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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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE TAG W 0000 Bldg. 00 This visit was for the investigation of complaints W 0000 #IN00401197 and #IN00421880. Complaint #IN00401197: No deficiencies related to the allegation(s) are cited. Complaint #IN00421880: Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W154, W157, and W227. Unrelated deficiencies cited. Survey Dates: November 30, December 1, 4 and 5, 2023 Facility Number: 000724 Provider Number: 15G194 AIM Number: 100243320 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/11/23. W 0102 483.410 GOVERNING BODY AND MANAGEMENT Bldg. 00 The facility must ensure that specific

governing body and management requirements are met. Based on record review and interview for 8 of 8 W 0102 To correct the deficient practice, 01/05/2024 clients living in the group home (A, B, C, D, E, F, G Client A will not be returning to and H), the facility failed to meet the Condition of group home upon discharge from Participation: Governing Body. The facility's the hospital admissions. All staff governing body neglected to implement its have been trained regarding policies and procedures to identify three clients ResCare ANEM policy, ANEM (C, G and H) were scared of client A, prevent staff reporting, and ensuring clients feel to client abuse, neglect and mistreatment, prevent safe in their home. Supervisory

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Patrick O'Heran QAM 12/20/2023

Any defiencystatement 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.

Event ID:

EXTERS FOR MEDICARE & MEDICAID SERVICES						-	IB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194		JILDING	DNSTRUCTION 00	(X3) DATE COMPI 12/05	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		•	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE ORD, IN 47421	•		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	,	DATE
	to client to client a	buse, ensure staff immediately			staff have been trained regar	ding	
		ns of client to client abuse to the			thorough investigations, repo	rting	
		ure thorough investigations			the results of an investigation	the	
	were conducted, et	nsure the results of			administrator within 5 working	9	
		e reported to the administrator			days, ensuring appropriate pl	lans	
	-	days and ensure client A had a			are in place and all		
	· ·	n from picking at wounds on his			recommendations for medica		
	head resulting in the	rips to the emergency room.			appointments implemented a		
					written, addressing concerns		
	Findings include:				reported from guardians, and		
					assessing clients feeling safe		
	· ·	W104. For 8 of 8 clients living in			their home. Additional monit	toring	
		A, B, C, D, E, F, G and H), the			will be achieved by the		
				Administrators completing da	ily		
		becedures to identify three			observations as well as daily		
		H) were scared of client A,			administrative meetings to dis		
	-	ent abuse, neglect and			any needs of the home. The		
	-	vent to client to client abuse,			administrative team will revie		
		diately reported allegations of			observation schedule monthly	-	
		se to the administrator, ensure			effectiveness and determine		
		ations were conducted, ensure stigations were reported to the			frequency at that time. The Q		
		in 5 working days and ensure			will hold weekly QA meetings	s with	
		to prevent him from picking at			individuals responsible for		
		I to prevent him from picking at id resulting in trips to the			investigations to: assign investigations, ensure		
	emergency room.	a resulting in unps to the			investigations, ensure	the	
	chiergeney room.				administrator within 5 working		
	2) Please refer to	W122. For 8 of 8 clients living in			days, ensure investigations a	•	
	· ·	A, B, C, D, E, F, G and H), the			thorough, and to ensure		
		g body failed to meet the			appropriate corrective actions	sare	
		cipation: Client Protections. The			in place. The QIDP/AS will		
		g body neglected to implement			complete weekly assessment	ts	
		ocedures to identify three			with clients and staff regardin		
		H) were scared of client A,			safety of the home and how t	•	
		ent abuse, neglect and			clients feel about their curren		
	-	vent to client to client abuse,			living situation. Ongoing		
	-	diately reported allegations of			monitoring will be completed	by	
		use to the administrator, ensure			the RM/AS/QIDP/LPN being	-	
		tions were conducted, ensure			home at least weekly observi		
		stigations were reported to the			coaching, and training staff.	-	
		- 1			<u> </u>		

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

Event ID:

ERN711 Facility ID: 000724

If continuation sheet Page 2 of 54

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION (X	(3) DATE SURVEY
AND PLAN	OF CORRECTION	CTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> 15G194 B. WING		00	COMPLETED 12/05/2023
		100101		ADDRESS CITY STATE 710 COD	12,00,2020
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD ONEGATE	
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN		DRD, IN 47421	
(X4) ID	ID SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE
		in 5 working days and ensure		peer review will meet to review a	
	-	to prevent him from picking at		investigations for thoroughness,	
		d resulting in trips to the		timely completion, and appropria	
	emergency room.			recommendations. Administrativ	'e
	This federal tag re	lates to complaint #IN00421880.		staff will complete weekly site review of the home to ensure sta	off
		aces to complaint #11000421060.		are trained and have the	
	9-3-1(a)			appropriate tools to complete the	eir
	> > 1(")			job thoroughly.	
V 0104	483.410(a)(1)				
	GOVERNING BC	DDY			
Bldg. 00	The governing bo	ody must exercise general			
th		nd operating direction over			
	the facility.				
		eview and interview for 8 of 8	W 0104	To correct the deficient practice,	01/05/202
		e group home (A, B, C, D, E, F, G		Client A will not be returning to	
		's governing body neglected to		group home upon discharge from	
		cies and procedures to identify		the hospital admissions. All stat	ff
		and H) were scared of client A,		have been trained regarding	
	-	ent abuse, neglect and		ResCare ANEM policy, ANEM	
	-	vent to client to client abuse,		reporting, and ensuring clients fe	
		diately reported allegations of		safe in their home. Supervisory	
		se to the administrator, ensure		staff have been trained regardin	-
	° °	tions were conducted, ensure stigations were reported to the		thorough investigations, reporting	•
		in 5 working days and ensure		the results of an investigation to	
		to prevent him from picking at		the administrator within 5 workin days, ensuring appropriate plans	-
		d resulting in trips to the		are in place and all	5
	emergency room.	a resulting in trips to the		recommendations for medical	
				appointments are implemented	as
	Findings include:			written, addressing concerns	
	6			reported from guardians, and	
	1) Please refer to	W149. For 9 of 20		assessing clients feeling safe in	
		ive reports reviewed affecting		their home. Additional monitori	
		E, F, G and H, the facility's		will be achieved by the	-
		glected to implement its		Administrators completing daily	
	policies and proce	dures to identify three clients		observations as well as daily	
	were scared of clie	ent A, prevent staff to client		administrative meetings to discu	ISS
		mistreatment, prevent to client			

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

Event ID:

ERN711 Facility ID: 000724

If continuation sheet Page 3 of 54

PRINTED: 01/08/2024

	VT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G194			3) DATE SURVEY COMPLETED 12/05/2023
	PROVIDER OR SUPPLIE	SR ALTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE ORD, IN 47421	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY C to client abuse, en allegations of clien administrator, ensi- were conducted, e investigations wer within 5 working of plan to prevent hin head resulting in t 2) Please refer to incident/investigat clients A, D, G an body failed to ensi- allegations of clien administrator. 3) Please refer to incident/investigat clients A, B, C, D, governing body fa investigations. 4) Please refer to incident/investigat clients A, B, C, D, governing body fa investigations wer within 5 working of 5) Please refer to incident/investigat clients A, D, G an body failed to ensi- actions were imple aggression toward fear of client A an	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION sure staff immediately reported in to client abuse to the ure thorough investigations nsure the results of the reported to the administrator days and ensure client A had a in from picking at wounds on his rips to the emergency room. W153. For 2 of 20 tive reports reviewed affecting d H, the facility's governing ure staff immediately reported int to client abuse to the W154. For 6 of 20 tive reports reviewed affecting b, E, F, G and H, the facility's iled to conduct thorough W156. For 4 of 20 tive reports reviewed affecting b, E, F, G and H, the facility's iled to ensure the results of the reported to the administrator days. W157. For 7 of 20 tive reports reviewed affecting d H, the facility's governing ure appropriate corrective emented to address client A's his peers, clients C, G and H's d client A's skin picking after s to the emergency room to	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) administrative team will review to observation schedule monthly for effectiveness and determine the frequency at that time. The QAM will hold weekly QA meetings wi individuals responsible for investigations to: assign investigations, ensure investigations are turned into the administrator within 5 working days, ensure investigations are thorough, and to ensure appropriate corrective actions at in place. The QIDP/AS will complete weekly assessments with clients and staff regarding to safety of the home and how the clients feel about their current living situation. Ongoing monitoring will be completed by the RM/AS/QIDP/LPN being in to home at least weekly observing coaching, and training staff. The peer review will meet to review at investigations for thoroughness, timely completion, and appropria recommendations. Administrative staff will complete weekly site review of the home to ensure sta are trained and have the appropriate tools to complete th job thoroughly.	he DATE
		W227. For 1 of 3 clients in the			

CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTERS FOR	R MEDICARE & MEDIC					B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPL	ETED
		15G194	B. WING		12/05/	2023
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	115 ST	address, city, state, zip cod "ONEGATE DRD, IN 47421		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDEDIS DI AN OF CORRECTIO	T	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F	E	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
	ensure client A had his head wounds af	ility's governing body failed to a plan addressing picking at ter falls with injury. ates to complaint #IN00421880.				
W 0122	483.420(a)	TIONS				
Bldg. 00	CLIENT PROTECTIONS		W 0122	To correct the deficient prac Client A will not be returning group home upon discharge the hospital admissions. All have been trained regarding ResCare ANEM policy, ANE reporting, and ensuring client safe in their home. Supervi staff have been trained regat thorough investigations, rep the results of an investigation the administrator within 5 wi days, ensuring appropriate are in place and all recommendations for medic appointments are implement written, addressing concern reported from guardians, an assessing clients feeling sat their home. Additional mor will be achieved by the Administrators completing do observations as well as dail administrative meetings to co any needs of the home. The administrative team will revi-	to staff staff M hts feel sory anding orting orting orting blans al ted as s d fe in hitoring aily y liscuss ne ew the	01/05/2024

