PRINTED:	04/17/2023
FORM API	PROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-039	

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	Findings include: Policy is followed. Monitoring of		Based on record rev incident reports affe and B), the facility and procedures for exploitation, mistre individuals' rights to financial exploitation	view and interview for 6 of 7 ecting clients (former client A failed to implement its policy prohibiting abuse, neglect, atment and/or violation of o prevent 1) an incident of on of former client A and 2)	wo)149	on the Abuse, Neglect, and Exploitation Policy and disciplinary action will be given the policy is not followed. Area Supervisor and Residential Manager will ensure that the	n if a	04/09/2023
	ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		Findings include:						

Mark

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Slaughter

04/09/2023

NTERS FOR MEDICARE & MEDICAID SERVICES						ОМ	B NO. 0938-039
	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G159			VILDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/21/2023	
	PROVIDER OR SUPPLIE	ER ALTERNATIVES SE IN		1337 E	ADDRESS, CITY, STATE, ZIP COD SOUTHVIEW LN IN 47454		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
	On 3/17/23 at 12:4 Bureau of Develop (BDDS) incident in conducted. The re- affecting former c 1) BDDS incident "[Former client A] that on 10/31/22 F told [former client client A's] bank ac- pay her own house [Former staff #1]] administrative lear Investigation Sum 12/5/22 indicated, was initiated after [former staff #1], name] and told [for (\$500.00) for [form Conclusion: It is s was dishonest three not turn in receipt second interview. took \$500 from [f Recommendations staff #1]. IDT (int [former client A] in closed and funds the Fund Managemen Reimburse [former Review and revised staff on finances and ANE (Abuse, Neg Review bill of right client A]".	40 PM, a review of the facility's pmental Disabilities Services reports and investigations was view indicated the following lient A and client B: report dated 11/30/22 indicated,] reported to staff at day program ResCare staff [former staff #1] t A] to take \$500 out of [former cocount so [former staff #1] could e payment. Plan to Resolve: has been placed on ve pending investigation". Imary dated 11/29/22 through "Introduction: An investigation [former client A] alleged staff, took her to [financial institution ormer client A] to withdraw \$500 mer staff #1's] personal use ubstantiated [former staff #1] oughout the investigation, did s, and did not show for a The allegations [former staff #1] former client A] are substantiated. s: Term (termination) [former erdisciplinary team) to meet with to get external bank account ransferred to RFMS (Resident t Service) account or spent. er client A]. File a police report. e financial assessment. Retrain and receipts. Retrain staff on elect and Exploitation) policy. hts and grievance with [former			 ANE will be done by The Program Anager, Area Supervisor, an Residential Manager to ensurincidents of possible abuse, neglect, and exploitation are reported to the QA departmer IDT conducted focused review of former Client A ISP updated to include risk for exploitation. The Facility retrained ston client fund management and client fund manager and more by the QIDP, Area Supervisor Residential Manager and more by the Program Manager. And discrepancy will be immediated reported and reviewed to ensight proper accounting for all client the facility. The Facility will retrained ston fall risk plans and reviall clients to ensure client need are met. Any new findings wirequire staffing training. Fall Risk Protocol will be reviewed and the Nurse, Area Supervisor and QIDP will more staff to ensure plans are being followed as written. An IDT wheld if it is determined addition supports are needed and staff be retrained. A Monthly random site review will be conducted by a member of the administrative to ensure plans are followed as written and environmental concerns are reported to ResCare's Maintenance Manager. 	nd e all nt. and taff nd reekly or nthly y y y y y y y y y y y y y y y y y y	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

