STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G442	A. BUILDING 00 B. WING	06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	402 EWING LN JEFFERSONVILLE, IN 47130

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W 0000 Bldg. 00	This visit was for a Post Certification Revisit (PCR) to the investigation of complaint #IN00426049 conducted on 1/19/24. Complaint #IN00426049: Not corrected. This survey was in conjunction with a PCR to the investigation of complaint #IN00426636. This survey was in conjunction with a PCR to the PCR to the pre-determined full annual recertification and state licensure survey and the investigation of complaint #IN00407148. Survey dates: 6/5/24, 6/6/24, 6/7/24 and 6/10/24. Facility Number: 000956 Provider Number: 15G442 AIM Number: 100244760 This deficiency also reflects a state finding in accordance with 460 IAC 9. Quality Review of this report completed by #15068 and #27547 on 6/19/24.	W 0000		
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A's fall risk plan incorporated the risk of syncope (loss of consciousness) and medical discharge instructions.	W 0240	The Facility will ensure that the Nurse will review all HRPs, with focus on Client A's fall HRP. Syncope will be added to the fall risk plan and then nurse will retrain the staff on all HRPs. The Facility will add nonslip	07/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tracy Callahan	Program Manager	07/01/2024

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	Findings include: An observation was conducted on 6/5/24 from 3:32 PM to 4:43 PM. During the observation, client A wore a hard plastic boot on her right foot. Upon entering the home, client A was seated at the dining room table with her leg elevated in a chair while wearing the boot around her ankle. At 4:23 PM, client A participated in the evening meal and continued to wear the boot on her right foot. Client A wore the hard plastic boot throughout the observation period. During this observation, new flooring was observed throughout the kitchen and dining room. On 6/6/24 at 10:21 AM, a review of the facility's Bureau of Disabilities Services (BDS) reports was conducted. The review indicated the following affecting client A: -BDS incident report dated 3/24/24 indicated, "It was reported [client A] went to sit down in a chair at the kitchen table and missed the chair causing her to fall onto her bottom. [Client A] was able to get up on her own. [Client A] then went to get her bread and condiments and fell a second time onto her bottom. [Client A] again was able to get up on her own. Staff notified the nurse and assessed [client A] for injuries noting no visible signs of redness or injuries, but [client A] stated her buttock was sore. A couple of hours later in the day, [client A] fell and immediately got herself back up when called to come take her medicine. [Client A] had no complaints of pain or discomfort. Staff notified the nurse who requested [client A] be transported to the ER (emergency room) for evaluation. Plan to Resolve: [Client A] was evaluated in the ER and discharged to her home. Discharge diagnosis: Lisfranc (bones in midfoot) fracture right foot ... Discharge		treads to the van steps and the interior floor of the van to help with client stability. The Facility staff will be retrained on assisting clients 1 by 1 especially those at risk for falls when entering and exiting the van. The Facility will ensure that staff are retrained on giving verbal prompts to Client A on ensuring she has gained her balance before trying to ambulate. The Facility will ensure follow up appointment with a Neurologist to rule out seizure activity. The Facility will ensure that the staff are trained on notifying the nurse immediately of all incidents regarding falls. The Facility will ensure that the Nurse will review all HRPs, with focus on Client A's fall HRP. Syncope will be added to the fall risk plan and then nurse will retrain the staff on all HRPs. The Facility will add nonslip treads to the van steps and the interior floor of the van to help with client stability. The Facility staff will be retrained on assisting clients 1 by 1 especially those at risk for falls when entering and exiting the van. The Facility will ensure that staff are retrained on giving verbal prompts to Client A on ensuring she has gained her balance before trying to ambulate. The Facility will ensure	

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	instructions: Referral to [Medical Provider Name] within 1 week. Non-weight bearing in boot and wheelchair. Follow-up primary care upon discharge for visit today. Staff have been trained on discharge instructions. Staff will continue to monitor [client A], ensure she follows all instructions, attends all follow-up appointments, and will notify the nurse of any changes". -BDS incident report dated 5/17/24 indicated, "It was reported [client A] had her head down and was not responding to staff when they called her name. Staff called 911 and [client A] was transported to the ER (emergency room) for evaluation. The nurse was notified. Plan to Resolve: [Client A] was evaluated in the ER and discharged to her home. Discharge diagnosis: Syncope (loss of consciousness), lightheadedness. Labs completed ... Discharge Instructions: Continue taking previously prescribed medications as directed. Change positions slowly and call for help if you begin feeling dizzy. Use ambulatory aid such as cane or walker. Get plenty of fluids. Follow-up with neurologist for further evaluation and management of lightheadedness and near syncope. Follow-up with PCP (primary care physician) as needed. Return to the ER for new or worsening symptoms. Staff have been trained on the discharge instructions. Staff will continue to monitor [client A], follow her plans in place, and notify the nurse of any changes. No further incidents have been reported". -BDS incident report dated 5/24/24 indicated, "It was reported [client A] wheeled herself into the kitchen and reported to staff she fell while in the restroom. Staff noted a knot on [client A's] forehead between her eyes at the top of her nose. Staff called 911 and [client A] was transported to		follow up appointment with a Neurologist to rule out seizure activity. The Facility will ensure that the staff are trained on notifying the nurse immediately of all incidents regarding falls.	

