

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G080	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2024
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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	STREET ADDRESS, CITY, STATE, ZIP COD 725 CARR ST MILAN, IN 47031
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W 0000 Bldg. 00	<p>This visit was for a pre-determined full annual recertification and state licensure survey.</p> <p>Survey dates: 11/4/24, 11/6/24, 11/7/24 and 11/8/24.</p> <p>Facility Number: 000623 Provider Number: 15G080 AIM Number: 100233870</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/26/24.</p>	W 0000		
W 0149 Bldg. 00	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS</p> <p>Based on record review and interview for 1 former client (#1), the facility failed to implement the abuse, neglect, exploitation, mistreatment and/or violation of individual's rights policy to prevent staff negligence to ensure former client #1's change in health status was immediately reported.</p> <p>Findings include:</p> <p>On 11/4/24 at 2:07 PM, a review of the facility's Bureau of Disabilities Services (BDS) incident reports and accompanying investigation summaries was conducted. The review indicated the following affecting former client #1:</p> <p>BDS incident report dated 8/2/24 indicated, "Investigation completed for the unknown injuries... Cause of injuries cannot be determined. However, timeline of events suggests noted</p>	W 0149	<p>W149: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Corrective Action: All staff retrained on the Abuse and Neglect Policy. (Attachment A) Rescare terminated 3 employees as a result of the investigation with former client (1). (Attachment B) All BDDS reportable incidents are reviewed by Rescare Management during Peer Review. QIDP conducts IDT team</p>	12/12/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anna Brison	Program Director	12/10/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined other safeguards 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 disclosed 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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	<p>change in breathing, decreased appetite, insomnia and vomiting on 7/21 (2024), likely resulted in trauma on that date during 3rd shift, from an undetermined source resulting in redness on forehead (bruising) and other significant injuries... It is substantiated the site lead did not follow policies and procedures, neglecting to report changes in condition to the nurse between 7/16 and 7/22... Plan to Resolve: Preventive measures: 1) Operation-wide retraining to be conducted on all nursing / medical procedures and protocols. 2) Termination of employment: [former staff #1], [former staff #2] and [former staff #3] for policy violations. 3) Documentation retraining with [name of group home] staff...".</p> <p>Investigation summary dated 7/22/24 through 7/30/24 indicated, "Introduction:... On 7/21/24 [former client #1] vomited but walking and eating normally. She started to appear not to feel well, wheezing, staff took her O2 (oxygen saturation) with a reading of 88 and she was taken to [name of hospital]... At ER (emergency room) she was diagnosed with Bilateral Pneumothorax (collapse of lungs), broken ribs old and new, Bilateral iliac wing (pelvic) fractures, liver lesion (mass/tumor), small iliac GI (gastrointestinal blockage in small intestine) obstruction...</p> <p>Fact Findings:...</p> <p>7/16-7/19 (2024) - coughing present...</p> <p>7/17 - Nurse visit in home notes no concerns, no cough present...</p> <p>7/18 - Sleeping more than usual noted with stiff neck noted upon return from day program...</p> <p>7/18 - Spending more time in her wheelchair than normal...</p> <p>7/19 - Coughing reported to site lead...</p> <p>7/21 - [Former client #1] sitting up in her bed awake rather than laying down per usual,</p>		<p>meetings following a reportable incident to discuss the incident, outcomes and plans for what can be put in place to prevent future incidents.</p> <p>Quality Assurance Coordinator tracks all incident, BDDS and internal reports into a database. The database will be used to track patterns or trends with incidents and will be utilized during peer reviews and quarterly safety meetings.</p> <p>Monitoring of Corrective Action:</p> <p>The Program Manager will review all Individual Support Plans and Behavior Support Plans to ensure plans meet all needs of the individuals served.</p> <p>IDT meeting forms are sent to the Program Manager for review.</p> <p>Abuse and Neglect Policy will be trained annually and reviewed monthly with all staff.</p> <p>Rescare Administration will have monthly meetings to discuss trends and patterns with individuals.</p> <p>Completion Date: 12/12/24</p>	
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	<p>decreased appetite, insomnia (sleep disorder), redness noted on forehead, vomiting. Reported to site lead.</p> <p>7/22 - Bruising noted on forehead, poor appetite, labored breathing. All present when site supervisor on duty, but no action taken until after SL (site lead) leaves site...</p> <p>Review of Change in Condition Policy: Any significant change in a member's physical, mental, or psychological status must be reported to a nurse or supervisor and evaluated timely...</p> <p>Conclusion: Cause of injuries cannot be determined. However, the timeline of events suggest noted change in breathing, decreased appetite, insomnia and vomiting on 7/21, likely resulted in trauma on that date during 3rd shift, from an undetermined source, resulting in redness on forehead (bruising) and other significant injuries. It is substantiated the site lead did not follow policies and procedures, neglecting to report changes in condition to the nurse between 7/16 - 7/22...</p> <p>Investigation Peer Review:... 1) Review and revise BSP (Behavior Support Plan) as needed... 2) Operation-wide retraining to be conducted... nursing/medical procedures and policies... 3) Termination of employment: [Former staff #1], [former staff #2], and [former staff #3] for violations of change in condition policy... 4) Retraining to [name of group home] home staff, to be conducted by AS (Area Supervisor) for entering timely services delivery logs and to ensure all flowsheets documentation is completed accurately and thoroughly during each shift... 5) AS will ensure an updated phone/fax list is posted in the home reflecting the current nurse and her contact information..."</p>			

