STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00446036. Complaint #IN00446036: Federal/state deficiencies related to the allegation(s) were cited at W149 and W154. Unrelated deficiencies cited. Survey dates: December 2, 3, 4, 5 and 6, 2024 Facility Number: 013405 Provider Number: 15G811 AIM Number: 201267570 These deficiencies also reflect state findings in accordance with 410 IAC 16.2-5. Quality Review of this report completed by #15068 on 12/18/24.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY Based on observation and interview for 4 of 4 sampled clients (A, B, C and D) and 16 additional clients (E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S and T), the facility's governing body failed to exercise operating direction over the facility by failing to ensure the facility remained in good repair. Findings include: Observations were conducted at the facility on 12/2/24 from 11:15 AM until 12:35 PM and on 12/3/24 from 7:33 AM until 8:30 AM. During the observations, the following issues were noted affecting clients A, B, C, D, E, F, G, H, I, J, K, L, M,	W 0104	To correct the deficient practice, all DSP's have been trained on reporting maintenance issues timely. All maintenance issues are being monitored and contracted out for resolution. The administrative staff will conduct daily walk-throughs of the facility to ensure all maintenance issues are reported, as well as any cleanliness issues. All staff, Site Supervisors, QAC, QIDP, and PM will be retrained on reporting maintenance issues timely to the	01/06/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Henry Overton	Operations Support Specialist	01/02/2025

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	N, O, P, Q, R, S and T: -In the shower room off the Pacers Hallway, the first shower stall was missing a 3" (inch) by 3" tile from the drain. There was not a shower head or a shower handle. There was an area 8" by 8" in the ceiling where paint was peeling. -In the second shower stall there were 2 empty souffle cups containing residue of body soap. There was a green towel on the floor. -The chalkboard wall in the dining room had a 1' (foot) by 2' (foot) hole with red wires exposed. -Bedroom #11 did not have have a door handle on the bedroom door and there was missing wood on the backside of the door. -There were various holes on all four walls that have been patched and not repainted in bedroom #11. There was not a door knob on the door leading to the locked bathroom. -The shower room on the Colts hallway had dirty clothes and a towel on the floor. There was an empty souffle cup with body soap on the ledge of the tub. -In the Colts hallway bathroom there was an area on the tiles on the ceiling of the shower that was black and discolored. -In bedroom #14 there was a 2" by 2" hole on the wall behind the bedroom door. -The bathroom in the Colts hallway was missing tile in front of the toilet. There was a strong smell of urine. -The door frame was missing from bedroom #4. -The supply closet on the Colts hallway was missing the door frame. -In the kitchen/dining room in the recreation building there was a bed frame leaning against the wall. -The table in the kitchen/ dining room in the recreation building was missing trim on the edge of the table.		Maintenance supervisor. The PM and maintenance supervisor will keep a maintenance log and meet weekly to review maintenance issues and plans for resolution.	

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	-There was a boarded up window in Bedroom #11. -The corner window in the dining room had 2 boards on the outside of the window. There was a 4" by 4" area in the ceiling with wires hanging down. The door frame on the kitchen door leading out of the kitchen was missing. There were 2 missing drawers in the island counter. There were 2 missing drawers in the cabinets on the west wall in the kitchen. -The corner window in the dining room/day room of the facility had missing and cracked drywall below the window. There was missing dry wall on the west wall surrounding a pipe. An interview was conducted on 12/2/24 at 11:25 AM with staff #4. Staff #4 stated,"the souffle cups in the hallway bathroom are cups of body wash. They should have been thrown away after a shower." An interview was conducted on 12/2/24 at 11:30 AM with client R. Client R stated, "I have a hole in the wall behind my door. I have told the staff, but nothing has been done about it." An interview was conducted on 12/2/24 at 11:45 AM with staff #24. Staff #24 stated, "[Client C] broke the shower handle off several weeks ago and it has never been repaired." An interview was conducted on 12/2/24 at 12:38 PM with MS (Maintenance Staff). The MS stated, "the red wires that are exposed by the hole in the wall in the dining room are low voltage wires to the smoke alarms." The MS stated, "I have applied for a transfer to be at the facility full time. There are a lot of repairs that are needed. I was kind of shocked to see the building in this condition."			

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	An interview was conducted on 12/2/24 at 1:12 PM with staff #32. Staff #32 stated the substance on the ceiling in the shower "looks like mold." An interview was conducted on 12/2/24 at 1:37 PM with staff #28. Staff #28 stated the substance on the ceiling in the shower "looks like mold." An interview was conducted on 12/2/24 at 3:06 PM with staff #4. Staff #4 stated the substance on the ceiling in the shower "looks like mildew." An interview was conducted on 12/3/24 at 4:00 PM with the QAC (Quality Assurance Coordinator). The QAC stated, "The issues with the cleanliness I don't attribute it to the staff. The common areas and bathrooms are bigger issues. The facility has not had a maintenance man." 5-1.3(h) 5-1.5(a)			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS Based on record review and interview for 3 of 4 clients in the sample (A, B and C) and 12 additional clients (E, F, G, H, I, J, L, M, N, P, Q and R), the facility failed to implement its policies and procedures to prevent physical and verbal abuse of client A by staff, client to client abuse, conduct thorough client to client aggression investigations identifying the scope of the investigation as potential abuse and concluding abuse occurred and ensure investigations included information pertaining to the incident and not details from unrelated incidents. Findings include:	W 0149	To correct the deficient practice, certified investigators will be retrained to include in investigation scopes, as applicable, if potential abuse is suspected, and in the conclusion will note if abuse is substantiated. All certified investigators will be retrained on completing investigations when EMS or law enforcement agencies are involved. All Site Supervisors will be retrained to ensure the 1:1 staffing assignments are thoroughly completed daily with no	01/06/2025

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	On 12/3/24 at 9:44 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) The 10/25/24 Bureau of Disabilities Services (BDS) incident report indicated, "On October 24, 2024 at 5:02pm [client A] attempted to engage in physical aggression towards a peer for no apparent reason and without precursors but staff was able to prevent the hit and prompted [client A] to walk to his room for coping skills. [Client A] was compliant and began to walk down [name] hallway. When staff checked on [client A's] peer, [client A] ran back up the hallway and again tried to engage in physical aggression towards his peer but staff again was able to stop contact. Staff redirected [client A] to his bedroom for his peers safety and coping skills. Staff attempted to assist him with coping skills but [client A] began to hit staff and attempted to bite them. At this time, trained staff initiated a guardian and HRC (Human Rights Committee) approved 3 person supine (restraint). Despite staff attempting to assist [client A] with coping skills, he continued to be agitated in the hold. Nurse assessed [client A] and administered a behavioral (medication) PO (by mouth) PRN (as needed). Staff was able to assist [client A] with his coping skills and he calmed down. He was released from the hold. The hold lasted 13 minutes. Nurse assessed him and noted no injuries. While in the hold, staff noticed a hole in [client A's] wall. When staff asked [client A] about the hole, he stated that he was eating the drywall because he was hungry and mad at his peer for an unknown reason. Nursing advised staff to transport [client A] to the [name] Emergency room where he was evaluated and the following diagnosis was made: 'Ingestion (unknown intent) (dry wall/insulation).' Discharge instructions state: 'Return to ER for severe		blanks. All DSP's and Site Supervisors will be retrained on client behavior support plans. Additional monitoring will be achieved by weekly administrative team observations to ensure staff are implementing all policies, procedures, documentation, and plans as written. The administrative team (PM, QAM, QAC, QIDP, DON) will evaluate the observation frequency monthly to determine if the observations should continue, decrease, or increase.	

