STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>		00	COMPLETED	
		15G811	B. WI	NG		12/06/	2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	-	DATE
W 0000							
Bldg. 00							
Diag. 00	This visit was for the investigation of complaint #IN00446036.		W 0	000			
	_	6036: Federal/state deficiencies tion(s) were cited at W149 and					
	Unrelated deficience	Unrelated deficiencies cited.					
Survey dates: Decem		mber 2, 3, 4, 5 and 6, 2024					
	Facility Number: 013405 Provider Number: 15G811 AIM Number: 201267570						
	accordance with 410	also reflect state findings in DIAC 16.2-5. his report completed by #15068					
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BOI	ΣΥ					
	sampled clients (A, clients (E, F, G, H, T), the facility's gov operating direction of ensure the facility refindings include:  Observations were classified from 11:15 12/3/24 from 7:33 A observations, the form	on and interview for 4 of 4 B, C and D) and 16 additional I, J, K, L, M, N, O, P, Q, R, S and terning body failed to exercise over the facility by failing to emained in good repair.  conducted at the facility on AM until 12:35 PM and on AM until 8:30 AM. During the flowing issues were noted B, C, D, E, F, G, H, I, J, K, L, M,	WO	104	To correct the deficient practice all DSP's have been trained or reporting maintenance issues timely. All maintenance issues being monitored and contracted out for resolution. The administrative staff will conducted daily walk-throughs of the facily to ensure all maintenance issues are reported, as well as any cleanliness issues. All staff, Si Supervisors, QAC, QIDP, and will be retrained on reporting maintenance issues timely to the same control of the control of th	are ed et ity ies te PM	01/06/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Henry Overton Operations Support Specialist 01/02/2025

Any defiency statement 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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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15G811		A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/06/2024		
NAME OF I	PROVIDER OR SUPPLIEF	R		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	In the shower room first shower stall we from the drain. The shower handle. The ceiling where paint -In the second show souffle cups contain There was a green of the chalkboard was (foot) by 2' (foot) he gedroom #11 did to the bedroom door at the backside of the -There were various have been patched at #11. There was not leading to the locked -The shower room clothes and a towel empty souffle cup with the tub.  -In the Colts hallwas on the tiles on the collack and discolored -In bedroom #14 the wall behind the bedroom at the back and discolored -In the kitchen from the tile in front of the toof urine.  -The door frame was the supply closet of the suppl	in off the Pacers Hallway, the as missing a 3" (inch) by 3" tile re was not a shower head or a are was an area 8" by 8" in the was peeling.  Wer stall there were 2 empty hing residue of body soap.  Wowel on the floor.  All in the dining room had a 1' ole with red wires exposed.  Anot have have a door handle on and there was missing wood on door.  Is holes on all four walls that and not repainted in bedroom a door knob on the door old bathroom.  On the Colts hallway had dirty on the floor. There was an area eiling of the shower that was d.  Here was a 2" by 2" hole on the droom door.  The Colts hallway was missing boilet. There was a strong smell as missing from bedroom #4.  The colts hallway was missing from bedroom #4.  The colts hallway was missing from bedroom #4.		TAG	Maintenance supervisor. The and maintenance supervisor with keep a maintenance log and riversely to review maintenance issues and plans for resolution	PM vill neet	DATE
	of the table.						

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		15G811	B. W	ING		12/06/2	2024
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP COD		
RES-CAF	DE INC			1	BLOOMINGTON STREET ICASTLE, IN 46135		
	T				IOAGILE, IN 40133		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ed up window in Bedroom #11.	+	IAU			DATE
		v in the dining room had 2					
		de of the window. There was a					
	4" by 4" area in the	ceiling with wires hanging					
		me on the kitchen door leading					
		vas missing. There were 2					
	_	the island counter. There were					
	in the kitchen.	n the cabinets on the west wall					
		v in the dining room/day room					
		nissing and cracked drywall					
	1	There was missing dry wall on					
	the west wall surrou	anding a pipe.					
		onducted on 12/2/24 at 11:25					
		Staff #4 stated,"the souffle bathroom are cups of body					
		have been thrown away after a					
	shower."	nave been unown away after a					
	An interview was co	onducted on 12/2/24 at 11:30					
		Client R stated, "I have a hole					
		ny door. I have told the staff,					
	but nothing has bee	n done about it."					
	An interview was co	onducted on 12/2/24 at 11:45					
		Staff #24 stated, "[Client C]					
		andle off several weeks ago					
	and it has never bee						
		onducted on 12/2/24 at 12:38					
		tenance Staff). The MS stated,					
		are exposed by the hole in the com are low voltage wires to					
		The MS stated, "I have					
		er to be at the facility full time.					
		epairs that are needed. I was					
		see the building in this					
	condition."	Č					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r ′		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED  B. WING 12/06/2024				
		15G811	B. WII			12/06/	ZUZ4 
NAME OF P	PROVIDER OR SUPPLIER			1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		onducted on 12/2/24 at 1:12					
		Staff #32 stated the substance					
	on the ceiling in the	shower "looks like mold."					
	An interview was co	onducted on 12/2/24 at 1:37					
		Staff #28 stated the substance					
	on the ceiling in the shower "looks like mold."						
	An interview was co	onducted on 12/2/24 at 3:06					
	PM with staff #4. S	Staff #4 stated the substance					
	on the ceiling in the	shower "looks like mildew."					
	An interview was co	onducted on 12/3/24 at 4:00					
	PM with the QAC (	Quality Assurance					
	Coordinator). The	QAC stated, "The issues with					
	the cleanliness I dor	n't attribute it to the staff. The					
	common areas and l	bathrooms are bigger issues.					
	The facility has not	had a maintenance man."					
	5-1.3(h)						
	5-1.5(a)						
W 0149	483.420(d)(1)						
	STAFF TREATME	ENT OF CLIENTS					
Bldg. 00							
		view and interview for 3 of 4	W 0	149	To correct the deficient practic	e,	01/06/2025
	_	e (A, B and C) and 12			certified investigators will be		
	· ·	E, F, G, H, I, J, L, M, N, P, Q and			retrained to include in		
	· ·	d to implement its policies and			investigation scopes, as		
		nt physical and verbal abuse			applicable, if potential abuse is		
	-	client to client abuse, conduct			suspected, and in the conclusi		
	thorough client to cl				will note if abuse is substantia		
	_	ifying the scope of the			All certified investigators will b	е	
		ential abuse and concluding ensure investigations			retrained on completing	***	
		n pertaining to the incident			investigations when EMS or la enforcement agencies are	vv	
		unrelated incidents.			involved. All Site Supervisors	will	
	and not details ifoli	amerated meldents.			be retrained to ensure the 1:1	vvill	
	Findings include:				staffing assignments are		
	.8				thoroughly completed daily wit	h no	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/06/2024	
NAME OF I	PROVIDER OR SUPPLIEI	₹	•		ADDRESS, CITY, STATE, ZIP COD		
RES-CAI	RE INC				BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDEDIC DI AN OE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		AM, a review of the facility's			blanks. All DSP's and Site		
	_	ve reports was conducted and			Supervisors will be retrained of	n	
	indicated the follow	ving:			client behavior support plans.		
	1) #1 10/05/04 P	6D: 131: G			Additional monitoring will be		
	· ·	ureau of Disabilities Services			achieved by weekly administra		
		ort indicated, "On October 24,			team observations to ensure s	кап	
		ient A] attempted to engage in a towards a peer for no			are implementing all policies,	nd	
		d without precursors but staff			procedures, documentation, a plans as written. The	HU	
		the hit and prompted [client			administrative team (PM, QAN	1	
	_	oom for coping skills. [Client A]			QAC, QIDP, DON) will evalua		
	_	began to walk down [name]			the observation frequency mo		
		f checked on [client A's] peer,			to determine if the observation		
		up the hallway and again tried			should continue, decrease, or		
		al aggression towards his peer			increase.		
		able to stop contact. Staff					
	redirected [client A	] to his bedroom for his peers					
	safety and coping s	kills. Staff attempted to assist					
	him with coping sk	ills but [client A] began to hit					
	staff and attempted	to bite them. At this time,					
		ed a guardian and HRC (Human					
	-	approved 3 person supine					
		staff attempting to assist					
		ing skills, he continued to be					
	~	. Nurse assessed [client A]					
		behavioral (medication) PO (by					
		eded). Staff was able to assist					
		coping skills and he calmed ased from the hold. The hold					
		Nurse assessed him and noted					
		n the hold, staff noticed a hole					
	-	When staff asked [client A]					
		tated that he was eating the					
		was hungry and mad at his					
	1 -	n reason. Nursing advised					
	_	lient A] to the [name]					
		where he was evaluated and the					
		s was made: 'Ingestion					
		dry wall/insulation).' Discharge					
		Return to ER for severe					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G811		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  12/06/2024		
NAME OF P	PROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET NCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	changes. Call his do adjustments. Follow week.' [Client A] had checks and the hole repaired. [Client A] PICA (ingestion of does not have a hist aren't edible. [Client Campus without further the state of the place of the state	isciplinary Team Meeting /24/24, [client A] was found in his drywall that he had peeled of the wall. When staff asked he stated that he was hungry. Incident report that he had proximately one hour prior to assessed by nursing staff and Hospital for an evaluation. The last to return to the hospital if abdominal pain, vomiting, or acted about the behavior.  It was recommended that his acted about the behavior.  It the facility, [client A] was checks following this incident moved in order to block and wall. Additionally, staff his bedroom for supervision. Intacted and is in agreement ures and adjustments to [client wall was used. Discussed as for [client A's] plan and for for his safety.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/06/2024	
NAME OF P	ROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR Ingesting non-food	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION items will be added to [client	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	wall/furniture check A's] bedroom to che behaviors/damage. open at this time. [c checks at this time. across the hall will of sight on [client A] [Client A] will see [10/25/24 to discuss follow up with [nan see if any nutritiona culprit. A new high made for this behav work with his BC (lient A).	Support Plan). Hourly as will be implemented in [client eck for further PICA Door to bedroom will remain lient A] will remain on 5 minute The 1:1 (one on one) staff from position the chair to have line a] during overnight hours. Iname of psychiatrist] on behaviors. Nurse manager will the of primary care physician] to all deficiencies may be the risk medical care plan will be ior. [Client A] will continue to Behavior Clinician) on eticing relaxation/coping			
	On 12/2/24 at 4:08 Coordinator (QAC) investigation conducted about why we didn'doing an investigatial though the staff we documentation of the On 12/3/24 at 12:50 Manager (QAM) in conduct an investigation discuss the incident QAM indicated he is up and safety measure conduct an investigation of the conduct and conduct and conduct an investigation of the conduct and conduct an investigation o	PM, the Quality Assurance indicated there was no cted. She stated, "Not sure t investigate it. I asked about on." The QAC indicated there questioned there was no			

