PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

					SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 04/21/2021	
		15G811	B. WING		04/21/	2027
NAME OF P	PROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET NCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
W 0000						
Bldg. 00	visit included the in	pre-determined full state licensure survey. This vestigation of complaints 00341232, #IN00330633,	W 0000			
	-	13478: Substantiated, no to the allegation(s) are cited.				
	•	11232: Substantiated, no to the allegation(s) are cited.				
	Complaint #IN0033 to lack of sufficient	80633: Unsubstantiated, due evidence.				
	-	22643: Substantiated, no to the allegation(s) are cited.				
	Dates of Survey: 4/3 and 4/21/21.	5/21, 4/6/21, 4/7/21, 4/8/21				
	Facility Number: 01 Provider Number: 1 AIMS Number: 201	5G811				
	These deficiencies also reflect state findings in accordance with 410 IAC 16.2-5. Quality Review of this report completed by #15068 on 4/27/21.					
W 0102	483.410 GOVERNING BOI	DY AND MANAGEMENT				
Bldg. 00	The facility must e governing body ar requirements are	ensure that specific nd management met.				
	Based on observation interview, the facility	on, record review and ty failed to meet the	W 0102	Individuals residing in the facil should have access throughou	-	05/21/2021

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED
		15G811	B. W	ING		04/21/2021
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			1		
DEC CAE	DE INC				BLOOMINGTON STREET	
RES-CAF	RE INC			GREEN	NCASTLE, IN 46135	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Condition of Partici	pation: Governing Body for			the day to food and drink items	s,
	4 of 4 sampled clier	nts (#1, #2, #3 and #4), plus			without having to ask staff for	
	16 additional clients	s (#5, #6, #7, #8, #9, #10,			assistance unless a specific ar	nd
	#11, #12, #13, #14,	#15, #16, #17, #18, #19 and			approved restriction is in place	
	#20).				The facility will provide a "snac	;k
					drawer" which will contain a	
	The governing body	failed to exercise general			variety of healthy snacks so th	at
		operating direction over the			individuals who are not restrict	
	facility to ensure the	e facility met the Condition			from these items can access	
	of Participation: Ac	tive Treatment Services for 3			snack items when they are	
	of 4 sampled clients	s (#1, #3 and #4), plus 8			hungry. In addition there will	pe
	additional clients (#	5, #10, #15, #16, #17, #18,			access to drink items in the	
	#19 and #20).				refrigerator.	
					All staff will be in-serviced to	
	The governing body	failed to exercise general			ensure that there is adequate	food
	policy, budget and	operating direction over the	and drink available, in the kitchen			nen
	facility to ensure cli	ent #5's television stand was			area, for individuals to access	
	in good repair and h	is television worked			throughout the day.	
	properly, client #8 l	nad a bedframe for his			The dietary manager will be	
	mattress and client	#13's nightstand was in good			in-serviced to ensure that thes	e
	repair, to ensure cli	ents #1, #3, and #4's rights in			food and drink items are availa	ıble
	regards to access to	food, to ensure client #3 had			and accessible in the snack	
	the opportunity to p	articipate in community			drawer and the refrigerator.	
	activities, to ensure	clients #3, #11, #12 and #13			Residential Managers will be	
	were provided and	encouraged to wear clothing			in-serviced to ensure that they	are
	in good repair and o	lean clothes and to ensure a			verifying, throughout their shift	s
	system to accurately	y account for clients #1, #2,			that snacks and drinks are	
	#3, #4, #12, and #1:	5's personal possessions, to			available. This will be verified	on
	ensure the QIDP (Q	ualified Intellectual			the RM checklist, and reviewe	d by
	Disabilities Profess	ional) integrated, monitored			the PM weekly.W102 The facil	ity
	and coordinated clie	ents #1, #2, #3, #4, #5, #10,			ensures governing body and	
	#11, #12, #13, #15,	#16, #17, #18, #19 and			management requirements are	;
	#20's active treatme	ent programs, to ensure			met.	
	clients #1, #3, #10,	#16, #18, #19 and #20's			*in the past year individual	
	active treatment pro	grams were consistently and			community activities had been	
	aggressively impler	nented, to ensure client #20			restricted due to COVID. The	se
	had a plan to increa	se the time he spends out of			restrictions have since been	
	his bedroom, to ens	ure the clients #3, #4, #5,			reduced or lifted.	
		and #20 served themselves			Facility staff (PM, RM or BC) w	<i>i</i> ill
	during dinner, to en	sure clients #1, #3, #16 and			conduct individual meetings w	th
					i .	l

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 2 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		ľ	ILDING	nstruction <u>00</u>	(X3) DATE : COMPL 04/21 /	ETED	
NAME OF I	PROVIDER OR SUPPLIER			1306 S	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	#11, #12, #13, #15 a encouraged to wear clean clothes, to ensintervention of lock was incorporated in program plans, to enservices addressed devacuation drills un clients #1, #2, #3, # #11, #12, #13, #14, #20 and to ensure harms of chairs, table cleaned and disinfectients #1, #2, #3, # #11, #12, #13, #14, #20. Findings include: 1. The governing be policy, budget and of facility to ensure the of Participation: Act of 4 sampled clients additional clients (# #19 and #20). Pleas 2. The governing be policy, budget and of facility to ensure clients additional clients (# #19 and #20). Pleas 2. The governing be policy, budget and of facility to ensure clients additional clients (# #19 and #20). Pleas 2. The governing be policy, budget and of facility to ensure clients additional clients (# #19 and #20). Pleas	nsure clients #1, #3, #10, and #18 were provided and clothing in good repair and sure the systematic ing the laundry room door to clients #1, #2, #3, and #4's nsure the facility's nursing client #13's falls, to conduct der varied conditions for 4, #5, #6, #7, #8, #9, #10, #15, #16, #17, #18, #19 and igh-touch areas (door knobs, es, chairs and couches) were cted throughout the shift for 4, #5, #6, #7, #8, #9, #10, #15, #16, #17, #18, #19 and object of the condition over the efacility met the Condition tive Treatment Services for 3 and #4), plus 8 5, #10, #15, #16, #17, #18,			each client to discuss wants at needs in regards to accessing community. These will be not in an IDT meeting and incorporated into their program plans. Regular community outings have been re-instated prior to this correction date. A individuals will participate in community outings and also in workshop or day treatment as warranted in the individual program plan. Outings will be scheduled and documented each day by the DSP staff and Residential Managers. These outings will reviewed by the Program Manager to ensure completion and will be recorded on the monthly and quarterly reviews All individuals will have appropriate, clean and well-fitt clothing in good repair and in sufficient supply. All staff will be in-serviced to enure that all clients are provid with and encouraged to wear clothing in good repair and cle clothes. PM, QIDP's and RM's will be in-serviced to ensure that personal inventories are accurupdated in a real time fashion to ensure a system to accurate account for client's personal possessions. New and complete inventories all client belongings, including not limited clothing will be	the tated and late, and alely	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		l í	UILDING	onstruction 00	(X3) DATE : COMPL 04/21 /	ETED	
NAME OF F	ROVIDER OR SUPPLIER		<u>, </u>	1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET ICASTLE, IN 46135		
RES-CAF (X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN REGULATORY OR in good repair and of system to accurately #3, #4, #12, and #13; ensure the QIDP (Q) Disabilities Profess; and coordinated clic #11, #12, #13, #15, #20's active treatment professively impler had a plan to increate his bedroom, to ensure the #20's active treatment individualized, to ensure the #20's active treatment individualized, to ensure the #11, #12, #13, #15; encouraged to wear clean clothes, to ensure the was incorporated in program plans, to ensure the services addressed evacuation drills unclients #1, #2, #3, #11, #12, #13, #14, #20 and to ensure he arms of chairs, table cleaned and disinferents #1, #2, #3, ##11, #12, #13, #14, #20 and to ensure he arms of chairs, table cleaned and disinferents #1, #2, #3, ##11, #13, #14, #13, #14, #13, #14, #30, ##11, #12, #3, ##11, #12, #3, ##11, #13, #14, #30, ##11, #12, #3, ##11, #3, #3, #3, #3, #3, #3, #3, #3, #3, #3	conal) integrated, monitored ents #1, #2, #3, #4, #5, #10, #16, #17, #18, #19 and not programs, to ensure #16, #18, #19 and #20's grams were consistently and mented, to ensure client #20 se the time he spends out of the clients #3, #4, #5, #15, 20 served themselves during exclients #1, #3, #16 and not schedules were the systematic ing the laundry room door to clients #1, #2, #3, and #4's insure the facility's nursing exclients #1, #2, #3, and #4's insure the facility's nursing exclient #13's falls, to conduct der varied conditions for 4, #5, #6, #7, #8, #9, #10, #15, #16, #17, #18, #19 and igh-touch areas (door knobs, es, chairs and couches) were extend throughout the shift for 4, #5, #6, #7, #8, #9, #10, #15, #16, #17, #18, #19 and		GREEN ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) completed by the RM. The R will accurately document all belongings, ensuring that thes belongings are present, in goo repair and fitting and appropria for the individual. The Program Manager will rever monthly, individual inventories ensure that they are present a accurate. Administrative observations we occur at least two times daily fat least 60 days to ensure that individuals are dressed in clear and well fitting clothing. All staff will be in-serviced on the policy for active treatment. The will include, but is not limited to ensuring that all individuals are prompted at least every 15 minutes during waking hours to participate in active treatment, be encouraged All staff will be in-serviced on specifics related to each individuals program plan. Facility staff (PM, RM or BC) we conduct individual meetings we each client to discuss wants a needs in regard to accessing to community. These will be not in an IDT meeting and incorporated into their program plans. Regular community outings have been re-instated prior to this correction date. As individuals will participate in dividuals will participate in individuals will participate in individu	M e od ate riew, to nd ill for the nis o, e o to vill ith nd he tated	(X5) COMPLETION DATE
					community outings and also ir workshop or day treatment as warranted in the individual	ı	