DXLN11 Facility ID: 000695

If continuation sheet Page 2 of 20

PRINTED: 04/17/2023 FORM APPROVED

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		. ,	E SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G159	A. BUILDING B. WING	00		pleted 1/2023
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CO)	
RES CA	RE COMMUNITY /	ALTERNATIVES SE IN		E SOUTHVIEW LN I, IN 47454		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	JLD BE PROPRIATE	COMPLETIO
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	client A's record w indicated the follo	vas conducted. The review wing:				
		0		Persons Responsible: P	rogram	
	-Individual Suppo	rt Plan (ISP) dated 3/1/22		Manager, Area Supervis	or, QIDP,	
	indicated, "Individ	lual Profile: [Former client A]		Nurse, Residential Mana		
	is at risk for explo	itation".		Maintenance Manager, a	-	
		anagement Service Statement				
		ough 12/22/22 indicated, "Date:				
		cription: Reimbursement				
	Credit: \$540.00	".				
	On 3/20/23 at 1:39	PM, Qualified Intellectual				
	Disabilities Profes	sional (QIDP) was interviewed.				
	The QIDP was ask	ked about the incident of former				
	client A being exp	loited and the determination				
	reimburse former	client A \$540.00. The QIDP				
	indicated she had	returned to work and had been				
		QIDP for about 3 months prior to				
	-	bloitation. The QIDP was asked				
		ned from the investigative				
	· ·	P stated, "That staff (former				
	· · ·	(sic) money from [former client				
		as asked how much of former				
		ad been exploited. The QIDP				
		The QIDP was asked if an				
		totaling \$540.00 had been				
		missing receipts. The QIDP				
		QIDP was asked if the incident				
	-	s isolated or if any other clients				
		by exploitation. The QIDP				
		tarily. That lady worked there				
		9 years, so it impacted those				
		nt A and her housemates)". The				
	-	what corrective actions occurred				
	-	exploitation. The QIDP stated,				
		it lost her job. We did				
		ng) on ANE (Abuse, Neglect				
	_	we do refreshers (training) on				
	it (abuse, neglect a	and exploitation policy)". The				

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G159 03/21/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE QIDP was asked if a failure to implement the ANE policy occurred. The QIDP stated, "By the one individual (former staff #1), right". The QIDP was asked if former staff #1 should have supported former client A to appropriately manage and spend her finances. The QIDP stated, "Yes, staff should". The QIDP indicated the ANE policy should be implemented at all times. At 2:21 PM, the QIDP stated, "At all times, correct". 2 A) BDDS incident report dated 11/9/22 indicated, "It was reported staff was assisting [client B] to the bathroom when she lost her balance and fell (on 11/8/22) on her right knee then sat on the floor. Staff assisted [client B] from the floor and to the restroom. Staff completed skin assessment and found a ¹/₂ inch red spot on [client B's] right knee. Plan to Resolve: Staff will continue to contact Nurse for all falls". Investigation Summary dated 11/15/22 indicated, "Description of incident: On 11/8/22 staff (former staff #2) was helping [client B] to the bathroom after doing bed checks at 12:15 am. [Former staff #2] found that [client B] had an accident. [Former staff #2] helped [client B] to stand up and asked her if she was ready to walk to the bathroom. When they started to walk [client B] went down on her right knee then sat down on the floor. Staff helped her up and to the bathroom. While helping her to clean up staff noted a small $\frac{1}{2}$ (inch) by $\frac{1}{2}$ (inch) light red mark on her right knee. Nurse notified ... Conclusion: Substantiated. Client did fall. Recommendations: Staff continue to follow fall risk plan". 2 B) BDDS incident report dated 11/18/22 indicated, "It was reported [client B] was in the bathroom when she turned to sit on the toilet, she lost her balance and fell (on 11/17/22) to the floor. DXLN11 Facility ID: 000695 Page 4 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

04/17/2023

PRINTED:

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		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G159				(X3) DATE SURVEY COMPLETED 03/21/2023	
	PROVIDER OR SUPPLIE	ALTERNATIVES SE IN	-		DDRESS, CITY, STATE, ZIP C SOUTHVIEW LN N 47454	COD	
(X4) ID PREFIX		7 STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	DATE
		taff assisted [client B] from the					DITL
	floor and complete	ed skin assessment. No injuries will assist [client B] as needed".					
	"Description of in	mary dated 12/15/22 indicated, cident: On 11/17/22 [client B]					
	e .	I to use the restroom. She went					
		ace away from the toilet. She					
		nd went down onto her bottom.					
		necked her for injuries. None					
		clusion: Substantiated. Yes					
	[client B] did fall.	[Client B] is in PT (physical					
	therapy) to help w	ith her balance.					
	Recommendations	: Her PT continue until					
	everything has bee	en done to help [client B] with					
	her balance".						
	2 C) PDDS inside	nt report dated 12/29/22					
		-					
	-	B] had been sitting on the					
		semate told staff [client B] had					
		Staff asked [client B] what					
		indicated she was trying to get					
		and fell $(12/29/22)$ on her face.					
		e to get up on her own but					
	received an inch lo	ong bruise on her left cheek.					
	Plan to Resolve: S	taff notified the nurse and					
	reminded [client E] that she needs to get assist					
	from staff. Staff w	ill continue to monitor [client B]					
		se of any changes. [Client B]					
		of pain or discomfort".					
	Investigation Sum	mary dated 1/4/23 indicated,					
	-	cident: [Client B] was sitting on					
		ving room. A housemate yelled					
		taff that [client B] had fell. Staff					
		ng room and asked [client B]					
		e stated that she was trying to					
		lropped and fell forwards onto					
		sion: Substantiated. Yes, [client					
	B] did fall. Recom	mendations: Re-train staffing					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/21/2023 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE supervisors on ensuring appropriate staffing levels are in place to implement the client's plans". 2 D) BDDS incident report dated 2/14/23 indicated, "It was reported staff was assisting [client B] down the stairs at day program. [Client B] fell (on 2/14/23) and hit her leg on a stair. Staff was able to prevent [client B] from falling down the stairs. Plan to Resolve: Staff completed skin assessment and found a 5-inch bruise and two 1-inch bumps on her right shin. Nurse was contacted. Staff applied ice to the area and propped [client B's] leg up. Investigation Summary dated 2/15/23 indicated, "Description of incident: Staff was helping [client B] downstairs when she fell. She caught her ® (right) shin on a stair. Staff caught her before she could completely fall. They helped her sit down on the stairs and assessed her for injuries. She had 2 bumps and a bruise ... Conclusion: Substantiated. Yes [client B] fell. Recommendations: Falls risk plan will (be) changed to show that staff are to walk in front of her down any stairs". 2 E) BDDS incident report dated 2/23/23 indicated, "It was reported [client B] was walking into the doctor's office when she tripped stepping up onto the sidewalk. [Client B] fell (on 2/22/23) to the ground landing on her knees. Plan to Resolve: Staff assisted [client B] from the ground and completed skin assessment. [Client B] sustained a 1/2 inch abrasion on her right knee. First aid was applied. [Client B] has a Fall Risk Plan which was being followed at the time of the fall". Investigation Summary dated 2/23/23 indicated, "Description of incident: [Client B] was walking from the van to the door of the Dr. (doctor) office. Event ID: DXLN11 Facility ID: 000695 Page 6 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/21/2023 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE When she went to step up onto the sidewalk she stumbled and went down on her ® (right) knee. She had a ¹/₂ (inch) scrape that was bleeding. Staff helped her up check (sic) knees ... Conclusion: Substantiated. Yes, [client B] did fall. Recommendations: Staff will remind [client B] that (sic) to lift her foot higher". On 3/20/22 at 10:44 AM, a focused review of client B's record was conducted. The review indicated the following: -Individual Support Plan (ISP) dated 11/1/22 indicated, "Priority Objectives: ... 4. Navigating her environment in a safe manner ...". -Fall Risk Protocol dated 2/22/23 indicated, "APPROACH: 1. Staff will assist [client B] with ambulation (especially when waking for am (morning) med pass) when necessary to ensure her safety, and encourage her to stand up straight when walking and always looking ahead of herself. Staff will VP (verbally prompt) [client B] to slow down when walking fast. 2. Staff will keep environment free of any obstacles to prevent falls. Staff will ensure [client B] has tennis shoes on when ambulating. 3. Nurse will notify physician of any injury and document in medical record. 4. Staff will notify nurse of any falls and complete report for QA (Quality Assurance) department. 5. Staff will physically assist and provide verbal cues and reminders with ambulation and when getting on and off of the van, also when walking on uneven surfaces and around parking curbs, or other objects that are a risk for falling. 6. Staff will VP client to not 'plop' into a chair when trying to sit provide education to client when needed on reaching back to feel for her seat when sitting down. 7. Staff will encourage [client B] to use handrails and monitor while taking a bath. 8. The Event ID: DXLN11 Facility ID: 000695 Page 7 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/21/2023 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE nurse will review all documentation at site visits. 