STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G080	A. BUILDING 00 B. WING	01/22/2021

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RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CARR ST MILAN, IN 47031

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W 0000 Bldg. 00	This visit was for the investigation of Complaint #IN00333573 and Complaint #IN00323803. This visit was in conjunction with a pre-determined full annual recertification and state licensure survey. This visit included a Covid-19 focused infection control survey. Complaint #IN00333573: Substantiated, Federal and state deficiency related to the allegation(s) was cited at W149. Complaint #IN00323803: Substantiated, Federal and state deficiency related to the allegation(s) was cited at W149. Survey dates: 1/19/21, 1/20/21, 1/21/21 and 1/22/21. Facility Number: 000623 Provider Number: 15G080 AIMS Number: 100233870 This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 and #27547 on 2/4/21.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 19 of 19 incident reports affecting client A, client B and former client H, the facility failed to implement its policy and procedures for prohibiting Abuse,	W 0149	**W149:** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of	02/21/2021

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

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	Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights to 1) address former client H's continued pattern of elopement behavior and 2) address the pattern of falls for clients A, B and former client H. Findings include: 1) On 1/19/21 at 2:08 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and Investigative Summaries was completed. The reports indicated: -BDDS report dated 4/3/20 indicated, "[Former client H] is assessed as an elopement risk and has a BSP (Behavior Support Plan) to address elopement... Staff continued to encourage [former client H] to return to the home until he was out of sight of staff. [Former client H] was out of eyesight of staff for appropriately (sic) 20 minutes... Staff called another staff and [former client H] was found at the corner of [street name] and [highway name] about ¾ mile from the group home...". Investigation summary dated 4/7/20 indicated, "Factual findings: ...6. [Former client H] was gone from the group home and out of sight of staff for appropriately (sic) 20 minutes...". -BDDS report dated 5/13/20 indicated, "... When the staff came back into the living room [former client H] was sitting on the couch eating the bag of peanuts. Staff asked [former client H] about the peanuts and [former client H] got upset. [Former client H] got up from the couch ran out the front door and down the road. Staff called another staff that lives in town and that staff went to look for [former client H]. Staff found [former client H] walking on [street name] down from the home.		the client. **Corrective Action:** ·All staff retrained on the Abuse and Neglect Policy. **(Attachment A)** ·All BDDS reportable incidents are reviewed by Rescare Management during Peer Review. ·QIDP conducts IDT team meetings following a reportable incident to discuss the incident, outcomes and plans for what can be put in place to prevent future incidents. ·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. ·Area Supervisor and QIDP will review all ISP and BSP's during monthly staff meetings to ensure we are being proactive to prevent incidents. ·Former client (H) moved to waiver setting 10/20/20. ·QIDP will update BSP's annually and as needed. **Monitoring of Corrective Action:** ·The Program Manager will review all Individual Support Plans and Behavior Support Plans to ensure plans meet all needs of the	

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	Staff returned [former client H] to the house. He (former client H) had no injuries. [Former client H] was gone from the home for approximately 10 minutes". Investigation summary dated 5/19/20 indicated, "Factual Findings:... 7. [Former client H] was gone from the group home and out of sight of staff for appropriately (sic) 10 minutes". -BDDS report dated 6/12/20 indicated, "... At about 10:20 PM, [former client H] was upset and ran out the front door, down the driveway and processed (sic) to run down the road. Staff call(ed) 911 for assistance. Police officers located [former client H] at about 10:30 PM and brought him back to the home...". Investigation summary dated 6/18/20 indicated, "Factual findings:... 7. [Former client H] was gone from the group home and out of sight of staff for appropriately (sic) 10 minutes. Police returned [former client H] to the group home and purchased him a soft drink to get him out of the police car". -BDDS report dated 6/28/20 indicated, "The home had just finished having dinner. Another client was in the kitchen cabinets getting out food and [former client H] yelled at him to get out of the cabinets. Staff told [former client H] 'don't yell at him, I don't want him to attack you'. [Former client H] got mad and 'stormed' out the front door and out of sight of staff. Staff called 911 to report the elopement and obtain police assistance to return [former client H] to the home. [Name of sheriff's office] officer located [former client H] and returned him to the home...". Investigation summary dated 7/3/20 indicated, "...		individuals served. ·IDT meeting forms are sent to the Program Manager for review. ·Abuse and Neglect Policy will be trained annually and reviewed monthly with all staff. ·Rescare Administration will have monthly meetings to discuss trends and patterns with individuals. **Completion Date: 2/21/21**	