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 4 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES DF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BUILDING B. WING	00	COMPLETED 04/21/2021
NAME OF PI	ROVIDER OR SUPPLIE RE INC	R	1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES 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)	(X5) COMPLETION DATE
				program plan. All staff will be in-serviced on family style dining. This will include encouraging individual participate in ISP goals as rel to meals and actively particip in the meal time process. Individuals who are eligible to begin outside day service are already scheduled, or in the process of doing so. For individuals who are not elito go to outside day service, facility will ensure that no few than two life skills class opportunities are scheduled a made available to all individual living in the facility. Facility staff (PM, RM or BC) conduct individual meetings we each client to discuss wants a needs in regards to accessing community. These will be not in an IDT meeting and incorporated into their prograplans. Regular community outings have been re-instated prior to this correction date. Individuals will participate in community outings and also it workshop or day treatment as warranted in the individual program plan. Outings will be scheduled and documented each day by the DSP staff and Residential Managers. These outings we reviewed by the Program Manager to ensure completion and will be recorded on the	als to ates ating bligible the er and als will with and g the otated m black all and als black and als black and g the otated black and als black and g the otated black and als black and also

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Facility ID: 013405

If continuation sheet

Page 5 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/21/2021
NAME OF PI	ROVIDER OR SUPPLIER	1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
			monthly and quarterly reviews Two times per day, for at least administrators will conduct and treatment observations. These observations will be meant to active in nature to ensure that staff demonstrate competency active treatment and knowledge goals and objectives as written individual program plans. All staff will be in-serviced on specifics related to each individuals program plan. All staff will be in-serviced on policy for active treatment. The will include, but is not limited the ensuring that all individuals are prompted at least every 15 minutes during waking hours the participate in active treatment, be encouraged to participate if formal and informal opportunit for active treatment. In regard specifically to client the IDT will meet to discuss proactive ways in which to acclimate him to his environm and encourage him to spend I time in his room. Since the survey some additions have be made to better support client number 20 including adding no cancelling headphones, allowing and has met with the psychiatrist to adjust some medications. Two times per day, for at least administrators will conduct active treatment observations. These days of the survey some additions and the survey some medications.	t 60, tive se be all v in ge of n in the his o, e o to n all ties #20 ent ess een oise ng pass ne t 60, tive

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 6 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BUILDING B. WING	00	COMPLETED 04/21/2021
NAME OF P	ROVIDER OR SUPPLIEI	3	1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				observations will be meant to active in nature to ensure that staff demonstrate competency active treatment and knowledge goals and objectives as writter individual program plans. All staff will be in-serviced on policy for active treatment. The will include, but is not limited the ensuring that all individuals are prompted at least every 15 minutes during waking hours the participate in active treatment, be encouraged All staff will be in-serviced on specifics related to each individuals program plan. All staff will be in-serviced on family style dining. This will include encouraging individual participate in ISP goals as related to meals and actively participate in the meal time process. All staff will be in-serviced on policy for active treatment. The will include, but is not limited the ensuring that all individuals are prompted at least every 15 minutes during waking hours the participate in active treatment. The times during waking hours the encouraged to participate in formal and informal opportunited for active treatment. Two times per day, for at least days, administrators will conductive treatment observations. These observations will be meant to be active in nature to ensurt that all staff demonstrate	all / in ge of n in the his o, e to , to ls to ates ating the his o, e to

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 7 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEF CORRECTION IDENTIFICATION NUMBER: 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/21/2021
NAME OF P	ROVIDER OR SUPPLIER RE INC	1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
			competency in active treatment and knowledge of goals and objectives as written in individing program plans including dietal and mealtime goals as well as family style dining. Individuals who are eligible to begin outside day service are already scheduled, or in the process of doing so. For individuals who are not eligible to go to outside day service, the facility will ensure that no fewer than two life skills class opportunities are scheduled at made available to all individual living in the facility. Facility staff (PM, RM or BC) we conduct individual meetings we each client to discuss wants at needs in regards to accessing community. These will be not in an IDT meeting and incorporated into their program plans. Regular community outings have been re-instated prior to this correction date. Individuals will participate in community outings and also in workshop or day treatment as warranted in the individual program plan. Outings will be scheduled and documented each day by the DSP staff and Residential Managers. These outings will reviewed by the Program Manager to ensure completion and will be recorded on the monthly and quarterly reviews	gible ne er nd als will ith nd the tated n

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Facility ID: 013405

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Page 8 of 135

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	OF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BUILDING B. WING	00	COMPLETED 04/21/2021
NAME OF P	ROVIDER OR SUPPLIEI	₹	1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
				In regard specifically to client – the IDT will meet to discuss proactive ways in which to acclimate him to his environm and encourage him to spend time in his room. Since the survey some additions have to made to better support client number 20 including adding no cancelling headphones, allow him alternative times for med and dining, and has met with psychiatrist to adjust some medications. All individuals will have appropriate, clean and well-fit clothing in good repair and in sufficient supply. All staff will be in-serviced to enure that all clients are proving with and encouraged to wear clothing in good repair and cle clothes. PM, QIDP's and RM's will be in-serviced to ensure that personal inventories are accuupdated in a real time fashion to ensure a system to accurate account for client's personal possessions. New and complete inventories all client belongings, including not limited clothing will be completed by the RM. The Find will accurately document all belongings are present, in goor repair and fitting and appropriate the individual. The Program Manager will resulted.	eent dess deen oise ing pass the ting ded dean rate, and rely s of g but RM se od ate

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Page 9 of 135

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	T OF DEFICIENCIES DF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BUILDING B. WING	00	COMPLETED 04/21/2021
NAME OF P	ROVIDER OR SUPPLIE RE INC	R	1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES 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 APPROPR DEFICIENCY)	DATE
				monthly, individual inventorie ensure that they are present accurate. Administrative observations occur at least two times daily at least 60 days to ensure the individuals are dressed in cleand well fitting clothing. Facility PM and QIPD's will be in-serviced to ensure that all active treatment schedules a individualized to meet the ne each individual living in the facility. All Active treatment schedules be updated to ensure that the individualized for the needs, and schedules of each individualized for the needs, and schedules of each individualized reviewed at least, at the qual meetings to ensure the schedules of endividuals. Active treatment schedules of endividuals. Two times per day, for at least administrators will conduct and treatment observations. The observations will be meant to active in nature to ensure the staff demonstrate competent active treatment and knowledgoals and objectives as writter individual program plans. The observations will include observations will include observations and ensuring the occurrence of the staff of the program plans. The observations will include observations and ensuring the observations and ensuring the occurrence of the staff of the program plans.	and will v for at ean De are deds of es will ey are wants dual vill be rterly dules of the vill be staff, to be st 60, ctive ese b be at all cy in dge of een in nese erving

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If continuation sheet

Page 10 of 135

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	of correction identification number: 15G811	A. BUILDING B. WING	00	COMPLETED 04/21/2021
NAME OF I	PROVIDER OR SUPPLIER	1306 S	ADDRESS, CITY, STATE, ZIP CODE B BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
			staff are aware of their location and understand how to use the	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general			
	policy, budget, and operating direction over the facility. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 16 additional clients (#5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure client #5's television stand was in good repair and his television worked properly, client #8 had a bedframe for his mattress and client #13's nightstand was in good repair, to ensure clients #1, #3, and #4's rights in regards to access to food, to ensure client #3 had the opportunity to participate in community activities, to ensure clients #3, #11, #12 and #13 were provided and encouraged to wear clothing in good repair and clean clothes and to ensure a system to accurately account for clients #1, #2, #3, #4, #12, and #15's personal possessions, to ensure the QIDP (Qualified Intellectual Disabilities Professional) integrated, monitored and coordinated clients #1, #2, #3, #4, #5, #10, #11, #12, #13, #15, #16, #17, #18, #19 and #20's active treatment programs, to ensure clients #1, #3, #10, #16, #18, #19 and #20's active treatment programs were consistently and aggressively implemented, to ensure client #20 had a plan to increase the time he spends out of his bedroom, to ensure clients #3, #4, #5, #15, #16, #17, #19 and #20 served themselves during dinner, to ensure the clients #1, #3, #16 and #20's active treatment schedules were	W 0104	Individuals residing in the facil should have access throughout the day to food and drink items without having to ask staff for assistance unless a specific at approved restriction is in place. The facility will provide a "snac drawer" which will contain a variety of healthy snacks so the individuals who are not restrict from these items can access snack items when they are hungry. In addition there will access to drink items in the refrigerator. All staff will be in-serviced to ensure that there is adequate and drink available, in the kitch area, for individuals to access throughout the day. The dietary manager will be in-serviced to ensure that these food and drink items are available and accessible in the snack drawer and the refrigerator. Residential Managers will be in-serviced to ensure that they verifying, throughout their shift that snacks and drinks are available. This will be verified the RM checklist, and reviewed the PM weekly.	at s, and s. ck at ted be food then see the able of are the see the se

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 11 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		l í	ILDING	onstruction 00	(X3) DATE : COMPL 04/21 /	ETED	
NAME OF P	ROVIDER OR SUPPLIER		•	1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	#11, #12, #13, #15 a encouraged to wear clean clothes, to ensintervention of lock was incorporated in program plans, to enservices addressed devacuation drills un clients #1, #2, #3, # #11, #12, #13, #14, #20 and to ensure harms of chairs, table cleaned and disinfectients #1, #2, #3, # #11, #12, #13, #14, #20. Findings include: 1. Observations were 1:29 PM to 3:08 PM AM to 12:04 PM. To following: Observation on 4/5/ -At 1:29 PM, client personal belongings client #8 showed so belongings, his mat bedframe. Client #8 left the room with share with others. -At 2:24 PM, client why his mattress was	ing the laundry room door to clients #1, #2, #3, and #4's naure the facility's nursing client #13's falls, to conduct der varied conditions for 4, #5, #6, #7, #8, #9, #10, #15, #16, #17, #18, #19 and igh-touch areas (door knobs, es, chairs and couches) were cted throughout the shift for 4, #5, #6, #7, #8, #9, #10, #15, #16, #17, #18, #19 and #16, #17, #18, #19 and #17, #18, #19 and #18, #19, #19, #19, #19, #19, #19, #19, #19			Two times per day, for at least days there will be administration monitoring to ensure that individual rights are being met that clients have access to head food and snack items, unless otherwise restricted per the individual program plan. The facility ensures the rights all clients. *in the past year individual community activities had been restricted due to COVID. The restrictions have since been reduced or lifted. Facility staff (PM, RM or BC) voonduct individual meetings we each client to discuss wants an needs in regards to accessing community. These will be not in an IDT meeting and incorporated into their program plans. Regular community outings have been re-instated prior to this correction date. A individuals will participate in community outings and also in workshop or day treatment as warranted in the individual program plan. Outings will be scheduled and documented each day by the DSP staff and Residential Managers. These outings will reviewed by the Program Manager to ensure completion and will be recorded on the monthly and quarterly reviews	and althy of see vill the tated on	
ı	going anywhere. It's	s a real pain in the a**" and			All individuals will have		