9. Staff will assist [client B] in attending all appointments with PCP (primary care physician) and any referrals to specialists as well as completing any lab work and other tests ordered. 10. Staff will encourage [client B] to walk slowly, counting her steps. 11. Staff will be trained on all aspects of [client B's] care and training verification is kept at the main office. 12. The nurse will review the risk plan at least quarterly and revised as needed. 13. Staff will provide education to [client B] regarding her condition as needed to ensure that she has information to make informed decisions about her care ... ". -Physical Therapy discharge summary dated 1/12/23 indicated, "Patient seen for physical therapy for weakness and preventing falls. Patient will discharge from therapy after today's date. Recommends straight cane for ambulation ...". Client B's fall risk protocol indicated physical assistance during client B's ambulation was required but did not indicate a methodology for how staff should provide the physical assistance. Client B's fall risk protocol did not indicate adaptive supports, such as the recommended use of a walking cane at the time of discharge from Physical Therapy services and/or the team decision for the use of adaptive support devices. Client B's fall risk protocol did not identify the proper positioning of staff during client B's ambulation, such the location of staff in proximity to client B when ambulating stairs to prevent falls. On 3/20/23 at 1:39 PM, the Nurse and Qualified Intellectual Disabilities Professional (QIDP) were interviewed. The Nurse and QIDP were asked about client B's pattern of falls and implementation of her falls risk protocol. Both the Event ID: DXLN11 Facility ID: 000695 Page 8 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G159		IDENTIFICATION NUMBER	A. BU	(x2) multiple construction a. building <u>00</u> B. wing		(X3) DATE SURVEY COMPLETED 03/21/2023	
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP CO SOUTHVIEW LN	DD	
RES CA	RE COMMUNITY /	ALTERNATIVES SE IN			IN 47454		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	OULD BE	(X5) COMPLETIO
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	ndicated client B would					
	-	k pace, not pay attention during					
	ambulation and/or	wait for staff to assist her. The					
		vere asked about client B's fall					
	-	c of description for staff					
		e during ambulation and the					
	-	evices to aid client B with her					
		Nurse and QIDP indicated the					
		eam reviewed for additional					
		client B was discharged from					
		nd adaptive supports were					
		vate the risk for falls due to client					
		during ambulation. The Nurse					
		ked about the lack of					
	-	ff physical assistance such as					
		pulated down stairs and/or up					
		, the QIDP stated, "When on					
	-	ff are to the side. Going down					
		in front. We have two staff in					
		The QIDP indicated client B's					
	-	equired further review for					
		ng staff physical assistance A. At 2:11 PM, the Nurse stated,					
	-	e descriptive for physical					
	-	.8 PM, the OIDP stated, "We're					
		staff interpretation". The QIDP					
	U	ked if the Abuse, Neglect,					
		reatment and/or Violation of					
	•	(ANE) policy should be					
	-	QIDP and Nurse indicated the					
	·	d be implemented at all times. At					
		P stated, "At all times, correct".					
	On 3/20/23 at 2:51	PM, the Reporting and					
		se, Neglect, Exploitation,					
		Violation of Individual's Rights					
		ed $2/28/23$ was reviewed. The					
		ated, "ResCare strictly prohibits					
		ploitation, mistreatment, or					
		lividual's rights".					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G159	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	x3) date survey completed 03/21/2023
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	1337 E	ADDRESS, CITY, STATE, ZIP COD E SOUTHVIEW LN , IN 47454	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	This federal tag rel 9-3-2(a)	ates to complaint #IN00396326.			
N 0240	483.440(c)(6)(i) INDIVIDUAL PR0	DGRAM PLAN			
Bldg. 00	relevant intervent toward independ Based on observati interview for 2 of 3 facility failed to en- described staff phy ambulation while u fall risk plan descr during ambulation. Findings include: 1) An observation the day service pro 3:45 PM. At 2:42 1 introduced client A face was covered i purple bruises arou Client A was asked Client A stated, "Y and down. Client A watch me" and ind was asked if she w the time of the fall using her walker and down. Client A was working alright du broken at the time her walker was not what happened to o	ion, record review and 3 sampled clients (A and B), the sure: 1) client A's fall risk plan viscal assistance during using her walker and 2) client B's ibed staff physical assistance	W 0240	 The Facility will retrain St on the Abuse, Neglect, and Exploitation Policy and disciplinary action will be given the policy is not followed. Area Supervisor and Residential Manager will ensure that the Abuse, Neglect, and Exploitatio Policy is followed. Monitoring of ANE will be done by The Progra Manager, Area Supervisor, and Residential Manager to ensure incidents of possible abuse, neglect, and exploitation are reported to the QA department. The Facility will retrain all staff on fall risk plans and revier all clients to ensure client needs are met. Any new findings will require staffing training. Fall Risk Protocol will be reviewed and the Nurse, Area Supervisor and QIDP will monit staff to ensure plans are being followed as written. An IDT will held if it is determined additiona supports are needed and staff to be retrained. The IDT will review facilit 	if n am all all w s or be al