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	7. [Former client H] was gone from the group home and out of sight of staff for appropriately (sic) 25-30 minutes. Police returned [former client H] to the group home and purchased him a soft drink and a pack of cigarettes...". -BDDS report dated 7/24/20 indicated, "[Former client H] came to staff and said he wanted to go to the store to get a soft drink. Staff explained that the other staff had just left to pick up other clients from the day program and he would need to wait until they returned. [Former client H] became upset and started (sic) he would go on his own and told staff to call the police and have him arrested. [Former client H] walked out the front door and processed (sic) to walk down the road out of sight of staff. Staff called 911 for assistance. [City] police department responded, called the home stating they had [former client H] and taking him to the gas station to purchase a soft drink. Police returned [former client H] to the home. He (former client H) was out of sight of staff for appropriately (sic) 35 minutes". Investigation summary dated 7/27/20 indicated, "Factual findings:... 7. [Former client H] was gone from the group home and out of sight of staff for appropriately (sic) 35 minutes. Police returned [former client H] to the group home and purchased him a soft drink". -BDDS report dated 7/25/20 indicated, "[Former client H] went to staff and said he wanted to go to the store to get a soft drink. Staff explained they were unable to go to the store but would go later. [Former client H] got upset and said he wanted to go now and was going by himself. [Former client H] walked out the door, staff tried to redirect not to leave but he continued to walk down the road. Staff watched [former client H] walk out of sight,			

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	went back inside the house and called the police. At about 12:10 PM, staff saw [former client H] walk into the yard without police. Staff called 911 to report [former client H] had returned to the home on his own". Investigation summary dated 7/27/20 indicated, "Factual Findings:... 7. [Former client H] was gone from the home for appropriately (sic) 45 minutes...". -BDDS report dated 8/4/20 indicated, "[Former client H] and staff was (sic) sitting on the front porch. [Former client H] asked staff to go get his money, the van keys and take him to the store. Staff walked inside the house got his money and keys and when staff walked back outside [former client H] was gone. Staff called 911 for assistance. Police found [former client H] and returned him to the group home. [Former client H] did not have any injuries. [Former client H] was out of eyesight of staff for appropriately (sic) 33 minutes". Investigation summary dated 8/6/20 indicated, "Factual findings:... 8. [Former client H] was gone from the group home and out of sight of staff for appropriately (sic) 33 minutes. Police returned [former client H] to the group home". -BDDS report dated 8/4/20 indicated, "[Former client H] was asleep in bed. He came out to the office talking about losing his pipe. Staff stated his pajamas were wet and she asked him if he had wet the bed. [Former client H] pulled a pack of cigarettes from the pocket of his pajamas pants and he was angry the cigarettes were wet. [Former client H] began to yell at staff to help him dry the cigarettes. Staff stated she told [former client H] he probably wet the bed because of all the soft drinks he has been buying and drinking. [Former			

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	client H] stated he was leaving and ran out the front door. Staff called police to report the elopement. Police called back to the home stating they found him at [name] gas station that he was standing in the store drinking a soft drink and refused to get in the police vehicle and return to the group home. Staff went to the gas station and [former client H] agreed to return to the home". Investigation summary dated 8/6/20 indicated, "Factual findings:... 8. [Former client H] was gone from the group home and out of sight of staff for appropriately (sic) 40 minutes...". -BDDS report dated 5/21/20 indicated, "Today while the Nurse was completing her weekly review of the home [former client H] told her he had fell (sic). [Former client H] had pulled up his pant leg to show the Nurse his left knee stating he had fell while getting the mail but couldn't remember what day. His left knee has a 2" (inch) round abrasion that has scabbed over...". Investigation summary dated 5/28/20 indicated, "When the Nurse came to the home to complete a med (medication) pass observation [former client H] asked if she wanted to look at his right knee. [Former client H] stated he fell but couldn't say when or how". Was medical treatment needed as a result of the fall? "Quarter sized scabbed over area right knee". -BDDS report dated 7/2/20 indicated, "Staff had taken [former client H] to the store to purchase a soft drink. When he got out of the car the [name] distributor products had fallen over into the parking lot and [former client H] was watching the [name] distributor, talking and not paying attention to where he was walking. [Former client H] tripped over the sidewalk curb and fell forward			