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G811  AND PLAN OF CORRECTION A. BUILDING 00  B. WING			COMPLETED  12/06/2024				
NAME OF I	PROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CA	RE INC				CASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREF		CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION  DS incident report indicated,	TA	G .	BEHELIKETY		DATE
		2024 at 4:50pm [client B] was in					
	· ·	he became agitated. He stated					
	The state of the s	se of the death of his					
	_	and cousin (these deaths					
	-	r). [Client B] then engaged in					
	property destruction	n by throwing a chair, causing					
	it to break a window	w (staff got this cleaned up and					
	•	iced). He then took a piece of					
		cut his right wrist. Staff tried					
	-	onfiscate the piece of glass but					
		to cut staff each time. Staff					
		Emergency Medical					
		d and transported [client B] to					
	1 2 2	Room where he was evaluated the [name of psychiatric					
		f city] where he is still currently					
		empted to assess [client B]					
		client B] refused to allow her.					
	_	s unknown at this time"					
		lisciplinary Team Meeting					
	_	returning to the facility, he will					
	_	d for up to 30 days per					
		l gestures in the BSP					
	`	Plan). Due to the acts of self					
		ures, he will remain without					
		up to 14 days (reviewed after 7 inserviced about all changes.					
	• /	iced that AYSIS (Advanced					
		rect that AT 1818 (Navanced					
		be utilized immediately upon					
		of self injury. [Client B] will be					
		s for 24 hours upon return and					
	will remain in the r	esidential building for an					
	additional 24 hours	. Restitution will start after the					
		riction, QIDP (Qualified					
		ities Professional) will work					
		payment plan (per his BSP).					
	[Client B] will see I	his psychiatrist on 11/22/24.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		15G811	B. W	ING		12/06	/2024
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD		
RES-CAI	RE INC				BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		oval of all recommendations					
		an internet/social media					
	restriction or supervision as the team deems necessary."						
	necessary.						
	There was no docur	mentation the facility					
	conducted an investigation.						
		2 AM, the Quality Assurance					
		indicated there was no					
	_	icted. The QAC stated she					
		o do one. Didn't cross my					
		ndicated the incident occurred a day room however she did not					
		mera system operator for a clip					
		e QAC stated the incident					
	"should have been i						
		) PM, the Quality Assurance					
		idicated there was no					
	_	e incident. The QAM stated, ould have been investigated."					
	_	d although the incident was					
	,	e IDT convened, corrective					
	_	mented and the facility had a					
	plan for what to do.	-					
	2) The 11/19/24 D	DC mamout indicated IIO					
	· /	DS report indicated, "On during the behavior with [client					
	•	S and IM (intramuscular) PRN					
		d in incident report 1623955. A					
		f physical and verbal abuse.					
		improper use of physical					
		intimidation. As the day of					
		es reported to [client A]. The					
	,	avior Clinician) continue to					
	provide emotional s	support to [client A]."					
	The 11/22/24 Inves	tigative Summary indicated, "It					
		t [former Site Supervisor] was					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	A. Bl	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/06/2024	
NAME OF I	PROVIDER OR SUPPLIEI	₹		1306 S I	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	physically aggressi A]. It is substantial Supervisor] was ve Individual [client A] properly followed I ensuring [client A]s notifying [staff #5] immediately called  On 12/2/24 at 4:17 former Site Supervabused client A. The staff placed herself of client A hitting I the restraint, the formation are in his room and friends due to his bear of the lip. Client I did the lip. The Factual Findin "There is a history between [client A] have a history of bear [Client A] has targent aggression. This in intense. Proper rational plans were properly suspected.  Conclusion: It is suplans were properly suspected.  The investigation we by the scope not inclient to client aggression.	ve towards Individual [client ted that [former Site rbally aggressive towards at]. It is substantiated that staff ResCare Policy and Procedure at safety by immediately of the allegations, who then [Program Manager]."  PM, the QAC indicated the isor physically and verbally the QAC indicated the former from top of client A in retaliation ther. The QAC indicated prior to the restaff told client to "put his at told him he did not have any ehavior.  14 PM, client A hit client I on I not have injuries.  of the Investigation indicated, the instances contributing to this low behavior plans properly?" ges section indicated, in part, y of peer to peer incidents and [client I]; [client A] does being the main aggressor. Bet behavior of physical acident was not violent or to was followed. Behavior of followed. No abuse is					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	r í	JILDING	nstruction 00	(X3) DATE COMPL 12/06/	ETED
NAME OF	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CA	RE INC				CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ated.		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	5) The 11/4/24 BD November 3, 2024 at the dayroom tabl suddenly entered the [client I]. He then et towards [client I] by I's] neck in an attentimmediately intervolute [client A] from cho [client A] to his begin using his coping engaging in physica Both consumers ret without further issue. The 11/5/24 Scope "To determine circular event. Did staff for the Factual Finding"Nurse assessed be injuries. There is a incidents between [A] does have a hist aggressor. [Client aggressor. [Client physical aggression violent or intense. Behavior plans were are to make sure the [client I] at all time Conclusion: It is unplans were properly. The investigation we by the scope not incident to client aggressor.	S report indicated, "On at 6:05pm [client I] was standing e with staff when [client A] e dayroom and approached ngaged in physical aggression by placing his hands on [client appet to choke him but staff ened and was able to prevent king [client I]. Staff redirected aroom where they assisted him skills and educated him on not all aggression towards peers. The proper state of the Investigation indicated, anstances contributing to this low behavior plans properly?" The proper state of the peer client A] and [client I]; [Client bory of peer to peer client A] and [client I]; [Client bory of being the main A] has target behavior of and the properly followed, and the properly followed is and properly followed. This incident was not properly followed. The proper state of the peer client A] and so the proper state of the peer client A] and so the properly followed. The properly followed is substantiated that behavior of followed."					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G811		A. BUILDING B. WING	00	COMPLETED 12/06/2024	
NAME OF I	PROVIDER OR SUPPLIER	1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	6) The 11/12/24 BDS report indicated, "On November 11, 2024 at 12:35pm the AD (Area Director) was taking a group of clients to the recreational room to make cookies. [Client N] started walking to the door but staff informed him that it wasn't his turn to go to the rec room at that time. [Client N] ignored staff and continued walking towards the door. [Client P] stepped in front of [client N] and said 'Hey buddy, you can't go'. This agitated [client N] and he engaged in physical aggression towards [client P] by grabbing his neck and then his shirt and pulling on it, causing it to rip. [Client P] did not retaliate. Staff immediately intervened and separated both consumers. Immediately after [client N] was separated from [client P], he began to hit staff multiple times. At this time, trained staff initiated a guardian and HRC approved 3 person supine hold. Despite staff attempting to assist [client N] with his coping skills, he continued to be combative while in the hold. Nurse assessed [client N] and administered a behavioral IM PRN. Staff was able to assist [client N] with his coping skills and he calmed down. He was released from the hold. The hold lasted 25 minutes. Nurse assessed [client P] and noted a red mark on the left side of his neck. That mark is currently no longer there. Both consumers returned to normal programming without further issues."  The 11/13/24 Scope of the Investigation indicated, "To determine circumstances contributing to this event." The Factual Findings indicated, "Nurse assessed [client N] and noted no injuries. Nurse assessed [client P] and noted a red mark on the left side of his neck. That mark is currently no longer there. Both consumers returned to normal programming without further issues. [Client N] has target behaviors of physical aggression.				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		12/06/	/2024
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			BLOOMINGTON STREET		
DEC CAI	DE INC						
RES-CAF	RE INC			GREEN	ICASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	There is not a histor	ry of peer to peer occurrences					
	between [client P] and [client N]. Proper ratio was followed. Behavior plans were properly followed.  No ANEM  (Abuse/Neglect/Exploitation/Mistreatment) from						
	staff is suspected."						
	1	vas not thorough as evidenced					
	by the scope not indicating the facility identified client to client aggression as potential abuse and the conclusion not indicating whether or not						
	abuse was substantiated.						
	7) The 11/14/24 BDS report indicated, "On						
		at 8:50 am [client I] was sitting					
	I -	room. [Client I] had been					
	_	shouting throughout the					
		is incident, but was calm and					
	-	Client A] then comes running					
	I .	y. [Client I] notices [client A]					
	_	begins to move away. [Client					
	_	and engaged in physical					
	00	him by briefly choking him					
	_	his room. Staff walked with					
		nurse while other staff					
		on using coping skills if he is					
		ging in physical aggression					
	_	f assessed both consumers					
	1	es. Both consumers returned to					
	normal programmir	ng without further issues."					
		tigative Summary indicated the					
	_	igation was, "To determine					
		ributing to this event." The					
	_	ited, "[Former Site					
	Supervisor] stated that when she asked [client I]						
	what had happened, he stated that [client A] had						
		assessed both consumers and					
		There is a history of peer to					
	peer incidents betw	een [client A] and [client I];					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		15G811	B. W	ING		12/06	/2024
				CTREET	DDDECC CITY CTATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CA	DE INIC				ICASTLE, IN 46135		
RES-CA	RE INC			GREEN	ICASTLE, IN 40133		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	[client A] does have	e a history of being the main					
	aggressor. [Client.	A] has target behavior of					
	physical aggression. This incident was not						
	violent or intense.	Proper ratio was followed.					
	Behavior plans wer	e not properly followed; staff					
	are to make sure the	ey are between [client A] and					
	[client I] at all times. No abuse is suspected."						
	The Conclusion indicated, "It is unsubstantiated						
	that behavior plans were properly followed."						
	The investigation w	vas not thorough as evidenced					
	by the scope not indicating the facility identified						
	client to client aggression as potential abuse and						
	the conclusion not indicating whether or not						
	abuse was substantiated.						
	8) The 11/22/24 B	DS report indicated, "On					
	November 22, 2024	4 at 4:34 pm [client A] was					
	eating dinner when	[client C], who was walking					
	around, approached	l [client A's] table and took his					
	drink. [Client A] ju	mped up and ran after [client C]					
	and bit him on his l	eft upper arm. [Client C] did not					
	retaliate. Staff imm	ediately intervened and					
	separated both clien	nts. Staff walked with [client C]					
	-	ile other staff got [client A]					
	another drink. Nurs	se assessed [client A] and					
		Jurse assessed [client C] and					
	-	ameter bruising with 2"					
		ks around the bruising. Both					
		l to normal programming."					
	The 11/27/24 Scope	e of the Investigation indicated,					
	"To determine circu	umstances contributing to this					
	event. Did staff fol	llow behavior plans properly?"					
		gs section indicated, "Nurse					
		and noted a 1" diameter					
		ameter teeth marks around the					
	-	lent was not violent or intense.					
	-	ry of peer to peer incidents					
		and [client C]; [client A] does					
	[						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15G811	B. W	ING		12/06	/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	₹			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
INLO-OAI	T. IIVO			CITELL			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	_	eing the main aggressor. This					
		olent or intense. [Client A] has					
	target behavior of physical aggression. [Client C]						
	has target behavior of inappropriate access to						
	food. Proper ratio was followed. Behavior plans						
		wed. No abuse is suspected."					
	The Conclusion indicated, "It is substantiated						
	that behavior plans were properly followed."						
	The investigation was not thorough as evidenced						
	by the scope not indicating the facility identified						
	client to client aggression as potential abuse and						
	the conclusion not indicating whether or not						
	abuse was substantiated.						
	9) On 9/9/24 at 6:40	PM client G bit client F on the					
	nose, pinched client	t P on the left arm then hit and					
	scratched client B.	Clients B, F and P did not have					
	injuries.						
	The 9/12/24 Scope	of the Investigation indicated,					
	_	imstances contributing to this					
		Findings section indicated, in					
		istory of peer to peer incidents					
	_	nd client F]; [client G] does					
	have a history of be	ing the main aggressor. [Client					
	_	iors of verbal and physical					
		ries, instigation, and					
		oper ratio was followed. [Client					
		nis was not followed during					
		e were no staff within arms					
	reach of [client G].	Per staffing assignment sheet					
	for 9.9.24, [client G	[6] was assigned a 1:1 staff until					
	noon; there were no	ot any staff names written in					
	other time slots. No	abuse is suspected."					
	The investigation was not thorough as evidenced						
	by the scope not indicating the facility identified						
	client to client aggression as potential abuse and						
		clusion indicating whether or					
	not abuse was subst	_					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  12/06/2024	
NAME OF P	ROVIDER OR SUPPLIEF		1306 S	ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET NCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION	
	· · · · · · · · · · · · · · · · · · ·	:20 PM client G shoved client F and hit his head. Client F did				
	determine circumstaevent." The Factua part, "Neurocheck and all vitals have be the There is not a history of being the target behaviors of aggression, boundar noncompliance. Pro G] has 1:1 (one one followed. No abuse the investigation where was not a common abuse was substant) On 9/12/24 clie back. Client I had not the followed. The factua part, "[client L] demain aggression. [Cliphysical aggression.	ries, instigation, and oper ratio was followed. [Client one) status; this was properly is suspected."  ras not thorough as evidenced dicating the facility identified ession as potential abuse and clusion indicating whether or cantiated.  Int L smacked client I in the o injuries.  of Investigation indicated, "To ances contributing to this I Findings section indicated, in oes have a history of being the ient L] has target behaviors of and boundaries. Proper ratio twior plans were properly				
	by the scope not inc	as not thorough as evidenced dicating the facility identified ession as potential abuse and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		15G811	B. W	ING		12/06	2024
NAME OF F	PROVIDER OR SUPPLIER	·		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWINEDIC DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	there was not a con-	clusion indicating whether or					
	not abuse was subst	tantiated.					
	in the face two time (Self Injurious Behathe face. Clients B  The 9/20/24 Scope determine circumstatevent." The Factual part, ""[Client I] haggression, physica Self-Injurious Behathas target behaviors instigation. There is peer-to-peer incider	230 PM client I punched client B es. Client I then engaged in SIB eavior) by punching himself in and I had no injuries.  of Investigation indicated, "To ances contributing to this Findings section indicated, in has target behaviors of verbal laggression, non-compliance, evior, and instigation. [Client B] is of verbal aggression and is a history of attempted his between [Client I and client is followed. No ANEM from					
	by the scope not inc client to client aggre there was not a con- not abuse was subst	vas not thorough as evidenced dicating the facility identified ession as potential abuse and clusion indicating whether or tantiated.					
		him in (sic) left side and then left side of his face. Clients B s.					
	The 9/30/24 Scope determine circumstatevent. Did staff fol The Factual Finding [Client I] has target aggression, physica Self- Injurious Behabas target behaviors	of Investigation indicated, "To ances contributing to this low behavior plans properly?" gs section indicated in part, " behaviors of verbal l aggression, non-compliance, avior, and instigation. [Client B] s of verbal aggression, a, and instigation. There is a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15G811	B. WI	NG		12/06/	/2024
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		1306 S	BLOOMINGTON STREET		
RES-CAI	RE INC			GREEN	ICASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ed peer-to-peer incidents and B]. Proper ratio was					
	-	4					
		or plans were properly followed. tements matched RestAssured					
		ANEM from staff is suspected.					
		substantiated that staff followed					
	behavior plans pro						
	l cenavior plans pro	perry.					
	The investigation v	was not thorough as evidenced					
	_	idicating the facility identified					
		ression as potential abuse and					
	the conclusion not indicating whether or not						
abuse was substantiated.							
	14) On 9/24/24 at 11:35 AM client L smacked client						
	F in the face. Clies	nt L then ran down the hall and					
	hit client P in the f	ace. Clients F, L and P did not					
	have any injuries.						
	TI 0/20/24 C	CT					
	_	e of Investigation indicated, "To					
		tances contributing to this					
		llow behavior plans properly?"  ngs section indicated in part,					
		ic environments are a					
		er for [client L]. There is not a					
		peer incidents between [clients					
		lient L] does have a history of					
		gressor. [Client L] has target					
		cal aggression and boundaries.					
		ollowed. Per [client L's] behavior					
	_	ce themselves between [client					
	-	possible; staff did not initially					
	do this. No abuse	-					
		lid not properly follow [client					
	L's] behavior plan.						
	The investigation was not thorough as evidenced						
		dicating the facility identified					
		ression as potential abuse and					
	the conclusion not	indicating whether or not					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BU		(X2) MULTIPLE CO A. BUILDING B. WING			
NAME OF P	PROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
TAG	abuse was substanti  15) On 9/24/24 at 5 towel and slapped of then hit client R on did not have injurie  The 10/1/24 Scope determine circumstatevent. Did staff foll The Factual Finding "There is not a his between [clients P, behaviors of physic Staff properly follow No abuse is suspect properly follow con  The investigation w by the scope not inc client to client aggrethe conclusion not if abuse was substanti  16) On 9/25/24 at 3 in his bedroom usin to scratch his left ar gone into client M's the face twice. Clie was taken to the loc suicidal ideation.  The 10/1/24 Scope determine circumstatevent. Did staff foll	ated.  25 PM client Q picked up a lient P in the face. Client Q his cheek. Clients P, Q and R s.  of Investigation indicated, "To ances contributing to this ow behavior plans properly?" as section indicated in part, story of peer to peer incidents Q and R]. [Client Q] has target al aggression and boundaries. wed consumers behavior plans. ed. Conclusion: Staff did asumers behavior plan."  Tas not thorough as evidenced dicating the facility identified ession as potential abuse and indicating whether or not	TAG	DEFICIENCY)	DATE
	"Camera shows the enters [client M's] r 3:11 pm, [client M]	nat at 3:09:44 pm [client I] oom and exits at 3:09:55 pm; at exits his room holding his face re is not a history of			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15G811	B. WIN	NG		12/06	/2024
			<del></del>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	t			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
	Г						ı
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL	] 1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)		DATE
		nts between [clients I and M].					
		llowed. Behavior plans were					
	properly followed. No ANEM from staff is suspected.						
		bstantiated that staff followed					
	behavior plans prop						
	ochavioi pians prop	city.					
	The investigation w	as not thorough as evidenced					
		licating the facility identified					
		ession as potential abuse and					
	the conclusion not indicating whether or not						
	abuse was substantiated.						
	17) On 9/25/24 at 11:49 AM client A bit client H on						
	the left arm. Client	s A and H did not have any					
	injuries.						
		of Investigation indicated, "To					
		ances contributing to this					
		ow behavior plans properly?"					
		gs, section indicated in part,					
	_	n aggressive behavior, these tense or violent. There is a					
		eer incidents between [clients					
		does have a history of being					
		[Client A] has target behavior					
		ion. [Client H] has a target					
		ng, causing agitation.					
		e properly followed. No abuse					
	is suspected.						
	_	bstantiated that behavior					
	plans were properly						
	The investigation w	as not thorough as evidenced					
	by the scope not inc	licating the facility identified					
	client to client aggression as potential abuse and						
the conclusion not indicating whether or not							
	abuse was substanti	ated.					
	18) On 9/26/24 at 8	:17 AM client A smacked client					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G811		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVI         A. BUILDING       00       COMPLETED         B. WING       12/06/2024			
NAME OF PI	ROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP	BE COMPLETION
TAG	H in the face. Staff time later client H w client A walked aro client H's right wris not have any injuried. The Scope of the In determine circumstate event. Did staff followed in the Factual Finding There is a history of between [client A at history of being the has target behavior of H] has a target behavior of H] has a target behavior. However, I is sulplans were properly the investigation w by the scope not indicate the conclusion in the conclusion not in abuse was substantion. The Scope of the Indetermine circumstate event. Did staff followed in the factual Finding There is not a history of being the has target behavior of proper ratio was followed. It is sufficiently the conclusion of the satisfication of the proper ratio was followed. It is not a history of being the has target behavior of properly followed. It	vestigation indicated, "To ances contributing to this low behavior plans properly?" as, section indicated in part," Epeer to peer incidents and H]; [client A] does have a main aggressor. [Client A] of physical aggression. [Client avior of obsessing, causing is suspected. Obstantiated that behavior followed."  as not thorough as evidenced dicating the facility identified ession as potential abuse and andicating whether or not ated.  Et 10 PM client A struck client C the face. Clients A and C did	TAG	DEFICIENCY)	DATE