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	abdominal pain, persistent vomiting, or behavior changes. Call his doctor to discuss medication adjustments. Follow up with your doctor in one week.' [Client A] has been placed on 5 minute checks and the hole in the drywall has been repaired. [Client A] does not have a diagnosis of PICA (ingestion of non-nutritive substances) and does not have a history of ingesting items that aren't edible. [Client A] returned to the residential campus without further issues." The 10/25/24 Interdisciplinary Team Meeting indicated, "...On 10/24/24, [client A] was found in his bedroom eating his drywall that he had peeled away from the rest of the wall. When staff asked what he was doing, he stated that he was hungry. It was noted in the incident report that he had eaten his dinner approximately one hour prior to this. [Client A] was assessed by nursing staff and was sent to [name] Hospital for an evaluation. The recommendation was to return to the hospital if there is any severe abdominal pain, vomiting, or behavioral changes. It was recommended that his psychiatrist be contacted about the behavior. When he returned to the facility, [client A] was placed on 5 minute checks following this incident and his dresser was moved in order to block access to the damaged wall. Additionally, staff was placed outside his bedroom for supervision. The guardian was contacted and is in agreement with all safety measures and adjustments to [client A's] plan. The maintenance man was contacted for wall repair. A reinforced wall was used. Discussed wall/furniture checks for [client A's] plan and continued supervision for his safety. RECOMMENDATIONS:			

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	Ingesting non-food items will be added to [client A's] BSP (Behavior Support Plan). Hourly wall/furniture checks will be implemented in [client A's] bedroom to check for further PICA behaviors/damage. Door to bedroom will remain open at this time. [client A] will remain on 5 minute checks at this time. The 1:1 (one on one) staff from across the hall will position the chair to have line of sight on [client A] during overnight hours. [Client A] will see [name of psychiatrist] on 10/25/24 to discuss behaviors. Nurse manager will follow up with [name of primary care physician] to see if any nutritional deficiencies may be the culprit. A new high risk medical care plan will be made for this behavior. [Client A] will continue to work with his BC (Behavior Clinician) on developing and practicing relaxation/coping skills." There was no documentation the facility conducted an investigation. On 12/2/24 at 4:08 PM, the Quality Assurance Coordinator (QAC) indicated there was no investigation conducted. She stated, "Not sure about why we didn't investigate it. I asked about doing an investigation." The QAC indicated although the staff were questioned there was no documentation of the interviews. On 12/3/24 at 12:50 PM, the Quality Assurance Manager (QAM) indicated the facility did not conduct an investigation. The IDT convened to discuss the incident and implement a plan. The QAM indicated he felt there needed to be follow up and safety measures put in place but did not conduct an investigation. The QAM stated the facility "didn't give ourselves credit for doing what we did."			

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	2) The 11/14/24 BDS incident report indicated, "On November 13, 2024 at 4:50pm [client B] was in the dayroom when he became agitated. He stated he was upset because of the death of his grandma, brother, and cousin (these deaths occurred years prior). [Client B] then engaged in property destruction by throwing a chair, causing it to break a window (staff got this cleaned up and the window is replaced). He then took a piece of glass and began to cut his right wrist. Staff tried multiple times to confiscate the piece of glass but [client B] would try to cut staff each time. Staff called 911. EMT's (Emergency Medical Technicians) arrived and transported [client B] to [name] Emergency Room where he was evaluated and was admitted to the [name of psychiatric facility] in [name of city] where he is still currently admitted. Nurse attempted to assess [client B] before he left but [client B] refused to allow her. Date of discharge is unknown at this time...." The 11/14/24 Interdisciplinary Team Meeting indicated, "...Upon returning to the facility, he will be campus restricted for up to 30 days per response to suicidal gestures in the BSP (Behavior Support Plan). Due to the acts of self injury/suicidal gestures, he will remain without 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.			

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	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. 3) The 11/18/24 BDS report indicated, "On 11/17/24 at 1:05pm during the behavior with [client A] resulting in YSIS and IM (intramuscular) PRN (as needed) reported in incident report 1623955. A staff was accused of physical and verbal abuse. The allegations are improper use of physical restraint and verbal intimidation. As the day of this report no injuries reported to [client A]. The QIDP and BC (Behavior Clinician) continue to provide emotional support to [client A]." The 11/22/24 Investigative Summary indicated, "It is substantiated that [former Site Supervisor] was			

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	physically aggressive towards Individual [client A]. It is substantiated that [former Site Supervisor] was verbally aggressive towards Individual [client A]. It is substantiated that staff properly followed ResCare Policy and Procedure ensuring [client A's] safety by immediately notifying [staff #5] of the allegations, who then immediately called [Program Manager]." On 12/2/24 at 4:17 PM, the QAC indicated the former Site Supervisor physically and verbally abused client A. The QAC indicated the former staff placed herself on top of client A in retaliation of client A hitting her. The QAC indicated prior to the restraint, the former staff told client to "put his a-- in his room" and told him he did not have any friends due to his behavior. 4) On 11/1/24 at 4:14 PM, client A hit client I on the lip. Client I did not have injuries. The 11/5/24 Scope of the Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings section indicated, in part, "...There is a history of peer to peer incidents between [client A] and [client I]; [client A] does have 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 were properly followed. No abuse is suspected. Conclusion: 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			

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	abuse was substantiated. 5) The 11/4/24 BDS report indicated, "On November 3, 2024 at 6:05pm [client I] was standing at the dayroom table with staff when [client A] suddenly entered the dayroom and approached [client I]. He then engaged in physical aggression towards [client I] by placing his hands on [client I's] neck in an attempt to choke him but staff immediately intervened and was able to prevent [client A] from choking [client I]. Staff redirected [client A] to his bedroom where they assisted him in using his coping skills and educated him on not engaging in physical aggression towards peers. Both consumers returned to normal programming without further issues." The 11/5/24 Scope of the Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings section indicated, in part, "...Nurse assessed both consumers and noted no injuries. There is a history of peer to peer incidents between [client A] and [client I]; [Client A] does have 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 were not properly followed; staff are to make sure they are between [client A] and [client I] at all times. No abuse is suspected. Conclusion: It is unsubstantiated 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.			

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	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 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." 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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	There is not a history 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." 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. 7) The 11/14/24 BDS report indicated, "On November 13, 2024 at 8:50 am [client I] was sitting in a chair in the dayroom. [Client I] had been obsessing and was shouting throughout the dayroom prior to this incident, but was calm and quiet at this time. [Client A] then comes running from Pacers hallway. [Client I] notices [client A] and stands up and begins to move away. [Client A] then chases him and engaged in physical aggression towards him by briefly choking him and then running to his room. Staff walked with [client I] to see the nurse while other staff educated [client A] on using coping skills if he is upset and not engaging in physical aggression towards peers. Staff assessed both consumers and noted no injuries. Both consumers returned to normal programming without further issues." The 11/20/24 Investigative Summary indicated the Scope of the Investigation was, "To determine circumstances contributing to this event." The investigation indicated, "...[Former Site Supervisor] stated that when she asked [client I] what had happened, he stated that [client A] had choked him. Nurse assessed both consumers and noted no injuries. There is a history of peer to peer incidents between [client A] and [client I];			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

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	[client A] does have 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 were not properly followed; staff are to make sure they 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 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. 8) The 11/22/24 BDS report indicated, "On November 22, 2024 at 4:34 pm [client A] was eating dinner when [client C], who was walking around, approached [client A's] table and took his drink. [Client A] jumped up and ran after [client C] and bit him on his left upper arm. [Client C] did not retaliate. Staff immediately intervened and separated both clients. Staff walked with [client C] to see the nurse while other staff got [client A] another drink. Nurse 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 to normal programming." The 11/27/24 Scope of the Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings section indicated, "Nurse assessed [client C] and noted a 1" diameter bruising with 2" diameter teeth marks around the bruising. This incident was not violent or intense. There is not a history of peer to peer incidents between [client A] and [client C]; [client A] does			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	have a history of being the main aggressor. This incident was not violent 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 were properly followed. 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 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, "To determine circumstances contributing to this event." The Factual Findings section indicated, in part, "...There is a history of peer to peer incidents between [client G and client F]; [client G] does have a history of being the main aggressor. [Client G] has target behaviors of verbal and physical aggression, boundaries, instigation, and noncompliance. Proper ratio was followed. [Client G] has 1:1 status; this was not followed during this incident as there were no staff within arms reach of [client G]. Per staffing assignment sheet for 9.9.24, [client G] was assigned a 1:1 staff until noon; there were not 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 there was not a conclusion indicating whether or not abuse was substantiated.			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