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

Event ID:

ERN711 Facility ID: 000724

)724 If continu

If continuation sheet Page 5 of 54

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	X3) DATE S	
AND PLAN	OF CORRECTION	identification number 15G194	A. BUILDING <u>00</u> B. WING			COMPLETED 12/05/2023	
	PROVIDER OR SUPPLIE	ALTERNATIVES SE IN	_	115 ST	DDRESS, CITY, STATE, ZIP COD ONEGATE RD, IN 47421		
	1	Y STATEMENT OF DEFICIENCIE		ID			(X5)
(X4) ID PREFIX		NCY MUST BE PRECEDED BY FULL	1	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		DR LSC IDENTIFYING INFORMATION	1	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
		ations were conducted, ensure			frequency at that time. The QA	м	Diffe
		stigations were reported to the			will hold weekly QA meetings v		
		in 5 working days and ensure			individuals responsible for		
		n to prevent him from picking at			investigations to: assign		
	wounds on his head resulting in trips to the			investigations, ensure			
	emergency room.	8 1			investigations are turned into the	ne	
					administrator within 5 working		
	2) Please refer to	W153. For 2 of 20			days, ensure investigations are	,	
		tive reports reviewed affecting			thorough, and to ensure		
	-	d H, the facility failed to ensure			appropriate corrective actions a	are	
		reported allegations of client to			in place. The QIDP/AS will		
	client abuse to the	administrator.			complete weekly assessments		
					with clients and staff regarding		
	3) Please refer to	W154. For 6 of 20			safety of the home and how the		
	incident/investigative reports reviewed affecting clients A, B, C, D, E, F, G and H, the facility failed			clients feel about their current			
				living situation. Ongoing			
	to conduct thoroug	gh investigations.			monitoring will be completed by	/	
					the RM/AS/QIDP/LPN being in	the	
	4) Please refer to	W156. For 4 of 20			home at least weekly observing	g,	
	incident/investigat	tive reports reviewed affecting			coaching, and training staff. Th	ne	
	clients A, B, C, D	, E, F, G and H, the facility failed			peer review will meet to review	all	
		ts of investigations were			investigations for thoroughness	s,	
	reported to the adu	ninistrator within 5 working			timely completion, and appropr	iate	
	days.				recommendations. Administrati	ve	
					staff will complete at least a		
	/	W157. For 7 of 20			weekly site review of the home		
		tive reports reviewed affecting			ensure staff are trained and ha		
		d H, the facility failed to ensure			the appropriate tools to comple	te	
		tive actions were implemented			their job thoroughly.		
		A's aggression toward his peers,					
		I's fear of client A and client A's					
		falls requiring trips to the					
	emergency room to close the wounds he reopened.						
	· · ·	W227. For 1 of 3 clients in the					
		cility failed to ensure client A					
	had a plan address after falls with inju	sing picking at his head wounds ury.					

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Event ID:

ERN711 Facility ID: 000724

PRINTED: 01/08/2024 FORM APPROVED

If continuation sheet Page 6 of 54

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/08/2024 FORM APPROVED

OMB	NO.	0938-039	

STATEME AND PLAN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		A. BUILD B. WING		СОМР 12/05	e survey leted 5/2023
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	1	TREET ADDRESS, CITY, STATE, ZIP CO 15 STONEGATE EDFORD, IN 47421	DD	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	II PRE	D PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	ECTION DULD BE PROPRIATE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION lates to complaint #IN00421880.	TA	AG DEFICIENCY)		DATE
	9-3-2(a)					
W 0149	483.420(d)(1) STAFF TRFATM	ENT OF CLIENTS				
Bldg. 00	The facility must written policies a mistreatment, ne Based on record re- incident/investigat clients A, B, C, D, neglected to imple procedures to iden client A, prevent s mistreatment, prev- ensure staff immed client to client abut thorough investigat the results of invest administrator with client A had a plan wounds on his hea emergency room. Findings include: On 12/1/23 at 9:18 incident/investigat indicated the follor 1) On 7/1/23 at 5: group home witnes 7/5/23 BDS report to report an instan- occurred on or abo visiting the home [waiting for his tab repeatedly attempt	develop and implement ind procedures that prohibit glect or abuse of the client. wiew and interview for 9 of 20 ive reports reviewed affecting E, F, G and H, the facility ment its policies and tify three clients were scared of taff to client abuse, neglect and ent to client to client abuse, diately reported allegations of se to the administrator, ensure tions were conducted, ensure tigations were reported to the in 5 working days and ensure a to prevent him from picking at d resulting in trips to the	W 0149	9 To correct the deficient all staff have been train regarding ResCare ANE ANEM reporting, and er clients feel safe in their Supervisory staff have be regarding thorough inve- reporting the results of a investigation the admini- within 5 working days, e appropriate plans are in all recommendations fo appointments are imple written, addressing con- reported from guardians assessing clients feeling their home. Additional in will be achieved by the Administrators completi observations as well as administrative meetings any needs of the home. administrative team will observation schedule m effectiveness and deter frequency at that time. will hold weekly QA mee- individuals responsible investigations to: assign investigations are turne	ed EM policy, nsuring home. been trained estigations, an strator ensuring place and r medical mented as cerns s, and g safe in monitoring ng daily daily to discuss The review the ionthly for mine the The QAM etings with for	01/05/2024

STATEMENT C	F DEFICIENCIES CORRECTION	x1) provider/supplier/clia identification number 15G194	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/05/2023	
	VIDER OR SUPPLIE	R ALTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP CO FONEGATE ORD, IN 47421	do	
(X4) ID Free Fix TAG to tag to <tdtag< td=""> to t</tdtag<>	SUMMARY (EACH DEFICIE REGULATORY O be with others. bblet away from h xplanation. This o bocking and grunti vas going back inty vas initiated as raisin vas initiated when olunteers A volum eported to APS (# DDS on 7-5-23 try vas abuse by an en- name] group hom 7]. Report include motional abuse to ubstantiated that busive with [clier former staff #7] we client B]." Staff # /14/23. The investigation ed and blue correct here were striked to vording and addit ind blue.	⁷ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION [Staff #7] came and yanked the im with no warning or caused [client B] to be agitated, ng. The staff told him that, 'he to his room.' She grabbed him ysically swung him around and to his room. [Staff #7] is g her voice and telling [client B] e doing this today.'" The the allegation on 7/5/23. The twe Summary was a draft with ctions throughout the report. ndicated, "An investigation i. [guardian], someone who teer guardian (sic) with [name] Adult Protective Services) and hat she witnessed what she felt mployee of ResCare at the e.on (sic) 7-1-23 by [former staff led physical abuse, mental, and wards [client B] It is [former staff #7] was physically at B]. It is Substantiated that vas verbally abusive toward 47 was terminated for abuse on	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY) administrator within 5 w days, ensure investigat thorough, and to ensure appropriate corrective a in place. The QIDP/AS complete weekly assess with clients and staff re safety of the home and clients feel about their of living situation. Ongoin, monitoring will be comp the RM/AS/QIDP/LPN home at least weekly o coaching, and training a peer review will meet to investigations for thoro timely completion, and recommendations. Adm staff will complete at lea weekly site review of th ensure staff are trained the appropriate tools to their job thoroughly.	OULD BE PPROPRIATE COMPLETIC DATE vorking ions are ions are e actions are will isments garding the how the current g bleted by being in the bserving, staff. The o review all ughness, appropriate ninistrative ast a e home to and have	

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OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** 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 15G194 12/05/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 abuse. The QAC indicated she was unsure how to remove the strike throughs and red and blue corrections in the report. The QAC indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. On 12/1/23 at 11:32 AM, the Quality Assurance Manager (QAM) indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. 2) On 8/31/23 (no time indicated), staff #4 found a glass pipe and lighter on a shelf in the bathroom at the group home. The 9/8/23 investigation indicated, "...[Staff #8] came to work at 9pm on Wednesday 8/30/23. When [staff #8] left the group home on Thursday 8/31/23, he left a meth pipe and lighter in the bathroom. DSP's (sic) [staff #4, #3 and #9] saw the pipe and lighter. [Staff #8] came back to the group home, went into the bathroom, and got the pipe and lighter. [Staff #4] did take a picture of the pipe and lighter, then called [Program Manager] " Staff #8's statement in the investigation indicated, "Stated he got to work at 9pm on 8/30/23. Stated he worked his shift and left [name of group home] around 9:20am on 8/31/23. Stated when he got home, he remembered he left the pipe and lighter in the bathroom. Stated he got back to the group home between 9:30am and 9:45am. Stated he went into the home, went to the bathroom, got the pipe and lighter, and then he left. Stated he did not mean to bring the pipe into the home. Stated he had been in a hurry when he got out of his car and accidentally picked up the pipe. Stated it fell out of his pocket in the bathroom, and he laid it on the shelf and then forgot about it. Stated he did not use any drugs while on the job. Stated the pipe was a meth pipe." The investigation indicated, ERN711 Facility ID: 000724 Page 9 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 "...Conclusion: It is substantiated [staff #8] left a meth pipe and lighter on the bathroom shelf at [name of group home]. Addendum 10-2-23: It is substantiated [staff #8] violated Rescare Drug and Alcohol-Free Workplace Policy." Staff #8 was terminated on 10/2/23. -There were no interviews asking if staff #8 seemed to be under the influence of drugs while at work on 8/31/23 or any other day. -There was no documentation the results of the investigation were reported to the administrator within 5 working days. On 12/1/23 at 11:32 AM, the Quality Assurance Manager (QAM) indicated no one reported concerns about former staff #8 being under the influence of drugs while working at the group home. The QAM indicated the investigation should have asked staff if they suspected staff #8 working while under the influence of drugs. The QAM indicated the investigation was not thorough. The QAM indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. On 12/1/23 at 11:32 AM, the Quality Assurance Coordinator (QAC) stated, when asked if she addressed staff #8 being under the influence of drugs at the group home, "I know I did but didn't put it in the investigation." The QAC indicated the investigation was not thorough without this information. The QAC indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. 3A) A 10/24/23 Investigative Summary indicated, "On 10/14/23 at 12:46pm the clients of [name of group home] were outside, [client A] was upset Event ID: ERN711 Facility ID: 000724 Page 10 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE because he forgot his book, staff asked him to wait a minute and they would go and get it. [Client A] then went over to [client G] and twisted his ear, he then reached over to [client D] and bent to fingers backward. Staff intervened and redirected [client A] back into the house and counseled him on not hurting his peers and using his coping skills when he becomes upset. Both [clients D and G] were checked out for any injuries and none were found." -The 10/23/23 BDS report indicated staff reported the incident to the administrator on 10/23/23. Staff failed to immediately report allegations of abuse to the administrator. -There were no interviews with clients D and G. The investigation was not thorough. -The investigation included one staff interview. The investigation did not include which staff was working at the time of the incident. The investigation was not thorough. -The investigation indicated, "All plans, policy, and procedures were followed appropriately." The investigation failed to identify client A's Behavior Support Plan for physical aggression not being implemented to prevent it from happening. The investigation was not thorough. -The results of the investigation were not submitted to the administrator within 5 working days. On 12/1/23 at 11:32 AM, the QAM indicated staff should immediately notify the administrator of allegations of abuse. The QAM indicated the investigation was not thorough. He indicated the investigation should identify the staff present at Event ID: ERN711 Facility ID: 000724 Page 11 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