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15G811	B. WI	NG		12/06/	/2024
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	plans were properly	followed."					
	_	vas not thorough as evidenced					
		dicating the facility identified					
		ession as potential abuse and					
		indicating whether or not					
	abuse was substantiated. 20) The 10/2/24 BDS incident report indicated "On						
		-					
	October 1, 2024 at 12:10pm [client J] was in the dayroom and appeared to be calm and in a good						
	mood. When his peers returned to campus from						
	an outing, [client J] immediately approached						
	[client B] and attempted to talk to him. [Client B]						
	politely informed [client J] that he did not want to						
	talk to him. [Client J] did not say anything and						
	_	n Pacer's hallway. [Client J]					
	_	[client P's] door open and					
	1	im. A staff member stepped					
		to separate them but [client J]					
		ent P] and they both began to					
		the staff member still between					
		rate them. Other staff showed					
		staff was attempting to					
	_	nd [client P], [client B] entered					
		gan to hit [client J] as well. At					
	this time, a staff me	ember placed [client J] on the					
	floor and placed he	r body over him in an attempt					
	to protect him. Dur	ing this time, [client P]					
	continued to try to l	harm [client J] by kicking at					
	him, missing and ki	icking staff in her stomach.					
	[Client B] then stor	nped on the back of [client J's]					
	head, causing his fa	ace to hit the floor and his					
		f was able to separate all					
		d with [client J] out of the					
		[Client P] then began to kick					
		loor in an attempt to open it to					
	get outside. Staff prevented [client P] from doing						
	so. [Client B] then attempted to hit staff but was						
		d to the dayroom by another					
	staff. Staff was able	e to assist [client P] with coping					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  12/06/2024	
NAME OF F	PROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP CO BLOOMINGTON STREE NCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION (X5) DULD BE PPROPRIATE COMPLETION DATE	
	trouble calming dovassessed [client B] a PO PRN. [Client B] skills and he calmed transported to [nam was evaluated and tamade: 'Physical assa Contusion. (Homicithen admitted to [Pscity], IN where he is assessed [client P] a injuries. Nurse as unwas transported to the initial Investigation indicated the dates of intervied Additionally, the suffactual findings in the ummary were not due to addressing asked for clarifical incident, the facil Investigative Surintroduction, but investigation were the dates of intervied the dates of intervied the dates of intervied to addressing asked for clarifical incident, the facil Investigative Surintroduction, but investigation were the dates of intervied to the incident. The summary also in staff is suspected.	ntive Summary received of investigation for this				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF I	PROVIDER OR SUPPLIER	· {		ADDRESS, CITY, STATE, ZIP COD	
RES-CA	RE INC			S BLOOMINGTON STREET NCASTLE, IN 46135	
	T	OTA TEMENT OF DEFICIENCIE		T	(VE)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE
	The Investigative	e Summary indicated this			
	incident did occi	ar. The investigation was not			
	thorough as evid	lenced by the scope not			
	indicating the fac	cility identified client to client			
	aggression as po	tential abuse, dates being			
	incorrect, non-re	elevant information being			
	included in the in	nvestigation, and the			
	conclusion not indicating whether or not				
	abuse was substa	antiated.21) The 10/2/24			
	BDS incident report indicated, "On October				
	1, 2024 at 3:26pm [client I] was on the				
	porch with staff being separate (sic)				
	programmed due	e to verbal aggression. He			
	asked staff to go	inside so that he could use			
	the bathroom. On	nce inside, he was not being			
	loud or disruptiv	e. As soon as he got inside,			
	[client A] sudder	nly approached [client I],			
	grabbed his right	t arm, and bit it. [Client I]			
	did not retaliate.	Staff immediately redirected			
	[client A] to his	bedroom where they were			
	able to assist hin	n with coping skills. Nurse			
	_	A] and noted no injuries.			
	Nurse assessed [	client I] and noted a bite			
	mark on his righ	t forearm, no bleeding and			
	skin was not bro	ken. Both consumers			
	returned to norm	nal programming without			
	further issues."T	he Investigative Summary			
		r the incident, indicated the			
	biting did occur.	The same Investigative			
	Summary also in	ndicated "this incident was			
	not violent or int	tense," "No abuse is			
	suspected," and '	"it is substantiated that			
	1			•	