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	10) On 9/10/24 at 1:20 PM client G shoved client F causing him to fall and hit his head. Client F did not have injuries. The 9/17/24 Scope of Investigation indicated, "To determine circumstances contributing to this event." The Factual Findings section indicated, in part, "...Neurochecks were started on [client F] and all vitals have been within normal range. There is not a history of peer to peer incidents between [clients G and F]; [Client G] does have a history of being the main aggressor. [Client G] has target behaviors of verbal and physical aggression, boundaries, instigation, and noncompliance. Proper ratio was followed. [Client G] has 1:1 (one on one) status; this was properly followed. 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 there was not a conclusion indicating whether or not abuse was substantiated. 11) On 9/12/24 client L smacked client I in the back. Client I had no injuries. The 9/18/24 Scope of Investigation indicated, "To determine circumstances contributing to this event." The Factual Findings section indicated, in part, "...[client L] does have a history of being the main aggressor. [Client L] has target behaviors of physical aggression and boundaries. Proper ratio was followed. Behavior plans were properly followed. 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			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	there was not a conclusion indicating whether or not abuse was substantiated. 12) On 9/15/24 at 3:30 PM client I punched client B in the face two times. Client I then engaged in SIB (Self Injurious Behavior) by punching himself in the face. Clients B and I had no injuries. The 9/20/24 Scope of Investigation indicated, "To determine circumstances contributing to this event." The Factual Findings section indicated, in part, "..."[Client I] has target behaviors of verbal aggression, physical aggression, non-compliance, Self-Injurious Behavior, and instigation. [Client B] has target behaviors of verbal aggression and instigation. There is a history of attempted peer-to-peer incidents between [Client I and client B]. Proper ratio was followed. No ANEM from staff 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 there was not a conclusion indicating whether or not abuse was substantiated. 13) On 9/23/24 at 6:20 PM client I lunged towards client B and kicked him in (sic) left side and then hit him in (sic) the left side of his face. Clients B and I had no injuries. The 9/30/24 Scope of Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings section indicated in part, "... [Client I] has target behaviors of verbal aggression, physical aggression, non-compliance, Self- Injurious Behavior, and instigation. [Client B] has target behaviors of verbal aggression, physical aggression, and instigation. There is a			

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RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

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	history of attempted peer-to-peer incidents between [clients I and B]. Proper ratio was followed. Behavior plans were properly followed. Staff and client statements matched RestAssured camera feed. No ANEM from staff is suspected. Conclusion: It is substantiated that staff followed behavior plans properly." 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. 14) On 9/24/24 at 11:35 AM client L smacked client F in the face. Client L then ran down the hall and hit client P in the face. Clients F, L and P did not have any injuries. The 9/30/24 Scope of Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings section indicated in part, "...Loud and chaotic environments are a documented trigger for [client L]. There is not a history of peer to peer incidents between [clients F, L and P], but [client L] does have a history of being the main aggressor. [Client L] has target behaviors of physical aggression and boundaries. Proper ratio was followed. Per [client L's] behavior plan, staff is to place themselves between [client L] and peers when possible; staff did not initially do this. No abuse is suspected. Conclusion Staff did not properly follow [client L's] behavior plan." 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			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

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	abuse was substantiated. 15) On 9/24/24 at 5:25 PM client Q picked up a towel and slapped client P in the face. Client Q then hit client R on his cheek. Clients P, Q and R did not have injuries. The 10/1/24 Scope of Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings section indicated in part, "...There is not a history of peer to peer incidents between [clients P, Q and R]. [Client Q] has target behaviors of physical aggression and boundaries. Staff properly followed consumers behavior plans. No abuse is suspected. Conclusion: Staff did properly follow consumers behavior plan." 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. 16) On 9/25/24 at 3:09 PM client I was discovered in his bedroom using a broken CD (Compact Disc) to scratch his left arm. Client I reported he had gone into client M's bedroom and punched him in the face twice. Client M had no injuries. Client I was taken to the local ER (Emergency Room) for suicidal ideation. The 10/1/24 Scope of Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings section indicated in part, "...Camera shows that at 3:09:44 pm [client I] enters [client M's] room and exits at 3:09:55 pm; at 3:11 pm, [client M] exits his room holding his face with his hands. There is not a history of			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

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	peer-to-peer incidents between [clients I and M]. Proper ratio was followed. Behavior plans were properly followed. No ANEM from staff is suspected. Conclusion: It is substantiated that staff followed behavior plans properly." 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. 17) On 9/25/24 at 11:49 AM client A bit client H on the left arm. Clients A and H did not have any injuries. The 10/2/24 Scope of Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings, section indicated in part, "...Though this is an aggressive behavior, these incidents are not intense or violent. There is a history of peer to peer incidents between [clients A and H]. [Client A] does have a history of being the main aggressor. [Client A] has target behavior of physical aggression. [Client H] has a target behavior of obsessing, causing agitation. Behavior plans were properly followed. No abuse is suspected. Conclusion; 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. 18) On 9/26/24 at 8:17 AM client A smacked client			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

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	H in the face. Staff calmed both clients. A short time later client H was sitting on the couch and client A walked around the dayroom, grabbed client H's right wrist and bit it. Clients A and H did not have any injuries. The Scope of the Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings, section indicated in part,"... There is a history of peer to peer incidents between [client A and H]; [client A] does have a history of being the main aggressor. [Client A] has target behavior of physical aggression. [Client H] has a target behavior of obsessing, causing agitation. No abuse is suspected. Conclusion: 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. 19) 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. The Scope of the Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings, section indicated in part,"... There is not a history of peer to peer incidents between [clients A and C]; [Client A] does have a history of being the main aggressor. [Client A] has target behavior of physical aggression. Proper ratio was followed. Behavior plans were properly followed. No abuse is suspected. Conclusion: It is substantiated that behavior			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	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. 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 began to walk down Pacer's hallway. [Client J] suddenly slammed [client P's] door open and began shouting at him. A staff member stepped between them to try to separate them but [client J] lunged towards [client P] and they both began to hit each other, with the staff member still between them trying to separate them. Other staff showed up to assist. While staff was attempting to separate [client J] and [client P], [client B] entered the hallway and began to hit [client J] as well. At this time, a staff member placed [client J] on the floor and placed her body over him in an attempt to protect him. During this time, [client P] continued to try to harm [client J] by kicking at him, missing and kicking staff in her stomach. [Client B] then stomped on the back of [client J's] head, causing his face to hit the floor and his tooth to break. Staff was able to separate all clients. Staff walked with [client J] out of the building for safety. [Client P] then began to kick and punch Pacer's door 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 able to be redirected to the dayroom by another staff. Staff was able to assist [client P] with coping			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

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	skills and he calmed down. [Client B] was having trouble calming down and requested a PRN. Nurse assessed [client B] and administered a behavioral PO PRN. [Client B] was able to use his coping skills and he calmed down. [Client J] was transported to [name] Emergency room where he was evaluated and the following diagnosis was made: 'Physical assault. Laceration to the chin. Contusion. (Homicidal ideation).' [Client J] was then admitted to [Psychiatric facility] in [name of city], IN where he is currently still admitted. Nurse assessed [client P] and [client B] and noted no injuries. Nurse as unable to assess [client J] as he was transported to the ER." The initial Investigative Summary received indicated the dates of investigation for this incident were 10/14/24 to 10/21/24, the introduction indicated the date was 10/1/24, and the dates of interview were 10/14/24 and 10/21/24. Additionally, the summary of interviews and factual findings in the initial Investigative S ummary were not relevant to this incident due to addressing a separate incident. When asked for clarification on the date of incident, the facility provided a different Investigative Summary with the same introduction, but indicated the dates of investigation were 10/1/24 to 10/8/24 and the dates of interview were 10/1/24 and 10/8/24. The interviews and factual findings in this Investigative Summary were relevant to the incident. The same Investigative Summary also indicated "No ANEM from staff is suspected," and "it is substantiated that behavior plans were properly followed."			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	The Investigative Summary indicated this incident did occur. The investigation was not thorough as evidenced by the scope not indicating the facility identified client to client aggression as potential abuse, dates being incorrect, non-relevant information being included in the investigation, and the conclusion not indicating whether or not abuse was substantiated.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 to verbal aggression. He asked staff to go inside so that he could use the bathroom. Once inside, he was not being loud or disruptive. As soon as he got inside, [client A] suddenly approached [client I], grabbed his right arm, and bit it. [Client I] did not retaliate. Staff immediately redirected [client A] to his bedroom where they were able to assist him with coping skills. Nurse assessed [client A] and noted no injuries. Nurse assessed [client I] and noted a bite mark on his right forearm, no bleeding and skin was not broken. Both consumers returned to normal programming without further issues."The Investigative Summary dated 10/8/24 for the incident, indicated the biting did occur. The same Investigative Summary also indicated "this incident was not violent or intense," "No abuse is suspected," and "it is substantiated that			