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 12 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	A. BUILDING 00 COMPLETED		
		15G811	B. W	ING		04/21/2021
		<u> </u>		CTDEET A	ADDRESS CITY STATE ZID CODE	
NAME OF P	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE	
					BLOOMINGTON STREET	
RES-CAF	RE INC			GREEN	ICASTLE, IN 46135	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	client #8 then left to return to the day room.				appropriate, clean and well-fitt	ing
	, in the second				clothing in good repair and in	
	-At 2:51 PM, client	#13's bedroom had a			sufficient supply.	
	nightstand next to h	nis wardrobe. The nightstand			All staff will be in-serviced to	
	was missing a top of	drawer and the bottom drawer			enure that all clients are provid	ded
	hung down and me	tal railing was exposed. Client			with and encouraged to wear	
	#13 was asked abou	ut his nightstand being broken,			clothing in good repair and cle	an
	but his response wa	as not understandable.			clothes.	
					PM, QIDP's and RM's will be	
	-At 2:59 PM, client	#5 approached and said			in-serviced to ensure that	
	hello. Client #5 ind	icated he had a CD collection			personal inventories are accur	ate,
	and wanted to share	e.			updated in a real time fashion	and
					to ensure a system to accurate	ely
	-At 3:01 PM, client	#5 pointed to his CD			account for client's personal	
	collection and his p	osted notes with the total			possessions.	
	number of CD's he	had collected. Client #5's			New and complete inventories	of
	television stand in l	his bedroom had a piece of			all client belongings, including	but
	trim torn off and hu	ing from the top of the			not limited clothing will be	
	television stand. Cl	ient #5 was asked if anything			completed by the RM. The R	M
	was broken in his re	oom. Client #5 pointed to his			will accurately document all	
	television as he ind	icated he was going to be			belongings, ensuring that thes	е
	_	at #5 indicated his television			belongings are present, in goo	
		is television stand was broken.			repair and fitting and appropria	ate
		s protruded along the top			for the individual.	
		's television stand and a piece			The Program Manager will rev	
	of trim hung down	from the top side.			monthly, individual inventories	
					ensure that they are present a	nd
	Observation on 4/6	/21:			accurate.	
					Administrative observations wi	
	· · · · · · · · · · · · · · · · · · ·	nt #5 and client #13 were in			occur at least two times daily f	
	-	clients #4, #12, #14 and staff			at least 60 days to ensure that	
		droom was observed again and			individuals are dressed in clea	n
	-	of his television stand hung			and well fitting clothing.	
	down and multiple glued pegs continued to				*in the past year individual	
	-	top section of the television			community activities had been	
	stand.				restricted due to COVID. The	se
	4. 10 51 .35				restrictions have since been	
	· ·	nt #16 stepped into the			reduced or lifted.	
	-	to staff #13, "[Client #8] is			Facility staff (PM, RM or BC) v	
	stuck in his room"	and used force with his left			conduct individual meetings w	ith

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì í	ULTIPLE CC UILDING	ONSTRUCTION 00	(X3) DATE COMPL		
11112 121111	or conduction	15G811	B. W			04/21/	
		100011				0 1/2 1/	2021
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	ent #8's bedroom door. The			each client to discuss wants a		
		own the hallway to client #8's			needs in regards to accessing		
		the door and indicated he			community. These will be no	tated	
		enance to come look at client			in an IDT meeting and		
	#8's door.				incorporated into their prograr	n	
					plans. Regular community		
		nt #16 and client #8 stood in			outings have been re-instated		
		ted about client #8's door			prior to this correction date.	All	
	_	hanked client #16 for			individuals will participate in		
		Thile in the hallway, client			community outings and also ir		
		ned on the floor and was			workshop or day treatment as		
	without a bedframe.				warranted in the individual		
	A	5.404 1 -1:4 .41.21-			program plan.		
		F#9 entered client #13's			Outings will be scheduled and documented each day by the		
		ted he was going on an nightstand remained beside			DSP staff and Residential		
	-	ontinued to be missing the top			Managers. These outings wil	l bo	
		drawer hung down and metal			reviewed by the Program	i be	
		drawer to slide on was		Manager to ensure completion			
		de of nightstand. During this			and will be recorded on the	•	
	-	person had come into the			monthly and quarterly reviews		
		client #8's door handle to			All staff will be in-serviced on		
	his bedroom door.	one and a designation of			policy for active treatment. T		
					will include, but is not limited t		
	On 4/6/21 at 3:55 P	M, staff #9 was interviewed.			ensuring that all individuals ar		
		about client #5's television			prompted at least every 15		
	and television stand	being in good repair, client			minutes during waking hours t	0	
	#8's bedframe, and	client #13's broken			participate in active treatment,	to	
	nightstand. Staff #9	stated, "[Client #13's]			be encouraged		
	nightstand just recen	ntly broke, about a week ago".			All staff will be in-serviced on		
		f a work order had been			specifics related to each		
		client #13's nightstand. Staff			individuals program plan.		
	· ·	now". Staff #9 indicated client			Facility staff (PM, RM or BC) v		
	-	and dissemble his bedframe			conduct individual meetings w		
		ssemble his bed. Staff #9			each client to discuss wants a		
		m (client #8) take it apart, but			needs in regard to accessing t		
		f #9 was asked where client			community. These will be no	tated	
		ocated. Staff #9 stated,			in an IDT meeting and	_	
	•	ed". Staff #9 was asked how			incorporated into their program	n	
	iong client #8 had g	one without a bedframe. Staff			plans. Regular community		

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING <u>00</u> COMPLETED			ETED	
		15G811	B. W				
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER						
DEC CAE	DE INO			1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135			
RES-CAF	RE INC			GREEN	ICASTLE, IN 40135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	#9 stated, "About 3	weeks". Staff #9 stated client			outings have been re-instated		
	#5's issues with his	television and television			prior to this correction date. A	All .	
	stand were problem	s that had continued from the			individuals will participate in		
	previous annual sur	vey. Staff #9 stated, "It's the			community outings and also in		
	-	evision) stand. It's the same			workshop or day treatment as		
	· ·	s, it's a cable issue. He used			warranted in the individual		
	to watch [name]".				program plan.		
	. ,				All staff will be in-serviced on		
	On 4/6/21 at 5:39 P	M, staff #14 was			family style dining. This will		
		14 was asked if client #13's			include encouraging individual	s to	
	nightstand was brok	ten. Staff #14 stated, "Yes".			participate in ISP goals as rela		
	_	l how long client #13's			to meals and actively participa		
		broken. Staff #14 stated,			in the meal time process.		
	-	longer". Staff #14 was asked if			Individuals who are eligible to		
		en submitted to repair client			begin outside day service are		
		aff #14 stated, "No, I don't			already scheduled, or in the		
	-	as asked about client #5's			process of doing so.		
		ision stand. Staff #14 stated,			For individuals who are not elig	aible	
		ff #14 indicated she was			to go to outside day service, th	· 1	
		broken television stand for 2			facility will ensure that no fewe		
		to work from being off. Staff			than two life skills class		
		as not sure if a work order			opportunities are scheduled ar	nd	
		to repair client #5's			made available to all individua		
	-	was asked about client #8's			living in the facility.		
		rom his bedroom. Staff #14			Facility staff (PM, RM or BC) w	vill	
	_	t out. [Client #8] jumped on it			conduct individual meetings wi		
	-	ds broke". Staff #14 was			each client to discuss wants ar		
		ent #8 had gone without a			needs in regards to accessing	1	
	_	stated, "About a month".			community. These will be not	I	
		l if a work order had been			in an IDT meeting and		
		client #8's bedframe. Staff			incorporated into their program	n l	
	• •	know. There shouldn't be any			plans. Regular community		
		o in a bed with a bedframe".			outings have been re-instated		
					prior to this correction date. A	AII I	
	On 4/7/21 at 1:30 P	M, the Program Manager	1		individuals will participate in		
		ed. The PM was asked about			community outings and also in		
		and television stand being			workshop or day treatment as		
		at #8's bedframe, and client			warranted in the individual		
		tand. The PM indicated client			program plan.		
	_	peen ordered and would be	1		Outings will be scheduled and		
	l		1		1		