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W 0214 Bldg. 00	<p>On 11/7/24 at 12:47 PM, the Qualified Intellectual Disabilities Professional/Investigator (QIDP) was interviewed. The QIDP was asked about former client #1's incident of unknown injuries and the conclusion of the investigation. The QIDP stated, "She had a bruise and they (staff) did not report it". The QIDP was asked about the implementation of the abuse, neglect and exploitation policy and how staff negligence had occurred. The QIDP stated, "That they did not report the unknown injury. There were several days where she was not feeling well". The QIDP indicated staff failed to communicate the health status change of former client #1 to both nursing services and their Area Supervisor. The QIDP was asked if neglect had been substantiated. The QIDP stated, "Yes". The QIDP was asked if the abuse, neglect and/or exploitation policy should be implemented at all times. The QIDP stated, "Yes".</p> <p>On 11/7/24 at 2:17 PM, a review of the Abuse, Neglect, Exploitation policy dated 7/18/11 indicated, "Staff actively advocate for the rights and safety of all individuals... ResCare strictly prohibits abuse, neglect, exploitation, mistreatment...".</p> <p>9-3-2(a) 483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#2), the facility failed to assess client #2's excessive sleeping and lack of engagement in her daily routine and activities.</p> <p>Findings include:</p>	W 0214	<p>W214: Individual Program Plan</p> <p>Corrective Action: QIDP put in place a sleep tracking for use during day program hours to track the frequency of client (2) sleeping.</p>	12/12/2024
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	<p>An observation was conducted at client #2's day service location on 11/6/24 from 9:32 AM to 10:44 AM. Upon entering client #2's day service, client #2 was lying on a bean bag with a blanket over her. Client #2 remained on the bean bag with the blanket over her through the duration of the observation. At 10:03 AM, Day Service Staff (DSS #1) was asked what client #2 liked to do while at day program. DSS #1 indicated she had only worked at the day service location for 2 weeks, paused and stated, "We'll take her outside". DSS #1 was asked if client #2 liked lying on the bean bag. DSS #1 stated, "Yes, she does".</p> <p>At 10:06 AM, the Day Service Team Lead and DSS #3 used verbal prompts with client #2 requesting she get up to participate in activities. Client #2 declined. At 10:07 AM, the Day Service Team Lead stated, "She refuses a lot. She'll get up to eat and tell us when she needs to go to the bathroom". The Day Service Team Lead was asked if client #2 had a goal to monitor her participation and/or refusals. The Day Service Team Lead stated, "We'll put it in our notes". The Day Service Team Lead indicated client #2 was lethargic and stated, "She'll fall asleep just trying to walk". The Day Service Team Lead was asked about client #2's past experiences with day service activities, as it was indicated client #2 was temporarily participating at this location until her previous location was operational once again. Day Service Team Lead indicated she had not worked at the previous location and stated as she shook her head yes, "I asked the same question when I started. Yes, that's normal. The most they've ever got her to do is sit outside 10 minutes. I would love to see her get more involved. Things that she likes, she'll tell you the most wild stories. We tried to get her to paint a</p>		<p>(Attachment C) QIDP trained all day program staff on the updated sleep tracking. (Attachment D) There will be weekly day program observations completed by either the Area Supervisor, QIDP, Nurse or Program Manager. (Attachment E)</p> <p>Monitoring of Corrective Action: The QIDP, Area Supervisor, Nurse and Program Manager will complete and turn in Day Program Observations to the Program Manager for monitoring and to ensure completion. The QIDP will update all client plans annually and as needed and ensure all staff are trained on any plans or changes to plans. QIDP will review plans quarterly with IDT to ensure all issues are being addressed.</p> <p>Completion Date: 12/12/24</p>	