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	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.22) The 10/3/24 BDS incident report indicated, "On October 2, 2024 at 8:40 am [client I] was in the dayroom obsessing about Halloween and became agitated and began to yell. Staff redirected him to his bedroom for his safety as he is a target to his peers. [Client I] calmed down and remained sitting on his bed. Another client advised staff that they had seen [client A] enter [client I's] bedroom. As staff is approaching [client I's] room, they notice the door is shut. Shortly after, they observe [client A] exit [client I's] room and walk to his own room. When staff asked [client I] if he had been hurt, [client I] 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 arm. No bleeding with skin still intact. Both consumers returned to normal programming without further issues."The Investigative Summary dated 10/9/24 for the incident, indicated the biting did occur. The same Investigative Summary also indicated "this incident was not violent or intense," "No			

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	abuse is suspected," and "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.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 stood up and began to walk around the dayroom. At this time, his peer [client C] walked over to his plate and took food from it. [Client A] saw this and engaged in physical aggression towards [client C] by biting his left hand. Staff immediately intervened and walked with [client C] to the nruse's (sic) station. Staff educated [client A] on using his coping skills when he becomes upset. Nurse assessed [client A] and noted no injuries. Nurse 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 same Investigative Summary also indicated "this incident was not violent or intense," "No abuse is suspected," and "it is substantiated that behavior plans were properly followed."The investigation was not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	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.24) The 10/7/24 BDS incident report indicated, "On October 4, 2024 at 2:20pm, [client M] was at the table in the dayroom when for an unknown reason, he threw his milk on the floor and began to run down Colt's hallway. As he was running down the hall, he ran past [client A] and slapped him on the left side of his forehead before continuing to his bedroom. [Client A] did not retaliate. While in his room, [client M] began to throw his laundry basket and fan at staff as well as charged at staff while yelling. [Client M] then began to hit the wall with his hands and then his head. At this time, trained staff initiated a guardian and HRC approved 3 person supine. Despite staff attempting to assist him in calming down, he 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 the hold. The hold lasted 39 minutes. Nurse assessed both consumers and noted no injuries. Neurochecks were initiated on [client M] and all vitals have been within normal range."The Investigative Summary dated 10/11/24 for the incident, indicated the slapping did occur. The same			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	Investigative Summary also indicated "No abuse is suspected," and "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.25) The 10/16/24 BDS incident report indicated, "On October 15, 2024 at 8:16am [client E] was walking up Pacers hallway towards the dayroom when [client H] approached him and got into his personal space. [Client E] asked [client H] to back up and [client H] retaliated by slapping [client E's] hand and then attempted to spit on [client E]. Staff immediately intervened and redirected [client H] away from [client E]. Nurse assessed both consumers and noted no injuries. Both consumers returned to normal programming without further issues."The Investigative Summary received for this incident indicated investigation dates of 10/15/24 to 10/22/24, the date in the introduction was indicated to be 10/6/24, and the interview dates were indicated to be 10/22/24.No definitive date of incident was available due to conflicting information on the provided Investigative Summary. The same Investigative Summary also indicated "This incident was not violent or intense," "No abuse is suspected," and "it			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	is substantiated that behavior plans were properly followed." The Investigative Summary indicated this incident did occur. The investigation was not thorough as evidenced by the scope not indicating the facility identified client to client aggression as potential abuse, dates being incorrect, non-relevant information being included in the investigation, and the conclusion not indicating whether or not abuse was substantiated.26) The 10/15/24 BDS incident report indicated, "On October 14, 2024 at 5:00pm [client J] was in the dayroom talking to peers. One of his peers was talking to staff when [client J] suddenly shouted 'f*** you!' and threw a water bottle at [client B] for unknown reason. [Client J] then charged towards [client B] and hit him in his face and then kicked him in his leg. At this time, trained staff initiated a guardian and HRC approved 2 person escort to [client J's] room for his safety due to multiple peers beginning to target [client J]. Nurse assessed [client J] and administered a behavioral PO PRN. Per his plan, [city] Police Department was called. Officers arrived to campus. After reviewing camera footage, officers placed [client J] in handcuffs and arrested him. He was transported to [name] County Jail where he stayed overnight. [Client J] was released from the jail and back to ResCare on 10.15.24 at 10:00am. Nurse			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	assessed both consumers and noted no injuries."The Investigative Summary received for this incident indicated investigation dates of 10/14/24 to 10/21/24, the date in the introduction was indicated to be 10/1/24, and the interview dates were indicated to be 10/14/24 and 10/21/24. No definitive date of incident was available due to conflicting information on the provided Investigative Summary. The same Investigative Summary also indicated "No ANEM from staff is suspected," and "it is substantiated that behavior plans were properly followed." The Investigative Summary indicated this incident did occur. The investigation was not thorough as evidenced by the scope not indicating the facility identified client to client aggression as potential abuse, dates being incorrect, non-relevant information being included in the investigation, and the conclusion not indicating whether or not abuse was substantiated.27) The 10/24/24 BDS incident report indicated, "On October 23, 2024 at 4:30pm [client I] was in the dayroom socializing with staff when [client A] entered the dayroom and began walking around before suddenly approaching [client I] and slapping him in his face. Staff intervened and redirected [client A] to his bedroom in Pacers hallway. Shortly after, [client A] exited his room and began walking up and down Pacers hallway. When staff			

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	walked down Pacers hallway, [client A] suddenly engaged in physical aggression towards staff by biting her arm. That staff member called for assistance and at this time, trained staff initiated a guardian and HRC approved 3 person supine. Despite staff attempting to assist [client A] with coping skills, he continued to be agitated in the hold. Nurse assessed [client A] and administered a behavioral IM PRN. [Client A] was able to use coping skills and he was released from the hold. The hold lasted 24 minutes. [Client A] then sat on his bed and listened to his headphones. 20 minutes later, [client A] reentered 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 and assist him with coping skills but he continued to be agitated and began to shout at and attempt to hit staff. At this time, trained staff initiated a guardian and HRC approved 3 person supine. Staff was able to assist [client A] with coping skills and he was released from the hold. The hold lasted 20 minutes. Nurse assessed [client A] and noted no injuries. Nurse assessed [client I] and noted a bite mark to his left index finger. Nurse cleaned the wound and ointment was applied. Both consumers returned to normal programming without further issues."The Investigative Summary			

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	dated 10/30/24 for the incident, indicated the biting did occur. The same Investigative Summary also indicated "This incident was not violent or intense," "Behavior plans were not properly followed," "No abuse is suspected," and "It is unsubstantiated 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.28) The 10/28/24 BDS incident report indicated "On October 27, 2024 at 1:40 pm [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, [client A] suddenly ran towards [client I], who was sitting on the couch watching TV, and placed his hand on [client I's] neck and briefly choked him before letting go and running back to his room in Pacers hall. Staff walked with [client I] to the nurse's station to be assessed while other staff educated [client A] on not engaging in physical aggression towards peers. Both consumers returned to normal programming without further issues."The Investigative Summary dated 11/1/24 for the incident, indicated the choking did occur. The same Investigative Summary also indicated "This incident was			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	not violent or intense," "Behavior plans were not properly followed," "No abuse is suspected," "It is unsubstantiated that behavior plans were not 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.On 12/3/24 at 11:10 AM, the Program Manager indicated client to client aggression was 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 the facility had a policy and procedure prohibiting abuse. The QAC indicated she substantiated the clients' plans were implemented as written by the staff. She indicated she did not indicate in the scope she was investigating client to client aggression as abuse. She indicated she did not indicate in the Conclusion whether or not client to client aggression was substantiated as abuse.On 12/3/24 at 12:50 PM, the QAM indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QAM indicated the facility had a policy and procedure			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	prohibiting abuse. The QAM indicated the facility should conduct thorough investigations. The QAM indicated the conclusions of client to client aggression investigations need to determine whether or not abuse occurred.On 12/4/24 at 10:47 AM, the facility's 11/10/23 Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights policy indicated, "ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare, local, state and federal guidelines... ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights. These include and are defined as any of the following: corporal punishment i.e. forced physical activity, contingent exercise, hitting, pinching, the application of pain or noxious stimuli, the use of electric shock, the infliction of physical pain, seclusion in an area which exit is prohibited, negative practice or overcorrection, visual or facial screening, verbal abuse including screaming, swearing, name-calling, belittling, damaging an individual's self-respect or dignity, failure to			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	follow physician's orders, denial of sleep, shelter, food, drink, physical movement for prolonged periods of time, Medical treatment or care or use of bathroom facilities... The Program Manager will assign an investigative team. A full investigation will be conducted by investigators who have received training from Labor Relations Association and ResCare's internal procedures on investigations. ResCare will not allow for nepotism during the conducting, directing, reviewing or other managerial activity of an investigation into an allegation of abuse, neglect, exploitation or mistreatment, by prohibiting friends and relatives of an alleged perpetrator from engaging in these managerial activities. The assigned investigator will complete a detailed investigative case summary based on witness statements and other evidence collected. When all witness statements, documentation, etc. provide evidence that the allegation is substantiated then the ANE (abuse, neglect and exploitation) allegation is substantiated...."This federal tag relates to complaint #IN00446036.5-1.2(24)(l)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS Based on record review and interview for 3 of 4 clients in the sample (A, B and C) and 12 additional clients (E, F, G, H, I, J, L, M, N, P, Q and R), the facility failed to conduct thorough investigations of client A's ingestion of drywall	W 0154	To correct the deficient practice, certified investigators will be retrained to include in investigation scopes as applicable, if potential abuse is suspected, and in the	01/06/2025