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	the ER for evaluation. The nurse was notified. Plan to Resolve: [Client A] was evaluated in the ER and discharged to her home. Discharge diagnosis: Head injury, adult. No signs of fractures noted. Head injury information sheets were provided. Discharge instructions: Follow-up with PCP (primary care physician) in 2 to 3 days. Staff have been trained on the head injury information sheets and discharge instructions. Staff will continue to monitor [client A] and notify the nurse of any changes. The ID (interdisciplinary) team will meet to discuss additional measures needed to better assist [client A]. No further incidents have been reported". On 6/6/24 at 11:49 AM, a focused review of client A's record was conducted. The review indicated the following: Fall Risk Plan dated 6/5/24 indicated, "Problem Risk of Falls ... Goal: Will have no injury related to falls through June 2025... Approach: 1. Staff will provide stand-by assistance with helping [client A] onto the van. 2. Staff will keep the environment free of any obstacles to prevent falls. 3. Staff will encourage client to wear shoes while ambulating/transferring. 4. Staff will ensure that [client A] wears walking boot while ambulating as prescribed by Orthopedic specialist. 5. Staff will notify nurse of any falls...". -No syncope health risk plan was available for review. On 6/6/24 at 12:18 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about client A's falls with injuries. The QAM stated, "We met and did a trend analysis. We've seen what you're seeing. [Qualified Intellectual Disabilities Professional/QIDP] did			

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	additional training with staff. [Nurse] is doing more follow-up with OT/PT (Occupational Therapy/Physical Therapy)...". The QAM indicated the team did not find any one particular contributing factor to the falls. The QAM indicated she would provide additional follow-up for medical discharge paperwork for the diagnosis of syncope. On 6/6/24 at 1:55 PM, a review was conducted of medical discharge paperwork for the diagnosis of syncope. The review indicated the following: "[Client A's] 12/2023 fall risk plan has the following approach: 'Staff will provide stand-by assistance with helping [client A] onto the van... Staff will keep the environment free of any obstacles to prevent falls... Staff will encourage client to wear shoes while ambulating/transferring... Staff will ensure that [client A] wears walking boot while ambulating as prescribed by Orthopedic specialist'... [Client A] attended her follow-up appointment on 3/28/24. Physician/Consultant Orders: Right 2nd/3rd Metatarsal (bones in foot) base fractures - boney Lisfranc (broken foot) injury. Can weight bearing in boot for short distances only - cannot walk without boot. Recheck in 2 weeks for repeat x-rays. If stable, then no surgery. If fractures move, will need surgery for fractures... Staff need to monitor [client A] when she is ambulating and give verbal prompts to ensure she stands and gains her balance before ambulating... Conclusion: It is substantiated [client A] fell and there are risk plans in place which appropriately			

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	address falls and metatarsal fractures. It is substantiated [client A's] fall risk plans were being implemented at the time of each fall... Recommendation: Staff to monitor [client A] when she is ambulating and give verbal prompts to ensure she stands and gains her balance before ambulating". Medical Discharge dated 5/16/24 indicated, "Instructions:... Change positions slowly and call for help if you begin feeling dizzy. Use ambulatory aids such as cane or walker. Get plenty of fluids. Follow-up with neurologist for further evaluation and management of lightheadedness and near syncope. Follow-up with primary care provider as needed...". The recommendations for changing positions slowly and to call for help if feeling dizzy, the use of ambulatory aids and to drink plenty of fluids were not incorporated into client A's fall risk plan or a syncope risk plan. On 6/6/24 at 3:28 PM, the Nurse was interviewed. The Nurse was asked about client A's fall risk plan not indicating a risk of syncope to contribute to falls or a syncope risk plan available for review. The Nurse indicated a syncope risk plan had been developed and would provide a copy for review. The Nurse was asked how the hospital discharge instructions from a syncope diagnosis had been incorporated into client A's fall risk plan. The Nurse stated, "The only difference with syncope and fall risk is complaints of light headedness or dizzy. I could combine them. It really could have been combined with that. The only thing I see different is the client could report if she feels dizzy or lightheaded". The Nurse was asked if client A used ambulatory aids. The Nurse stated, "She does not". The Nurse was asked if other			

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	discharge instructions needed to be incorporated into client A's fall risk plan besides client A's reporting of feeling dizzy or lightheaded and need for staff assistance. The Nurse stated, "Getting plenty of fluids, yeah that's on here (syncope risk plan). Encourage water intake. I guess that should be more daily. I guess I should split that (fluid intake), encourage water daily and encourage her to consume at least 4 ounces of water at med (medication) administration. I may need to have both (risk plans). The Fall Risk plan is more along the line of assisting, wearing the boot, assistance on and off the van. I could incorporate more of the syncope for dizzy or lightheadedness (requesting staff assistance) into the falls plan". On 6/6/24 at 4:30 PM, a focused review of client A's 5/17/24 syncope risk plan was conducted. The review indicated, "Triggers to Notify Nurse: Complaints of dizziness or lightheaded... Expected Outcome: [Client A] will have no injuries related to falls from Syncope thru May 2025... Actions: 1) Medications as ordered, 2) Encourage water intake daily and at medication administration, 3) Change positions slowly, 4) Staff will encourage [client A] to report if she is feeling dizzy or lightheaded, 5) Staff will assist as needed when getting on and off the van, 6) Staff will keep environment free of obstacles that may cause a fall...". Based on review of client A's fall risk plan, syncope risk plan and interview with the Nurse, client A's risk plan for the prevention of falls did not indicate the medical discharge instruction for client A to ask for help when feeling dizzy or lightheaded. The Nurse indicated further review of client A's fall risk and syncope risk plans to determine if one plan or two was needed. The Nurse indicated more detail could be added to			

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	both the fall risk and syncope risk plan such as, asking for help when dizzy or lightheaded in the fall risk plan and 4 ounces of fluid intake during medication administration for the syncope risk plan. In addition, the Nurse indicated follow-up to obtain a neurological consult to rule out the potential for seizure activity and/or any neurological factors was being pursued and any necessary revision would be made for client A's health risk plans. This deficiency was cited on 1/19/24. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaint #IN00426049. 9-3-4(a)			