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 15 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		UILDING	00	COMPI	
		15G811	B. W	ING		04/21	/2021
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			BLOOMINGTON STREET		
RES-CA	RE INC				ICASTLE, IN 46135		
INLO-OA	· · · · · · · · · · · · · · · · · · ·			OILLI			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	replaced. The PM is	ndicated he was not aware of			documented each day by the		
	any issues with clie	nt #5's television or			DSP staff and Residential		
	television stand bei	ng broken or client #13's			Managers. These outings will	l be	
	nightstand being br	oken. The PM indicated client			reviewed by the Program		
	#5's financial resou	rces would be reviewed and if			Manager to ensure completion	า	
	client #5 did not ha	ve enough finances to replace			and will be recorded on the		
	his television stand,	, the facility would ensure a			monthly and quarterly reviews		
	television stand was	s obtained to replace it. The			Two times per day, for at leas	t 60,	
	PM indicated a new	nightstand would be obtained			administrators will conduct ac	tive	
	to replace client #13	3's broken nightstand. The			treatment observations. The	se	
	PM was asked if the	e facility should be			observations will be meant to	be	
	maintained and in good repair. The PM stated,				active in nature to ensure that	all	
	"Yes, absolutely!".				staff demonstrate competency	/ in	
					active treatment and knowled	ge of	
	2. The governing bo	ody failed to ensure clients			goals and objectives as writte	n in	
	#1, #3, and #4's rigl	nts in regards to access to			individual program plans.		
	food. Please see W	125.			All staff will be in-serviced on		
				specifics related to each			
	3. The governing bo	ody failed to ensure client #3			individuals program plan.		
	had the opportunity	to participate in community			All staff will be in-serviced on	the	
	activities. Please se	e W136.			policy for active treatment. T	his	
					will include, but is not limited t	0,	
	4. The governing bo	ody failed to ensure clients			ensuring that all individuals ar	е	
	#3, #11, #12 and #1	3 were provided and			prompted at least every 15		
	encouraged to wear	clothing in good repair and			minutes during waking hours t	:0	
	clean clothes and to	ensure a system to			participate in active treatment	, to	
	accurately account	for clients #1, #2, #3, #4,			be encouraged to participate i	n all	
	#12, and #15's perso	onal possessions. Please see			formal and informal opportunit	ies	
	W137.				for active treatment.		
					In regard specifically to client	#20	
	5. The governing bo	ody failed to ensure the QIDP			- the IDT will meet to discuss		
	integrated, coordina	ated and monitored clients #1,			proactive ways in which to		
	#2, #3, #4, #5, #10,	#11, #12, #13, #15, #16,			acclimate him to his environm	ent	
	#17, #18, #19 and #	20's active treatment			and encourage him to spend I	ess	
	programs by failing	to ensure the client #3 had			time in his room. Since the		
	the opportunity to p	participate in community			survey some additions have b	een	
		clients #1, #3, #10, #16,			made to better support client		
	#18, #19 and #20's	active treatment programs			number 20 including adding n	oise	
	· ·	nd aggressively implemented,			cancelling headphones, allow		
	I	had a plan to increase the			him alternative times for med	-	
	1					•	

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DAT			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED
		15G811	B. W	NG		04/21/2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER					
550.045	IIIO				BLOOMINGTON STREET	
RES-CAF	RE INC			GREEN	ICASTLE, IN 46135	
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	BROWDERIG BLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)		DATE
	time he spends out	of his bedroom, to ensure			and dining and has met with th	ne
	clients #3, #4, #5, #	15, #16, #17, #19 and #20			psychiatrist to adjust some	
		luring dinner, to ensure			medications.	
		and #20's active treatment			Two times per day, for at least	60.
		vidualized, to ensure clients			administrators will conduct act	
		2, #13, #15 and #18 were			treatment observations. Thes	
		raged to wear clothing in			observations will be meant to b	
	•	an clothes and to ensure the			active in nature to ensure that	
		tion of locking the laundry			staff demonstrate competency	
	•	proprated into clients #1, #2,			active treatment and knowledg	
		n plans. Please see W159.			goals and objectives as writter	
	1 8	1			individual program plans.	
	6. The governing bo	ody failed to ensure clients			All staff will be in-serviced on t	he
		8, #19 and #20's active			policy for active treatment. The	
		were consistently and			will include, but is not limited to	
		nented. Please see W196.			ensuring that all individuals are	
	aggressively implem				prompted at least every 15	
	7. The governing bo	ody failed to ensure client #20	minutes during waking hours to			0
		se the time he spends out of			participate in active treatment,	
	his bedroom. Please	-			be encouraged	
					All staff will be in-serviced on	
	8. The governing bo	ody failed to ensure clients			specifics related to each	
		5, #17, #19 and #20 served			individuals program plan.	
		linner. Please see W249.				
	8				All staff will be in-serviced on	
	9. The governing bo	ody failed to ensure the clients			family style dining. This will	
		's active treatment schedules			include encouraging individual	s to
	were individualized				participate in ISP goals as rela	
					to meals and actively participa	
	10. The governing b	oody failed to ensure clients			in the meal time process.	
		2, #13, #15 and #18 were			All staff will be in-serviced on t	he
		raged to wear clothing in			policy for active treatment. Th	
	-	an clothes. Please see W268.			will include, but is not limited to	
	1				ensuring that all individuals are	
	11. The governing h	oody failed to ensure the			prompted at least every 15	
		tion of locking the laundry			minutes during waking hours to	0
	-	propried into clients #1, #2,			participate in active treatment,	
		n plans. Please see W289.			be encouraged to participate in	
	, F8				formal and informal opportuniti	
	12. The governing h	oody failed to ensure the			for active treatment.	
	-2. 1 50 (Similar	,				

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		A. BUILDING B. WING	NSTRUCTION 00	COMPLETED 04/21/2021
NAME OF I	PROVIDER OR SUPPLIER RE INC	1306 S	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	facility's nursing services addressed client #13's falls in order to prevent recurrence. Please see W331. 13. The governing body failed to conduct evacuation drills under varied conditions for clients (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20). Please see W441. 14. The governing body failed to ensure high-touch areas (door knobs, arms of chairs, tables, chairs and couches) were cleaned and disinfected throughout the shift for clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20. Please see W455. 5-1.2(24)(1)		Two times per day, for at least days, administrators will conductive treatment observations. These observations will be me to be active in nature to ensur that all staff demonstrate competency in active treatment and knowledge of goals and objectives as written in individual program plans including dietar and mealtime goals as well as family style dining. Individuals who are eligible to begin outside day service are already scheduled, or in the process of doing so. For individuals who are not eligible to go to outside day service, the facility will ensure that no fewer than two life skills class opportunities are scheduled at made available to all individual living in the facility. Facility staff (PM, RM or BC) we conduct individual meetings we each client to discuss wants at needs in regards to accessing community. These will be not in an IDT meeting and incorporated into their program plans. Regular community outings have been re-instated prior to this correction date. A individuals will participate in community outings and also in workshop or day treatment as warranted in the individual program plan. Outings will be scheduled and documented each day by the	gible ne er and lis vill ith and the tated in All

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 18 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 15G811		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/21/2021		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
			DSP staff and Residential Managers. These outings wil reviewed by the Program Manager to ensure completion and will be recorded on the monthly and quarterly reviews In regard specifically to client: — the IDT will meet to discuss proactive ways in which to acclimate him to his environm and encourage him to spend I time in his room. Since the survey some additions have b made to better support client number 20 including adding no cancelling headphones, allowing him alternative times for med and dining, and has met with the psychiatrist to adjust some medications. All individuals will have appropriate, clean and well-fittic clothing in good repair and in sufficient supply. All staff will be in-serviced to enure that all clients are proviewith and encouraged to wear clothing in good repair and cleatothes. PM, QIDP's and RM's will be in-serviced to ensure that personal inventories are accurated account for client's personal possessions. New and complete inventories all client belongings, including not limited clothing will be completed by the RM. The Reconstructions and the RM.	ent ess een oise ing pass the ting ded ean eate, and ely s of but		

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 19 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BUILDING 00 B. WING		COMPLETED 04/21/2021		
NAME OF P	ROVIDER OR SUPPLIEI	₹	STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET				
RES-CAF	RE INC		GREEN	NCASTLE, IN 46135			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				will accurately document all belongings, ensuring that thes belongings are present, in good repair and fitting and appropriate for the individual. The Program Manager will revision monthly, individual inventories ensure that they are present a accurate. Administrative observations will occur at least two times daily fat least 60 days to ensure that individuals are dressed in clear and well fitting clothing. Facility PM and QIPD's will be inserviced to ensure that all active treatment schedules are individualized to meet the need each individual living in the facility. All Active treatment schedules will individualized for the needs, we and schedules of each individualized for the needs, we and schedules of each individualized for the needs, we and schedules of each individualized for the needs of individuals. Active treatment schedules will reviewed at least, at the quarter meetings to ensure the schedules of individuals. Active treatment schedules will posted and available for all state including direct support staff to able to access at any time. Two times per day, for at least administrators will conduct act treatment observations. These observations will be meant to be active in nature to ensure that staff demonstrate competency.	ate riew, to nd fill for tinn e ds of will y are rants ual II be erly ules the II be aff, b be to		

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 20 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	AN OF CORRECTION IDENTIFICATION NUMBER: 15G811 A. BUILDING 00 B. WING		COMPLETED 04/21/2021					
NAME OF P	ROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP CODE				
RES-CAF	RE INC			BLOOMINGTON STREET NCASTLE, IN 46135				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
				active treatment and knowledge goals and objectives as writter individual program plans. The observations will include obse access to active treatment observations and ensuring that staff are aware of their location and understand how to use the Policies and procedures promithe growth, development, and independence of the client. All individuals will have appropriate, clean and well-fitt clothing in good repair and in sufficient supply. All staff will be in-serviced to enure that all clients are provid with and encouraged to wear clothing in good repair and cle clothes. All staff will be in-serviced to ensure understanding of individignity. PM, QIDP's and RM's will be in-serviced to ensure that personal inventories are accurupdated in a real time fashion to ensure a system to accurate account for client's personal possessions. New and complete inventories all client belongings, including not limited clothing will be completed by the RM. The R will accurately document all belongings, ensuring that thes belongings are present, in goor repair and fitting and appropria for the individual. The Program Manager will reventories and representations are repair and fitting and appropriate for the individual.	n in in esse riving at in eem. ote ting ded ean ely ely es of but in the ely electron electro			

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 21 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BUILDING 00 B. WING		COMPLETED 04/21/2021	
NAME OF P	ROVIDER OR SUPPLIEI	3	1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET NCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				monthly, individual inventories ensure that they are present a accurate. Administrative observations we occur at least two times daily at least 60 days to ensure that individuals are dressed in clear and well-fitting clothing. The Behavior Consultant and Program Manager will be in-serviced to ensure understanding that all interver used to manage client behavior are incorporated into program plans, for any client effected. Restrictive interventions will be written into program plans and approved by guardians as well the HRC. All interventions will be review for relevancy by the IDT at ear quarterly meeting and revised needed. All individuals will be assessed upon admission and ongoing any high risk care plan needs, including factors that may lead falls. The DON will investigate all factorer to assess the root cause and need for intervention, and prevention of further falls and potential injury. All staff will be in-serviced on each individual high risk plans how to intervene to ensure clies afety. The facility holds evacuation of under varied conditions The Program Manager will be	and rill for t an ntions or e d II as red ch as d on d to alls in e I	