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	leading to a trip to the emergency room, client B's self-injurious behavior and subsequent admission to a psychiatric facility and attempts to use broken glass to stab staff, conduct thorough client to client aggression investigations identifying the scope of the investigation as potential abuse and concluding abuse occurred, and ensure investigations included information pertaining to the incident and not details from unrelated incidents. Findings include: On 12/3/24 at 9:44 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) The 10/25/24 Bureau of Disabilities Services (BDS) incident report indicated, "On October 24, 2024 at 5:02pm [client A] attempted to engage in physical aggression towards a peer for no apparent reason and without precursors but staff was able to prevent the hit and prompted [client A] to walk to his room for coping skills. [Client A] was compliant and began to walk down [name] hallway. When staff checked on [client A's] peer, [client A] ran back up the hallway and again tried to engage in physical aggression towards his peer but staff again was able to stop contact. Staff redirected [client A] to his bedroom for his peers safety and coping skills. Staff attempted to assist him with coping skills but [client A] began to hit staff and attempted to bite them. At this time, trained staff initiated a guardian and HRC (Human Rights Committee) approved 3 person supine (restraint). Despite staff attempting to assist [client A] with coping skills, he continued to be agitated in the hold. Nurse assessed [client A] and administered a behavioral (medication) PO (by mouth) PRN (as needed). Staff was able to assist		conclusion will note if abuse is substantiated or unsubstantiated. All certified investigators will be retrained on completing investigations when EMS or law enforcement agencies are involved. All Site Supervisors will be retrained to ensure the 1:1 staffing assignments are thoroughly completed daily with no blanks. All DSP's and Site Supervisors will be retrained on client behavior support plans. Additional monitoring will be achieved by weekly administrative team observations to ensure staff 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 determine if the observations should continue, decrease, or increase.	

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	[client A] with his coping skills and he calmed down. He was released from the hold. The hold lasted 13 minutes. Nurse assessed him and noted no injuries. While in the hold, staff noticed a hole in [client A's] wall. When staff asked [client A] about the hole, he stated that he was eating the drywall because he was hungry and mad at his peer for an unknown reason. Nursing advised staff to transport [client A] to the [name] Emergency room where he was evaluated and the following diagnosis was made: 'Ingestion (unknown intent) (dry wall/insulation).' Discharge instructions state: 'Return to ER for severe abdominal pain, persistent vomiting, or behavior changes. Call his doctor to discuss medication adjustments. Follow up with your doctor in one week.' [Client A] has been placed on 5 minute checks and the hole in the drywall has been repaired. [Client A] does not have a diagnosis of PICA (ingestion of non-nutritive substances) and does not have a history of ingesting items that aren't edible. [Client A] returned to the residential campus without further issues." The 10/25/24 Interdisciplinary Team Meeting indicated, "...On 10/24/24, [client A] was found in his bedroom eating his drywall that he had peeled away from the rest of the wall. When staff asked what he was doing, he stated that he was hungry. It was noted in the incident report that he had eaten his dinner approximately one hour prior to this. [Client A] was assessed by nursing staff and was sent to [name] Hospital for an evaluation. The recommendation was to return to the hospital if there is any severe abdominal pain, vomiting, or behavioral changes. It was recommended that his psychiatrist be contacted about the behavior. When he returned to the facility, [client A] was placed on 5 minute checks following this incident			

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	and his dresser was moved in order to block access to the damaged wall. Additionally, staff was placed outside his bedroom for supervision. The guardian was contacted and is in agreement with all safety measures and adjustments to [client A's] plan. The maintenance man was contacted for wall repair. A reinforced wall was used. Discussed wall/furniture checks for [client A's] plan and continued supervision for his safety. RECOMMENDATIONS: Ingesting non-food items will be added to [client A's] BSP (Behavior Support Plan). Hourly wall/furniture checks will be implemented in [client A's] bedroom to check for further PICA behaviors/damage. Door to bedroom will remain open at this time. [client A] will remain on 5 minute checks at this time. The 1:1 (one on one) staff from across the hall will position the chair to have line of sight on [client A] during overnight hours. [Client A] will see [name of psychiatrist] on 10/25/24 to discuss behaviors. Nurse manager will follow up with [name of primary care physician] to see if any nutritional deficiencies may be the culprit. A new high risk medical care plan will be made for this behavior. [Client A] will continue to work with his BC (Behavior Clinician) on developing and practicing relaxation/coping skills." There was no documentation the facility conducted an investigation. On 12/2/24 at 4:08 PM, the Quality Assurance Coordinator (QAC) indicated there was no investigation conducted. She stated, "Not sure about why we didn't investigate it. I asked about doing an investigation." The QAC indicated			

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	although the staff were questioned there was no documentation of the interviews. On 12/3/24 at 12:50 PM, the Quality Assurance Manager (QAM) indicated the facility did not conduct an investigation. The IDT convened to discuss the incident and implement a plan. The QAM indicated he felt there needed to be follow up and safety measures put in place but did not conduct an investigation. The QAM stated the facility "didn't give ourselves credit for doing what we did." 2) The 11/14/24 BDS incident report indicated, "On November 13, 2024 at 4:50pm [client B] was in the dayroom when he became agitated. He stated he was upset because of the death of his grandma, brother, and cousin (these deaths occurred years prior). [Client B] then engaged in property destruction by throwing a chair, causing it to break a window (staff got this cleaned up and the window is replaced). He then took a piece of glass and began to cut his right wrist. Staff tried multiple times to confiscate the piece of glass but [client B] would try to cut staff each time. Staff called 911. EMT's (Emergency Medical Technicians) arrived and transported [client B] to [name] Emergency Room where he was evaluated and was admitted to the [name of psychiatric facility] in [name of city] where he is still currently admitted. Nurse attempted to assess [client B] before he left but [client B] refused to allow her. Date of discharge is unknown at this time...." The 11/14/24 Interdisciplinary Team Meeting indicated, "...Upon returning to the facility, he will be campus restricted for up to 30 days per response to suicidal gestures in the BSP (Behavior Support Plan). Due to the acts of self injury/suicidal gestures, he will remain without			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	12/06/2024

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	3) On 11/1/24 at 4:14 PM, client A hit client I on the lip. Client I did not have injuries. The 11/5/24 Scope of the Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings section indicated, in part, "...There is a history of peer to peer incidents between [client A] and [client I]; [client A] does have 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 were properly followed. No abuse is suspected. Conclusion: 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. 4) The 11/4/24 BDS report indicated, "On November 3, 2024 at 6:05pm [client I] was standing at the dayroom table with staff when [client A] suddenly entered the dayroom and approached [client I]. He then engaged in physical aggression towards [client I] by placing his hands on [client I's] neck in an attempt to choke him but staff immediately intervened and was able to prevent [client A] from choking [client I]. Staff redirected [client A] to his bedroom where they assisted him in using his coping skills and educated him on not engaging in physical aggression towards peers. Both consumers returned to normal programming without further issues." The 11/5/24 Scope of the Investigation indicated, "To determine circumstances contributing to this			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	12/06/2024