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	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTITUTION OF CORRECTION IDENTIFICATION NUMBER A. BUILDING OUT B. WING		onstruction 00	(X3) DATE COMPL 12/06/	ETED	
NAME OF I	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP COD		
RES-CA	RE INC			BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID	ı	STATEMENT OF DEFICIENCIE	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	 TAG	DEFICIENCY)		DATE
	1	vere properly followed."The				
	1	s not thorough as evidenced				
		indicating the facility				
		to client aggression as				
	I -	and the conclusion not				
	1	ner or not abuse was				
		) The 10/3/24 BDS				
	1	ndicated, "On October 2,				
		[client I] was in the				
	1	ing about Halloween and				
	_	and began to yell. Staff				
		his bedroom for his safety				
	1	to his peers. [Client I]				
		d remained sitting on his				
		ent advised staff that they				
	_	A] enter [client I's]				
		ff is approaching [client I's]				
	1	e the door is shut. Shortly				
	· ·	ve [client A] exit [client I's]				
		o his own room. When staff				
		f he had been hurt, [client I]				
		arm as [client A] had bit				
	` ′	assessed [client A] and				
		s. Nurse assessed [client I]				
		mark on his upper right				
		g with skin still intact. Both				
		ned to normal programming				
		ssues."The Investigative				
	I	10/9/24 for the incident,				
		ing did occur. The same				
	I -	mmary also indicated "this				
	incident was not	violent or intense," "No				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	r í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 12/06/	ETED
NAME OF I	PROVIDER OR SUPPLIER	2	•	1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	abuse is suspecte	ed," and "it is substantiated					
	that behavior pla	ns were properly					
	followed."The ir	vestigation was not thorough					
	as evidenced by	the scope not indicating the					
	facility identified	d client to client aggression as					
	potential abuse a	and the conclusion not					
	indicating wheth	er or not abuse was					
	substantiated.23	The 10/4/24 BDS incident					
	report indicated,	"On October 3, 2024 at					
	12:40pm [client	A] was sitting down eating					
	lunch when he s	tood up and began to walk					
	around the dayro	oom. At this time, his peer					
	[client C] walked	d over to his plate and took					
	food from it. [Cl	ient A] saw this and					
	engaged in phys	ical aggression towards					
	[client C] by biti	ng his left hand. Staff					
	immediately inte	ervened and walked with					
	[client C] to the	nruse's (sic) station. Staff					
	educated [client	A] on using his coping skills					
	when he become	es upset. Nurse assessed					
	[client A] and no	oted no injuries. Nurse					
	assessed [client of	C] and noted a red mark to					
	left thumb with	skin intact. The mark is not					
	there currently. I	Both consumers returned to					
	normal program	ming without further					
	issues."The Inve	stigative Summary dated					
	10/10/24 for the	incident, indicated the biting					
	did occur. The sa	ame Investigative Summary					
	also indicated "t	his incident was not violent					
	or intense," "No	abuse is suspected," and "it					
	is substantiated t	that behavior plans were					
	properly followe	ed."The investigation was not					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/06/2024		
NAME OF I	PROVIDER OR SUPPLIEI	3	•	1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	lenced by the scope not					
	1	cility identified client to client					
		tential abuse and the					
		ndicating whether or not					
		antiated.24) The 10/7/24					
		port indicated, "On October					
	1	m, [client M] was at the					
	1	oom when for an unknown					
		his milk on the floor and					
	_	vn Colt's hallway. As he					
	was running dov	vn the hall, he ran past [client					
	A] and slapped l	nim on the left side of his					
	forehead before	continuing to his bedroom.					
	[Client A] did no	ot retaliate. While in his					
	room, [client M]	began to throw his laundry					
	basket and fan a	t staff as well as charged at					
	staff while yellir	ng. [Client M] then began to					
	hit the wall with	his hands and then his head.					
	At this time, trai	ned staff initiated a guardian					
	and HRC approv	ved 3 person supine.					
	Despite staff atte	empting to assist him in					
	calming down, h	ne continued to be agitated.					
	Nurse assessed [	client M] and administered					
	a behavioral IM	PRN. Staff was able to					
	assist [client M]	in calming down and he was					
	released from th	e hold. The hold lasted 39					
	minutes. Nurse a	assessed both consumers					
		uries. Neurochecks were					
		nt M] and all vitals have					
	_	nal range."The Investigative					
		10/11/24 for the incident,					
	_	pping did occur. The same					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		15G811	B. WI	NG		12/06/	2024
NAME OF 1	PROVIDER OR SUPPLIER	}	•		ADDRESS, CITY, STATE, ZIP COD		
		•			BLOOMINGTON STREET		
RES-CA	KE INC			GREEN	ICASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAG		mmary also indicated "No	1	TAG			DATE
		ed," and "it is substantiated					
	_	ans were properly					
	_	nvestigation was not thorough					
		the scope not indicating the					
	1						
	I -	d client to client aggression as					
	^	and the conclusion not					
		her or not abuse was					
	1	) The 10/16/24 BDS					
	•	ndicated, "On October 15,					
	1	[client E] was walking up					
	1	owards the dayroom when					
		ached him and got into his					
	1	Client E] asked [client H]					
		client H] retaliated by					
		E's] hand and then attempted					
	1 -	E]. Staff immediately					
		edirected [client H] away					
		Nurse assessed both					
		noted no injuries. Both					
	consumers return	ned to normal programming					
	without further is	ssues."The Investigative					
	Summary receiv	ed for this incident indicated					
	investigation dat	tes of 10/15/24 to 10/22/24,					
	the date in the in	troduction was indicated to					
	be 10/6/24, and t	the interview dates were					
	indicated to be 1	0/22/24.No definitive date					
	of incident was a	available due to conflicting					
	information on the	he provided Investigative					
	Summary. The s	ame Investigative Summary					
	also indicated "T	This incident was not violent					
	or intense," "No	abuse is suspected," and "it					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		15G811	B. WI	NG		12/06/	/2024
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					BLOOMINGTON STREET		
RES-CAI	KE INC			GKEEN	ICASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		hat behavior plans were		TAG			DATE
		ed." The Investigative					
	1	· ·					
	Summary indicated this incident did occur.  The investigation was not thorough as						
		e scope not indicating the					
	1	d client to client aggression as					
	_	dates being incorrect,					
	1 -	ormation being included in					
		C					
	1	, and the conclusion not					
	1	er or not abuse was					
	1	The 10/15/24 BDS					
	•	ndicated, "On October 14,					
		[client J] was in the					
	'	to peers. One of his peers					
	_	aff when [client J] suddenly					
	I -	u!' and threw a water bottle					
		unknown reason. [Client J]					
	_	vards [client B] and hit him					
		nen kicked him in his leg. At					
	this time, trained	I staff initiated a guardian and					
	HRC approved 2	e person escort to [client					
	J's] room for his	safety due to multiple peers					
	beginning to targ	get [client J]. Nurse assessed					
	[client J] and adr	ninistered a behavioral PO					
	PRN. Per his pla	n, [city] Police Department					
	was called. Offic	cers arrived to campus.					
		camera footage, officers					
		in handcuffs and arrested					
		nsported to [name] County					
		yed overnight. [Client J]					
		m the jail and back to					
		5.24 at 10:00am. Nurse					
			1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15G811	B. WI	NG		12/06/	2024
NAME OF B	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
					BLOOMINGTON STREET		
RES-CAF	RE INC			GREEN	ICASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
		nsumers and noted no					
	"	vestigative Summary received					
		indicated investigation dates					
		0/21/24, the date in the					
		indicated to be 10/1/24,					
		v dates were indicated to be					
		21/24. No definitive date					
	of incident was a	vailable due to conflicting					
	information on the	he provided Investigative					
	Summary. The sa	ame Investigative Summary					
	also indicated "N	No ANEM from staff is					
	suspected," and '	'it is substantiated that					
	behavior plans w	vere properly followed." The					
	Investigative Sur	mmary indicated this incident					
	did occur. The in	nvestigation was not					
	thorough as evid	enced by the scope not					
	indicating the fac	cility identified client to client					
	_	tential abuse, dates being					
		levant information being					
		nvestigation, and the					
		ndicating whether or not					
		antiated.27) The 10/24/24					
		port indicated, "On October					
	_	om [client I] was in the					
		zing with staff when [client					
	1	ayroom and began walking					
	_	ddenly approaching [client					
		im in his face. Staff					
		edirected [client A] to his					
		ers hallway. Shortly after,					
		his room and began walking					
	up and down Pac	cers hallway. When staff					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15G811	B. WI	NG		12/06/	2024
NAME OF I	PROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP COD		
DEC CAI	DE INC				BLOOMINGTON STREET ICASTLE, IN 46135		
RES-CAI	RE INC			GREEN	ICASTLE, IN 40135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	TE	COMPLETION DATE
1710		cers hallway, [client A]		1710			DITTE
		ed in physical aggression					
	1 2 2	biting her arm. That staff					
	1	for assistance and at this					
		ff initiated a guardian and					
	· ·	B person supine. Despite					
	1 1	to assist [client A] with					
		continued to be agitated in					
		assessed [client A] and					
		ehavioral IM PRN. [Client					
		se coping skills and he was					
	-	e hold. The hold lasted 24					
	minutes. [Client	A] then sat on his bed and					
	_	eadphones. 20 minutes later,					
	[client A] reente	red the dayroom and					
	immediately app	proached [client I] and bit his					
		intervened and redirected					
	[client A] to his	room where they attempted					
	to talk to him and	d assist him with coping					
	skills but he con	tinued to be agitated and					
	began to shout a	t and attempt to hit staff. At					
	this time, trained	l staff initiated a guardian and					
	HRC approved 3	B person supine. Staff was					
	able to assist [cli	ient A] with coping skills and					
	he was released:	from the hold. The hold					
	lasted 20 minute	s. Nurse assessed [client A]					
	and noted no inju	uries. Nurse assessed [client					
	I] and noted a bi	te mark to his left index					
	finger. Nurse cle	eaned the wound and					
	ointment was ap	plied. Both consumers					
	returned to norm	nal programming without					
	further issues."T	he Investigative Summary					
	I		1				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	r í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 12/06/	ETED
NAME OF I	PROVIDER OR SUPPLIEF	2			DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET	•	
RES-CAI	RE INC			GREEN	CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		or the incident, indicated					
	the biting did oc	cur. The same Investigative					
	1	idicated "This incident was					
	not violent or int	ense," "Behavior plans were					
	not properly foll	owed," "No abuse is					
	suspected," and	"It is unsubstantiated that					
	behavior plans w	vere properly followed."The					
	investigation wa	s not thorough as evidenced					
	by the scope not	indicating the facility					
	identified client	to client aggression as					
	potential abuse a	and the conclusion not					
	indicating wheth	er or not abuse was					
	substantiated.28	The 10/28/24 BDS					
	incident report in	ndicated "On October 27,					
	2024 at 1:40 pm	[client A] came in to the					
	dayroom from h	is room in Pacers hall and					
	began to walk ar	ound the dayroom. For no					
	apparent reason	and without precursors,					
	[client A] sudder	nly ran towards [client I],					
	who was sitting	on the couch watching TV,					
	and placed his ha	and on [client I's] neck and					
	briefly choked h	im before letting go and					
	running back to	his room in Pacers hall. Staff					
	walked with [cli	ent I] to the nurse's station to					
	be assessed whil	e other staff educated					
	[client A] on not	engaging in physical					
	aggression towar	rds peers. Both consumers					
	returned to norm	al programming without					
	further issues."T	he Investigative Summary					
	dated 11/1/24 for	r the incident, indicated the					
	choking did occu	ar. The same Investigative					
	Summary also in	ndicated "This incident was					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 12/06/2024
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>		ADDRESS, CITY, STATE, ZIP COD	
RES-CAI	RE INC			S BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION Tense," "Behavior plans were	TAG	DEFICIENCE	DATE
		owed," "No abuse is			
		s unsubstantiated that			
	behavior plans w				
	1	evestigation was not thorough			
		the scope not indicating the			
	I -	d client to client aggression as			
	I	and the conclusion not			
	indicating wheth	er or not abuse was			
	substantiated.On	12/3/24 at 11:10 AM, the			
	Program Manage	er indicated client to client			
	aggression was a	abuse and the facility should			
	prevent abuse of	the clients. The PM			
	indicated the fac	ility had a policy and			
	procedure prohib	piting abuse.On 12/3/24 at			
	11:32 AM, the Q	AC indicated client to			
	client aggression	was abuse and the facility			
	_	buse of the clients. The			
	QAC indicated to	he facility had a policy and			
		piting abuse. The QAC			
		ostantiated the clients' plans			
	1 *	ed as written by the staff.			
		e did not indicate in the			
	_	vestigating client to client			
		use. She indicated she did			
		e Conclusion whether or not			
	1	ggression was substantiated			
		3/24 at 12:50 PM, the			
	_	client to client aggression			
		ne facility should prevent			
		nts. The QAM indicated			
	the facility had a	policy and procedure			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/06/2024		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD		
RES-CAI	RE INC				BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	1	e. The QAM indicated the					
	facility should c	C					
	_	The QAM indicated the					
		lient to client aggression					
		eed to determine whether or					
		red.On 12/4/24 at 10:47					
		s 11/10/23 Reporting and					
		buse, Neglect, Exploitation,					
		a Violation of Individual's					
		dicated, "ResCare staff					
	· ·	e for the rights and safety of					
		All allegations or occurrences					
	1	t, exploitation, mistreatment,					
		n Individual's rights shall be					
	_	ppropriate authorities					
	"	ropriate supervisory channels					
		oughly investigated under the					
	_	are, local, state and federal					
	1 ~	sCare strictly prohibits					
	_	exploitation, mistreatment, or					
		ndividual's rights. These					
		defined as any of the					
	1	oral punishment i.e. forced					
		, contingent exercise, hitting,					
		plication of pain or noxious					
	· ·	of electric shock, the infliction					
		seclusion in an area which					
	_	l, negative practice or					
		visual or facial screening,					
		luding screaming, swearing,					
	_	elittling, damaging an					
	ındividual's self-	respect or dignity, failure to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE ( A. BUILDING B. WING	OO OO	(X3) DATE SURVEY COMPLETED 12/06/2024		
NAME OF I	PROVIDER OR SUPPLIEF	3	1306	FADDRESS, CITY, STATE, ZIP COD S BLOOMINGTON STREET ENCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLE DATE	TION
		s's orders, denial of sleep,				
		nk, physical movement for				
		ds of time, Medical				
		e or use of bathroom				
	facilities The	Program Manager will assign				
		team. A full investigation will				
	1	investigators who have				
	received training	g from Labor Relations				
	Association and	ResCare's internal				
	procedures on in	vestigations. ResCare will				
	not allow for neg	potism during the				
	conducting, dire	cting, reviewing or other				
	managerial activ	ity of an investigation into an				
	allegation of abu	ise, neglect, exploitation or				
	mistreatment, by	prohibiting friends and				
	relatives of an al	leged perpetrator from				
	engaging in thes	e managerial activities. The				
	assigned investig	gator will complete a detailed				
	investigative cas	e summary based on witness				
	statements and o	ther evidence collected.				
	When all witnes	s statements, documentation,				
	etc. provide evid	lence that the allegation is				
	substantiated the	en the ANE (abuse, neglect				
	and exploitation	) allegation is				
	substantiated"	This federal tag relates to				
	complaint #IN00	0446036.5-1.2(24)(1)				
W 0154	483.420(d)(3) STAFF TREATME	ENT OF CLIENTS				
Bldg. 00						
	clients in the sampl additional clients (I R), the facility faile	view and interview for 3 of 4 e (A, B and C) and 12 E, F, G, H, I, J, L, M, N, P, Q and od to conduct thorough ient A's ingestion of drywall	W 0154	To correct the deficient practic certified investigators will be retrained to include in investig scopes as applicable, if poten abuse is suspected, and in the	ation tial	2025