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 22 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G811			COMPLETED 04/21/2021	
NAME OF P	PROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
				in-serviced on the policy for emergency evacuation drills. Evacuation drills will be schedle each month at a variety of time. The PM will complete a schedle for the year, of evacuation drill include the range of acceptable times to conduct the drills. Evacuation drills will be review at each quarterly safety committee review for adherence to the policy. Staff will ensure that all surface are disinfected, per policy multitimes a day. In addition the custodian will do a deep clean of surfaces each day. Individuals will be prompted to assist in cleaning all surfaces assisting with infection control well. Administrative observations with occur at least two times daily fat least 60 days to ensure adherence to infection control policy.	es. ule, s to e ved ce es tiple ing and as	
W 0125	483.420(a)(3) PROTECTION OF	CLIENTS RIGHTS				
Bldg. 00	clients. Therefore encourage individing rights as clients of citizens of the Uniright to file complaprocess. Based on observation	the facility must allow and ual clients to exercise their the facility, and as ted States, including the uints, and the right to due on, record review, and sampled clients (#1, #3, and	W 0125	Individuals residing in the facil should have access throughou	-	05/21/2021
	#4), the facility fail	ed to ensure clients #1, #3, gards to access to food.		the day to food and drink items without having to ask staff for		

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 23 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/21/2021		
NAME OF F	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	Findings include:				assistance unless a specific an approved restriction is in place The facility will provide a "snac) .	
	4/5/21 from 1:30 pr 4:20 pm through 6:: am through 9:00 an 3:00 pm, and on 4/7 11:15 am. Clients # present in the facilit observation period. Throughout the obs food in the refrigera bagged ice in the fr was no food availab cabinets in the kitch there were two cara clients in the kitche were available to cl Client #1's record w	the conducted in the facility on in through 2:45 pm, from 30 pm, on 4/6/21 from 7:30 in and from 2:30 pm through 1/21 from 9:15 am through 1/21 from			drawer" which will contain a variety of healthy snacks so the individuals who are not restrict from these items can access snack items when they are hungry. In addition there will access to drink items in the refrigerator. All staff will be in-serviced to ensure that there is adequate and drink available, in the kitch area, for individuals to access throughout the day. The dietary manager will be in-serviced to ensure that these food and drink items are available and accessible in the snack drawer and the refrigerator. Residential Managers will be	at ded be food nen	
	3/25/21 did not indi #1's access to food. Client #16 was inte and stated, "The foo I'm hungry, I have t Direct Support Prof interviewed on 4/5/ keep the food locke the drinks." DSP #13 was intervand stated, "All foo	r Support Plan (BSP) dated cate a restriction on client rviewed on 4/7/21 at 9:33 am od is kept locked up. When o ask staff for snacks." Tessional (DSP) #7 was 21 at 4:26 pm and stated, "We d. [Client #6] will get into riewed on 4/7/21 at 9:34 am d is kept locked. [Clients #7 of the snacks we have before			in-serviced to ensure that they verifying, throughout their shift that snacks and drinks are available. This will be verified the RM checklist, and reviewe the PM weekly. Two times per day, for at least days there will be administration monitoring to ensure that individual rights are being met that clients have access to here food and snack items, unless otherwise restricted per the individual program plan.	I on d by 60 ve	

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 24 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		ľ	UILDING	nstruction 00	(X3) DATE COMPL 04/21/	ETED	
NAME OF P	ROVIDER OR SUPPLIER			1306 S I	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	_	ve snacks, but they have to ask 5 minutes between."					
	4/7/21 at 11:30 am the snacks in the padoor is locked. The staff to get any food locked, it'll have to behavior plans. The Rights Committee) guardian approval." 2. Observations were 4/5/21 from 1:27 PM 4:20 PM to 6:32 PM 9:07 AM, 4/6/21 from 9:18 AM to 10 observations at the efficients #3 and #8. On 4/6/21 at 8:37 AM not have access to the clients have access staff for access where the the refrigeration of the clients have access. Staff for access where the conduct Individual Support Support Plan did not food at the facility. On 4/6/21 at 4:55 PM (BC) indicated there to the clients at all the "didn't know the sna 4/7/21 at 12:19 PM.	re conducted at the facility on M to 3:08 PM, 4/5/21 from M, 4/6/21 from 7:25 AM to om 10:23 AM to 12:05 PM, M to 3:00 PM, and 4/7/21 0:26 AM. During the facility, there was no food in the kitchen. There was no e kitchen accessible to accessible to the food. Client #8 stated "no "He indicated he had to ask on he wanted food. M, a review of client #3's ted. Client #3's ted. Client #3's 12/18/20 Plan and 3/25/21 Behavior of the include the locking of the message when the stated she in the BC stated she the food. The BC stated she the food of the BC indicated it was an state of the food.					
		ion. The BC stated she was					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 25 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/21	LETED	
NAME OF I	PROVIDER OR SUPPLIEF			1306 S I	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) it is being locked."		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	The BC indicated the (a) locked door." To go through staff food)." The BC she snacks was not being was aware client #1 stated the clients "c." On 4/6/21 at 4:57 P (PM) stated the "foot stated the clients were it." On 4/7/21 at 1:3 food was locked and due to client #15. To client who will stea indicated the food colient #15's behavior #15) would eat ever stopping him." The have to ask the staff On 4/6/21 at 5:21 P to Covid going through 2020, there was a define #14 stated, "There is clients without going the food. 3. Observations were 4/5/21 from 1:29 Plends and 1:20 PM, 4/6/21 at 6:32 PM, 4/6/21 at 6:32 PM, 4/6/21 at 6:59 PM to 6:32 PM, 4/6/21 at 6:59 PM to 6:59 PM to 11:20 AM. During facility, the food parand locked. This at On 4/6/21 at 4:08 PM.	the clients' food was "behind the BC stated the clients "have to get them (snacks and e was not aware the drawer for ag used. The BC stated she 5 was "taking it all." The BC an have access at any time." M, the Program Manager od is all locked up." The PM ere "getting into it and eating 88 PM, the PM indicated the d not accessible to the clients the PM stated, "we have a 1 it (food)." The PM evolud not be left out due to be performed to the client experiment. The PM stated the (client experiment) the performed the facility in December rawer full of fruit cups. Staff is no food available" to the get through a staff to access the conducted at the facility on M to 3:08 PM, from 4:20 for more performed to the stated of the observations at the next of the obser					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 26 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRU		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		04/21/	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	₹			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
	VE IIVO			OILLI			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	following:						
		t Plan dated 11/1/20 indicated,					
	"Safe Meal Preparation: [Client #4] will help						
		f the meal using safe cooking					
	_	erbal prompt 100% of the					
	opportunities per month across 3 consecutive months".						
	-Behavior Support Plan dated 3/25/21 indicated, "Rights Restrictions / PRN (as needed) Protocol: He (client #4) may use his key card to exit the						
		building when going on					
		outings. He will return it to					
	_	his return to the residential					
	_	be locked in the RM					
		er) closet Line of sight					
	_	ritchen in case [client #4]					
		nile using the kitchen					
	_	estricted from the kitchen for					
		wing repeated episodes of in the kitchen, this will be					
		the discretion of the					
	treatment team".	the discretion of the					
	u camient team						
	Client #4's ISD and	BSP did not indicate the need					
		s being locked or why client					
		owed access to the food					
	items.	owed access to the rood					
	items.						
	On 4/7/21 at 1:30 P	M, the Program Manager					
		yed. The PM was asked why					
		e being locked. The PM					
		will go through the foods					
	_	t it up. Client (client #4) has					
	access through the	-					
	ascess amough the	-					
	5-1.2(6)						
	3-1.2(0)						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 27 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		, ,	JILDING	00	(X3) DATE COMPL 04/21/	LETED	
NAME OF I	PROVIDER OR SUPPLIER			1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET NCASTLE, IN 46135		
NEO-OA	TE INO			OINELI			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	REGULATORY OR 483.420(a)(11) PROTECTION OF The facility must e clients. Therefore that clients have th in social, religious, activities. Based on observation review for 1 of 4 clients facility failed to ensopportunity to particulate activities. Findings include: Observations were of 4/5/21 from 1:27 PM 4:20 PM to 6:32 PM 9:07 AM, 4/6/21 from 4/6/21 from 2:18 PM from 9:18 AM to 10 observations at the fill the following of following of the following of following of the following of following of following of the following of fo	CLIENTS RIGHTS Insure the rights of all In the facility must ensure The opportunity to participate In and community group In the sample (#3), the Interview and record In the sample (#3), the Interview in the sample (#3), the Interview in community Interview and record Interview a	W		The facility ensures the rights all clients. *in the past year individual community activities had beer restricted due to COVID. The restrictions have since been reduced or lifted. Facility staff (PM, RM or BC) conduct individual meetings we each client to discuss wants a needs in regards to accessing community. These will be not in an IDT meeting and incorporated into their program plans. Regular community outings have been re-instated prior to this correction date. Individuals will participate in community outings and also in workshop or day treatment as warranted in the individual program plan. Outings will be scheduled and documented each day by the DSP staff and Residential Managers. These outings wireviewed by the Program Manager to ensure completio and will be recorded on the	of nese will vith and g the stated m l All	
	· ·	#13 stated client #12's n this day so she went to pick			monthly and quarterly reviews	5.	