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	event. Did staff follow behavior plans properly?" The Factual Findings section indicated, in part, "...Nurse assessed both consumers and noted no injuries. There is a history of peer to peer incidents between [client A] and [client I]; [Client A] does have 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 were not properly followed; staff are to make sure they are between [client A] and [client I] at all times. No abuse is suspected. Conclusion: It is unsubstantiated 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. 5) 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]			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	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 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." 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. There is not a history 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." 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. 6) The 11/14/24 BDS report indicated, "On November 13, 2024 at 8:50 am [client I] was sitting in a chair in the dayroom. [Client I] had been obsessing and was shouting throughout the dayroom prior to this incident, but was calm and quiet at this time. [Client A] then comes running			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	from Pacers hallway. [Client I] notices [client A] and stands up and begins to move away. [Client A] then chases him and engaged in physical aggression towards him by briefly choking him and then running to his room. Staff walked with [client I] to see the nurse while other staff educated [client A] on using coping skills if he is upset and not engaging in physical aggression towards peers. Staff assessed both consumers and noted no injuries. Both consumers returned to normal programming without further issues." The 11/20/24 Investigative Summary indicated the Scope of the Investigation was, "To determine circumstances contributing to this event." The investigation indicated, "...[Former Site Supervisor] stated that when she asked [client I] what had happened, he stated that [client A] had choked him. Nurse assessed both consumers and noted no injuries. There is a history of peer to peer incidents between [client A] and [client I]; [client A] does have 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 were not properly followed; staff are to make sure they 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 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. 7) The 11/22/24 BDS report indicated, "On November 22, 2024 at 4:34 pm [client A] was eating dinner when [client C], who was walking			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	around, approached [client A's] table and took his drink. [Client A] jumped up and ran after [client C] and bit him on his left upper arm. [Client C] did not retaliate. Staff immediately intervened and separated both clients. Staff walked with [client C] to see the nurse while other staff got [client A] another drink. Nurse 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 to normal programming." The 11/27/24 Scope of the Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings section indicated, "Nurse assessed [client C] and noted a 1" diameter bruising with 2" diameter teeth marks around the bruising. This incident was not violent or intense. There is not a history of peer to peer incidents between [client A] and [client C]; [client A] does have a history of being the main aggressor. This incident was not violent 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 were properly followed. 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. 8) On 9/9/24 at 6:40 PM client G bit client F on the nose, pinched client P on the left arm then hit and scratched client B. Clients B, F and P did not have injuries.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	12/06/2024

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	The 9/12/24 Scope of the Investigation indicated, "To determine circumstances contributing to this event." The Factual Findings section indicated, in part, "...There is a history of peer to peer incidents between [client G and client F]; [client G] does have a history of being the main aggressor. [Client G] has target behaviors of verbal and physical aggression, boundaries, instigation, and noncompliance. Proper ratio was followed. [Client G] has 1:1 status; this was not followed during this incident as there were no staff within arms reach of [client G]. Per staffing assignment sheet for 9.9.24, [client G] was assigned a 1:1 staff until noon; there were not 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 there was not a conclusion indicating whether or not abuse was substantiated. 9) On 9/10/24 at 1:20 PM client G shoved client F causing him to fall and hit his head. Client F did not have injuries. The 9/17/24 Scope of Investigation indicated, "To determine circumstances contributing to this event." The Factual Findings section indicated, in part, "...Neurochecks were started on [client F] and all vitals have been within normal range. There is not a history of peer to peer incidents between [clients G and F]; [Client G] does have a history of being the main aggressor. [Client G] has target behaviors of verbal and physical aggression, boundaries, instigation, and noncompliance. Proper ratio was followed. [Client G] has 1:1 (one on one) status; this was properly followed. No abuse is suspected."			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	The investigation was not thorough as evidenced by the scope not indicating the facility identified client to client aggression as potential abuse and there was not a conclusion indicating whether or not abuse was substantiated. 10) On 9/12/24 client L smacked client I in the back. Client I had no injuries. The 9/18/24 Scope of Investigation indicated, "To determine circumstances contributing to this event." The Factual Findings section indicated, in part, "...[client L] does have a history of being the main aggressor. [Client L] has target behaviors of physical aggression and boundaries. Proper ratio was followed. Behavior plans were properly followed. 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 there was not a conclusion indicating whether or not abuse was substantiated. 11) On 9/15/24 at 3:30 PM client I punched client B in the face two times. Client I then engaged in SIB (Self Injurious Behavior) by punching himself in the face. Clients B and I had no injuries. The 9/20/24 Scope of Investigation indicated, "To determine circumstances contributing to this event." The Factual Findings section indicated, in part, "..."[Client I] has target behaviors of verbal aggression, physical aggression, non-compliance, Self-Injurious Behavior, and instigation. [Client B] has target behaviors of verbal aggression and instigation. There is a history of attempted peer-to-peer incidents between [Client I and client B]. Proper ratio was followed. No ANEM from			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	staff 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 there was not a conclusion indicating whether or not abuse was substantiated. 12) On 9/23/24 at 6:20 PM client I lunged towards client B and kicked him in (sic) left side and then hit him in (sic) the left side of his face. Clients B and I had no injuries. The 9/30/24 Scope of Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings section indicated in part, "... [Client I] has target behaviors of verbal aggression, physical aggression, non-compliance, Self- Injurious Behavior, and instigation. [Client B] has target behaviors of verbal aggression, physical aggression, and instigation. There is a history of attempted peer-to-peer incidents between [clients I and B]. Proper ratio was followed. Behavior plans were properly followed. Staff and client statements matched RestAssured camera feed. No ANEM from staff is suspected. Conclusion: It is substantiated that staff followed behavior plans properly." 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. 13) On 9/24/24 at 11:35 AM client L smacked client F in the face. Client L then ran down the hall and hit client P in the face. Clients F, L and P did not have any injuries.			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

The 9/30/24 Scope of Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings section indicated in part, "...Loud and chaotic environments are a documented trigger for [client L]. There is not a history of peer to peer incidents between [clients F, L and P], but [client L] does have a history of being the main aggressor. [Client L] has target behaviors of physical aggression and boundaries. Proper ratio was followed. Per [client L's] behavior plan, staff is to place themselves between [client L] and peers when possible; staff did not initially do this. No abuse is suspected. Conclusion Staff did not properly follow [client L's] behavior plan."

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.

14) On 9/24/24 at 5:25 PM client Q picked up a towel and slapped client P in the face. Client Q then hit client R on his cheek. Clients P, Q and R did not have injuries.

The 10/1/24 Scope of Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings section indicated in part, "...There is not a history of peer to peer incidents between [clients P, Q and R]. [Client Q] has target behaviors of physical aggression and boundaries. Staff properly followed consumers behavior plans. No abuse is suspected. Conclusion: Staff did properly follow consumers behavior plan."

The investigation was not thorough as evidenced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	12/06/2024

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RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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. 15) On 9/25/24 at 3:09 PM client I was discovered in his bedroom using a broken CD (Compact Disc) to scratch his left arm. Client I reported he had gone into client M's bedroom and punched him in the face twice. Client M had no injuries. Client I was taken to the local ER (Emergency Room) for suicidal ideation. The 10/1/24 Scope of Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings section indicated in part, "...Camera shows that at 3:09:44 pm [client I] enters [client M's] room and exits at 3:09:55 pm; at 3:11 pm, [client M] exits his room holding his face with his hands. There is not a history of peer-to-peer incidents between [clients I and M]. Proper ratio was followed. Behavior plans were properly followed. No ANEM from staff is suspected. Conclusion: It is substantiated that staff followed behavior plans properly." 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. 16) On 9/25/24 at 11:49 AM client A bit client H on the left arm. Clients A and H did not have any injuries. The 10/2/24 Scope of Investigation indicated, "To determine circumstances contributing to this			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	12/06/2024

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	event. Did staff follow behavior plans properly?" The Factual Findings, section indicated in part, "...Though this is an aggressive behavior, these incidents are not intense or violent. There is a history of peer to peer incidents between [clients A and H]. [Client A] does have a history of being the main aggressor. [Client A] has target behavior of physical aggression. [Client H] has a target behavior of obsessing, causing agitation. Behavior plans were properly followed. No abuse is suspected. Conclusion; 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. 17) On 9/26/24 at 8:17 AM client A smacked client H in the face. Staff calmed both clients. A short time later client H was sitting on the couch and client A walked around the dayroom, grabbed client H's right wrist and bit it. Clients A and H did not have any injuries. The Scope of the Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings, section indicated in part,"... There is a history of peer to peer incidents between [client A and H]; [client A] does have a history of being the main aggressor. [Client A] has target behavior of physical aggression. [Client H] has a target behavior of obsessing, causing agitation. No abuse is suspected. Conclusion: It is substantiated that behavior plans were properly followed."			