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	IENT OF DEFICIENCIES AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	r í	UILDING	onstruction 00	(X3) DATE COMPL 12/06/	ETED
	F PROVIDER OR SUPPLIE	2		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	leading to a trip to self-injurious behave to a psychiatric face broken glass to state client to client aggridentifying the scorp potential abuse and and ensure investig pertaining to the inunrelated incidents  Findings include:  On 12/3/24 at 9:44 incident/investigati indicated the follow  1) The 10/25/24 B (BDS) incident rep 2024 at 5:02pm [cl physical aggression apparent reason and was able to prevent A] to walk to his rowas compliant and hallway. When staff [client A] ran back to engage in physical but staff again was redirected [client A safety and coping shim with coping sk staff and attempted trained staff initiate Rights Committee) (restraint). Despite [client A] with copagitated in the hold and administered a	the emergency room, client B's vior and subsequent admission ality and attempts to use a staff, conduct thorough ession investigations be of the investigation as concluding abuse occurred, ations included information cident and not details from			conclusion will note if abuse is substantiated or unsubstantiated. All certified investigators will be retrained on completing investigations when EMS or latenforcement agencies are involved. All Site Supervisors be retrained to ensure the 1:1 staffing assignments are thoroughly completed daily with blanks. All DSP's and Site Supervisors will be retrained of client behavior support plans. Additional monitoring will be achieved by weekly administrateam observations to ensure are implementing all policies, procedures, documentation, and plans as written. The administrative team (PM, QAM, QAC, QIDP, DON) will evaluate the observation frequency and effectiveness monthly to determ if the observations should continue, decrease, or increase.	ted. aw will th no on ative staff nd //, te	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	lì í	ILDING	nstruction <u>00</u>	(X3) DATE : COMPL 12/06/	ETED
NAME OF	PROVIDER OR SUPPLIER	R		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	down. He was releat lasted 13 minutes. In no injuries. While it in [client A's] wall. about the hole, he start drywall because he peer for an unknow staff to transport [c. Emergency room was following diagnosis (unknown intent) (dinstructions state: 'I abdominal pain, perchanges. Call his deadjustments. Follow week.' [Client A] he checks and the hole repaired. [Client A] PICA (ingestion of does not have a hist aren't edible. [Client campus without fur The 10/25/24 Intercent indicated, "On 10 his bedroom eating away from the rest what he was doing, It was noted in the eaten his dinner appears this. [Client A] was sent to [name] recommendation we there is any severe behavioral changes psychiatrist be continued.	coping skills and he calmed used from the hold. The hold Nurse assessed him and noted in the hold, staff noticed a hole When staff asked [client A] tated that he was eating the was hungry and mad at his in reason. Nursing advised lient A] to the [name] where he was evaluated and the swas made: 'Ingestion thry wall/insulation).' Discharge Return to ER for severe resistent vomiting, or behavior octor to discuss medication with your doctor in one as been placed on 5 minute in the drywall has been does not have a diagnosis of non-nutritive substances) and tory of ingesting items that at A] returned to the residential ther issues."  Hisciplinary Team Meeting /24/24, [client A] was found in his drywall that he had peeled of the wall. When staff asked he stated that he was hungry. Incident report that he had proximately one hour prior to be assessed by nursing staff and Hospital for an evaluation. The last or return to the hospital if abdominal pain, vomiting, or a It was recommended that his acted about the behavior.					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/06/2024	
NAME OF F	PROVIDER OR SUPPLIEI	<b>.</b>		1306 S I	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG	and his dresser was access to the damage was placed outside. The guardian was continued supervision of the plant of the guardian was continued supervision. The maintenance may repair. A reinforced wall/furniture check continued supervision of the plant	items will be added to [client or Support Plan). Hourly as will be implemented in [client eck for further PICA] Door to bedroom will remain on 5 minute of the 1:1 (one on one) staff from position the chair to have line of during overnight hours.  [name of psychiatrist] on behaviors. Nurse manager will one of primary care physician] to all deficiencies may be the risk medical care plan will be vior. [Client A] will continue to Behavior Clinician) on cticing relaxation/coping  mentation the facility tigation.  PM, the Quality Assurance		TAG			DATE
	investigation condu about why we didn	indicated there was no neted. She stated, "Not sure t investigate it. I asked about ion." The QAC indicated					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/06/2024	
NAME OF P	ROVIDER OR SUPPLIER			1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
		ere questioned there was no					<i>B</i> z
	Manager (QAM) in conduct an investig discuss the incident QAM indicated he up and safety measu conduct an investig	PM, the Quality Assurance dicated the facility did not ation. The IDT convened to and implement a plan. The felt there needed to be follow ares put in place but did not ation. The QAM stated the ourselves credit for doing					
	"On November 13, the dayroom when I he was upset becaus grandma, brother, a occurred years prior property destruction it to break a window the window is repla glass and began to comultiple times to comultip	OS incident report indicated, 2024 at 4:50pm [client B] was in the became agitated. He stated see of the death of his and cousin (these deaths of). [Client B] then engaged in the bythrowing a chair, causing the vertical seed of the then took a piece of cout his right wrist. Staff tried of state the piece of glass but to cut staff each time. Staff Emergency Medical diand transported [client B] to Room where he was evaluated of the [name of psychiatric ficity] where he is still currently compted to assess [client B] lient B] refused to allow her.					
	indicated, "Upon be campus restricted response to suicidal (Behavior Support)	disciplinary Team Meeting returning to the facility, he will of for up to 30 days per gestures in the BSP Plan). Due to the acts of self ares, he will remain without					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15G811		A. BUILDING B. WING	00	COMPLETED 12/06/2024
NAME OF I	PROVIDER OR SUPPLIER	1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135	
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	personal items for up to 14 days (reviewed after 7 days). Staff will be inserviced about all changes. Staff will be inserviced that AYSIS (Advanced You're Safe I'm Safe - restraint system) intervention should be utilized immediately upon destruction or acts of self injury. [Client B] will be on 15 minute checks for 24 hours upon return and will remain in the residential building for an additional 24 hours. Restitution will start after the 30 day campus restriction, QIDP (Qualified Intellectual Disabilities Professional) will work with [client B] on a payment plan (per his BSP). [Client B] will see his psychiatrist on 11/22/24. Guardian is in approval of all recommendations and is considering an internet/social media restriction or supervision as the team deems necessary."  There was no documentation the facility conducted an investigation.  On 12/3/24 at 11:32 AM, the Quality Assurance Coordinator (QAC) indicated there was no investigation conducted. The QAC stated she was "not directed to do one. Didn't cross my mind." The QAC indicated the incident occurred in the common area day room however she did not ask the facility's camera system operator for a clip of the incident. The QAC stated the incident "should have been investigated."  On 12/3/24 at 12:50 PM, the Quality Assurance Manager (QAM) indicated there was no investigation for the incident. The QAM stated, "I would agree it should have been investigated."  The QAM indicated although the incident was not investigated, the IDT convened, corrective actions were implemented and the facility had a plan for what to do.			