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 28 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BUILDING 00 B. WING		COMPLETED 04/21/2021	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
RES-CAF	RE INC			BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIENC	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	record was conducted documentation clien in the community in exception of attending Client #3's 3/25/21 I indicated, in part, " desired items from the personal outing day for him" On 4/7/21 at 12:42 If (BC) indicated part of facility was not going the community of the c	M, a review of client #3's ed. There was no at #3 had attended an outing the past 12 months with the ng medical appointments. Behavior Support Plan .[client #3] continues to get the community on his but staff retrieve these items PM, the Behavior Consultant of the Covid protocol at the ng into the community. The extrieve the items for the				
	clients at this time fi stated, "I don't unde stopped." On 4/7/21 at 1:38 PI (PM) stated, "I thou	rom the community. The BC rstand why the van rides M, the Program Manager ght they (the staff) were t Not aware the clients				
W 0137 Bldg. 00	The facility must endients. Therefore, that clients have the appropriate person	CLIENTS RIGHTS Insure the rights of all In the facility must ensure In eright to retain and use In all possessions and				
	interview for 4 of 4 #3 and #4) and 4 ad #13 and #15), the fa #3, #11, #12 and #11 encouraged to wear clean clothes and to	clothing in good repair and ensure a system to or clients #1, #2, #3, #4,	W 0137	The facility ensures the rights of all clients All individuals will have appropriate, clean and well-fittic clothing in good repair and in sufficient supply. All staff will be in-serviced to enure that all clients are provide with and encouraged to wear	ing	

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 29 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING On			(X3) DATE COMPL		
AND PLAN	OF CORRECTION		B. WI		00	1	
		15G811	b. WI			04/21	/2021
NAME OF F	ROVIDER OR SUPPLIER	}		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					BLOOMINGTON STREET		
RES-CAF	RE INC			GREEN	ICASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					clothing in good repair and cle	ean	
	Findings include:				clothes. PM, QIDP's and RM's will be		
	A. Observations were conducted at the facility on				in-serviced to ensure that		
	4/5/21 from 1:27 PI	M to 3:08 PM, 4/5/21 from			personal inventories are accu	rate,	
	4:20 PM to 6:32 PM	M, 4/6/21 from 7:25 AM to			updated in a real time fashion	and	
	9:07 AM, 4/6/21 fro	om 10:23 AM to 12:05 PM,			to ensure a system to accurat	ely	
		M to 3:00 PM, and 4/7/21			account for client's personal		
		0:26 AM. During the			possessions.		
		facility, the following issues			New and complete inventories		
were noted:					all client belongings, including	but	
					not limited clothing will be		
1) Client #17 wore the same clothes throughout				completed by the RM. The R	XIMI		
	the observations.				will accurately document all		
	2) On 1/5/21 from	1:27 PM to 3:08 PM, client			belongings, ensuring that these belongings are present, in goo		
	· ·	o tight and could not be			repair and fitting and appropri		
	-	. At 2:20 PM, client #12			for the individual.	aic	
		o pull his pants up due to			The Program Manager will rev	/iew	
		e #1 unbuckled client #12's			monthly, individual inventories		
	-	up and buckled his belt. The			ensure that they are present a		
		buckle the button and zip			accurate.		
		At 2:24 PM, client #12 left			Administrative observations w	rill	
	the medication area	to use the restroom. When			occur at least two times daily	for	
	he returned at 2:26	PM, nurse #1 had to assist			at least 60 days to ensure tha	t	
	client #12 again due	e to his pants falling down. At			individuals are dressed in clea	an	
	6:10 PM, client #12	2 asked staff for assistance			and well fitting clothing.		
	with his belt.						
	3) On 4/5/21 at 2·5	52 PM, client #11 was					
	wearing two right s						
	4) On 4/5/21 at 5:0	00 PM, client #13's shoes					
	were on the wrong	feet.					
	5) On 4/6/21 at 7:4	2 AM, client #3 was wearing					
	the same clothes fro	_					
	On 4/6/21 at 3:37 P	'M, a review of client #3's					
	record was conduct						
							1

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 30 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G811	(X2) MULTIPLE C A. BUILDING B. WING	OO OOSTRUCTION		SURVEY LETED /2021
NAME OF P	PROVIDER OR SUPPLIEF		1306 9	ADDRESS, CITY, STATE, ZIP CODI B BLOOMINGTON STREET NCASTLE, IN 46135	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
		facility documented client ssions on an inventory.				
	(BC) indicated the dinventories should be	M, the Behavior Consultant clients' personal possession be completed upon admission cly but she was not sure the				
	(PM) indicated the inventories should be and updated at least there should be two one in the clients' fi program binders. The unable to find any one of the control of the	M, the Program Manager clients' personal possession be completed upon admission annually. The PM indicated copies of the inventories, le on the unit and one in their the PM indicated he was of the clients' inventories. The conducted in the group m 1:30 pm through 2:45 pm, gh 6:30 pm, on 4/6/21 from 200 am and from 2:30 pm and on 4/7/21 from 9:15 am Clients #1, #2, #3, #4, #12, ant in the group home for the ervation period.				
	jeans with a belt and Professional (DSP) adjust his belt. Whe up, his pants were to zipped or buttoned	Opm, client #12 was wearing d a polo shirt. Direct Support #13 assisted client #12 to en client #12 lifted his shirt oo small and could not be at the waist.				
		was reviewed on 4/7/21 at ot include an inventory of his				
	DSP #13 was interv	riewed on 4/5/21 at 2:22 pm				

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 31 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G811		A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/21/2021	
NAME OF F	ROVIDER OR SUPPLIER			1306 S E	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	keep noticing him we clothes. I don't knot His stuff has just va on 3rd shift. There' They're way too sm Program Manager (4/7/21 at 1:55 pm at pants should fit him his clothes. Some of people's clothes at the shift with it and blue jogging in the shift with blue jogging in the shift with blue jogging in the shift with blue in the shift with	PM) #1 was interviewed on and stated, "[Client #12's] I. I wonder if those weren't dients will take other imes." I pm, client #15 was wearing an unbuttoned plaid shirt over pants. Im, client #15 was wearing a use jogging pants. Im, client #15 was wearing a use jogger pants. The pants are smeared across the front I pant #15 indicated dry baskets in his bedroom. The baskets out and sorted are were no pants in the opened all of his dresser g closet space, there were no client #15's bedroom. Client in the have clothing in the					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 32 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		04/21/	2021
NAME OF B	NOVADED OD GLIDDLIEF		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF			1306 S	BLOOMINGTON STREET		
RES-CAF					ICASTLE, IN 46135		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE
		nly have one pair of pants. I I don't ever wash these pants					
		e anything else to wear while					
	these are being washed."						
	these are being washed.						
	DSP #13 was interviewed on 4/7/21 at 9:34 am						
	and stated, "[Client #15] has been wearing the						
	same pair of pants for months. He wears the						
		3 days before he washes					
	them."						
	DCD #0						
		ewed on 4/5/21 at 2:27 pm					
	and stated, "[Client #15] will throw his clothing away. That's a behavior he has. He'll do it with						
	other people's cloth						
	other people's cloth	ics 100.					
	Behavior Specialist	t (BS) #1 was interviewed on					
	-	and stated, "[Client #15] has a					
		ng his own clothing away. It's					
	listed in his behavio	or plan under property					
	destruction." BS#	1 stated, "He should have					
		ts, socks, and underwear. If					
		s away, and he has no other					
	-	ld check his inventory sheet					
		it all went. If he doesn't have					
		e should provide additional					
	items."						
	PM #1 stated "If a	client only has one pair of					
		ovide more. He should have 4					
	-	ninimum. I would expect 2					
		s and seasonal pants as well."					
	•	-					
	3. Client #1's record	d was reviewed on 4/7/21 at					
		ot include an inventory of his					
	belongings.						
	4 (01)	1 470					
		d was reviewed on 4/7/21 at					
		ot include an inventory of his					
	belongings.						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 33 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CC A. BUILDING	00	(X3) DATE SURVEY COMPLETED	
		15G811	B. WING		04/21/2021
NAME OF P	ROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET ICASTLE, IN 46135	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	10:58 am and did no belongings. 6. Client #4's record	It was reviewed on 4/7/21 at of include an inventory of his It was reviewed on 4/7/21 at of include an inventory of his			
	on 4/7/21 at 10:44 a inventories every ye shopping or bring th the clients' financial managers' closet."	er (RM) #3 was interviewed am and stated, "We update the ear or when [the clients] go nings home. We keep them in I binders, locked in the RM #3 stated, "The the binders. I don't know			
	and stated, "We do a If [a client] buys son inventory. If they g back with something PM #1 was interview stated, "When the cl	ewed on 4/5/21 at 2:27 pm inventory one time each year. mething, we add it to his go on a home visit and come g, we add it to the inventory." wed on 4/7/21 at 1:55 pm and lient comes in, there should ssion inventory completed.			
	should update the in	es back from an outing, they aventory. We should have a and there is one kept in the any of them."			
W 0159 Bldg. 00	be integrated, coo	e treatment program must rdinated and monitored by			
	Based on observation interview for 4 of 4	tual disability professional. on, record review and sampled clients (#1, #2, #3 ditional clients (#5, #10, #11,	W 0159	*in the past year individual community activities had been restricted due to COVID. The	