01/08/2024

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OMB NO. 0938-039 CENTERS FOR MEDICARE & MEDICAID SERVICES 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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 the time of the incident and include interviews with all pertinent staff and clients. The QAM indicated the timeframe for reporting the results of investigations was 5 working days. On 12/1/23 at 11:32 AM, the QAC indicated staff should immediately notify the administrator of allegations of abuse. The QAC indicated the investigation was not thorough. She indicated the investigation should identify the staff present at the time of the incident and include interviews with all pertinent staff and clients. 3B) A 10/24/23 Investigation Summary indicated, "On 10/16/23 at 5:07pm the clients were eating dinner. [Client A] got done eating first and wanted to color using the dining room table. Staff asked him to wait until supper was over so he would have more room, since everyone else was still eating. [Client A] became upset, he reached over and pulled on [client H's] ear. Staff redirected [client A], staff counseled him on using his coping skills when he is upset. [Client H] was checked for injuries to his ears and none were found." -The staff failed to immediately report an allegation of abuse to the administrator. -The investigation did not include an interview with client H or his peers. The investigation was not thorough. -The investigation did not indicate how many staff were present at the time of the incident. There was one staff interviewed for the investigation. The investigation was not thorough. -The investigation indicated, "All plans, policy, Event ID: ERN711 Facility ID: 000724 Page 12 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

01/08/2024

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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01/08/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 CENTERS FOR MEDICARE & MEDICAID SERVICES 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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 what he did, went straight to his room without staff directing him to, he stayed in his room until he calmed down. Staff talked to him after about being nice to his peers. [Client D] was checked for any injuries, a quarter sized bruise was found on [client D's] upper right arm where it hit the back of the chair " -The 10/24/23 Investigation Summary contained the same information included in the 10/16/23. The investigation also included information regarding a client living in a different group home. There were no interviews with the staff and clients involved in the incident. The investigation was not thorough. On 12/1/23 at 11:32 AM, the QAM indicated the investigation was not thorough. The QAM indicated the client referenced in the investigation lived in a different group home and should not have been included in the investigation. On 12/1/23 at 11:32 AM, the QAC indicated the investigation was not thorough. On 11/30/23 at 2:13 PM, the Quality Assurance Coordinator (QAC) indicated prior to client A moving into the group home, she thought it was a good placement. The QAC indicated the group home was not used to behaviors. The QAC stated, "I think he'd be better off with higher functioning clients. The QAC indicated she was not aware of any of client A's peers being afraid of him and none of the clients act scared of him. On 11/30/23 at 2:36 PM, the Qualified Intellectual Disabilities Professional (QIDP) stated client A was admitted to a psychiatric hospital due to "things not going well." The QIDP indicated client A's behaviors were affecting the other Event ID: ERN711 Facility ID: 000724 Page 14 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

01/08/2024

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		Cor 12/	(X3) DATE SURVEY COMPLETED 12/05/2023	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		115 ST	ADDRESS, CITY, STATE, ZIP ONEGATE RD, IN 47421	COD	
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
	biting his hand and staying close to th	ets down and cries, client H d points at client A, and client G e staff. The QIDP indicated the alm before client A moved in.					
	"pretty calm at the A) moved in." Th G have been affec) PM, the nurse stated it was home prior to when he (client e nurse indicated clients C and ted the most by client A's					
	C complained of s was home with hin was spending mor	me. The nurse indicated clienttomach issues when client Am. The nurse indicated client Ce time in his bedroom isolatingt A. The nurse indicated client					
	shake and cry. Th with him and pat h	was having behaviors, would e nurse stated she "had to sit nim on the shoulder to comfort ndicated while she was sitting					
	indicating client A stated "Last week, ball upset and sad	vas pointing at client A was bothering him. The nurse [client G] was curled up in a looking due to [client A]." The e observed client G on 11/30/23					
	he was happy, exc his normal self du	s in the psychiatric hospital and ited, and seemed to be back to e to client A being gone. The ent A] is not appropriately o home."					
	did not think clien the group home. S an appropriate fit :	:30 AM, staff #3 indicated she t A was appropriately placed at Staff #3 stated client A was "not for the home." Staff #3 stated					
	the house in an up others as well. [C	isten, yells and screams. Had roar [Client C] been upset, lient A] has client to client [clients D, H and G]"					
		:55 AM, the guardian for clients icated she had been concerned					

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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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 about the clients' safety and wellbeing since client A moved into the group home. The guardian indicated she called BDS, Program Manager and the QIDP to express her concerns but received no responses alleviating her concerns. The guardian indicated the BDS representative told her it was client A's home as well. The guardian indicated client C had been emotional since client A moved in. On 11/30/23 at 12:17 PM, staff #4 indicated client A was not appropriately placed at the group home. Staff #4 stated client A was OK for awhile but since then had "caused a lot of problems." Client H has been biting his hands. Client C has been crying and more emotional. Staff #4 stated client A moving in, "Changed the whole dynamics of the house... Ripple effect. Whole dynamics changed." On 11/30/23 at 12:33 PM, client G indicated client A bothered him. Client G, when asked if he was scared of client A, indicated yes. On 11/30/23 at 12:42 PM, client H indicated client A bothered him. Client H hit his hand when the surveyor asked him about client A. Client H touched his head and said yes when asked if he was scared of client A. On 11/30/23 at 12:46 PM, staff #3 indicated the staff working at the group home did not document client A's behaviors as they should have. Staff #3 indicated the staff was told client A had no maladaptive behaviors when he moved in. On 11/30/23 at 12:53 PM, staff #4 indicated there was one night (she did not recall the date) the overnight shift staff moved client A's roommate's bed out of their bedroom and into the kitchen due Event ID: ERN711 Facility ID: 000724 Page 16 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

01/08/2024

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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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 to client A's screaming and turning the lights on and off in the room. Staff #4 stated client A "turned the house upside down. Clients nervous and upset. [Client F's] rectal digging increased when [client A's] behaviors increased." Staff #4 indicated since client A was in the psychiatric hospital, client C was much calmer, client H's hand biting decreased and client F was sleeping better. Staff #4 stated the home was "much calmer with [client A] gone." On 11/30/23 at 1:30 PM, client C stated "[Client A's] behaviors scare me. He got mad, angry, he hit me. Makes me nervous." Client C stated it was "a lot better with him gone. He bothers others as well. Everybody seems afraid of him. He's up all night. He falls a lot." On 11/30/23 at 2:36 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDP indicated the facility had a policy and procedure prohibiting abuse. On 12/1/23 at 11:32 AM, the Quality Assurance Manager (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. He indicated the staff should immediately report abuse to the administrator. The QAM indicated the incidents were not reported to BDS within 24 hours due to the staff failing to report abuse to the administrator immediately. On 11/30/23 at 2:13 PM, the Quality Assurance Coordinator (QAC) indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QAC indicated ERN711 Facility ID: 000724 Page 17 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

01/08/2024

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 12/05/2023		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			115 ST(ADDRESS, CITY, STATE, 2 ONEGATE RD, IN 47421	ZIP COD		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN O (EACH CORRECTIVE ACT CROSS-REFERENCED TO	ION SHOULD BE	(X5) COMPLETIC
TAG	REGULATORY C	PR LSC IDENTIFYING INFORMATION		TAG	DEFICIENC		DATE
	the facility had a p abuse.	olicy and procedure prohibiting					
	(14) On $(11/3)/23$ a	t 5:42 AM, client A fell in his					
		/3/23 BDS report indicated, "On					
		third shift staff was doing room					
		reported that [client A] had					
		ad had opened his door to his					
		imes. Staff was going to check					
	-	ommate. When staff opened the					
	door, [client A] we	ent to turn around and fell. He					
	hit his head on the	floor. Staff immediately went					
		y asked him if he could set (sic)					
		ied yes. Staff asked him if he					
		ides his head, [client A] replied					
	-	im up and to the couch, staff					
		his head and called 911. Staff					
		nt A] had a 2" by 1cm					
		n the left side of his forehead					
		g. EMS (Emergency Medical					
	· · · · ·	up and took [client A] to the pital did scans and everything					
		re. [Client A] was released at					
		doing head tracking on him and					
	will continue to m						
		at 1:58 AM, client A exited his					
		lead was bleeding. The $11/10/23$					
	-	ted, "On 11/10/23 at 1:58am at of his room, staff noticed that					
		ling. [Client A] had ripped his					
		all on 11/3/23 (IR#1520852).					
		sure to his head and called for					
		AS arrived at 2:08am, they					
		and left for the ER at 2:16am.					
	-	is head again. The stitches will					
	dissolve on their o						
		nome. Staff will follow the					
		e ER put on his discharge					
		e laceration clean and dry,					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

