client #2 with pouring water back into the pitcher and subsequently used the same pitcher of water during client #4's medication administration. Staff #2 was asked if the three small plastic cups were reused. Staff #2 indicated the three cups were used with clients #1, #2 and #4 as client #3 preferred to bring his own cup with him for his medication administration routine. Staff #2 stated, "We keep cups in here for the others (clients #1, #2 and #4)". Staff #2 stated, "I can see where that could make someone sick. I helped pour that water back in there".			

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	On 9/27/23 at 3:33 PM, the Nurse was interviewed. The Nurse was asked about the reuse of the three plastic cups during medication administration being stacked together and water poured back in the pitcher of water used for the medication administration routine. The Nurse indicated the small plastic cups being reused needed to be replaced to prevent sanitation issues. The Nurse stated, "They need to get the cups (new) with the water". On 9/27/23 at 3:50 PM, the Program Manager (PM) was interviewed. The PM asked about the reuse of the three plastic cups during medication administration being stacked together and water poured back in the pitcher of water used for the medication administration routine. The PM stated, "We need to go to getting their own cups". The PM indicated the practice of reusing cups and pouring water back into the pitcher needed to be reviewed to ensure sanitation practices were being implemented during medication administration routines. 9-3-7(a)			