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	<p>turkey with us or read stories. Sometimes I will sit beside her while she's lying down and read. A lot of times she'll tell me to go away, she wants to sleep. I don't know if she has her days and nights turned around or if it's medication. I could not say".</p> <p>At 10:21 AM, client #2 continued to lay on the bean bag with a blanket pulled up over her. DSS #3 was asked how long she had worked with client #2. DSS #3 stated, "I've worked with her since 7/3/24". DSS #3 was asked if she worked with client #2 when she attended the previous location or the current temporary placement for day services. DSS #3 stated, "Yes" and indicated she had worked with client #2 in both locations. DSS #3 was asked if client #2 would lay on the bean bag and disengage from activities at both locations. DSS #3 stated, "Yes, every day". DSS #3 was asked if client #2 was sleeping. DSS #3 stated, "98 % of the time". DSS #3 was asked why she felt client #2 slept while attending day service. DSS #3 stated, "I would say meds (medications)". DSS #3 was asked if client #2 had a goal or methodology to track participation versus refusals and amount of time she slept while attending day program. DSS #3 stated, "Not that I know of ... I've questioned why she's not worked with to use a cane (visual impairment) for walking. A sleep study might be good. They learn a lot from those anymore".</p> <p>At 10:31 AM, the surveyor asked client #2 if she was awake and that he wanted to say goodbye before leaving. Client #2 did not respond, and an audible sound of deep breathing was heard coming from client #2.</p> <p>On 11/7/24 at 11:15 AM, a review of client #2's record was conducted. The review indicated the</p>			

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	<p>following:</p> <p>Individual Support Plan (ISP) dated 7/19/24 indicated the client's diagnoses included, but were not limited to: Attention Deficit Hyperactivity Disorder, Bipolar, Mood Disorder, Insomnia, Anxiety, Psychosis ... Autistic Disorder ... Legally Blind, Cerebral Palsy, Season/Environmental allergies, Headaches/Migraines, High Blood Pressure, Hyponatremia (low sodium) ... Thrombocytopenia (fewer blood platelets), Osteoporosis (weak bones)...</p> <p>Challenging Behaviors:...</p> <p>Disruptive Behavior: Yelling, screaming, cursing, or shouting when she is upset. Repeatedly talking to self in a loud voice. Repeatedly slamming her bedroom door...</p> <p>Self-Injurious Behavior: Behavior that is harmful to herself (i.e., head banging, pulling her hair, hitting head with hand/fist, hitting top of legs with hand/fist), pinching arms, banging legs against furniture. May make a comment that she is going to hurt/kill herself..</p> <p>Physical Aggression: Attempts to physically harm another person by hitting or slapping. Throwing items, grabbing at others...</p> <p>Lying: Exaggerated truths or non-truthful statements...</p> <p>Insomnia: Inability to fall asleep or stay asleep...</p> <p>Delusional Thoughts: Seeing and hearing things that are not present or true such as Grandpa died, grandma got sucked up by a tornado, looking out the window saying she sees people fighting,</p>			

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	<p>saying her skin is hot or on fire, saying there is a shooter, etc. Delusional thoughts leading to pacing the floor, pinching arms, banging legs against furniture, throwing items, grabbing at others, slamming her bedroom door, saying she is going to leave at a certain time...</p> <p>Generalized Anxiety, defined as: Excessive worrying over upcoming plans such as home visits. Feelings of uneasiness. Difficulty staying on task, excessive talking...".</p> <p>Interdisciplinary Team Meeting dated 10/24/24 indicated, "Medical:... 9/5 (2024) [Name of Doctor] states she needs muscle strengthening and recommends her to increase movement by moving around the house more with staff..</p> <p>Behavioral:... 4/11/24 Lamictal was increased to 25 mg (milligrams) BID (twice a day) and Fluvoxamine AM (morning) dose increased to 100 mg. Med (medication) reduction plan reviewed and criteria not met. Team agrees not to seek a medication reduction...</p> <p>Day Program/Workshop: Attends [name of day program], currently at the [city] location. She does tend to nap a lot at day program. Does seem to like the new music program. Has sat on the swing outside. Team agrees attending day program is beneficial to [client #2] to provide structure, routine, socialization...".</p> <p>Sleep Tracking Log dated October 2024 indicated the daytime hours Monday through Friday as "DP" for attending day program between 8 AM through 3 PM. Client #2's extended period of awake hours for an hour or more occurred on the following dates and times: 10/1/24 from 12 midnight to 2 AM...". Client #2's Sleep Tracking</p>			