01/08/2024

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01/08/2024

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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 On 12/1/23 at 1:01 PM, a review of an interdisciplinary team meeting on 11/14/23 was conducted. The notes indicated, "...Staff report unsteadiness and that there were no falls prior to the new medication of Clonazepam and Ambien. The team does not believe the Ambien is a benefit. [Name of nurse] will inquire further with the doctor and advocate a D/C (discontinue) if appropriate. The team reviewed each of the falls and the factors surrounding the incidents. [Name of nurse] will continue to maintain contact with wound care. Hand mittens were proposed as a tool to help [client A's] injuries heal...." The IDT did not indicate whether or not the IDT agreed with the recommendation to use hand mitts. There was no documentation the IDT discussed a knit hat or toboggan. On 12/1/23 at 10:27 AM, a review of client A's risk plans and program plans was conducted. Client A did not have a plan for skin picking. There was no plan to keep client A's head covered. There was no plan for the use of a knit hat or toboggan. There was no plan for the use of hand mitts. On 12/1/23 at 11:32 AM, the QAM indicated staff #2 was working alone at the time of the incident. The QAM indicated one staff during waking hours was not sufficient to manage and supervise the clients according to their program plans. The QAM indicated the investigation should have the staffing level at the group home. The QAM indicated due to the investigation not addressing one staff working at the time of the incident, the investigation was not thorough. On 12/1/23 at 11:32 AM, the QAC indicated staff #2 was working alone at the time of the incident. The QAC indicated one staff during waking hours was not sufficient to manage and supervise the ERN711 Facility ID: 000724 Page 21 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

01/08/2024

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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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 clients according to their program plans. The QAC indicated the investigation should have the staffing level at the group home. The QAC indicated due to the investigation not addressing one staff working at the time of the incident, the investigation was not thorough. On 12/5/23 at 9:09 AM, the nurse indicated she bought mittens and took them to the group home. The nurse indicated she did not think client A used the mittens due to his wounds being bandaged well. The nurse indicated client A wore a toboggan or a Santa Claus hat. The nurse stated "I didn't put in plan." The nurse indicated she was not aware of a plan to prevent client A from picking at his wounds. The nurse indicated there was no plan for mittens, hat and keeping his head covered to prevent him from picking. On 12/5/23 at 9:17 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated he left the IDT unclear whether or not the team agreed to the use of the mittens. The QIDP indicated he should have clarified whether or not the team agreed and documented it on the form. The QIDP indicated although interventions were put in place to prevent client A from picking at his wounds, there was no plan addressing the interventions. The QIDP indicated client A wore a hat and staff wrapped the wound better. The QIDP indicated there was no plan for skin picking, use of a hat, keeping his head covered and bandaging the wound. On 12/5/23 at 9:24 AM, the Associate Executive Director (AED) indicated there should have been a written plan developed for skin picking including keeping his head covered, wearing a hat, bandage and the use of mittens. Event ID: ERN711 Facility ID: 000724 Page 22 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

01/08/2024

PRINTED:

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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 4D) On 11/21/23 at 10:20 PM, client A fell in his bedroom. The 11/22/23 BDS report indicated, "On 11/21/23 at 10:20pm staff heard [client A's] bedroom door open and then a thud. Staff was already on their way to his room. [Client A] had fell (sic). Staff helped him up and into the living room. They checked him over and found a knot forming on the back of his head. They called for an ambulance. The EMS (Emergency Medical Services) arrived and took [client A] to the ER. They did a CT (computed tomography)scan of his head and spine. All scans came back negative. He was discharged from the ER " -There was no documentation of an investigation. On 12/1/23 at 11:32 AM, the Quality Assurance Manager (QAM) indicated an investigation should have been conducted. On 12/4/23 at 12:47 PM, a review of the facility's 11/10/23 Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights policy was conducted. The policy indicated, "ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare, local, state and federal guidelines... ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights... Any ResCare staff person who suspects an individual is the victim of abuse, neglect, exploitation or mistreatment of an individual should immediately notify the Program Manager " ERN711 Facility ID: 000724 Page 23 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

01/08/2024

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 15G194 B. WING 12/05/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 115 STONEGATE **RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE This federal tag relates to complaint #IN00421880. 9-3-2(a) W 0153 483.420(d)(2) STAFF TREATMENT OF CLIENTS Bldg. 00 The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 2 of 20 W 0153 To correct the deficient practice, 01/05/2024 incident/investigative reports reviewed affecting all staff have been trained clients A, D, G and H, the facility failed to ensure regarding ResCare ANEM policy staff immediately reported allegations of client to and ANEM reporting. Additional client abuse to the administrator. monitoring will be achieved by the Administrators completing daily Findings include: observations as well as daily administrative meetings to discuss On 12/1/23 at 9:18 AM, a review of the facility's any needs of the home. The incident/investigative reports was conducted and administrative team will review the indicated the following: observation schedule monthly for effectiveness and determine the 1) A 10/24/23 Investigative Summary indicated, frequency at that time. Ongoing "On 10/14/23 at 12:46pm the clients of [name of monitoring will be completed by group home] were outside, [client A] was upset the RM/AS/QIDP/LPN being in the because he forgot his book, staff asked him to home at least weekly observing, wait a minute and they would go and get it. [Client coaching, and training staff. A] then went over to [client G] and twisted his ear, he then reached over to [client D] and bent to fingers backward. Staff intervened and redirected [client A] back into the house and counseled him on not hurting his peers and using his coping skills when he becomes upset. Both [clients D and G] were checked out for any injuries and none were found." -The 10/23/23 BDS report indicated staff reported Event ID: ERN711 Facility ID: 000724 Page 24 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE the incident to the administrator on 10/23/23. Staff failed to immediately report allegations of abuse to the administrator. 2) A 10/24/23 Investigation Summary indicated, "On 10/16/23 at 5:07pm the clients were eating dinner. [Client A] got done eating first and wanted to color using the dining room table. Staff asked him to wait until supper was over so he would have more room, since everyone else was still eating. [Client A] became upset, he reached over and pulled on [client H's] ear. Staff redirected [client A], staff counseled him on using his coping skills when he is upset. [Client H] was checked for injuries to his ears and none were found." -The staff failed to immediately report an allegation of abuse to the administrator. On 12/1/23 at 11:32 AM, the Quality Assurance Manager indicated staff should immediately notify the administrator of allegations of abuse. On 12/1/23 at 11:32 AM, the Quality Assurance Coordinator indicated staff should immediately notify the administrator of allegations of abuse. 9-3-2(a) W 0154 483.420(d)(3) STAFF TREATMENT OF CLIENTS Bldg. 00 The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 6 of 20 W 0154 To correct the deficient practice, 01/05/2024 incident/investigative reports reviewed affecting all staff have been trained clients A, B, C, D, E, F, G and H, the facility failed regarding ResCare ANEM policy to conduct thorough investigations. and ANEM reporting. Supervisory staff have been trained on Findings include: reporting the results of an Event ID: ERN711 Facility ID: 000724 Page 25 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	incident/investigati indicated the follow 1) On 7/1/23 at 5:0 group home witness 7/5/23 BDS report to report an instance occurred on or abo visiting the home [waiting for his tabl repeatedly attempted B] went and got it at to be with others. It tablet away from h explanation. This c rocking and gruntine was going back int by the shirt and phy then forced him int described as raising that, 'we will not be guardian reported to 7/12/23 Investigati red and blue correct The investigation i was initiated when volunteersA volumed reported to APS (A BDDS on 7-5-23 th was abuse by an er [name] group homed #7]. Report includ emotional abuse to Substantiated that [abusive with [clien [former staff #7] w	AM, a review of the facility's ive reports was conducted and wing: 00 PM, a guardian visiting the ssed abuse of client B. The indicated, "[Guardian] called ee of abuse of [client B]. This ut 06/30 or 07/01. While client B] was sitting in his room et to charge. [Client B] ed to retrieve his tablet. [Client and went in to the living room [Staff #7] came and yanked the im with no warning or caused [client B] to be agitated, ng. The staff told him that, 'he o his room.' She grabbed him ysically swung him around and to his room. [Staff #7] is g her voice and telling [client B] e doing this today.'" The the allegation on 7/5/23. The ve Summary was a draft with stions throughout the report. ndicated, "An investigation [guardian], someone who teer guardian (sic) with [name] adult Protective Services) and hat she witnessed what she felt nployee of ResCare at the e.on (sic) 7-1-23 by [former staff ed physical abuse, mental, and wards [client B] It is [former staff #7] was physically tt B]. It is Substantiated that ras verbally abusive toward 47 was terminated for abuse on		investigation to the administrative within 5 working days. Additist monitoring will be achieved the Administrators completing days observations as well as daily administrative meetings to dany needs of the home. The administrative team will revise observation schedule monthe effectiveness and determine frequency at that time. The C will hold weekly QA meeting individuals responsible for investigations are turned in the administrator within 5 working days. Ongoing monitoring with completed by the RM/AS/QIDP/LPN being in thome at least weekly observe coaching, and training staff. peer review will meet to revise investigations for thoroughnet timely completion, and approximations.	onal by the aily iscuss ew the ly for the QAM s with o the g lil be he ring, The ew all ess,	