If continuation sheet Page 10 of 20

AND PLAN	OF CORRECTION	x1) provider/supplier/clia identification number 15G159	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/21/2023	
	PROVIDER OR SUPPLI	ER ALTERNATIVES SE IN	1337 E	ADDRESS, CITY, STATE, ZIP COD SOUTHVIEW LN IN 47454		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY OF Program Supervise witnessed client A indicated the fall of day service and w ramp to go to the Supervisor indicat staff lead was outs On 3/16/23 at 2:57 support lead was in client A's had a fa direct support lead someone walk with put in place someone (residential provid a copy of our inci- they're reflecting to during ambulation lead staff was aske adaptive equipment The day service lead walker with her an body. The wheels over it. [Client A] tennis balls. I don ResCare was here the door (van) as [ramp)". The day s day service provid staff must be prese ambulated from the transportation and the building when On 3/17/23 at 12:4 Bureau of Develop (BDDS) incident a	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION or was asked if anyone 's fall. The Program Supervisor occurred while client A attended as on her way down a concrete van for pick up. The Program ted a day service direct support side during client A's fall. B PM, the day service direct nterviewed and was asked if Il risk plan to prevent falls. The d stated, "She did. Having h her was not a part of it. We one to walk with her. They ler/interdisciplinary team) do get dent report, but I don't know if hat (staff to walk with client A t) at the home". The day service ed about client A's use of her nt during the incident of her fall. ad staff stated, "She had her told me staff looked at her t know if that made them look. at the time. The driver was at [client A] was coming down (the ervice lead staff indicated the ler was now implementing a ent and beside client A as she te day program to the van for in the morning when entering being dropped off. 40 PM, a review of the facility's pmental Disabilities Services reports and investigations was view indicated the following	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) additional needs of clients an staff will be retrained on recommendations. 5. A Monthly random site review will be conducted by a member of the administrative to ensure plans are followed a written and environmental concerns are reported to ResCare's Maintenance Man Persons Responsible: Progra Manager, Area Supervisor, Q Nurse, Residential Manager, Maintenance Manager, and E	d team as ager. m IDP,	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G159	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		СОМ	(X3) DATE SURVEY COMPLETED 03/21/2023	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	1337 8	i address, city, state, zip E SOUTHVIEW LN I, IN 47454	COD		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO	SHOULD BE	(X5) COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO TH DEFICIENCY)	EAPPROPRIATE	DATE	
	was reported [client from day program the sidewalk. [Client over the walker or Resolve: Staff com found two ³ / ₄ (inch ¹ / ₂ inch laceration 1 bruise on her left fi upper left arm, a 1 and a 1-inch bruiss first aid and contact services) for transpi evaluation. [Client (imagining) Head, X-ray (imagining) X-ray Left Should X-ray Spine Thora was diagnosed with of Left cheek, Cor compression fractt Erythromycin Opt (twice a day) for 7 Hydrocodone-Acee (tablet) every 6 ho [Client A] was als Ibuprofen for pain follow up with PC weeks". Investigation summ "Description of ind down the ramp at Back of walker can over the top of the called. Staff from [staff #3] placed a A's] face and appli (emergency medic	port dated 3/3/23 indicated, "It int A] was walking down ramp when her walker got caught on ent A] lost her balance and fell ito the sidewalk. Plan to inpleted a skin assessment and a) lacerations above her left eye, below her left eye, a 4-inch forearm, a 2-inch bruise on her -inch abrasion on her left knee, e on her left knee. Staff applied cted EMS (emergency medical port to ER (emergency room) for t A] was evaluated, a CT CT Maxillofacial (jaw and face), Left 5th Digit, X-ray Left Knee, er, X-ray Spine Lumbar, and acic was completed. [Client A] th Closed head injury, Skin tear itusion, Abrasion, and Thoracic ure. [Client A] was prescribed halmic (treat eye infection) BID days and taminophen (pain reliever) 1 tab urs PRN (as needed) for 3 days. o advised to use Tylenol and as needed. [Client A] is to P (primary care physician) in 1-2 mary dated 3/3/23 indicated, cident: [Client A] was walking [day service provider name]. ught on sidewalk. [Client A] fell walker onto her face. 911 was [day service provider name] and towel on the left side of [client ied pressure until EMS al services) arrived. She was e hospital by lead staff [staff					