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	<p>log indicated routine sleeping with occasional night of getting up for less than 30 minutes with regular sleep being obtained with the exception of 10/1/24. No data was recorded on 10/7/24 between the hours of 12 midnight to 6 AM. Insomnia is not indicated through client #2's sleep tracking.</p> <p>Sleep Tracking Log dated November 2024 indicated the daytime hours Monday through Friday as "DP" attending day program or "HV" attending a home visit. Client #2's November 2024 sleep tracking log did not indicate an extended period of time of an hour or more where client #2 was awake and not sleeping between midnight and 6 AM or 8:00 PM to midnight. Insomnia is not indicated through client #2's sleep tracking.</p> <p>On 11/7/24 at 11:26 AM, the Qualified Intellectual Disabilities Professional Designee (QIDPD) and the QIDP were interviewed. The QIDPs were asked about client #2's sleeping habits and the indication client #2 was sleeping more and disengaged from activities. The QIDPD indicated the interdisciplinary team had met and determined day program was believed to be beneficial to add routine and structure. At 11:52 AM, the QIDP stated, "Since the loss of eyesight, the sleeping is thought to be associated to the loss of eyesight. I think sleeping is a lot of the eyesight". The QIDP indicated client #2 had also experienced the passing of her grandmother and the interdisciplinary team's initial concern this could increase client #2's behaviors. The QIDP indicated an increase in behavior had not occurred.</p> <p>On 11/7/24 at 11:55 AM, the Area Supervisor (AS) was interviewed. The AS stated, "We try to get her to be more involved. She would want to go lay down". The AS indicated client #2 would want to go lay down after returning from day program and</p>			

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W 0240 Bldg. 00	<p>staff had worked with client #2 to stay up and remain in the common areas with her peers.</p> <p>On 11/7/24 at 12:07 PM, the Nurse was interviewed. The Nurse was asked about client #2's sleeping pattern and lack of engagement in activities. The Nurse stated, "I've made notes... I want to get better data and go to Neuro (Neurologist) and maybe a sleep study. We need weekend data as well". The Nurse indicated further follow up and assessment of client #2's sleep and routine was needed to rule out medical and/or behavioral concerns that could contributing factors.</p> <p>9-3-4(a) 483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN</p> <p>Based on observation, record review and interview for 1 of 3 sampled clients (#3), the facility failed to ensure client #3's restrictive intervention for securing latex gloves due to a newly developed behavior for ingesting non-edible items was across all settings and included her day program.</p> <p>Findings include:</p> <p>On 11/4/24 at 2:07 PM, a review of the facility's Bureau of Disabilities Services (BDS) incident reports was conducted. The review indicated the following affecting client #3:</p> <p>BDS incident report dated 10/21/24 indicated, "[Client #3] was saw (sic) in the ER (emergency room) on [date] for evaluation of passing latex gloves during a bowel movement ... Staff report Sunday during a bowel movement she again</p>	W 0240	<p>W240: Individual Program Plan</p> <p>Corrective action: The QIDP updated completed an addendum to client (3) Individual Support Plan. (Attachment F) QIDP trained all staff at the Day Program and home staff regarding the addendum to the Individual Support Plan for client (3). (Attachment G) There will be weekly day program observations completed by either the Area Supervisor, QIDP, Nurse or Program Manager. (Attachment E)</p>	12/12/2024