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

ERN711 Facility ID: 000724

If continuation sheet Page 26 of 54

PRINTED: 01/08/2024 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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 -The investigation was a draft as evidenced by red and blue corrections throughout the report. There were strike throughs used, changes to the wording and additional information added in red and blue. On 11/30/23 at 2:13 PM, the Quality Assurance Coordinator (QAC) indicated the allegation was substantiated and staff #7 was terminated for abuse. The OAC indicated she was unsure how to remove the strike throughs and red and blue corrections in the report. 2) On 8/31/23 (no time indicated), staff #4 found a glass pipe and lighter on a shelf in the bathroom at the group home. The 9/8/23 investigation indicated, "...[Staff #8] came to work at 9pm on Wednesday 8/30/23. When [staff #8] left the group home on Thursday 8/31/23, he left a meth pipe and lighter in the bathroom. DSP's (sic) [staff #4, #3 and #9] saw the pipe and lighter. [Staff #8] came back to the group home, went into the bathroom, and got the pipe and lighter. [Staff #4] did take a picture of the pipe and lighter, then called [Program Manager]...." Staff #8's statement in the investigation indicated, "Stated he got to work at 9pm on 8/30/23. Stated he worked his shift and left [name of group home] around 9:20am on 8/31/23. Stated when he got home, he remembered he left the pipe and lighter in the bathroom. Stated he got back to the group home between 9:30am and 9:45am. Stated he went into the home, went to the bathroom, got the pipe and lighter, and then he left. Stated he did not mean to bring the pipe into the home. Stated he had been in a hurry when he got out of his car and accidentally picked up the pipe. Stated it fell out of his pocket in the bathroom, and he laid it on the shelf and then forgot about it. Stated he did not Event ID: ERN711 Facility ID: 000724 Page 27 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:

FORM APPROVED

01/08/2024

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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 use any drugs while on the job. Stated the pipe was a meth pipe." The investigation indicated, "...Conclusion: It is substantiated [staff #8] left a meth pipe and lighter on the bathroom shelf at [name of group home]. Addendum 10-2-23: It is substantiated [staff #8] violated Rescare Drug and Alcohol-Free Workplace Policy." Staff #8 was terminated on 10/2/23. -There were no interviews asking if staff #8 seemed to be under the influence of drugs while at work on 8/31/23 or any other day. On 12/1/23 at 11:32 AM, the Quality Assurance Manager (QAM) indicated no one reported concerns about former staff #8 being under the influence of drugs while working at the group home. The QAM indicated the investigation should have asked staff if they suspected staff #8 working while under the influence of drugs. The QAM indicated the investigation was not thorough. On 12/1/23 at 11:32 AM, the Quality Assurance Coordinator (QAC) stated, when asked if she addressed staff #8 being under the influence of drugs at the group home, "I know I did but didn't put it in the investigation." The QAC indicated the investigation was not thorough without this information. 3) A 10/24/23 Investigative Summary indicated, "On 10/14/23 at 12:46pm the clients of [name of group home] were outside, [client A] was upset because he forgot his book, staff asked him to wait a minute and they would go and get it. [Client A] then went over to [client G] and twisted his ear, he then reached over to [client D] and bent to fingers backward. Staff intervened and redirected [client A] back into the house and counseled him Event ID: ERN711 Facility ID: 000724 Page 28 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

01/08/2024

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

01/08/2024

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	coping skills when checked for injuries found." -The investigation of	nseled him on using his he is upset. [Client H] was to his ears and none were did not include an interview peers. The investigation was				
	not thorough.					
	staff were present a There was one staff	did not indicate how many t the time of the incident. Finterviewed for the investigation was not				
	and procedures wer Staff will continue rights committee) a	ndicated, "All plans, policy, re followed appropriately to follow his HRC (Human nd guardian approved BSP lan)." The investigation was				
	investigation was n investigation should the time of the incide with all pertinent st	2 AM, the QAM indicated the ot thorough. He indicated the d identify the staff present at dent and include interviews aff and clients. The QAM would be retrained on h investigations.				
	investigation was n the investigation sh	2 AM, the QAC indicated the ot thorough. She indicated ould identify the staff present cident and include interviews aff and clients.				
	report indicated, "C came into the kitch	3:45 PM, the 10/24/23 BDS on 10/23/23 at 3:45pm [client A] en, he was yelling because he mpkin and staff could not fix it.				

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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 Staff tried to redirect him, and spend 1:1 (one on one) with him to help him calm down. [Client A] refused to be redirected, he went up to [client D] and pushed him. [Client D] was standing by a kitchen chair, staff kept him from falling completely over the chair. [Client A] realizing what he did, went straight to his room without staff directing him to, he stayed in his room until he calmed down. Staff talked to him after about being nice to his peers. [Client D] was checked for any injuries, a quarter sized bruise was found on [client D's] upper right arm where it hit the back of the chair " -The 10/24/23 Investigation Summary contained the same information included in the 10/16/23. The investigation also included information regarding a client living in a different group home. There were no interviews with the staff and clients involved in the incident. The investigation was not thorough. On 12/1/23 at 11:32 AM, the QAM indicated the investigation was not thorough. The QAM indicated the client referenced in the investigation lived in a different group home and should not have been included in the investigation. On 12/1/23 at 11:32 AM, the QAC indicated the investigation was not thorough. 6) On 11/21/23 at 10:20 PM, client A fell in his bedroom. The 11/22/23 BDS report indicated, "On 11/21/23 at 10:20pm staff heard [client A's] bedroom door open and then a thud. Staff was already on their way to his room. [Client A] had fell (sic). Staff helped him up and into the living room. They checked him over and found a knot forming on the back of his head. They called for an ambulance. The EMS (Emergency Medical ERN711 Facility ID: 000724 Page 31 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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01/08/2024

PRINTED: 01/08/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	PROVIDER OR SUPPLI RE COMMUNITY	^{ER} ALTERNATIVES SE IN	115 S	f address, city, state, zip cod TONEGATE ORD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL 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	
W 0156 Bldg. 00	They did a CT (cc head and spine. A was discharged fr -There was no do On 12/1/23 at 11: Manager (QAM) should have been This federal tag re 9-3-2(a) 483.420(d)(4) STAFF TREATM The results of al reported to the a representative o accordance with days of the incid Based on record r incident/investiga clients A, B, C, D to ensure the resu reported to the ad days. Findings include: On 12/1/23 at 9:1 incident/investiga indicated the follo 1) On 7/1/23 at 5 group home witho 7/5/23 BDS report to report an instar	cumentation of an investigation. 32 AM, the Quality Assurance indicated an investigation conducted. elates to complaint #IN00421880. MENT OF CLIENTS I investigations must be administrator or designated ir to other officials in 9 State law within five working lent. review and interview for 4 of 20 tive reports reviewed affecting 9, E, F, G and H, the facility failed Its of investigations were ministrator within 5 working 8 AM, a review of the facility's tive reports was conducted and	W 0156	To correct the deficient practice supervisory staff have been trai in reporting the results of an investigation to the administrato within 5 working days, and ensuring appropriate corrective actions are in place. Additional monitoring will be achieved by QAM holding weekly QA meetin with individuals responsible for investigations to: assign investigations, ensure investigations are turned into the administrator within 5 working days, ensure investigations are thorough, and to ensure appropriate corrective actions are in place. The QAM will track all	ned or The ngs e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 12/05/2023	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD FONEGATE ORD, IN 47421		
RES CA (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O visiting the home waiting for his tab repeatedly attemp B] went and got it to be with others. tablet away from I explanation. This rocking and grunt: was going back in by the shirt and pl then forced him in described as raisin that, 'we will not b guardian reported 7/12/23 Investigat red and blue corre The investigation was initiated when volunteersA volur reported to APS (A BDDS on 7-5-23 f was abuse by an e [name] group hom #7]. Report include emotional abuse to Substantiated that abusive with [client [former staff #7] v [client B]." Staff 7/14/23.	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION [client B] was sitting in his room let to charge. [Client B] ted to retrieve his tablet. [Client and went in to the living room [Staff #7] came and yanked the nim with no warning or caused [client B] to be agitated, ing. The staff told him that, 'he to his room. [Staff #7] is g her voice and telling [client B] be doing this today." The the allegation on 7/5/23. The ive Summary was a draft with ctions throughout the report. indicated, "An investigation n [guardian], someone who tteer guardian (sic) with [name] Adult Protective Services) and that she witnessed what she felt mployee of ResCare at the the on (sic) 7-1-23 by [former staff ded physical abuse, mental, and owards [client B] It is [former staff #7] was physically nt B]. It is Substantiated that vas verbally abusive toward #7 was terminated for abuse on	ID PREFIX TAG	DRD, IN 47421 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLL CROSS-REFERENCED TO THE APPR DEFICIENCY) investigations and report f any concerns. The peer re meet to review all investig thoroughness, timely com and appropriate recomme Ongoing monitoring will b achieved by the quality ar committee meeting to disc previous investigations an recommendations for effectiveness, and pattern	to the ED eview will pations for pletion, endations. e nd safety cuss nd	(X5) COMPLETH DATE
	at the group home indicated, "[Staf	 ter on a shelf in the bathroom The 9/8/23 investigation f#8] came to work at 9pm on When [staff #8] left the 				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 15G194	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		CTION	(X3) DATE SURVEY COMPLETED 12/05/2023	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	115	EET ADDRES STONEG DFORD, IN	DD		
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFI	X (EA	PROVIDER'S PLAN OF CORR ACH CORRECTIVE ACTION SH SS-REFERENCED TO THE AF	DULD BE	(X5) COMPLETIC
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)	TROTRIATE	DATE
	pipe and lighter in #4, #3 and #9] saw came back to the g bathroom, and got did take a picture of called [Program M in the investigation work at 9pm on 8/ shift and left [nam on 8/31/23. Stated remembered he left bathroom. Stated between 9:30am at the home, went to lighter, and then h bring the pipe into in a hurry when he accidentally picked of his pocket in the shelf and then forg use any drugs whi was a meth pipe." "Conclusion: It i meth pipe and ligh [name of group ho substantiated [staff Alcohol-Free Wor terminated on 10/2 -There was no doc investigation were within 5 working of 3) A 10/24/23 Inv "On 10/14/23 at 12 group home] were because he forgot	umentation the results of the reported to the administrator					