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 12/06/2024	
NAME OF P	ROVIDER OR SUPPLIER	2	1306 S	ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
mo		14 PM, client A hit client I on	mo		DATE .
	"To determine circule event. Did staff fol The Factual Finding "There is a history between [client A] as targed aggression. This in intense. Proper ratiplans were properly suspected. Conclusionally behavior plans were the investigation where the suspected of the investigation where the conclusion not in abuse was substantially as the dayroom table suddenly entered the [client I]. He then entowards [client I] by I's] neck in an attentimmediately interverse [client A] from chotal client A] to his beginning in physical Both consumers ret without further issue.	S report indicated, "On at 6:05pm [client I] was standing e with staff when [client A] e dayroom and approached ngaged in physical aggression y placing his hands on [client apt to choke him but staff ened and was able to prevent king [client I]. Staff redirected droom where they assisted him skills and educated him on not al aggression towards peers.			
	_	umstances contributing to this			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	r í	JILDING	nstruction 00	(X3) DATE : COMPL 12/06/	ETED
NAME OF F	PROVIDER OR SUPPLIEF			1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	event. Did staff fol The Factual Finding "Nurse assessed be injuries. There is a incidents between [A] does have a hist-aggressor. [Client physical aggression violent or intense. Behavior plans were are to make sure the [client I] at all time Conclusion: It is unplans were properly  The investigation we by the scope not incident to client aggression the conclusion not incident to client aggression which is the conclusion of the conclusion. It is the conclusion of the concl	low behavior plans properly?" gs section indicated, in part, both consumers and noted no history of peer to peer client A] and [client I]; [Client bry of being the main a A] has target behavior of broper ratio was followed. This incident was not proper ratio was followed, and properly followed; staff bry are between [client A] and bry and buse is suspected. Substantiated that behavior brofollowed."  The same of thorough as evidenced dicating the facility identified dession as potential abuse and indicating whether or not					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/06/2024	
NAME OF F	PROVIDER OR SUPPLIER			1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE	(X5) COMPLETION DATE
	combative while in [client N] and admi Staff was able to as skills and he calmed the hold. The hold I assessed [client N] assessed [client P] a left side of his neck longer there. Both oprogramming without The 11/13/24 Scope "To determine circular event." The Factua assessed [client N] assessed [client N] assessed [client P] a left side of his neck longer there. Both oprogramming without has target behaviors. There is not a history between [client P] a followed. Behavior No ANEM (Abuse/Neglect/Expstaff is suspected."  The investigation who by the scope not incomplete the conclusion not in abuse was substantial.  6) The 11/14/24 BI November 13, 2024 in a chair in the day obsessing and was adayroom prior to the similar and the staff is the suspected.	e of the Investigation indicated, amstances contributing to this I Findings indicated, "Nurse and noted no injuries. Nurse and noted a red mark on the That mark is currently no consumers returned to normal out further issues. [Client N] of physical aggression. The plans were properly followed. The plans were					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G811	B. W	ING		12/06/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	2			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
(VA) ID	OLD OVER DAY	CT A TEMENT OF DEFICIENCIE		ID.		<u> </u>	075)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
IAG		y. [Client I] notices [client A]	+	IAG			DATE
	·	egins to move away. [Client					
	_	and engaged in physical					
	aggression towards him by briefly choking him						
		his room. Staff walked with					
	_	nurse while other staff					
		on using coping skills if he is					
		ging in physical aggression					
		f assessed both consumers					
	_	es. Both consumers returned to					
		ng without further issues."					
	1 5						
	The 11/20/24 Inves	tigative Summary indicated the					
	Scope of the Investigation was, "To determine						
	_	ributing to this event." The					
		ted, "[Former Site					
		hat when she asked [client I]					
	what had happened,	, he stated that [client A] had					
	choked him. Nurse	assessed both consumers and					
	noted no injuries. T	There is a history of peer to					
	peer incidents between	een [client A] and [client I];					
	[client A] does have	e a history of being the main					
	aggressor. [Client A	A] has target behavior of					
		. This incident was not					
		Proper ratio was followed.					
	_	e not properly followed; staff					
		ey are between [client A] and					
		s. No abuse is suspected."					
		licated, "It is unsubstantiated					
	that behavior plans	were properly followed."					
	The intill	rea mot themough as soid.					
	_	ras not thorough as evidenced					
		licating the facility identified ession as potential abuse and					
		ndicating whether or not					
	abuse was substanti	_					
	aouse was suosianti	aicu.					
	7) The 11/22/24 Di	DS report indicated, "On					
		at 4:34 pm [client A] was					
		[client C], who was walking					
	cating uniner when	[enent C], who was walking					

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	OF CORRECTION			COMPLETED 12/06/2024			
NAME OF I	PROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CAI	RE INC				CASTLE, IN 46135		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	R LSC IDENTIFYING INFORMATION		ΓAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	DATE
1110		I [client A's] table and took his					2112
		mped up and ran after [client C]					
	and bit him on his left upper arm. [Client C] did not						
	retaliate. Staff imm	ediately intervened and					
	separated both clien	nts. Staff walked with [client C]					
	to see the nurse wh	ile other staff got [client A]					
	another drink. Nurs	se assessed [client A] and					
	noted no injuries. Nurse assessed [client C] and						
	noted a 1" (inch) diameter bruising with 2"						
	diameter teeth marks around the bruising. Both						
	consumers returned	I to normal programming."					
	The 11/27/24 Scope	e of the Investigation indicated,					
	"To determine circumstances contributing to this						
	event. Did staff follow behavior plans properly?"						
	The Factual Finding	gs section indicated, "Nurse					
		and noted a 1" diameter					
	bruising with 2" dia	ameter teeth marks around the					
	bruising. This incid	lent was not violent or intense.					
	There is not a histor	ry of peer to peer incidents					
	between [client A]	and [client C]; [client A] does					
	have a history of be	eing the main aggressor. This					
		olent or intense. [Client A] has					
		physical aggression. [Client C]					
	-	of inappropriate access to					
	_	vas followed. Behavior plans					
		wed. No abuse is suspected."					
		licated, "It is substantiated					
	that behavior plans	were properly followed."					
	The investigation w	vas not thorough as evidenced					
	by the scope not inc	dicating the facility identified					
	client to client aggr	ression as potential abuse and					
		indicating whether or not					
	abuse was substant	iated.					
		0 PM client G bit client F on the					
		t P on the left arm then hit and					
		Clients B, F and P did not have					
	injuries.						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G811		A. BUILDING B. WING	00	COMPLE S 12/06/2	TED	
NAME OF F	PROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET NCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E RIATE	(X5) COMPLETION DATE
	"To determine circule event." The Factual part, "There is a hetween [client G as have a history of be G] has target behave aggression, boundar noncompliance. Pro G] has 1:1 status; the this incident as there reach of [client G]. for 9.9.24, [client G noon; there were no other time slots. No The investigation we by the scope not incident to client aggrethere was not a common abuse was substant abuse was substant and have injuries.  The 9/17/24 Scope determine circumstate event." The Factual part, "Neurocheck and all vitals have be There is not a history of being the target behaviors of aggression, boundar noncompliance. Pro	20 PM client G shoved client F and hit his head. Client F did  of Investigation indicated, "To ances contributing to this I Findings section indicated, in as were started on [client F] been within normal range. The sy of peer to peer incidents and F]; [Client G] does have a main aggressor. [Client G] has werbal and physical cries, instigation, and oper ratio was followed. [Client one) status; this was properly				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  12/06/2024			
NAME OF P	PROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET NCASTLE, IN 46135	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
TAG	The investigation we by the scope not incedient to client aggrethere was not a concount abuse was substantially and the scope of the sc	ras not thorough as evidenced dicating the facility identified ession as potential abuse and clusion indicating whether or antiated.  Int L smacked client I in the or injuries.  of Investigation indicated, "To ances contributing to this I Findings section indicated, in pes have a history of being the ient L] has target behaviors of and boundaries. Proper ratio vior plans were properly is suspected."  Tas not thorough as evidenced dicating the facility identified ession as potential abuse and clusion indicating whether or	TAG	DEFICIENCY	DATE
	instigation. There is peer-to-peer incider	s of verbal aggression and s a history of attempted ats between [Client I and client s followed. No ANEM from			

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	OF CORRECTION	IDENTIFICATION NUMBER  15G811	A. BUILDING 00  B. WING			COMPLETED 12/06/2024	
NAME OF I	PROVIDER OR SUPPLIEF	8		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	by the scope not indeclient to client aggrethere was not a commot abuse was substantially on 9/23/24 at 6 client B and kicked hit him in (sic) the land I had no injuried. The 9/30/24 Scope determine circumstevent. Did staff for the Factual Finding [Client I] has target aggression, physical Self- Injurious Behabas target behaviors physical aggression history of attempted between [clients I a followed. Behavior Staff and client stat camera feed. No A Conclusion: It is subehavior plans proper the investigation where the scope not inclient to client aggrethe conclusion not in abuse was substantial. 13) On 9/24/24 at 1 F in the face. Client.	220 PM client I lunged towards him in (sic) left side and then left side of his face. Clients B is.  of Investigation indicated, "To ances contributing to this low behavior plans properly?" ges section indicated in part, " behaviors of verbal laggression, non-compliance, avior, and instigation. [Client B] is of verbal aggression, and instigation. There is a dipeer-to-peer incidents in B]. Proper ratio was replans were properly followed. It is a plans were properly followed. It is suspected.					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BUI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/06/2024	
NAME OF	PROVIDER OR SUPPLIE RE INC	R		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	determine circums event. Did staff fol The Factual Findir "Loud and chaot documented trigge history of peer to p F, L and P], but [c] being the main agg behaviors of physi Proper ratio was for plan, staff is to pla L] and peers when do this. No abuse did not properly for The investigation who by the scope not in client to client agg the conclusion not abuse was substant 14) On 9/24/24 at towel and slapped then hit client R or did not have injuring The 10/1/24 Scope determine circums event. Did staff fol The Factual Findir "There is not a hetween [clients P behaviors of physi Staff properly follow compared to proper to	5:25 PM client Q picked up a client P in the face. Client Q his cheek. Clients P, Q and R						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G811		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING				X3) DATE SURVEY COMPLETED 12/06/2024	
NAME OF F	PROVIDER OR SUPPLIEI RE INC	₹		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	TE	(X5) COMPLETION DATE
	client to client aggr	dicating the facility identified ession as potential abuse and indicating whether or not intention in the control in the contr					
	in his bedroom using to scratch his left and gone into client M's the face twice. Client	e:09 PM client I was discovered ag a broken CD (Compact Disc) rm. Client I reported he had as bedroom and punched him in ent M had no injuries. Client I cal ER (Emergency Room) for					
	determine circumst event. Did staff foll The Factual Findin, "Camera shows the enters [client M's] is 3:11 pm, [client M] with his hands. The peer-to-peer incider Proper ratio was fo properly followed. suspected.	of Investigation indicated, "To ances contributing to this low behavior plans properly?" gs section indicated in part, that at 3:09:44 pm [client I] froom and exits at 3:09:55 pm; at lexits his room holding his face there is not a history of that between [clients I and M]. Illowed. Behavior plans were No ANEM from staff is					
	by the scope not inc	vas not thorough as evidenced dicating the facility identified ession as potential abuse and indicating whether or not					
	· /	1:49 AM client A bit client H on s A and H did not have any					
		of Investigation indicated, "To ances contributing to this					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	(X3) DATE	SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		15G811	B. WII	NG		12/06/2024	
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIE	R			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG		low behavior plans properly?"		IAG			DATE
		gs, section indicated in part,					
		an aggressive behavior, these					
	_	atense or violent. There is a					
		peer incidents between [clients					
		A] does have a history of being					
		: [Client A] has target behavior					
		sion. [Client H] has a target					
	1	ing, causing agitation.					
		re properly followed. No abuse					
	is suspected.						
	Conclusion; It is su	ubstantiated that behavior					
	plans were properly	y followed."					
	_	was not thorough as evidenced					
		dicating the facility identified					
		ression as potential abuse and					
		indicating whether or not					
	abuse was substant	tiated.					
	17) 0 - 0/26/24 - 4	0.17 AM -1: A11-1:					
	1	8:17 AM client A smacked client from the calmed both clients. A short					
		was sitting on the couch and					
		ound the dayroom, grabbed					
		st and bit it. Clients A and H did					
	not have any injuri						
	not have any injuri	cs.					
	The Scope of the I	nvestigation indicated, "To					
		tances contributing to this					
		llow behavior plans properly?"					
		igs, section indicated in part,"					
		of peer to peer incidents					
	1	and H]; [client A] does have a					
	_	e main aggressor. [Client A]					
		of physical aggression. [Client					
	H] has a target behavior of obsessing, causing						
	agitation. No abuse						
	~	ubstantiated that behavior					
	plans were properly	y followed."					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15G811		ľ	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 12/06/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF			1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	by the scope not inc	vas not thorough as evidenced dicating the facility identified ession as potential abuse and indicating whether or not lated.					
	18) On 9/28/24 at 6:10 PM client A struck client C on the right side of the face. Clients A and C did not have any injuries.						
	determine circumst event. Did staff fol The Factual Finding There is not a history between [clients A history of being the has target behavior Proper ratio was fol properly followed.	avestigation indicated, "To ances contributing to this low behavior plans properly?" gs, section indicated in part," ry of peer to peer incidents and C]; [Client A] does have a main aggressor. [Client A] of physical aggression. Howed. Behavior plans were No abuse is suspected. bstantiated that behavior of followed."					
	by the scope not inc	vas not thorough as evidenced dicating the facility identified ession as potential abuse and indicating whether or not lated.					
	October 1, 2024 at dayroom and appea mood. When his pe an outing, [client J] [client B] and attem politely informed [client began to walk down suddenly slammed	OS incident report indicated "On 12:10pm [client J] was in the red to be calm and in a good ers returned to campus from immediately approached apted to talk to him. [Client B] client J] that he did not want to J] did not say anything and a Pacer's hallway. [Client J] [client P's] door open and im. A staff member stepped					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  A. BUILDING  15G811  B. WING			COMPL 12/06/	ETED				
	PROVIDER OR SUPPLIER	3	STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET					
RES-CAI	RE INC			GREEN	CASTLE, IN 46135			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE TAG DEFICIENCY)		Ē	(X5) COMPLETION DATE	
	between them to try lunged towards [cli hit each other, with them trying to sepa up to assist. While separate [client J] a the hallway and beg this time, a staff me floor and placed he to protect him. Dure continued to try to him, missing and ki [Client B] then stor head, causing his fa tooth to break. Staff clients. Staff walke building for safety. and punch Pacer's of get outside. Staff pr so. [Client B] then able to be redirected staff. Staff was able skills and he calmed trouble calming dowassessed [client B]. PO PRN. [Client B] skills and he calmed transported to [Nam was evaluated and the made: 'Physical ass Contusion. (Homicothen admitted to [Pecity], IN where he is assessed [client P] a injuries. Nurse as unwas transported to the control of the control	to separate them but [client J] ent P] and they both began to the staff member still between rate them. Other staff showed staff was attempting to and [client P], [client B] entered gan to hit [client J] as well. At ember placed [client J] on the r body over him in an attempt ing this time, [client P] harm [client J] by kicking at ficking staff in her stomach. Inped on the back of [client J's] ace to hit the floor and his f was able to separate all d with [client J] out of the [Client P] then began to kick floor in an attempt to open it to revented [client P] from doing attempted to hit staff but was d to the dayroom by another e to assist [client P] with coping d down. [Client B] was having was able to use his coping d down. [Client J] was and administered a behavioral ] was able to use his coping d down. [Client J] was and Emergency room where he che following diagnosis was ault. Laceration to the chin. idal ideation).' [Client J] was sychiatric facility] in [name of s currently still admitted. Nurse and [client B] and noted no nable to assess [client J] as he						
			I	l				