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	<p>passed several latex gloves requiring staff to manually remove. After she returned from day program yesterday she again passed latex gloves with staff manually removing. Nurse has contacted the PCP (primary care physician) for follow up and received a referral to psych (psychologist). Also, as preventative measures [client #3] has been placed in line of sight (supervision) during waking hours and latex gloves have been secured in the med (medication) room". Plan to Resolve: [Client #3] is not assessed with this behavior and does not currently require psych services. [Client #3] does not have a history of this sort of behavior. As preventative measures [client #3] has been placed in eyesight during waking hours, latex gloves secured in the med room, increasing monitoring of bowel movement with the Nurse contacted after one day of no bowel movement".</p> <p>BDS incident report dated 11/3/24 indicated, "[Client #3] is a [age] old female. She has developed a new behavior of eating non-edible items (latex gloves). She has been seen in the ER (emergency room)... Her BSP (Behavior Support Plan) has been revised adding strategies to prevent this behavior including keeping her in line of sight during walking (sic) hours. Last evening [client #3] was sitting next to a client that had a rubber band around papers. The client removed the rubber band from the papers and the (sic) handed to [client #3]. [Client #3] put the rubber band in her mouth and swallowed it before staff could get the rubber band. The two ER visits resulted with the attending physician stating the non-edible items of plastic would pass without issues. Plan to Resolve: [Client #3] remains in line of sight during waking hours. [Client #3] swallowed the rubber band very quickly before staff could get the rubber band. Her BSP has been</p>		<p>Monitoring of Corrective Action:</p> <p>The QIDP, Area Supervisor, Nurse and Program Manager will complete and turn in Day Program Observations to the Program Manager for monitoring and to ensure completion.</p> <p>The QIDP will update all client plans annually and as needed and ensure all staff are trained on any plans or changes to plans.</p> <p>QIDP will review plans quarterly with IDT to ensure all issues are being addressed.</p> <p>Completion Date: 12/12/24</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G080	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/08/2024
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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	STREET ADDRESS, CITY, STATE, ZIP CODE 725 CARR ST MILAN, IN 47031
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	<p>revised. Staff will continue to monitor [client #3]".</p> <p>An observation was conducted at the facility operated day service location on 11/6/24 from 12:28 PM to 1:30 PM. During the observation, client #3 remained in the movie room with a group of peers and staff #1 from her group home. At 1:10 PM, blue latex gloves were observed on top of a bookshelf with a box of blue latex gloves inside a plastic dispenser that hung on the wall adjacent to a bathroom toilet. The blue latex gloves were not secured in the day program's medication administration room.</p> <p>On 11/7/24 at 10:23 AM, client #3's record was reviewed. The review indicated the following:</p> <p>Individual Support Plan Addendum dated 10/22/24 indicated, "Purpose of Meeting: On Friday 10/18/24 during a bowel movement staff found two small pieces of a latex glove during a bowel movement. She was evaluated at [name of hospital] ER (emergency room). An x-ray and CT scan was (sic) completed finding two kidney stones - referred to urology and psych. [Client #3] is not assessed with behavior of eating non-edible objects and has no history of this behavior. On Sunday 10/20/24 and Monday 10/21/24 she passed latex gloves with bowel movements. As preventative measures the team has agreed to the below revisions to her plan...</p> <p>Changes to be implemented to current plan</p> <ol style="list-style-type: none"> [Client #3] will remain in line of sight of staff during waking hours including restroom usage... Develop a definition for eating non-food items... Addendum of a reactive strategy should [client #3] place a non-edible object in her mouth... <p>How changes to the current plan with be</p>			

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	<p>implemented:</p> <p>Definition: Eating Non-Food items; Defined as: Anytime [client #3] attempts to place a non-edible object in her mouth. Notify the nurse if she eats a non-edible item...</p> <p>Add to Proactive Strategies: [Client #3] is to be in line of staff during waking hours including restroom usage...</p> <p>Add to environmental strategies: All gloves are to be kept in the med room...".</p> <p>On 11/7/24 at 11:05 AM, the Qualified Intellectual Disabilities Professional Designee (QIDPD) and the Qualified Intellectual Disabilities Professional (QIDP) were interviewed. The QIDPs were asked about client #3's incidents of ingesting latex gloves and the restriction for securing the gloves in the medication administration room across all environments such as the day program. The QIDPD stated, "If she's kept in eyesight, across all environments, we need to look a little deeper. Within the home, kept in the med room. We need an IDT (interdisciplinary team meeting)". At 11:10 AM, the QIDP stated, "We have another IDT schedule on the 14th (November 2024)". The QIDPD and QIDP indicated further follow up was needed by the interdisciplinary team to consider all environments where client #3 had access to latex gloves, the responsibilities to ensure line of sight supervision was maintained and how and where gloves would be secured to limit client #3's access to them while attending day program.</p> <p>9-3-4(a)</p>			