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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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 he then reached over to [client D] and bent to fingers backward. Staff intervened and redirected [client A] back into the house and counseled him on not hurting his peers and using his coping skills when he becomes upset. Both [clients D and G] were checked out for any injuries and none were found." -The results of the investigation were not submitted to the administrator within 5 working days. 4) A 10/24/23 Investigation Summary indicated, "On 10/16/23 at 5:07pm the clients were eating dinner. [Client A] got done eating first and wanted to color using the dining room table. Staff asked him to wait until supper was over so he would have more room, since everyone else was still eating. [Client A] became upset, he reached over and pulled on [client H's] ear. Staff redirected [client A], staff counseled him on using his coping skills when he is upset. [Client H] was checked for injuries to his ears and none were found." -The results of the investigation were not submitted to the administrator within 5 working days. On 12/1/23 at 11:32 AM, the Quality Assurance Manager (QAM) indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. On 12/1/23 at 11:32 AM, the Quality Assurance Coordinator (QAC) indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. 9-3-2(a) Event ID: ERN711 Facility ID: 000724 Page 35 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

01/08/2024

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		x1) provider/supplier/clia identification number 15G194	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 12/05/2023		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421				
(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 APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
W 0157 Bldg. 00	If the alleged viol corrective action Based on record re- incident/investigat clients A, D, G and appropriate correct to address client A clients C, G and H skin picking after f emergency room to reopened. Findings include: On 12/1/23 at 9:18 incident/investigat indicated the follow 1A) A 10/24/23 Ir "On 10/14/23 at 12 group home] were because he forgot I wait a minute and A] then went over he then reached ov fingers backward. [client A] back into on not hurting his skills when he becaus and G] were check were found."	wiew and interview for 7 of 20 ive reports reviewed affecting d H, the facility failed to ensure tive actions were implemented 's aggression toward his peers, 's fear of client A and client A's falls requiring trips to the to close the wounds he	wo	0157	To correct the deficient practi supervisory staff have been to in reporting the results of an investigation to the administra- within 5 working days, and ensuring appropriate correctiv- actions are in place. Additionar- monitoring will be achieved bo QAM holding weekly QA mee- with individuals responsible for investigations to: assign investigations, ensure investigations are turned into administrator within 5 working days, ensure investigations a thorough, and to ensure appropriate corrective actions in place. The QAM will track a investigations and report to th any concerns. The peer revie- meet to review all investigation thoroughness, timely complet and appropriate recommenda Ongoing monitoring will be achieved by the quality and s committee meeting to discuss previous investigations and recommendations for effectiveness, and patterns.	rained ator ye al y The tings or the g re all re ED w will ns for ion, tions. afety	01/05/2024

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

Event ID:

ERN711 Facility ID: 000724

If continuation sheet Page 36 of 54

PRINTED: 01/08/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 CENTERS FOR MEDICARE & MEDICAID SERVICES 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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 not being implemented to prevent it from happening. On 12/1/23 at 11:32 AM, the Quality Assurance Coordinator (QAC) indicated staff should immediately notify the administrator of allegations of abuse. The QAC indicated the investigation was not thorough. She indicated the investigation should identify the staff present at the time of the incident and include interviews with all pertinent staff and clients. 1B) A 10/24/23 Investigation Summary indicated, "On 10/16/23 at 5:07pm the clients were eating dinner. [Client A] got done eating first and wanted to color using the dining room table. Staff asked him to wait until supper was over so he would have more room, since everyone else was still eating. [Client A] became upset, he reached over and pulled on [client H's] ear. Staff redirected [client A], staff counseled him on using his coping skills when he is upset. [Client H] was checked for injuries to his ears and none were found." -The investigation did not include an interview with client H or his peers. -The investigation indicated, "All plans, policy, and procedures were followed appropriately... Staff will continue to follow his HRC (Human rights committee) and guardian approved BSP (behavior support plan)." 1C) On 10/23/23 at 3:45 PM, the 10/24/23 BDS (Bureau of Disabilities Services) report indicated, "On 10/23/23 at 3:45pm [client A] came into the kitchen, he was yelling because he broke his plastic pumpkin and staff could not fix it. Staff tried to redirect him, and spend 1:1 (one on one) Event ID: ERN711 Facility ID: 000724 Page 37 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

01/08/2024

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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 with him to help him calm down. [Client A] refused to be redirected, he went up to [client D] and pushed him. [Client D] was standing by a kitchen chair, staff kept him from falling completely over the chair. [Client A] realizing what he did, went straight to his room without staff directing him to, he stayed in his room until he calmed down. Staff talked to him after about being nice to his peers. [Client D] was checked for any injuries, a quarter sized bruise was found on [client D's] upper right arm where it hit the back of the chair " -The 10/24/23 Investigation Summary contained the same information included in the 10/16/23. The investigation also included information regarding a client living in a different group home. There were no interviews with the staff and clients involved in the incident. On 11/30/23 at 2:13 PM, the QAC indicated prior to client A moving into the group home, she thought it was a good placement. The QAC indicated the group home was not used to behaviors. The QAC stated, "I think he'd be better off with higher functioning clients. The QAC indicated she was not aware of any of client A's peers being afraid of him and none of the clients act scared of him. On 11/30/23 at 2:36 PM, the Qualified Intellectual Disabilities Professional (QIDP) stated client A was admitted to a psychiatric hospital due to "things not going well." The QIDP indicated client A's behaviors were affecting the other clients: client C gets down and cries, client H biting his hand and points at client A, and client G staying close to the staff. The QIDP indicated the group home was calm before client A moved in. Event ID: ERN711 Facility ID: 000724 Page 38 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

01/08/2024

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** 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 15G194 12/05/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 On 12/1/23 at 2:10 PM, the nurse stated it was "pretty calm at the home prior to when he (client A) moved in." The nurse indicated clients C and G have been affected the most by client A's presence in the home. The nurse indicated client C complained of stomach issues when client A was home with him. The nurse indicated client C was spending more time in his bedroom isolating himself from client A. The nurse indicated client G, when client A was having behaviors, would shake and cry. The nurse stated she "had to sit with him and pat him on the shoulder to comfort him." The nurse indicated while she was sitting with client G, he was pointing at client A indicating client A was bothering him. The nurse stated "Last week, [client G] was curled up in a ball upset and sad looking due to [client A]." The nurse indicated she observed client G on 11/30/23 while client A was in the psychiatric hospital and he was happy, excited, and seemed to be back to his normal self due to client A being gone. The nurse stated, "[Client A] is not appropriately placed at the group home." On 11/30/23 at 11:30 AM, staff #3 indicated she did not think client A was appropriately placed at the group home. Staff #3 stated client A was "not an appropriate fit for the home." Staff #3 stated client A "doesn't listen, yells and screams. Had the house in an uproar... [Client C] been upset, others as well. [Client A] has client to client (aggression) with [clients D, H and G] " On 11/30/23 at 11:55 AM, the guardian for clients B, C, D and G indicated she had been concerned about the clients' safety and wellbeing since client A moved into the group home. The guardian indicated she called BDS, Program Manager and the QIDP to express her concerns but received no responses alleviating her concerns. The guardian ERN711 Facility ID: 000724 Page 39 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

PRINTED:

01/08/2024

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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 indicated the BDS representative told her it was client A's home as well. The guardian indicated client C had been emotional since client A moved in. On 11/30/23 at 12:17 PM, staff #4 indicated client A was not appropriately placed at the group home. Staff #4 stated client A was OK for awhile but since then had "caused a lot of problems." Client H has been biting his hands. Client C has been crying and more emotional. Staff #4 stated client A moving in, "Changed the whole dynamics of the house... Ripple effect. Whole dynamics changed." On 11/30/23 at 12:33 PM, client G indicated client A bothered him. Client G, when asked if he was scared of client A, indicated yes. On 11/30/23 at 12:42 PM, client H indicated client A bothered him. Client H hit his hand when the surveyor asked him about client A. Client H touched his head and said yes when asked if he was scared of client A. On 11/30/23 at 12:46 PM, staff #3 indicated the staff working at the group home did not document client A's behaviors as they should have. Staff #3 indicated the staff was told client A had no maladaptive behaviors when he moved in. On 11/30/23 at 12:53 PM, staff #4 indicated there was one night (she did not recall the date) the overnight shift staff moved client A's roommate's bed out of their bedroom and into the kitchen due to client A's screaming and turning the lights on and off in the room. Staff #4 stated client A "turned the house upside down. Clients nervous and upset. [Client F's] rectal digging increased when [client A's] behaviors increased." Staff #4 Event ID: ERN711 Facility ID: 000724 Page 40 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

01/08/2024

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	A. E	BUILDING VING	DNSTRUCTION 00	Cor 12/	te survey Mpleted 05/2023
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		115 ST	ADDRESS, CITY, STATE, ZIP ONEGATE IRD, IN 47421	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	hospital, client C w biting decreased ar Staff #4 stated the [client A] gone."	ent A was in the psychiatric vas much calmer, client H's hand id client F was sleeping better. home was "much calmer with 0 PM, client C stated "[Client					
	A's] behaviors scar hit me. Makes me was "a lot better w	e me. He got mad, angry, he nervous." Client C stated it ith him gone. He bothers erybody seems afraid of him.					
	bedroom. The 11/7 11/3/23 at 5:42am checks. The staff r already been up an room a couple of ti	5:42 AM, client A fell in his 3/23 BDS report indicated, "On third shift staff was doing room reported that [client A] had d had opened his door to his imes. Staff was going to check					
	door, [client A] we hit his head on the to [client A]. They up, [client A] repli- hurt anywhere besi	mmate. When staff opened the ent to turn around and fell. He floor. Staff immediately went v asked him if he could set (sic) ed yes. Staff asked him if he des his head, [client A] replied					
	applied pressure to reported that [clien (centimeter) cut on and it was bleeding Services) showed to hospital. The hosp came back negative	im up and to the couch, staff his head and called 911. Staff t A] had a 2" by 1cm t he left side of his forehead g. EMS (Emergency Medical up and took [client A] to the ital did scans and everything e. [Client A] was released at					
	will continue to mo						
	bedroom and his he BDS report indicat	at 1:58 AM, client A exited his ead was bleeding. The 11/10/23 ed, "On 11/10/23 at 1:58am t of his room, staff noticed that					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/08/2024