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 34 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CC UILDING	00	COMPI		
		15G811		ING	00	04/21	
				CTREET	ADDRESS, CITY, STATE, ZIP CODE	0 .,	
NAME OF F	PROVIDER OR SUPPLIER	2			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		#17, #18, #19 and #20), the			restrictions have since been		
		tellectual Disabilities			reduced or lifted.		
		to integrate, monitor and			Facility staff (PM, RM or BC)		
		1, #2, #3, #4, #5, #10, #11,			conduct individual meetings v		
		#17, #18, #19 and #20's			each client to discuss wants a		
	_	ograms by failing to ensure			needs in regards to accessing	-	
		e opportunity to participate in			community. These will be no	otated	
	1	es, to ensure clients #1, #3,			in an IDT meeting and		
		and #20's active treatment			incorporated into their program	П	
		sistently and aggressively			plans. Regular community outings have been re-instated	ı	
	implemented, to ensure client #20 had a plan to				prior to this correction date.		
	increase the time he spends out of his bedroom, to ensure clients #3, #4, #5, #15, #16, #17, #19				individuals will participate in	All	
	and #20 served themselves during dinner, to				community outings and also i	n	
		3, #16 and #20's active			workshop or day treatment as		
		s were individualized, to			warranted in the individual	•	
		3, #10, #11, #12, #13, #15			program plan.		
		ded and encouraged to wear			Outings will be scheduled and	4	
	1	pair and clean clothes and to			documented each day by the	4	
		ic intervention of locking the			DSP staff and Residential		
		was incorporated into clients			Managers. These outings wi	ll be	
	#1, #2, #3 and #4's	-			reviewed by the Program		
	, ,	F8 F			Manager to ensure completio	n	
	Findings include:				and will be recorded on the		
					monthly and quarterly reviews	S.	
	1. The QIDP failed	to integrate, monitor and					
		's active treatment program					
		client #3 had the opportunity					
	to participate in con	nmunity activities. Please see					
	W136.						
	2 El 0155 6 11 1						
		to integrate, monitor and					
		1, #3, #10, #16, #18, #19					
		atment programs by failing to					
		3, #10, #16, #18, #19 and					
	#20's active treatme						
	Please see W196.	gressively implemented.					
	1 10asc see W 190.						
	3. The QIDP failed	to integrate, monitor and					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 35 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BUILDING 00 B. WING		COMPLETED 04/21/2021	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE B BLOOMINGTON STREET		
RES-CAF	RE INC			NCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
		to ensure client #20 had a time he spends out of his				
	coordinate clients #3 #19 and #20's active failing to ensure client	to integrate, monitor and 3, #4, #5, #15, #16, #17, treatment programs by ents #3, #4, #5, #15, #16, rved themselves during 7249.				
	coordinate clients # treatment programs	to integrate, monitor and 1, #3, #16 and #20's active by failing to ensure clients's active treatment schedules. Please see W250.				
	coordinate clients # #15 and #18's active failing to ensure clie #13, #15 and #18 we	to integrate, monitor and 1, #3, #10, #11, #12, #13, treatment programs by ents #1, #3, #10, #11, #12, ere provided and encouraged good repair and clean clothes.				
	coordinate clients # treatment programs systematic intervent room door was inco	to integrate, monitor and 1, #2, #3 and #4's active by failing to ensure the ion of locking the laundry reporated into the clients #1, ram plans. Please see W289.				
W 0195 Bldg. 00	treatment services Based on observatio interview, the facilit	nsure that specific active requirements are met. n, record review and	W 0195	W196 Each client will receive a continuous active treatment program	a 05/21/2021	

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 36 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO UILDING	ONSTRUCTION 00	COMPI		
		15G811	B. W		00	04/21	
		100011				0 1/2 1	2021
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
RES-CAF	RE INC				BLOOMINGTON STREET NCASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	Services for 3 of 4	sampled clients (#1, #3 and			All staff will be in-serviced on	the	
		al clients (#5, #10, #15, #16,			policy for active treatment. T	his	
	#17, #18, #19 and #	•			will include, but is not limited		
	, ,	,			ensuring that all individuals a		
	The facility failed to	o ensure clients #1, #3, #10,			prompted at least every 15		
	-	‡20's active treatment			minutes during waking hours	to	
		sistently and aggressively			participate in active treatment		
		sure client #20 had a plan to			be encouraged		
	increase the time he	e spends out of his bedroom,			All staff will be in-serviced on		
	to ensure clients #3	, #4, #5, #15, #16, #17, #19			specifics related to each		
	and #20 served then	nselves during dinner and to			individuals program plan.		
	ensure clients #1, #	3, #16 and #20's active			Facility staff (PM, RM or BC)	will	
	treatment schedules were individualized.				conduct individual meetings v	/ith	
					each client to discuss wants a	ınd	
	Findings include:				needs in regard to accessing	the	
					community. These will be no	tated	
	1. The facility failed	d to ensure clients #1, #3,			in an IDT meeting and		
		and #20's active treatment			incorporated into their progra	m	
		sistently and aggressively			plans. Regular community		
	implemented. Pleas	se see W196.			outings have been re-instated		
					prior to this correction date.	All	
		d to ensure client #20 had a			individuals will participate in		
	-	time he spends out of his			community outings and also i		
	bedroom. Please se	e W227.			workshop or day treatment as	;	
					warranted in the individual		
		d to ensure clients #3, #4, #5,			program plan.		
		and #20 served themselves			All staff will be in-serviced on		
		orograms were implemented			family style dining. This will	la 4a	
	during opportunitie	s. Please see W249.			include encouraging individua		
	4 TEL C 1114 C 11	1			participate in ISP goals as rel		
		d to ensure clients #1, #3, e treatment schedules were			to meals and actively participation in the meal time process.	aurig	
					•		
	individualized. Plea	ise see w 230.			Individuals who are eligible to begin outside day service are		
					already scheduled, or in the		
					process of doing so.		
					For individuals who are not el	iaible	
			to go to outside day service, the				
					facility will ensure that no few		
					than two life skills class	O.	
					Light Wo life skills class		

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

Event ID:

FAZ411 Fac

Facility ID: 013405

If continuation sheet

Page 37 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/21/2021
NAME OF P	ROVIDER OR SUPPLIEF		1306 S	ADDRESS, CITY, STATE, ZIP CODE B BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
				opportunities are scheduled a made available to all individual living in the facility. Facility staff (PM, RM or BC) conduct individual meetings veach client to discuss wants a needs in regards to accessing community. These will be not in an IDT meeting and incorporated into their prograplans. Regular community outings have been re-instated prior to this correction date. individuals will participate in community outings and also i workshop or day treatment as warranted in the individual program plan. Outings will be scheduled and documented each day by the DSP staff and Residential Managers. These outings wereviewed by the Program Manager to ensure completion and will be recorded on the monthly and quarterly reviews. Two times per day, for at least administrators will conduct and treatment observations. The observations will be meant to active in nature to ensure that staff demonstrate competency active treatment and knowledgoals and objectives as writter individual program plans.	will with and g the otated m All All ns. St 60, stive se be t all y in ge of
W 0196 Bldg. 00		receive a continuous active			
	treatment progran	n, which includes			

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 38 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 00 COMPLETED 15G811 B. WING 04/21/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1306 S BLOOMINGTON STREET **RES-CARE INC** GREENCASTLE. IN 46135 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. Based on observation, record review and W 0196 W196 Each client will receive a 05/21/2021 continuous active treatment interview for 2 of 4 sampled clients (#1 and #3), plus 5 additional clients (#10, #16, #18, #19 and program #20), the facility failed to ensure clients #1, #3, All staff will be in-serviced on the #10, #16, #18, #19 and #20's active treatment policy for active treatment. This programs were consistently and aggressively will include, but is not limited to, implemented. ensuring that all individuals are prompted at least every 15 Findings include: minutes during waking hours to participate in active treatment, to be encouraged A. Observations were conducted in the facility on 4/5/21 from 1:30 pm through 2:45 pm, from All staff will be in-serviced on specifics related to each 4:20 pm through 6:30 pm, on 4/6/21 from 7:30 am through 9:00 am and from 2:30 pm through individuals program plan. 3:00 pm, and on 4/7/21 from 9:15 am through Facility staff (PM, RM or BC) will 11:15 am. Clients #1, #10, #18, and #19 were conduct individual meetings with each client to discuss wants and present in the facility for the duration of the observation period. needs in regard to accessing the community. These will be notated 1. On 4/5/21 at 1:30 pm, client #1 was outside in an IDT meeting and throwing a football. Direct Support Professional incorporated into their program (DSP) #9 was seated in a chair on an outdoor plans. Regular community patio. 6 other clients were sitting in chairs or outings have been re-instated lying on the concrete. At 1:53 pm, client #1 was prior to this correction date. All throwing a football. DSP #9 stated, "I'm warning individuals will participate in you. If a ball hits up here. Just come and sit community outings and also in down." Client #1 continued throwing the workshop or day treatment as warranted in the individual football. At 2:44 pm, client #1 was lying on a

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 39 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/21/2021		
NAME OF I	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	mattress on the floor of his bedroom. There were no sheets on the mattress. Client #1 was playing video games on a television sitting on the floor at the foot of the mattress. On 4/5/21 at 4:48 pm, client #1 went into the kitchen and put on gloves. Client #1 helped prepare the evening meal. Staff answered client #1's questions about how to prepare the different foods. At 5:10 pm, client #1 went to sit in the day room. At 6:01 pm, there was an announcement for all clients to wash their hands. Client #1 went to the table and sat down. Client #1 was served ham, potatoes, and a slice of bread. Client #1 refused broccoli. Staff did not prompt client #1 to serve himself. On 4/6/21 at 7:30 am, client #1 was in his bedroom with the door shut. At 8:58 am, client #1 came out of his room and went into the kitchen. Client #1 got Pop-Tarts and sat at a dining table to eat. Client #1 was wearing the same clothing as the day before. Client #1 was interviewed on 4/6/21 at 2:38 pm and stated, "I've been in bed all day. I got up for breakfast and lunch. Staff didn't ask me to go to life skills. I haven't been sleeping, I've been on [social media] all day. They didn't ask me to take a shower or brush my teeth. I'll probably do that on 2nd shift. I'm not sure when I last changed my clothes. I've been wearing this for a while." Direct Support Professional (DSP) #2 was interviewed on 4/6/21 at 2:56 pm. DSP #2 was not able to identify any of client #1's goals or objectives. Residential Manager (RM) #3 was interviewed on 4/6/21 at 9:15 am and stated, "I was trained on		program plan. All staff will be in-serviced on family style dining. This will include encouraging individual participate in ISP goals as related to meals and actively participate in the meal time process. Individuals who are eligible to begin outside day service are already scheduled, or in the process of doing so. For individuals who are not eligible to go to outside day service, the facility will ensure that no fewer than two life skills class opportunities are scheduled a made available to all individual living in the facility. Facility staff (PM, RM or BC) we conduct individual meetings we each client to discuss wants a needs in regards to accessing community. These will be not in an IDT meeting and incorporated into their program plans. Regular community outings have been re-instated prior to this correction date. Individuals will participate in community outings and also in workshop or day treatment as warranted in the individual program plan. Outings will be scheduled and documented each day by the DSP staff and Residential Managers. These outings wireviewed by the Program Manager to ensure completion and will be recorded on the	gible ne er nd als will with nd the tated m		
	on 4/0/21 at 9:15 am and stated, "I was trained on	1	and will be recorded on the			