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	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. 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. The Scope of the Investigation indicated, "To determine circumstances contributing to this event. Did staff follow behavior plans properly?" The Factual Findings, section indicated in part,"... There is not a history of peer to peer incidents between [clients A and C]; [Client A] does have a history of being the main aggressor. [Client A] has target behavior of physical aggression. Proper ratio was followed. Behavior plans were properly followed. No abuse is suspected. Conclusion: 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. 19) 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 began to walk down Pacer's hallway. [Client J] suddenly slammed [client P's] door open and began shouting at him. A staff member stepped			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	12/06/2024

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RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

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	between them to try to separate them but [client J] lunged towards [client P] and they both began to hit each other, with the staff member still between them trying to separate them. Other staff showed up to assist. While staff was attempting to separate [client J] and [client P], [client B] entered the hallway and began to hit [client J] as well. At this time, a staff member placed [client J] on the floor and placed her body over him in an attempt to protect him. During this time, [client P] continued to try to harm [client J] by kicking at him, missing and kicking staff in her stomach. [Client B] then stomped on the back of [client J's] head, causing his face to hit the floor and his tooth to break. Staff was able to separate all clients. Staff walked with [client J] out of the building for safety. [Client P] then began to kick and punch Pacer's door 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 able to be redirected to the dayroom by another staff. Staff was able to assist [client P] with coping skills and he calmed down. [Client B] was having trouble calming down and requested a PRN. Nurse assessed [client B] and administered a behavioral PO PRN. [Client B] was able to use his coping skills and he calmed down. [Client J] was transported to [Name] Emergency room where he was evaluated and the following diagnosis was made: 'Physical assault. Laceration to the chin. Contusion. (Homicidal ideation).' [Client J] was then admitted to [Psychiatric facility] in [name of city], IN where he is currently still admitted. Nurse assessed [client P] and [client B] and noted no injuries. Nurse as unable to assess [client J] as he was transported to the ER." The initial Investigative Summary received indicated the dates of investigation for this incident were 10/14/24 to 10/21/24, the			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	introduction indicated the date was 10/1/24, and the dates of interview were 10/14/24 and 10/21/24. Additionally, the summary of interviews and factual findings in the initial Investigative Summary were not relevant to this incident due to addressing a separate incident. When asked for clarification on the date of incident, the facility provided a different Investigative Summary with the same introduction, but indicated the dates of investigation were 10/1/24 to 10/8/24 and the dates of interview were 10/1/24 and 10/8/24. The interviews and factual findings in this Investigative Summary were relevant to the incident. The same Investigative Summary also indicated "No ANEM from staff is suspected," and "it is substantiated that behavior plans were properly followed." The Investigative Summary indicated this incident did occur. The investigation was not thorough as evidenced by the scope not indicating the facility identified client to client aggression as potential abuse, dates being incorrect, non-relevant information being included in the investigation, and the conclusion not indicating whether or not abuse was substantiated. 20) 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 to verbal aggression. He asked staff to go inside so that he could use the bathroom. Once inside, he was not being loud or disruptive. As soon as he got inside, [client A] suddenly approached [client I], grabbed his right arm, and bit it. [Client I] did not retaliate. Staff immediately redirected [client A] to his bedroom where they were able to assist him			

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	with coping skills. Nurse assessed [client A] and noted no injuries. Nurse assessed [client I] and noted a bite mark on his right forearm, no bleeding and skin was not broken. Both consumers returned to normal programming without further issues."The Investigative Summary dated 10/8/24 for the incident, indicated the biting did occur. The same Investigative Summary also indicated "this incident was not violent or intense," "No abuse is suspected," and "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.21) The 10/3/24 BDS incident report indicated, "On October 2, 2024 at 8:40 am [client I] was in the dayroom obsessing about Halloween and became agitated and began to yell. Staff redirected him to his bedroom for his safety as he is a target to his peers. [Client I] calmed down and remained sitting on his bed. Another client advised staff that they had seen [client A] enter [client I's] bedroom. As staff is approaching [client I's] room, they notice the door is shut. Shortly after, they observe [client A] exit [client I's] room and walk to his own room. When staff asked [client I] if he had been hurt, [client I]			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	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 arm. No bleeding with skin still intact. Both consumers returned to normal programming without further issues."The Investigative Summary dated 10/9/24 for the incident, indicated the biting did occur. The same Investigative Summary also indicated "this incident was not violent or intense," "No abuse is suspected," and "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.22) The 10/4/24 BDS incident report indicated, "On October 3, 2024 at 12:40pm [client A] was sitting down eating lunch when he stood up and began to walk around the dayroom. At this time, his peer [client C] walked over to his plate and took food from it. [Client A] saw this and engaged in physical aggression towards [client C] by biting his left hand. Staff immediately intervened and walked with [client C] to the nruse's (sic) station. Staff educated [client A] on using his coping skills when he becomes upset. Nurse assessed [client A] and noted no injuries. Nurse			

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	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 same Investigative Summary also indicated "this incident was not violent or intense," "No abuse is suspected," and "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.23) The 10/7/24 BDS incident report indicated, "On October 4, 2024 at 2:20pm, [client M] was at the table in the dayroom when for an unknown reason, he threw his milk on the floor and began to run down Colt's hallway. As he was running down the hall, he ran past [client A] and slapped him on the left side of his forehead before continuing to his bedroom. [Client A] did not retaliate. While in his room, [client M] began to throw his laundry basket and fan at staff as well as charged at staff while yelling. [Client M] then began to hit the wall with his hands and then his head. At this time, trained staff initiated a guardian and HRC approved 3 person supine. Despite staff attempting to assist him in			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	calming down, he 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 the hold. The hold lasted 39 minutes. Nurse assessed both consumers and noted no injuries. Neurochecks were initiated on [client M] and all vitals have been within normal range."The Investigative Summary dated 10/11/24 for the incident, indicated the slapping did occur. The same Investigative Summary also indicated "No abuse is suspected," and "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.24) The 10/16/24 BDS incident report indicated, "On October 15, 2024 at 8:16am [client E] was walking up Pacers hallway towards the dayroom when [client H] approached him and got into his personal space. [Client E] asked [client H] to back up and [client H] retaliated by slapping [client E's] hand and then attempted to spit on [client E]. Staff immediately intervened and redirected [client H] away from [client E]. Nurse assessed both consumers and noted no injuries. Both consumers returned to normal programming			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	without further issues."The Investigative Summary received for this incident indicated investigation dates of 10/15/24 to 10/22/24, the date in the introduction was indicated to be 10/6/24, and the interview dates were indicated to be 10/22/24.No definitive date of incident was available due to conflicting information on the provided Investigative Summary. The same Investigative Summary also indicated "This incident was not violent or intense," "No abuse is suspected," and "it is substantiated that behavior plans were properly followed." The Investigative Summary indicated this incident did occur. The investigation was not thorough as evidenced by the scope not indicating the facility identified client to client aggression as potential abuse, dates being incorrect, non-relevant information being included in the investigation, and the conclusion not indicating whether or not abuse was substantiated.25) The 10/15/24 BDS incident report indicated, "On October 14, 2024 at 5:00pm [client J] was in the dayroom talking to peers. One of his peers was talking to staff when [client J] suddenly shouted 'f*** you!' and threw a water bottle at [client B] for unknown reason. [Client J] then charged towards [client B] and hit him in his face and then kicked him in his leg. At this time, trained staff initiated a guardian and HRC approved 2 person escort to [client			