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	into the side of store building. He had scratches on the top of his head and knees. He was taken to [hospital name] ER (emergency room) for evaluation. At the ER the attending physician stated there was no need for a CT (computerized imaging) scan of his head and no other test were needed. He was released from the ER with order to apply triple antibiotic ointment to injuries areas". Investigation summary dated 7/3/20 indicated, "... [former client H] was watching the [name] distributor, talking and not paying attention to where he was walking. He tripped over the sidewalk curb and fell forward into the side of the store building". -BDDS report dated 7/31/20 indicated, "[Former client H] was standing in the doorway facing the doorframe and suddenly fell to the floor. Staff immediately assisted [former client H] up from the floor and checked him for injuries. Staff found no visual injuries but [former client H] was complaining of slight pain in both of his hands. Staff assisted him to the couch where he sat down had no further issues". Investigation summary dated 8/5/20 indicated, "[Former client H] was standing in the doorway (front door) facing the door frame and suddenly fell forward out the door and onto (the) concrete porch". Was medical treatment needed as a result of the fall? "No visual injuries (sic) sat on the couch for a few minutes and stated he was fine". -BDDS report dated 8/18/20 indicated, "[Former client H] was in the house and saw a staff pull in the driveway for work. [Former client H] immediately ran out the front door to greet the oncoming staff. He tripped over the concrete speed bump at the end of the driveway and fell to			

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	his knees. Staff assisted him up, checked for injuries finding his right knee to be skinned. Staff applied first aid. [Former client H] did not complain of pain". Investigation summary dated 8/18/20 indicated, "[Former client H] was inside the house, saw the oncoming staff pull in the driveway and went outside to greet her. [Former staff #2] pulled in (and) said [former client H] running/walking fast and tripped over (the) concrete strip at (the) end of the driveway". -BDDS report dated 8/18/20 indicated, "[Former client H] was standing in the living room talking to staff about sitting outside on the porch smoking. Staff told [former client H] they would be right with him and before staff turned around, she heard a loud thump. Staff turned around and [former client H] was sitting on the floor in front of the doorway. Staff assisted him up, he broke his glasses during the fall but had no visual injuries. [Former client H] did not complain of any pain". Investigation summary dated 8/18/20 indicated, "2020: 8/18/20 - morning (2 falls same day) rushed out of house to meet on coming staff. Fell over concrete slab in driveway. 7/30/20 - standing in the front doorway and suddenly fell. Fell asleep. No injuries. 7/2/20 - fell while walking into store, scratches head and knees - ER (emergency room). 5/21/20 - fell on sidewalk R (right) knee quarter size scratch. Recommendation: Seeking neurology review". 2) On 1/19/21 at 2:08 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and Investigative Summaries was completed. The reports indicated:			

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	-BDDS report dated 5/17/20 indicated, "last night during staff's hourly bed check staff found [client A] on his bedroom floor laying (sic) beside his bed with his comforter around him... [Client A] stated he fell when he started to get up to use the bathroom. [Client A] is assessed as a fall risk and has a fall plan". Investigation summary dated 5/17/20 indicated, "... staff was completing a routine hourly bed check at 12:45 AM she walked into [client A's] room, saw he wasn't in his bed nor was his comforter. (Staff) walked around bed he was laying (sic) on the floor (left side of his bed). He was laying (sic) on his left side". -BDDS report dated 8/13/20 indicated, "[Client A] was in his bedroom looking for a CD. He fell to his knees beside the bed. Staff heard the noise (sic) went to his bedroom and assisted him off the floor and to a chair. Staff checked him for injuries finding his right knee to have red marks. [Client A] stated he had no pain". Investigation summary dated 8/12/20 indicated, "[Client A] fell in his bedroom". Was medical treatment needed as a result of the fall? "No, staff assisted him to chair, saw no visual injuries, he stated he had no pain". -BDDS report dated 9/6/20 indicated, "Staff had walked back (sic) the hallway to complete a bed check and [client A] was standing in the bathroom holding onto the tank of the toilet and had urinated and defecated on the floor. Staff asked [client A] to let go of the toilet and let her help him to the shower chair to get a shower. [Client A] continued to stand holding the tank of the toilet and would not move. Staff attempted to help [client A] move toward the shower chair and he			