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/21/2023 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE #1] ... Conclusion: Substantiated. Yes, she did fall. Recommendations: [Day service provider name] staff will walk with [client A] to the van". On 3/20/23 at 10:30 AM, a focused review of client A record was conducted. The review indicated the following: -Individual Support Plan (ISP) dated 8/24/22 indicated, "Individual Profile:... She has care plans for risk for falls due to unsteady gait ... ". -Risk Protocol for unsteady gait dated 3/3/23 indicated, "Problem: Hx (history) of Falls/ Unsteady gait... Approach: 1. Staff will encourage [client A] to walk slowly, using a walker with wheels, and tennis balls on back wheels. 2. Staff will monitor for and report to nurse any increased unsteadiness of gait, all episodes of falls and will documented (sic) in the medical record. 3. Staff will provide first aid should a fall occur and notify nurse and documented in medical record. 4. Staff will provide a safe environment and continually orient to surroundings due to visual and hearing impairment. 5. Staff will assist with ambulation as needed. 6. Nurse will complete fall risk assessment quarterly to monitor risk for falls. 7. Staff will assist [client A] in attending all appointments with PCP (primary care physician) and any referrals to specialists as well as completing any lab work and other tests ordered. 8. Staff will be trained on all aspects of [client A's] care and training verification is kept at the main office. 9. The nurse will review the risk plan at least quarterly and revised as needed. 10. Staff will provide education to [client A] regarding her condition as needed to ensure that she has information to make informed decisions about her care ... ". Client A's unsteady gait risk protocol indicated DXLN11 Facility ID: 000695 Page 13 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G159	A. I			(X3) DATE SURVEY COMPLETED 03/21/2023	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		1337 E	ADDRESS, CITY, STATE, ZIP SOUTHVIEW LN IN 47454	COD	
(X4) ID PREFIX	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION (staff assistance) is left to		TAG	DEPICIENCE		DATE
	Bureau of Develop (BDDS) incident r	2:40 PM, a review of the facility's omental Disabilities Services eports and investigations was view indicated the following					
	indicated, "It was n [client B] to the ba balance and fell (o then sat on the floor the floor and to the assessment and fou	nt report dated 11/9/22 reported staff was assisting throom when she lost her n 11/8/22) on her right knee or. Staff assisted [client B] from restroom. Staff completed skin and a ½ inch red spot on [client un to Resolve: Staff will continue or all falls".					
	"Description of inc staff #2) was helpi after doing bed che #2] found that [clie staff #2] helped [cl her if she was read When they started on her right knee the helped her up and her to clean up state (inch) light red man notified Conclust	mary dated 11/15/22 indicated, ident: On 11/8/22 staff (former ng [client B] to the bathroom ecks at 12:15 am. [Former staff ent B] had an accident. [Former lient B] to stand up and asked y to walk to the bathroom. to walk [client B] went down hen sat down on the floor. Staff to the bathroom. While helping if noted a small ½ (inch) by ½ rk on her right knee. Nurse sion: Substantiated. Client did tions: Staff continue to follow					
	indicated, "It was n bathroom when sh lost her balance an	nt report dated 11/18/22 reported [client B] was in the e turned to sit on the toilet, she d fell (on 11/17/22) to the floor. taff assisted [client B] from the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G159	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		X3) DATE SURVEY COMPLETED 03/21/2023			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 1337 E SOUTHVIEW LN RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI, IN 47454								
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETIO		
TAG	floor and complete	R LSC IDENTIFYING INFORMATION ed skin assessment. No injuries will assist [client B] as needed".	TAG	DEFICIENCY)		DATE		