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	J's] room for his safety due to multiple peers beginning to target [client J]. Nurse assessed [client J] and administered a behavioral PO PRN. Per his plan, [city] Police Department was called. Officers arrived to campus. After reviewing camera footage, officers placed [client J] in handcuffs and arrested him. He was transported to [name] County Jail where he stayed overnight. [Client J] was released from the jail and back to ResCare on 10.15.24 at 10:00am. Nurse assessed both consumers and noted no injuries."The Investigative Summary received for this incident indicated investigation dates of 10/14/24 to 10/21/24, the date in the introduction was indicated to be 10/1/24, and the interview dates were indicated to be 10/14/24 and 10/21/24. No definitive date of incident was available due to conflicting information on the provided Investigative Summary. The same Investigative Summary also indicated "No ANEM from staff is suspected," and "it is substantiated that behavior plans were properly followed." The Investigative Summary indicated this incident did occur. The investigation was not thorough as evidenced by the scope not indicating the facility identified client to client aggression as potential abuse, dates being incorrect, non-relevant information being included in the investigation, and the conclusion not indicating whether or not			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	abuse was substantiated.26) The 10/24/24 BDS incident report indicated, "On October 23, 2024 at 4:30pm [client I] was in the dayroom socializing with staff when [client A] entered the dayroom and began walking around before suddenly approaching [client I] and slapping him in his face. Staff intervened and redirected [client A] to his bedroom in Pacers hallway. Shortly after, [client A] exited his room and began walking up and down Pacers hallway. When staff walked down Pacers hallway, [client A] suddenly engaged in physical aggression towards staff by biting her arm. That staff member called for assistance and at this time, trained staff initiated a guardian and HRC approved 3 person supine. Despite staff attempting to assist [client A] with coping skills, he continued to be agitated in the hold. Nurse assessed [client A] and administered a behavioral IM PRN. [Client A] was able to use coping skills and he was released from the hold. The hold lasted 24 minutes. [Client A] then sat on his bed and listened to his headphones. 20 minutes later, [client A] reentered 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 and assist him with coping skills but he continued to be agitated and began to shout at and attempt to hit staff. At			

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	this time, trained staff initiated a guardian and HRC approved 3 person supine. Staff was able to assist [client A] with coping skills and he was released from the hold. The hold lasted 20 minutes. Nurse assessed [client A] and noted no injuries. Nurse assessed [client I] and noted a bite mark to his left index finger. Nurse cleaned the wound and ointment was applied. Both consumers returned to normal programming without further issues."The Investigative Summary dated 10/30/24 for the incident, indicated the biting did occur. The same Investigative Summary also indicated "This incident was not violent or intense," "Behavior plans were not properly followed," "No abuse is suspected," and "It is unsubstantiated 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.27) The 10/28/24 BDS incident report indicated "On October 27, 2024 at 1:40 pm [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, [client A] suddenly ran towards [client I], who was sitting on the couch watching TV, and placed his hand on [client I's] neck and			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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	briefly choked him before letting go and running back to his room in Pacers hall. Staff walked with [client I] to the nurse's station to be assessed while other staff educated [client A] on not engaging in physical aggression towards peers. Both consumers returned to normal programming without further issues."The Investigative Summary dated 11/1/24 for the incident, indicated the choking did occur. The same Investigative Summary also indicated "This incident was not violent or intense," "Behavior plans were not properly followed," "No abuse is suspected," "It is unsubstantiated that behavior plans were not 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.On 12/3/24 at 11:10 AM, the Program Manager indicated client to client aggression was 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 the facility had a policy and procedure prohibiting abuse. The QAC indicated she substantiated the clients' plans			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

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RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

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	were implemented as written by the staff. She indicated she did not indicate in the scope she was investigating client to client aggression as abuse. She indicated she did not indicate in the Conclusion whether or not client to client aggression was substantiated as abuse.On 12/3/24 at 12:50 PM, the QAM indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QAM indicated the facility had a policy and procedure prohibiting abuse. The QAM indicated the facility should conduct thorough investigations. The QAM indicated the conclusions of client to client aggression investigations need to determine whether or not abuse occurred.This federal tag relates to complaint #IN00446036.5-1.2(24)(l)			
W 0191 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM Based on interview and record review for 2 of 4 clients in the sample (C and D) and 5 additional clients (E, H, J, K and M), the facility failed to ensure staff received competency based training on who received one on one (1:1) supervision at the facility. Findings include: On 12/2/24 at 1:12 PM, staff #32 indicated there were 4 clients who received one on one (1:1) staffing. Staff #32 did not indicate who received 1:1 staffing. On 12/2/24 at 1:37 PM, staff #28 indicated 7 clients	W 0191	To correct the deficient practice, all DSP's and site supervisors will be retrained on client supervision levels. At the monthly DSP and Site Supervisor meetings, the PM, BC, and QIDP will review the supervision levels and document on the agenda sheets.	01/06/2025

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	received 1:1 staffing (C, H, D, K, M, J and E). On 12/2/24 at 2:03 PM, staff #24 indicated there were 5 clients who receive 1:1 staffing (H, E, K, C, D and J). On 12/2/24 at 2:43 PM, staff #20 indicated there were 4 clients who receive 1:1 staffing (H, K, J and E). On 12/2/24 at 3:06 PM, staff #4 indicated there were 5 clients who 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 conducted. Client C's 10/11/24 Behavior Support Plan (BSP) indicated, "...[Client C] will have an assigned staff across all shifts. He will have 10 minute checks...." On 12/2/24 at 1:24 PM, a focused review of client D's record was conducted. Client D's 11/14/24 BSP indicated, "...[Client D] will have 1:1 approximately arms (sic) reach staffing due to potential risk for sexual aggression toward peers. When [client D] is sleeping, the staff member will be positioned in the hallway with the bedroom door at least slightly open so that supervision can be maintained. The 1:1 staff must ensure that there is not a peer in the bathroom when [client D] enters either his own bathroom or the hallway/lifeskills bathroom. [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 E's record was conducted. Client E's 10/10/24 BSP indicated, "...1:1 approximately arms (sic) reach			

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	staff supervision when awake due to an extensive history of self injury with items and ingesting non-food items... When he is awake in his bedroom, staff will do a room sweep to look for small items and will then position themselves in the hallway to supervise [client E] (door open). Staff should not be alone with him in his room due to [client E's] extensive history of false allegations against his staff. During overnight hours/when sleeping, [client E] will not have a 1:1 staff but staff must conduct a room sweep looking for any items that can be used for self harm/insertion into body orifices. Door remains open...." On 12/2/24 at 1:28 PM, a focused review of client H's record was conducted. Client H's 10/24/24 BSP indicated, "...[Client H] will have 1:1 staff supervision during all waking hours due to ongoing acts of aggression toward his peers. The 1:1 staff should stay between [client H] and any peers that he may hit. If [client H] is showing precursors or aggression toward peers, he should be programmed separately, away from all peers, with his 1:1 staff...." On 12/2/24 at 1:29 PM, a focused review of client J's record was conducted. Client J's 11/14/24 BSP indicated, "...Due to creating an unsafe environment/ongoing peer conflict in the residential building, [client J] will have a 1:1 staff during all shifts and he will temporarily reside in the movie room of the life skills building. Details of his 1:1 program are below: He will program in the admin building at this time for his safety and the safety of his peers. Smoke breaks will be on the back patio. Meals will take place in the rec room with his staff. [Client J] will utilize the rec room shower. Med pass will take place in the admin building...."			

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	15G811	A. BUILDING 00 B. WING	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, 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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 12/2/24 at 1:32 PM, a focused review of client K's record was conducted. Client K's 11/15/24 BSP indicated, "...[Client K] will have 1:1 approximately arms reach staff supervision when he is outside of his bedroom. His 1:1 staff is to remain between him and his peers to prevent peer to peer aggression. He will have 1:1 staff supervision when showering. When he is asleep, he will have 5 minute checks. Prior to going to sleep, the 1:1 staff will clear [client K's] bed of any hard/sharp items that may cause marks/injuries on his while he sleeps...." On 12/2/24 at 1:35 PM, a focused review of client M's record was conducted. Client M's 9/27/24 BSP indicated, "...[Client M] will have 15 minute checks by staff and staff will remain in between [client M] and his peers whenever possible due to [client M] sexually grabbing his peers and due to his impulsive acts of physical aggression...." On 12/2/24 at 4:08 PM, the Quality Assurance Coordinator (QAC) indicated there were 5 clients who receive 1:1 staffing (H, E, K, D and J). The QAC indicated the direct care staff should know who receives 1:1 staffing. The QAC indicated it was a staff training issue. On 12/5/24 at 11:50 AM, the Quality Assurance Manager indicated the staff should know who was 1:1. The QAM indicated the staff needed to be retrained. 5-1.3			