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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 his head was bleeding. [Client A] had ripped his stitches from his fall on 11/3/23 (IR#1520852). Staff applied pressure to his head and called for an ambulance. EMS arrived at 2:08am, they assessed [client A] and left for the ER (emergency room) at 2:16am. The ER stitched his head again. The stitches will dissolve on their own in 3-8 days. The ER sent him home. Staff will follow the instructions that the ER put on his discharge paper. Keeping the laceration clean and dry, covered and they may apply bacitracin (antibiotic ointment). Staff will monitor [client A] to make sure that he is redirected from rubbing the laceration." On 11/30/23 at 12:45 PM, a focused review of client A's daily charting was conducted. An 11/30/23 note on the back of client A's behavior tracking sheet indicated, "Ripped open a wound on his forehead w/ (with) his fingers. Took to ER." An 11/13/23 Incident Follow-Up Report indicated, "Did the Individual rip his stitches intentionally or was it accidental? We believe it was accidental. His stitches were fine when he went to bed. Our nurse thinks that it was probably itching from the healing and he was rubbing or scratching it in his sleep." 2C) On 11/13/23 at 5:10 PM, client A fell in the dining room. The 11/14/23 BDS report indicated, "On 11/13/23 at 5:10pm [client A] got up from the dining room table. He picked up his plate and turned to take his plate to the sink, he lost his balance and fell backwards. He hit his head on the floor. The staff went to him and helped him sit up. They asked him if he could stand and he said yes. They helped him up and onto a chair. Staff checked his head, they found a 1" (inch) wound ERN711 Facility ID: 000724 Page 42 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

01/08/2024

TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194			A. B	ULTIPLE CO UILDING	CON	(X3) DATE SURVEY COMPLETED			
		15G194	B. W	ING		- 12/	05/2023		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE					
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN		BEDFO	RD, IN 47421				
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR		(X5)		
REFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE APPROPRIATE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
	-	Staff called the nurse, the							
		send him to the ER. Staff called							
		The EMS arrived and took							
		R. At the ER he received two							
	-	wound. He will have the							
	-	10 days. He will follow up with							
	[name of doctor] in	n 1 to 2 weeks"							
		stigative Summary indicated,							
		11.13.23 when getting up from							
	the dining room ta	ble to take his plate to the sink.							
		p from the table, he went to turn							
		e and fell backwards. [Client							
	-	chind his chair and available to							
		as a 1" wound on the back of his							
		eceived two staples to close the							
		g to discharge papers, the							
		A's] forehead from a previous							
		reated. It was found he had							
	-	ches. The wound could not be							
	-	y cleaned it, bandaged it, and							
		head so he could not pick at it.							
		forehead is infected. [Client A]							
	-	ibiotics by the ER doctor. No							
		s wound was infected. [Staff							
		n duty Conclusion: It is							
		plans were followed at the time							
		1/13/23. Fall risk plan states that							
		uraged to use his walker and							
	staff are to help wi	th ambulation when needed."							
		8 PM, a focused review of client							
		was conducted. Client A's							
	0	e Instructions indicated,							
	-	today's visit: Fall. Head injury.							
		. Infected wound. Compulsive							
		nat to do next:Keep forehead							
		o not allow picking. Strong							
	_	g, knit hat or toboggan over							
	dressing. Discuss	hand mits (sic) with patient's							

Event ID: ERN711 Facility ID: 000724

If continuation sheet Page 43 of 54

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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 PCP (primary care provider) if necessary. Antibiotics as prescribed. Clindamycin 300 mg (milligrams/antibiotic) three times a day for secondary wound infection due to self picking. Follow up with [name of doctor] to discuss possible repair or further wound care. Staples to posterior head lac (laceration) must stay covered as well. Do not allow picking. Staples need removed in 10 days " 2D) On 11/21/23 at 10:20 PM, client A fell in his bedroom. The 11/22/23 BDS report indicated, "On 11/21/23 at 10:20pm staff heard [client A's] bedroom door open and then a thud. Staff was already on their way to his room. [Client A] had fell (sic). Staff helped him up and into the living room. They checked him over and found a knot forming on the back of his head. They called for an ambulance. The EMS (Emergency Medical Services) arrived and took [client A] to the ER. They did a CT (computed tomography)scan of his head and spine. All scans came back negative. He was discharged from the ER " On 12/1/23 at 1:01 PM, a review of an interdisciplinary team meeting on 11/14/23 was conducted. The notes indicated, "...Staff report unsteadiness and that there were no falls prior to the new medication of Clonazepam and Ambien. The team does not believe the Ambien is a benefit. [Name of nurse] will inquire further with the doctor and advocate a D/C (discontinue) if appropriate. The team reviewed each of the falls and the factors surrounding the incidents. [Name of nurse] will continue to maintain contact with wound care. Hand mittens were proposed as a tool to help [client A's] injuries heal " The IDT did not indicate whether or not the IDT agreed with the recommendation to use hand mitts. There was no documentation the IDT discussed a Event ID: ERN711 Facility ID: 000724 Page 44 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 12/05/2023			
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				115 ST	ADDRESS, CITY, STATE, ZIP ONEGATE ORD, IN 47421	TE, ZIP COD		
(X4) ID PREFIX	SUMMARY	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	SHOULD BE	(X5) COMPLETIC	
TAG	REGULATORY C knit hat or tobogga	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE	
	plans and program did not have a plan plan to keep client no plan for the use There was no plan On 12/5/23 at 9:09 bought mittens and The nurse indicate used the mittens di bandaged well. Th a toboggan or a Sa stated "I didn't put she was not aware from picking at his there was no plan	27 AM, a review of client A's risk plans was conducted. Client A n for skin picking. There was no A's head covered. There was to of a knit hat or toboggan. for the use of hand mitts. 9 AM, the nurse indicated she d took them to the group home. d she did not think client A ue to his wounds being ne nurse indicated client A wore nta Claus hat. The nurse in plan." The nurse indicated of a plan to prevent client A s wounds. The nurse indicated for mittens, hat and keeping his event him from picking.						
	On 12/5/23 at 9:17 Disabilities Profess the IDT unclear w the use of the mitter should have clariff agreed and docum indicated although to prevent client A there was no plan The QIDP indicate wrapped the woun there was no plan keeping his head c wound. On 12/5/23 at 9:24 Director (AED) in	² AM, the Qualified Intellectual sional (QIDP) indicated he left hether or not the team agreed to ens. The QIDP indicated he ed whether or not the team ented it on the form. The QIDP interventions were put in place from picking at his wounds, addressing the interventions. ed client A wore a hat and staff d better. The QIDP indicated for skin picking, use of a hat, overed and bandaging the AM, the Associate Executive dicated there should have been eloped for skin picking						
	_	eloped for skin picking his head covered, wearing a						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		A. BUILDING B. WING	onstruction (x 00	COMPLETED 12/05/2023			
	PROVIDER OR SUPPLIER	ER ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL 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		
	hat, bandage and t	the use of mittens. clates to complaint #IN00421880.					
W 0227 Bldg. 00	specific objective client's needs, ac comprehensive a paragraph (c)(3) Based on record r clients in the samp ensure client A ha his head wounds a Findings include: On 12/1/23 at 9:11 incident/investiga indicated the follo 1) On 11/3/23 at bedroom. The 11 Services (BDS) re 5:42am third shift The staff reported up and had opener of times. Staff wa roommate. When went to turn arour the floor. Staff in They asked him if replied yes. Staff besides his head, helped him up and	rogram plan states the es necessary to meet the s identified by the assessment required by of this section. eview and interview for 1 of 3 ple (A), the facility failed to a plan addressing picking at after falls with injury.	W 0227	To correct the deficient practice, the Supervisory and Nursing tea have been trained on ensuring appropriate plans are in place to meet client needs as well as following all medical recommendations. Additional monitoring will be achieved by th administrative team meeting dail to ensure the needs of each clie are met. The LPN will review all recommendations weekly to ensure plans are created when needed. The Nursing manager meet with the LPN weekly to discuss the medical needs of each client to ensure appropriate actions are being taken. Ongoing monitoring will be achieved by weekly nursing assessments as well as monthly record reviews t ensure client needs are met.	m ie y nt will		

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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 the left side of his forehead and it was bleeding. EMS (Emergency Medical Services) showed up and took [client A] to the hospital. The hospital did scans and everything came back negative. [Client A] was released at 10:45am. Staff is doing head tracking on him and will continue to monitor him." 2) On 11/10/23 at 1:58 AM, client A exited his bedroom and his head was bleeding. The 11/10/23 BDS report indicated, "On 11/10/23 at 1:58am [client A] came out of his room, staff noticed that his head was bleeding. [Client A] had ripped his stitches from his fall on 11/3/23 (IR#1520852). Staff applied pressure to his head and called for an ambulance. EMS arrived at 2:08am, they assessed [client A] and left for the ER (emergency room) at 2:16am. The ER stitched his head again. The stitches will dissolve on their own in 3-8 days. The ER sent him home. Staff will follow the instructions that the ER put on his discharge paper. Keeping the laceration clean and dry, covered and they may apply bacitracin (antibiotic ointment). Staff will monitor [client A] to make sure that he is redirected from rubbing the laceration." On 11/30/23 at 12:45 PM, a focused review of client A's daily charting was conducted. An 11/30/23 note on the back of client A's behavior tracking sheet indicated, "Ripped open a wound on his forehead w/ (with) his fingers. Took to ER." An 11/13/23 Incident Follow-Up Report indicated, "Did the Individual rip his stitches intentionally or was it accidental? We believe it was accidental. His stitches were fine when he went to bed. Our nurse thinks that it was probably itching from the healing and he was rubbing or scratching it in his Event ID: ERN711 Facility ID: 000724 Page 47 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