	 "Description of indigot up at 10:10 PM to turn around to fill lost her balance and Staff, [staff #5], ch were found Com [client B] did fall. therapy) to help w Recommendations everything has been her balance". 2 C) BDDS incide indicated, "[Client couch when a houre been on the floor. happened and she a toy she dropped [Client B] was abl received an inch to Plan to Resolve: S reminded [client E from staff. Staff w and notify the Nur denied complaints Investigation Sum "Description of indicated into the livin what happened, sh get a toy that she couch in the livin what happened, sh get a toy that she couch in the couch in the couch in the livin what happened, sh get a toy that she couch in the couch in the livin what happened, sh get a toy that she couch in the couch in the livin what happened, sh get a toy that she couch in the couch in the livin what happened, sh get a toy that she couch in the livin what happened when the couch in the couch in the livin what she c	: Her PT continue until en done to help [client B] with nt report dated 12/29/22 B] had been sitting on the semate told staff [client B] had Staff asked [client B] what indicated she was trying to get and fell (12/29/22) on her face. e to get up on her own but ong bruise on her left cheek. taff notified the nurse and b] that she needs to get assist ill continue to monitor [client B] of pain or discomfort". mary dated 1/4/23 indicated, cident: [Client B] was sitting on ving room. A housemate yelled taff that [client B] had fell. Staff g room and asked [client B] e stated that she was trying to kropped and fell forwards onto						
	B] did fall. Recom	sion: Substantiated. Yes, [client mendations: Re-train staffing uring appropriate staffing						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/21/2023 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE levels are in place to implement the clients plans". 2 D) BDDS incident report dated 2/14/23 indicated, "It was reported staff was assisting [client B] down the stairs at day program. [Client B] fell (on 2/14/23) and hit her leg on a stair. Staff was able to prevent [client B] from falling down the stairs. Plan to Resolve: Staff completed skin assessment and found a 5-inch bruise and two 1-inch bumps on her right shin. Nurse was contacted. Staff applied ice to the area and propped [client B's] leg up. Investigation Summary dated 2/15/23 indicated, "Description of incident: Staff was helping [client B] downstairs when she fell. She caught her ® (right) shin on a stair. Staff caught her before she could completely fall. They helped her sit down on the stairs and assessed her for injuries. She had 2 bumps and a bruise ... Conclusion: Substantiated. Yes [client B] fell. Recommendations: Falls risk plan will (be) changed to show that staff are to walk in front of her down any stairs". 2 E) BDDS incident report dated 2/23/23 indicated, "It was reported [client B] was walking into the doctor's office when she tripped stepping up onto the sidewalk. [Client B] fell (on 2/22/23) to the ground landing on her knees. Plan to Resolve: Staff assisted [client B] from the ground and completed skin assessment. [Client B] sustained a 1/2 inch abrasion on her right knee. First aid was applied. [Client B's] has a Fall Risk Plan which was being followed at the time of the fall". Investigation Summary dated 2/23/23 indicated, "Description of incident: [Client B] was walking from the van to the door of the Dr. (doctor) office. When she went to step up onto the sidewalk she Event ID: DXLN11 Facility ID: 000695 Page 17 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/21/2023 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE stumbled and went down on her ® (right) knee. She had a ¹/₂ (inch) scrape that was bleeding. Staff helped her up check (sic) knees ... Conclusion: Substantiated. Yes, [client B] did fall. Recommendations: Staff will remind [client B] that (sic) to lift her foot higher". On 3/20/22 at 10:44 AM, a focused review of client B's record was conducted. The review indicated the following: -Individual Support Plan (ISP) dated 11/1/22 indicated, "Priority Objectives 4. Navigating her environment in a safe manner ... ". -Fall Risk Protocol dated 2/22/23 indicated, "APPROACH: 1. Staff will assist [client B] with ambulation (especially when waking for am med pass) when necessary to ensure her safety, and encourage her to stand up straight when walking and always looking ahead of herself. Staff will VP (verbally prompt) [client B] to slow down when walking fast. 2. Staff will keep environment free of any obstacles to prevent falls. Staff will ensure [client B] has tennis shoes on when ambulating. 