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	slid down to the floor. Staff was unable to get him up from the floor and called 911 for assistance. EMS (emergency medical services) responded and got [client A] up from the floor and sat him in the shower chair. Staff checked him for injuries and found bruises developing on both arms". Investigation summary dated 9/6/20 indicated, "(At) 4:30 AM [client A] got out of bed and went to restroom. [Staff #3] heard his walker on (the) floor and went to check on him. She found him leaning over the toilet (stomach almost touching the toilet seat). He was stiff and afraid to move. She couldn't get him straightened back up, she had him slide to (the) floor but then couldn't get him off the floor (and) called 911 for assistance". 3) On 1/19/21 at 2:08 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and Investigative Summaries was completed. The reports indicated: -BDDS report dated 4/10/20 indicated, "[Client B] was sleeping in bed. He got up to go to the restroom, got his foot tangled in the comforter and fell forward. He fell to the floor on his stomach. Staff assisted him up and took him to the bathroom. Staff checked for injuries and found a small scratch on his chin/neck. [Client B] had urinated on self and staff cleaned him and assisted him to change his pajamas. Staff assisted him back to bed. [Client B] got up for the restroom a few times after the fall without any issues. Investigation summary dated 4/13/20 indicated, "Briefly describe the incident and sustained injury from the fall: [Client B] was asleep in bed. Staff had just completed a bed check and walked back into the office, Staff heard a noise, went back in [client B's] room and he was laying (sic) on the			

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	floor with his foot caught in the comforter... Do any changes need to be made to prevent future occurrences? He has a fall plan, bed rails, walker and a goal to sit up in bed a few minutes to gain bearings before standing". -BDDS report dated 6/18/20 indicated, "This morning staff heard a noise went to check and found [client B] laying (sic) on the floor with both legs in one leg of his pants. Staff assisted him up and saw no visual injuries". Investigation summary dated 6/23/20 indicated, "... [former staff #1] walked into [client B's] bedroom he was sitting in between bed and chair leaning on 02 (oxygen) tank with both legs in one pant leg of pants". -BDDS report dated 8/17/20 indicated, "[Client B] was walking into the house from the front porch. Another client was walking toward the door to go outside. [Client B] started to hurry to get through the door first and tripped over the threshold of the door and fell onto his knees. Staff assisted him up, checked him for injuries and saw no visual injuries". Investigation summary dated 8/21/20 indicated, "The clients were getting ready to leave for the day program... [client B] was on the porch, [client D] was walking toward the door and [client B] came hurrying through the door tripped, walker flew, and he went to his knees. (The) nurse helped him up and asked if he was trying to beat [client D] through the door and [client B] grinned". On 1/20/21 at 12:31 PM, the Program Manager (PM) was interviewed. The PM was asked about the implementation of the Abuse, Neglect, Exploitation (ANE) policy concerning former client			

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	H's elopements. The PM indicated elopement was considered an aspect of neglect with the provider policy and stated, "That (elopement by former client H), did happen". The PM was asked about the number of incidents where former client H, client A and client B had incidents that resulted in falls. The PM indicated the incidents of client A and client B's falls had occurred and both clients had fall risk plans. The PM was asked if the ANE policy should be implemented to prevent a pattern of elopement and falls and stated, "Yes, absolutely". On 1/20/21 at 3:04 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the implementation of the ANE policy concerning former client H's elopements. The QIDP stated, "Those (former client H's elopements) did occur". The QIDP indicated the police purchasing former client H drinks and or cigarettes during the elopements did not help the situation. The QIDP was asked about the number of incidents where former client H, client A and client B had incidents of falls. The QIDP indicated the incidents for falls had occurred. The QIDP indicated both client A and client B had fall risk plans and used walkers as adaptive devices to assist in their ambulation. The QIDP indicated client A had issues with his feet getting tangled up in his bedding and had a personal safety goal to address why supervision was need. The QIDP indicated client B had experienced falls from rushing and ambulating too quickly. The QIDP indicated client B had a fall risk plan which addressed staff monitoring his ambulation and the use of his walker. The QIDP was asked about the implementation of the ANE policy to prevent a pattern of elopement and falls and stated, "The ANE policy should be implemented at all times, I understand".			

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	15G080	A. BUILDING 00 B. WING	01/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CARR ST MILAN, IN 47031

(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
	On 1/20/21 at 2:53 PM, the Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights policy dated 7/10/19 was reviewed. The policy indicated, "ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare, local, state and federal guidelines ... ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights". This federal tag relates to complaints #IN00333573 and #IN00323803. 9-3-2(a)			