01/08/2024

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AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 12/05/2023	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		115 ST	NDDRESS, CITY, STATE, ZIP ONEGATE RD, IN 47421	COD	
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC
TAG	REGULATORY O sleep."	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	dining room. The "On 11/13/23 at 5: dining room table. turned to take his p balance and fell ba floor. The staff we They asked him if They asked him if They helped him w checked his head, that was bleeding. nurse told staff to a for an ambulance. [client A] to the El staples to close his staples removed in [name of doctor] in The 11/16/23 Inve "[Client A] fell on the dining room ta [Client A] stood up and lost his balance A's] walker was be him. [Client A] ha head. [Client A] m wound. According wound on [client A] incident was also t picked out the stift stitched again, they then wrapped his F The wound on his was prescribed ant one noticed that hi #2] was the staff o substantiated risk p	5:10 PM, client A fell in the 11/14/23 BDS report indicated, 10pm [client A] got up from the He picked up his plate and olate to the sink, he lost his ockwards. He hit his head on the ent to him and helped him sit up. he could stand and he said yes. p and onto a chair. Staff they found a 1" (inch) wound Staff called the nurse, the send him to the ER. Staff called The EMS arrived and took R. At the ER he received two wound. He will have the 10 days. He will follow up with a 1 to 2 weeks" stigative Summary indicated, 11.13.23 when getting up from ble to take his plate to the sink. o from the table, he went to turn e and fell backwards. [Client chind his chair and available to as a 1" wound on the back of his eccived two staples to close the g to discharge papers, the A's] forehead from a previous reated. It was found he had ches. The wound could not be y cleaned it, bandaged it, and need so he could not pick at it. forehead is infected. [Client A] ibiotics by the ER doctor. No s wound was infected. [Staff n duty Conclusion: It is plans were followed at the time 1/13/23. Fall risk plan states that					

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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 he should be encouraged to use his walker and staff are to help with ambulation when needed." On 12/1/23 at 12:58 PM, a focused review of client A's medical record was conducted. Client A's 11/13/23 Discharge Instructions indicated, "...Diagnosis from today's visit: Fall. Head injury. Laceration of head. Infected wound. Compulsive skin picking... What to do next: ...Keep forehead wound covered, do not allow picking. Strong head wrap dressing, knit hat or toboggan over dressing. Discuss hand mits (sic) with patient's PCP (primary care provider) if necessary. Antibiotics as prescribed. Clindamycin 300 mg (milligrams/antibiotic) three times a day for secondary wound infection due to self picking. Follow up with [name of doctor] to discuss possible repair or further wound care. Staples to posterior head lac (laceration) must stay covered as well. Do not allow picking. Staples need removed in 10 days " 4) On 11/21/23 at 10:20 PM, client A fell in his bedroom. The 11/22/23 BDS report indicated, "On 11/21/23 at 10:20pm staff heard [client A's] bedroom door open and then a thud. Staff was already on their way to his room. [Client A] had fell (sic). Staff helped him up and into the living room. They checked him over and found a knot forming on the back of his head. They called for an ambulance. The EMS (Emergency Medical Services) arrived and took [client A] to the ER. They did a CT (computed tomography)scan of his head and spine. All scans came back negative. He was discharged from the ER " On 12/1/23 at 1:01 PM, a review of an interdisciplinary team meeting on 11/14/23 was conducted. The notes indicated, "...Staff report unsteadiness and that there were no falls prior to ERN711 Facility ID: 000724 Page 49 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

01/08/2024

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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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 the new medications of Clonazepam and Ambien. The team does not believe the Ambien is a benefit. [Name of nurse] will inquire further with the doctor and advocate a D/C (discontinue) if appropriate. The team reviewed each of the falls and the factors surrounding the incidents. [Name of nurse] will continue to maintain contact with wound care. Hand mittens were proposed as a tool to help [client A's] injuries heal...." The IDT did not indicate whether or not the IDT agreed with the recommendation to use hand mitts. There was no documentation the IDT discussed a knit hat or toboggan. On 12/1/23 at 10:27 AM, a review of client A's risk plans and program plans was conducted. Client A did not have a plan for skin picking. There was no plan to keep client A's head covered. There was no plan for the use of a knit hat or toboggan. There was no plan for the use of hands mitts. On 12/5/23 at 9:09 AM, the nurse indicated she bought mittens and took them to the group home. The nurse indicated she did not think client A used the mittens due to his wounds being bandaged well. The nurse indicated client A wore a toboggan or a Santa Claus hat. The nurse stated "I didn't put in plan." The nurse indicated she was not aware of a plan to prevent client A from picking at his wounds. The nurse indicated there was no plan for mittens, hat and keeping his head covered to prevent him from picking. On 12/5/23 at 9:17 AM, the Qualified Intellectual Disabilities Professional (QIDP) indicated he left the IDT unclear whether or not the team agreed to the use of the mittens. The QIDP indicated he should have clarified whether or not the team agreed and documented it on the form. The QIDP indicated although interventions were put in place Event ID: ERN711 Facility ID: 000724 Page 50 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

01/08/2024

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 00 COMPLETED 15G194 B. WING 12/05/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 115 STONEGATE **RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE to prevent client A from picking at his wounds, there was no plan addressing the interventions. The QIDP indicated client A wore a hat and staff wrapped the wound better. The QIDP indicated there was no plan for skin picking, use of a hat, keeping his head covered and bandaging the wound. On 12/5/23 at 9:24 AM, the Associate Executive Director (AED) indicated there should have been a written plan developed for skin picking including keeping his head covered, wearing a hat, bandage and the use of mittens. This federal tag relates to complaint #IN00421880. 9-3-4(a) W 0249 483.440(d)(1) **PROGRAM IMPLEMENTATION** Bldg. 00 As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, interview and record W 0249 To correct the deficient practice, 01/05/2024 review for 2 of 5 non-sampled clients (D and F), all staff have been re-trained on all the facility failed to ensure their program plans client meal plans and following were implemented as written. plans as written. Additional monitoring will be achieved by the Findings include: Administrators completing daily observations. The administrative 1) On 11/30/23 from 11:40 AM to 1:16 PM, an team will review the observation observation was conducted at the group home. schedule monthly for effectiveness At 11:40 AM, client D was sitting at the dining and determine the frequency at room table eating lunch. Staff #3 and #4 were not that time. Ongoing monitoring will sitting at the table with client D supervising him. be completed by the Event ID: ERN711 Facility ID: 000724 If continuation sheet Page 51 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete

01/08/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 12/05/2023	
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	At 11:46 AM, staf and H. At 11:50 A room however she take drinks. At 12 eat unsupervised. coughed several ti down to assist clie During lunch, staf times, ensure he al thickened liquids a up while taking bir On 12/1/23 at 10:2 D's 3/10/23 Dining needs assistance w following portion bites alternating he Staff will encourag while taking bites. Plan indicated, " to adhere to diet re Staff will make su degrees position fo prepare meals accor fiber diet with Hou 4. Staff will ensur and alternating to ensure [client D's] correct eating tech meds crushed in so for signs/symptom intake such as cou gagging. Signs to coughing, choking wet voice, residuat	f #4 left to go pick up clients B M, staff #3 was in the dining was not prompting client D to :08 PM, client D continued to Client D took a drink and mes. At 12:12 PM, staff #4 sat nt D finish his lunch. f did not supervise client D at all ternated small bites with honey und ensure client D kept his chin		RM/AS/QIDP/LPN bein home at least weekly of coaching, and training s	bserving,	
		9 AM, the Quality Assurance				

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 12/05/2023 15G194 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **115 STONEGATE RES CARE COMMUNITY ALTERNATIVES SE IN** BEDFORD, IN 47421 (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 Manager (QAM) indicated client D's plans should be implemented as written. On 12/1/23 at 2:09 PM, the nurse indicated client D should be supervised at all times during meals due to being aspiration and choking risks. The nurse indicated client D's plans should be implemented as written. 2) On 11/30/23 from 11:40 AM to 1:16 PM, an observation was conducted at the group home. Throughout the observation when staff and/or clients entered the restrooms, there was no audible alert notifying the staff someone entered the restroom. This affected client F who was present in the group home throughout the observation. On 12/4/23 at 11:26 AM, a focused review of client F's 1/6/23 Individualized Support Plan (ISP) indicated, "...Manner in which the right will be modified: Freedom from access to bathroom doors without alarms. Reason the modification is needed: He is in need of supervision while in bathroom due to flushing objects down the toilet " On 12/1/23 at 11:32 AM, the QAM indicated there should be bathroom door alarms in use at the group home due to client F's behavior of stuffing and flushing items down the toilet. The QAM indicated client F's plan should be implemented as written. On 12/1/23 at 11:32 AM, the Quality Assurance Coordinator (QAC) indicated there should be bathroom door alarms in use at the group home due to client F's behavior of stuffing and flushing items down the toilet. The QAC indicated client F's plan should be implemented as written. Event ID: ERN711 Facility ID: 000724 Page 53 of 54 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

01/08/2024

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		A. BL	(x2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 12/05/2023		
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	should be bathroom group home due to and flushing items (towels, etc) down th	PM, the nurse indicated there door alarms in use at the client F's behavior of stuffing washcloths, towels, paper the toilet. The QAM indicated d be implemented as written.					

ERN711 Facility ID: 000724

If continuation sheet Page 54 of 54