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15G811		A. BUILDING 00 COMPLE' B. WING 12/06/2					
NAME	OF PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP COD		
RES	CARE INC				BLOOMINGTON STREET CASTLE, IN 46135		
(X4) II PREFI TAC	X (EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	introduction indicate the dates of interview. Additionally, the state factual findings in Summary were not addressing a separal clarification on the provided a different the same introduction investigation were dates of interview and fact Investigative Summincident. The same indicated "No ANE and "it is substantiate properly followed." indicated this incided. The investigation we by the scope not in client to client aggregates being incorrebeing included in the conclusion not indicated was substantiated.  20) The 10/2/24 B "On October 1, 202 porch with staff be due to verbal aggreginside so that he coinside, he was not being least he got inside, approached [client and bit it. [Client immediately red	ted the date was 10/1/24, and ew were 10/14/24 and 10/21/24. Immary of interviews and the initial Investigative relevant to this incident due to ate incident. When asked for date of incident, the facility at Investigative Summary with son, but indicated the dates of 10/1/24 to 10/8/24 and the were 10/1/24 and 10/8/24. The mal findings in this mary were relevant to the Investigative Summary also EM from staff is suspected," ated that behavior plans were					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BUILDING <u>00</u> C				3) DATE SURVEY COMPLETED 12/06/2024	
NAME OF I	PROVIDER OR SUPPLIEI	· ?			ADDRESS, CITY, STATE, ZIP COD	•	
RES-CA	DE INC				BLOOMINGTON STREET ICASTLE, IN 46135		
	ı		1	1	IOAGTEE, IN 40100		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	with coping skil	ls. Nurse assessed [client A]					
	and noted no inj	uries. Nurse assessed [client					
	I] and noted a bite mark on his right						
	forearm, no bleeding and skin was not						
	broken. Both con	nsumers returned to normal					
	programming wi	ithout further issues."The					
	Investigative Su	mmary dated 10/8/24 for the					
	incident, indicate	ed the biting did occur. The					
	same Investigati	ve Summary also indicated					
	"this incident wa	as not violent or intense," "No					
	abuse is suspected," and "it is substantiated						
	that behavior plans were properly						
	followed."The in	nvestigation was not thorough					
	as evidenced by	the scope not indicating the					
	facility identified	d client to client aggression as					
	potential abuse a	and the conclusion not					
	indicating wheth	ner or not abuse was					
	substantiated.21	) The 10/3/24 BDS					
	incident report in	ndicated, "On October 2,					
		[client I] was in the					
	l -	ing about Halloween and					
	1	and began to yell. Staff					
		his bedroom for his safety					
	1	to his peers. [Client I]					
		d remained sitting on his					
		ent advised staff that they					
	-	A] enter [client I's]					
		ff is approaching [client I's]					
		e the door is shut. Shortly					
	1	ve [client A] exit [client I's]					
		o his own room. When staff					
	asked [client I] i	f he had been hurt, [client I]					