3. Nurse will notify physician of any injury and document in medical record. 4. Staff will notify nurse of any falls and complete report for QA (Quality Assurance) department. 5. Staff will physically assist and provide verbal cues and reminders with ambulation and when getting on and off of the van, also when walking on uneven surfaces and around parking curbs, or other objects that are a risk for falling. 6. Staff will VP client to not 'plop' into a chair when trying to sit provide education to client when needed on reaching back to feel for her seat when sitting down. 7. Staff will encourage [client B] to use handrails and monitor while taking a bath. 8. The nurse will review all documentation at site visits. Event ID: DXLN11 Facility ID: 000695 Page 18 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 03/21/2023 15G159 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1337 E SOUTHVIEW LN **RES CARE COMMUNITY ALTERNATIVES SE IN PAOLI. IN 47454** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 9. Staff will assist [client B] in attending all appointments with PCP (primary care physician) and any referrals to specialists as well as completing any lab work and other tests ordered. 10. Staff will encourage [client B] to walk slowly, counting her steps. 11. Staff will be trained on all aspects of [client B's] care and training verification is kept at the main office. 12. The nurse will review the risk plan at least quarterly and revised as needed. 13. Staff will provide education to [client B] regarding her condition as needed to ensure that she has information to make informed decisions about her care ... ". -Physical Therapy discharge summary dated 1/12/23 indicated, "Patient seen for physical therapy for weakness and preventing falls. Patient will discharge from therapy after today's date. Recommends straight cane for ambulation ...". Client B's fall risk protocol indicated physical assistance was needed during client B's ambulation but did not indicate a methodology for how staff should provide the physical assistance. Client B's fall risk protocol did not indicate adaptive supports, such as the recommended use of a walking cane at the time of discharge from Physical Therapy services and/or the team decision for the use of adaptive support devices. Client B's fall risk protocol did not identify the proper positioning of staff during client B's ambulation, such as the location of staff in proximity to client B when ambulating stairs to prevent falls. On 3/20/23 at 1:39 PM, the Nurse and Qualified Intellectual Disabilities Professional (QIDP) were interviewed. The Nurse and QIDP were asked about client B's pattern of falls and implementation of her falls risk protocol. Both the Event ID: DXLN11 Facility ID: 000695 Page 19 of 20 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	quick pace, not pay and/or wait for staf QIDP were asked a protocol's lack of d assistance during a adaptive devices to Both the Nurse and interdisciplinary te supports, client B v therapy and addition determined to eleva B's lack of attention and QIDP were ask description for staf when client B amb upstairs. At 2:08 P uneven ground staf the stairs, staff are front and behind". fall risk protocol re revision concerning during ambulation. "I need to go more assistance". At 2:12 leaving it open to s the Nurse indicated review client B's fa	dicated client B ambulated in a vattention during ambulation f to assist her. The Nurse and about client B's fall risk escription for staff physical mbulation and the lack of vaid client B with her balance. I QIDP indicated the am reviewed for adaptive vas discharged from physical anal adaptive supports were ate the risk for falls due to client in during ambulation. The Nurse ted about the lack of f physical assistance such as ulated downstairs and/or M, the QIDP stated, "When on f are to the side. Going down in front. We have two staff in The QIDP indicated client B's equired further review for g staff physical assistance At 2:11 PM, the Nurse stated, descriptive for physical 8 PM, the QIDP stated, "We're taff interpretation". At 2:26 PM I a team meeting was needed to all risk protocol and stated, "so tance) is left to interpretation".					

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