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NAME OF I	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET	•	
RES-CA	RE INC				ICASTLE, IN 46135		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	showed staff his	arm as [client A] had bit					
	(sic) him. Nurse	assessed [client A] and					
	noted no injuries. Nurse assessed [client I]						
	and noted a bite mark on his upper right						
		g with skin still intact. Both					
		ned to normal programming					
		ssues."The Investigative					
	1	10/9/24 for the incident,					
		ing did occur. The same					
	Investigative Summary also indicated "this						
	incident was not violent or intense," "No						
	_	ed," and "it is substantiated					
	_	ans were properly					
		nvestigation was not thorough					
	1	the scope not indicating the					
	_	d client to client aggression as					
		and the conclusion not					
	1	ner or not abuse was					
		The 10/4/24 BDS incident					
	1 *	"On October 3, 2024 at					
		A] was sitting down eating					
		tood up and began to walk					
		oom. At this time, his peer					
		d over to his plate and took					
	_	lient A] saw this and					
		ical aggression towards					
		ing his left hand. Staff					
		ervened and walked with					
		nruse's (sic) station. Staff					
	_	A] on using his coping skills					
		es upset. Nurse assessed					
	[chem A] and no	oted no injuries. Nurse					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811			JILDING	onstruction 00	(X3) DATE COMPL 12/06/	ETED	
NAME OF I	PROVIDER OR SUPPLIEI	· R			ADDRESS, CITY, STATE, ZIP COD	•	
RES-CA	DE INC				BLOOMINGTON STREET ICASTLE, IN 46135		
	T	OT A TENTE OF DEPLOYED OF	1				975)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE  ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	assessed [client	C] and noted a red mark to					
	left thumb with	skin intact. The mark is not					
	there currently.	Both consumers returned to					
	normal programming without further						
	issues."The Investigative Summary dated						
	10/10/24 for the	incident, indicated the biting					
	did occur. The sa	ame Investigative Summary					
		his incident was not violent					
	•	abuse is suspected," and "it					
	is substantiated that behavior plans were						
	properly followed."The investigation was not						
	_	lenced by the scope not					
	_	cility identified client to client					
	1	tential abuse and the					
		ndicating whether or not					
		antiated.23) The 10/7/24					
		port indicated, "On October					
	_	m, [client M] was at the					
	1	oom when for an unknown					
	· ·	his milk on the floor and					
		vn Colt's hallway. As he					
	1	vn the hall, he ran past [client					
		nim on the left side of his					
		continuing to his bedroom.					
		ot retaliate. While in his					
		began to throw his laundry					
		t staff as well as charged at					
		ng. [Client M] then began to					
		his hands and then his head.					
		ned staff initiated a guardian					
		ved 3 person supine.					
	Despite staff atte	empting to assist him in					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		ì í	LDING	nstruction <u>00</u>	(X3) DATE COMPL 12/06/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	· {			DDRESS, CITY, STATE, ZIP COD		
RES-CA	RE INC				BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID	T	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	P	REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	e continued to be agitated.					
	-	client M] and administered					
		PRN. Staff was able to					
		in calming down and he was					
		e hold. The hold lasted 39					
		assessed both consumers					
	and noted no inju	uries. Neurochecks were					
	initiated on [clie	nt M] and all vitals have					
	been within norr	nal range."The Investigative					
	Summary dated	10/11/24 for the incident,					
	indicated the slapping did occur. The same						
	Investigative Sur	mmary also indicated "No					
	abuse is suspected	ed," and "it is substantiated					
	that behavior pla	ns were properly					
	followed."The ir	nvestigation was not thorough					
	as evidenced by	the scope not indicating the					
	facility identified	d client to client aggression as					
	potential abuse a	and the conclusion not					
	indicating wheth	er or not abuse was					
	substantiated.24	) The 10/16/24 BDS					
	incident report in	ndicated, "On October 15,					
	2024 at 8:16am	[client E] was walking up					
	Pacers hallway t	owards the dayroom when					
	[client H] approa	ached him and got into his					
	personal space. [	[Client E] asked [client H]					
	to back up and [o	client H] retaliated by					
	slapping [client]	E's] hand and then attempted					
	to spit on [client	E]. Staff immediately					
		edirected [client H] away					
		Nurse assessed both					
		noted no injuries. Both					
		ned to normal programming					
			1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPI A. BUILDIN B. WING		nstruction 00	(X3) DATE COMPL 12/06/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	<b>.</b>			ADDRESS, CITY, STATE, ZIP COD		
RES-CAI	RE INC				BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRI			(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		ssues."The Investigative					
	Summary receiv	ed for this incident indicated					
	investigation dat	es of 10/15/24 to 10/22/24,					
	the date in the in	troduction was indicated to					
	be 10/6/24, and t	the interview dates were					
	indicated to be 1	0/22/24.No definitive date					
	of incident was a	available due to conflicting					
	information on the	he provided Investigative					
	Summary. The s	ame Investigative Summary					
	also indicated "T	This incident was not violent					
	or intense," "No	abuse is suspected," and "it					
	is substantiated t	hat behavior plans were					
	properly followe	ed." The Investigative					
	Summary indica	ted this incident did occur.					
	The investigation	n was not thorough as					
	evidenced by the	e scope not indicating the					
	facility identified	d client to client aggression as					
	potential abuse,	dates being incorrect,					
	non-relevant info	ormation being included in					
	the investigation	, and the conclusion not					
	indicating wheth	er or not abuse was					
	substantiated.25	) The 10/15/24 BDS					
	incident report in	ndicated, "On October 14,					
	_	[client J] was in the					
	dayroom talking	to peers. One of his peers					
	was talking to st	aff when [client J] suddenly					
	shouted 'f*** yo	u!' and threw a water bottle					
		unknown reason. [Client J]					
	1	vards [client B] and hit him					
		nen kicked him in his leg. At					
	this time, trained	I staff initiated a guardian and					
	HRC approved 2	2 person escort to [client					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15G811		î ´	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 12/06/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	3		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	J's] room for his	safety due to multiple peers					
	beginning to targ	get [client J]. Nurse assessed					
	[client J] and administered a behavioral PO						
	PRN. Per his pla	n, [city] Police Department					
	was called. Office	cers arrived to campus.					
	After reviewing	camera footage, officers					
	placed [client J]	in handcuffs and arrested					
	him. He was tran	nsported to [name] County					
	Jail where he sta	yed overnight. [Client J]					
	was released from	m the jail and back to					
	ResCare on 10.15.24 at 10:00am. Nurse						
	assessed both consumers and noted no						
	injuries."The Inv	vestigative Summary received					
	for this incident	indicated investigation dates					
	of 10/14/24 to 10	0/21/24, the date in the					
	introduction was	s indicated to be 10/1/24,					
	and the interview	w dates were indicated to be					
	10/14/24 and 10	/21/24. No definitive date					
	of incident was a	available due to conflicting					
	information on t	he provided Investigative					
	Summary. The s	ame Investigative Summary					
	also indicated "N	No ANEM from staff is					
	suspected," and	"it is substantiated that					
	behavior plans w	vere properly followed." The					
	Investigative Sur	mmary indicated this incident					
	did occur. The in	vestigation was not					
	thorough as evid	lenced by the scope not					
	indicating the fa	cility identified client to client					
	aggression as po	tential abuse, dates being					
	incorrect, non-re	elevant information being					
	included in the in	nvestigation, and the					
	conclusion not in	ndicating whether or not					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G811					COMPLETED 12/06/2024	
NAME OF PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE,		
RES-CARE INC				06 S BLOOMINGTON S EENCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFI TAG	CROSS-REFERENCED TO	TION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
1710	<del> </del>	antiated.26) The 10/24/24	1710			DATE
		port indicated, "On October				
	1	pm [client I] was in the				
		zing with staff when [client				
	•	ayroom and began walking				
	_	iddenly approaching [client				
		nim in his face. Staff				
		edirected [client A] to his				
		ers hallway. Shortly after,				
	[client A] exited his room and began walking					
	up and down Pacers hallway. When staff					
	walked down Pa	cers hallway, [client A]				
	suddenly engage	ed in physical aggression				
	towards staff by	biting her arm. That staff				
	member called fe	or assistance and at this				
	time, trained stat	ff initiated a guardian and				
	HRC approved 3	3 person supine. Despite				
	staff attempting	to assist [client A] with				
	coping skills, he	continued to be agitated in				
	the hold. Nurse a	assessed [client A] and				
	administered a b	ehavioral IM PRN. [Client				
	A] was able to u	se coping skills and he was				
	released from the	e hold. The hold lasted 24				
	minutes. [Client	A] then sat on his bed and				
	listened to his headphones. 20 minutes later,					
	[client A] reente	red the dayroom and				
	immediately approached [client I] and bit his					
	left finger. Staff intervened and redirected					
	[client A] to his	room where they attempted				
	to talk to him an	d assist him with coping				
	skills but he con	tinued to be agitated and				
	began to shout at and attempt to hit staff. At					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G811		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  12/06/2024	
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD			
RES-CARE INC					BLOOMINGTON STREET ICASTLE, IN 46135			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENC!		DATE	
	this time, trained staff initiated a guardian and HRC approved 3 person supine. Staff was							
		ient A] with coping skills and						
	_	from the hold. The hold						
		s. Nurse assessed [client A]						
		uries. Nurse assessed [client						
		te mark to his left index						
	_	eaned the wound and						
	_	plied. Both consumers						
	returned to normal programming without							
	further issues."The Investigative Summary							
	dated 10/30/24 for the incident, indicated							
	the biting did oc	cur. The same Investigative						
	Summary also in	ndicated "This incident was						
	not violent or in	tense," "Behavior plans were						
	not properly foll	owed," "No abuse is						
	suspected," and	"It is unsubstantiated that						
	behavior plans v	vere properly followed."The						
	investigation wa	s not thorough as evidenced						
	by the scope not	indicating the facility						
	identified client	to client aggression as						
	_	and the conclusion not						
	1	ner or not abuse was						
	substantiated.27) The 10/28/24 BDS							
	incident report indicated "On October 27,							
	_	[client A] came in to the						
	dayroom from his room in Pacers hall and							
	began to walk around the dayroom. For no							
	apparent reason and without precursors,							
		nly ran towards [client I],						
	_	on the couch watching TV,						
	and placed his hand on [client I's] neck and							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/06/2024	
NAME OF PROVIDER OR SUPPLIER RES-CARE INC			1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET NCASTLE, IN 46135	•	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	briefly choked h	im before letting go and				
	running back to	his room in Pacers hall. Staff				
	walked with [cli	ent I] to the nurse's station to				
	be assessed whil	le other staff educated				
	[client A] on not	t engaging in physical				
	aggression towa	rds peers. Both consumers				
	returned to norm	nal programming without				
	further issues."T	The Investigative Summary				
	dated 11/1/24 fo	r the incident, indicated the				
	choking did occur. The same Investigative					
	Summary also in	ndicated "This incident was				
	not violent or intense," "Behavior plans were					
	not properly foll	owed," "No abuse is				
	suspected," "It is	s unsubstantiated that				
	behavior plans v	vere not properly				
	followed."The in	nvestigation was not thorough				
	as evidenced by	the scope not indicating the				
	facility identified	d client to client aggression as				
	potential abuse a	and the conclusion not				
	indicating wheth	ner or not abuse was				
	substantiated.Or	12/3/24 at 11:10 AM, the				
	Program Manag	er indicated client to client				
	aggression was a	abuse and the facility should				
	prevent abuse of the clients. The PM					
	indicated the facility had a policy and					
	procedure prohibiting abuse.On 12/3/24 at					
	11:32 AM, the QAC indicated client to					
	client aggression was abuse and the facility					
	should prevent abuse of the clients. The					
	QAC indicated t	the facility had a policy and				
	procedure prohil	biting abuse. The QAC				
	indicated she substantiated the clients' plans					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G811		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 12/06/2024			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET				
RES-CAF	RE INC		GREEN	NCASTLE, IN 46135			
(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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
W 0191 Bldg. 00	were implemented She indicated she scope she was in aggression as about not indicate in the client to client agas abuse. On 12/3 QAM indicated was abuse and the abuse of the client the facility had a prohibiting abuse facility should convestigations. To conclusions of client abuse occurre to complaint #IN 483.430(e)(2) STAFF TRAINING Based on interview clients in the sample clients (E, H, J, K and ensure staff received on who received on the facility.  Findings include:  On 12/2/24 at 1:12 were 4 clients who assaffing. Staff #32 and 1:1 staffing.	ed as written by the staff.  e did not indicate in the vestigating client to client use. She indicated she did e Conclusion whether or not gression was substantiated 6/24 at 12:50 PM, the client to client aggression e facility should prevent hts. The QAM indicated policy and procedure e. The QAM indicated the conduct thorough The QAM indicated the ient to client aggression ed to determine whether or ed. This federal tag relates 100446036.5-1.2(24)(1)  E PROGRAM  and record review for 2 of 4 e (C and D) and 5 additional htd M), the facility failed to d competency based training e on one (1:1) supervision at  PM, staff #32 indicated there received one on one (1:1) did not indicate who received	W 0191	To correct the deficient practic all DSP's and site supervisors be retrained on client supervis levels. At the monthly DSP an Site Supervisor meetings, the BC, and QIDP will review the supervision levels and docum on the agenda sheets.	DATE  Dec,  01/06/2025  will sion d  PM,		
	On 12/2/24 at 1:37	PM, staff #28 indicated 7 clients	1				

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
15G811		B. WING 12/06/2024					
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	2			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	received 1:1 staffing	g(C, H, D, K, M, J and $E)$ .					
	On 12/2/24 at 2:03	PM, staff #24 indicated there					
		receive 1:1 staffing (H, E, K, C,					
	D and J).						
	On 12/2/24 at 2:43 l	PM, staff #20 indicated there					
		receive 1:1 staffing (H, K, J and					
	E).						
	On 12/2/24 at 3:06	PM, staff #4 indicated there					
		receive 1:1 staffing (E, D, H, J					
	and K).						
	On 12/2/24 at 1:22 PM, a focused review of client						
	C's record was cond	lucted. Client C's 10/11/24					
	Behavior Support P	lan (BSP) indicated, "[Client					
	C] will have an assi	gned staff across all shifts. He					
	will have 10 minute	e checks"					
	On 12/2/24 at 1:24	PM, a focused review of client					
	D's record was cond	ducted. Client D's 11/14/24					
	BSP indicated, "[0	Client D] will have 1:1					
		s (sic) reach staffing due to					
	*	xual aggression toward peers.					
		sleeping, the staff member will					
	_	hallway with the bedroom					
		y open so that supervision can					
		1:1 staff must ensure that there					
	_	pathroom when [client D]					
	enters either his own bathroom or the						
		athroom. [Client D's] 1:1 staff					
	will remain outside the shower room during showers to make sure no other clients enter the shower room while [client D] is showering (target behavior: sexually inappropriate behaviors)"						
	On 12/2/24 at 1:26	PM, a focused review of client					
		lucted. Client E's 10/10/24 BSP					
indicated, "1:1 approximately arms (sic) reach							

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G811		A. Bl	A. BUILDING 00 COMPLET  B. WING 12/06/2			ETED			
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC				STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
	SUMMARY:  (EACH DEFICIEN  REGULATORY OR  staff supervision wh history of self injury non-food items W bedroom, staff will small items and wil the hallway to super Staff should not be to [client E's] extens against his staff. Du sleeping, [client E] staff must conduct a items that can be us body orifices. Door  On 12/2/24 at 1:28 if H's record was cond BSP indicated, "[a supervision during a ongoing acts of agg 1:1 staff should stay peers that he may he precursors or aggres be programmed sep with his 1:1 staff  On 12/2/24 at 1:29 if J's record was condition indicated, "Due to environment/ongoir residential building, during all shifts and the movie room of to of his 1:1 program a the admin building;	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION then awake due to an extensive with items and ingesting then he is awake in his do a room sweep to look for I then position themselves in rvise [client E] (door open). alone with him in his room due sive history of false allegations ring overnight hours/when will not have a 1:1 staff but a room sweep looking for any ed for self harm/insertion into remains open"  PM, a focused review of client fucted. Client H's 10/24/24 Client H] will have 1:1 staff all waking hours due to ression toward his peers. The between [client H] and any it. If [client H] is showing sision toward peers, he should arately, away from all peers,  PM, a focused review of client fucted. Client J's 11/14/24 BSP		1306 S	BLOOMINGTON STREET	ΤΈ	(X5) COMPLETION DATE		
	room with his staff.	ls will take place in the rec [Client J] will utilize the rec pass will take place in the							

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  TO SHARP THE PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER  15G811			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 12/06/2024	
NAME OF PROVIDER OR SUPPLIER  RES-CARE INC				1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
INLO-OAI	NE IIVO			OKLLIN	10A01EE, 114 40100	,	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG	On 12/2/24 at 1:32 K's record was cond BSP indicated, "[ approximately arms he is outside of his remain between hin to peer aggression. supervision when sl he will have 5 minu sleep, the 1:1 staff v hard/sharp items the his while he sleeps.  On 12/2/24 at 1:35 M's record was con BSP indicated, "[ checks by staff and [client M] and his p [client M] sexually his impulsive acts of On 12/2/24 at 4:08 Coordinator (QAC) who receive 1:1 sta QAC indicated the who receives 1:1 sta was a staff training On 12/5/24 at 11:50 Manager indicated	PM, a focused review of client ducted. Client K's 11/15/24 Client K] will have 1:1 s reach staff supervision when bedroom. His 1:1 staff is to an and his peers to prevent peer He will have 1:1 staff howering. When he is asleep, atte checks. Prior to going to will clear [client K's] bed of any at may cause marks/injuries on"  PM, a focused review of client ducted. Client M's 9/27/24 Client M] will have 15 minute staff will remain in between beers whenever possible due to grabbing his peers and due to of physical aggression"  PM, the Quality Assurance indicated there were 5 clients ffing (H, E, K, D and J). The direct care staff should know affing. The QAC indicated it		TAG	DEFICIENCY)		DATE
				ĺ			

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