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 40 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		04/21/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		He's supposed to shower			monthly and quarterly reviews.		
	1 .	y, and brush his teeth. He'll			Two times per day, for at least		
	_	We have life skills at 9:30			administrators will conduct act		
	am and 3:00 pm, bu	t he doesn't usually go."			treatment observations. Thes		
	G1:	1 4/6/01			observations will be meant to b		
		vas reviewed on 4/6/21 at			active in nature to ensure that		
		l's Individual Support Plan			staff demonstrate competency		
	(ISP) dated 8/31/20 "Needs:	indicated the following:			active treatment and knowledg	•	
	Needs to improve n	aanay ekille			goals and objectives as writter individual program plans.	1 111	
	Needs assistance to				ilidividuai piogram pians.		
	appointments.	schedule and keep					
	Needs supervision.						
	Needs to improve le	eigure skills					
	Needs to improve c						
	Needs to learn respo	_					
	Needs to improve k	-					
	Needs to learn shop						
	_	ommunication skills.					
	Needs to improve so						
	Needs to learn respo						
	Needs to improve so	-					
	Needs to learn to us						
	Needs to learn abou	-					
	Needs to learn to us	se banking facilities.					
	Needs to learn to bu	idget money.					
	Needs to improve se	ocial interaction.					
	Needs to improve so	ocial interaction with peers.					
	Needs to learn appr	opriate interaction with					
	women.						
		ll out main items on an					
	application.						
	Needs to learn to in						
	_	erform a job requiring use of					
	tools or machinery.						
		ive active interest in a hobby.					
	Needs to learn to initiate group activities.						
		iplication and division.					
	_	dding and subtracting skills.					
	Needs to improve h	ow to use tableware					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 41 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	NG		04/21/	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1306 S	BLOOMINGTON STREET		
RES-CAI	RE INC				CASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	IE	DATE
	correctly."						
	at:	1. 1100 1					
		ndicated ISP goals and					
	objectives in the fol	_					
		ministration, oral hygiene,					
		oping skills, community					
		nteraction, physical activity,					
	and cooking.						
	2. On 4/5/21 at 1:30) pm, client #10 was in his					
		oor shut. Client #10					
	remained in his roo	m throughout the observation					
	period ending at 2:4	45 pm on 4/5/21. Staff did					
	not attempt to enga	ge client #10 in activities.					
	On 4/5/21 at 4·20 n	m, client #10 was in his					
		oor shut. At 6:01 pm, there					
		ent for clients to wash their					
		Client #10 came out of his					
		a dining table. Client #10 was					
		es, broccoli, and bread. Staff					
		nt #10 to serve himself.					
		neal, client #10 returned to his					
	_	he door and remained there					
		observation period at 6:30					
	pm.	-					
		m, client #10 was in his					
		oor shut. At 8:13 am, staff					
	1 ^ ^) to take his medication.					
		ring the same jean shorts and					
		ore the previous afternoon and					
	1	m, client #10 was seated at a					
		oatmeal and Pop-Tarts. Client					
	#10 stated, "I'm going back to bed after breakfast.						
	1	e same clothes as yesterday.					
		ake a shower. I slept in my					
	l -	take off my belt or shoes."					
		ent #10 returned to his oor shut. He remained there					
	ocuroom with the d	oor shut. The remained there					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 42 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì í	ILTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15G811	B. WI		<u>00 </u>	04/21/	
NAME OF F	PROVIDER OR SUPPLIER			1306 S I	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135	<u> </u>	
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		observation period at 9:00					
	am.						
	bedroom with the d "I've been sleeping	m, client #10 was in his oor shut. Client #10 stated, all day. I slept through lunch. Tried to wake me up for life as sleeping."					
	-	servation periods, staff did o engage client #10 in any					
	and stated, "I just sl all day. There's not closed. I'm waiting	rviewed on 4/5/21 at 6:28 pm eep and watch TV (television) hing to do with the workshop for that to open, so I can get don't have activities for me					
		ewed on 4/6/21 at 2:56 pm know what goals [client #10] orking on."					
	stated, "[Client #10]	wed on 4/6/21 at 2:24 pm and] doesn't need to be prompted st let's us know when he's He's usually in his					
	3:22 pm. Client #10 indicated the follow "Needs: Needs to improve n	noney skills. to structure time and					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 43 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPLETED	
		15G811	B. WI	NG		04/21/	/2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	L			BLOOMINGTON STREET		
RES-CAF	DE INC						
RES-CAR	RE INC			GREEN	ICASTLE, IN 46135		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Needs supervision.						
	Needs to use approp	oriate tone of voice when					
	speaking.						
	Needs to improve le	eisure skills.					
	Needs to improve co	ooking skills.					
	Needs to learn response	onsibility.					
	Needs to improve k	itchen safety skills.					
	•	asic education skills.					
	Needs to improve v						
	Needs to learn shop	ping skills.					
	_	ommunication skills.					
	Needs to improve so						
	Needs to learn respo						
	Needs to improve so	ocial skills.					
	Needs to learn abou						
	Needs to learn to us	e banking facilities.					
	Needs to learn to bu	-					
	Needs to improve so						
	Needs to learn appro	opriate interaction with					
	women.						
		l out main items on an					
	application.						
	Needs to learn to in						
	_	erform a job requiring use of					
	tools or machinery.						
		ve active interest in a hobby.					
		itiate group activities.					
		iplication and division.					
	Needs to learn oral						
	Needs to learn pede						
		ey management skills.					
	Needs to learn hygic						
	-	dding and subtracting skills.					
	-	in Reporting Abuse Skills.					
	-	in Adaptive Equipment Skills.					
	_	exual responsibility.					
	Needs to improve sa	afe electronic skills."					
	C1:4 #10! IGB ' !	Bankad anala in sha C II					
		licated goals in the following					
	areas:		1				

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 44 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G811	(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 04/21 /	ETED
NAME OF F	PROVIDER OR SUPPLIER			1306 S E	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	Р.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	laundry, bathing, co	ninistration, oral hygiene, ping skills, cooking, ess, and money management.					
	bedroom with the de	pm, client #18 was in his por shut and remained there observation period at 2:45					
	bedroom with the dwas an announceme hands for dinner. Obedroom and sat at served ham, potatoed did not prompt clier. After his evening mbedroom, shut the dthe end of the observon 4/6/21 at 7:39 at	m, client #18 was in his oor shut. At 6:01 pm, there ent for clients to wash their lient #18 came out of his a dining table. Client #18 was es, broccoli, and bread. Staff at #18 to serve himself. eal, client #18 returned to his oor, and remained there until vation period at 6:30 pm. m, client #18 was eating g table. Client #18 was					
	wearing the same you before. At 7:43 am, he had brushed his t Client #18 stated, "I	ellow t-shirt he wore the day DSP #2 asked client #18 if eeth or washed his laundry. Not yet. I want to wait." DSP it now." Client #18 went into					
	· ·	10 was in his bedroom with the end of od at 9:00 am.					
	and stated, "I sleep nothing else to do. planned for us. We library, or outside.	rviewed on 4/6/21 at 7:39 am most of the day. There's Staff don't have anything can go to the gym, the We have to come up with an take us. They don't come up					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 45 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ILTIPLE CO ILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15G811	B. WII			04/21/	
				STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			BLOOMINGTON STREET		
RES-CAI	RE INC			GREEN	CASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	:	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	DSP #2 was intervi	ewed on 4/6/21 at 2:56 pm					
	and stated, "[Client #18] is usually asleep in bed. I don't know what his goals are."						
		ewed on 4/6/21 at 2:24 pm and					
	_] is supposed to brush his very day. He has a laundry					
		d to go on van rides and learn					
	how to get to places	_					
		was reviewed on 4/6/21 at					
	•	8's ISP dated 10/9/20					
	indicated the follow "Needs:	ving:					
	Needs to improve n	nonev skills					
	Needs to initiate ow	-					
	Needs assistance to						
	appointments.	-					
	Needs supervision.						
		priate tone of voice when					
	speaking.	. 1.11					
	Needs to improve to Needs to improve c						
	Needs to limprove c	~					
	Needs to improve k						
	Needs to learn shop	-					
	Needs to improve c	communication skills.					
	Needs to improve s						
	Needs to learn resp						
	Needs to improve s						
	Needs to learn to us	-					
	Needs to learn abou	it welfare facilities. se banking facilities.					
	Needs to learn to be Needs to learn to be	_					
	Needs to improve s						
	_	opriate interaction with					
	women.	-					
	Needs to learn to fi	ll out main items on an					
	application.						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 46 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		04/21/	2021
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R		1	BLOOMINGTON STREET		
RES-CAF	RE INIC				ICASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Needs to learn to in						
	-	erform a job requiring use of					
	tools or machinery.						
		ave active interest in a hobby.					
		nitiate group activities.					
		tiplication and division.					
	-	dding and subtracting skills.					
	Needs to improve h correctly.	now to use table ware					
	соггесну.						
	Client #18's ISD ind	dicated goals in the following					
	areas:	meated goals in the following					
		lministration, oral hygiene,					
		leaning his bedroom, bathing,					
		nizing personal space and					
	reporting abuse and						
	4. On 4/5/21 at 1:30	0 pm, client #19 was running					
		ys and jumping up and down.					
		ng behind client #19,					
	attempting to keep	up with him. At 1:49 pm,					
	client #19 ran towar	rd the kitchen. DSP #13 ran					
	next to client #19 as	nd blocked him from entering					
	the kitchen. At 1:5:	5 pm, client #19 attempted to					
		room. DSP #13 stated, "You					
	-	Ve can't have you drinking					
		continued to hop, walk, and job					
		up home until the end of the					
	observation period	at 2:45 pm.					
	0 4/5/01 : 4.00	1					
		om, client #19 was sitting on a					
		m. Client #19's 1 to 1 staff					
	-	o him. Client #19 sat on the					
		ng meal was served at 6:00					
	pm.						
	On 4/6/21 at 7·30 a	m, client #19 was lying in his					
		be sleeping. At 8:48 am,					
		at a dining table. Client					
		de out and backwards. The tag					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 47 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G811	r í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/21/	ETED
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	client #19 to turn his brought client #19 to cereal with milk and turned parallel to the chewed with his more fell out of his mouth the floor. DSP #2 of turn toward the table closed. DSP #2 bropieces and handed to time. Throughout the speak to client #19 communicate with light finished his breakfa for the watched with the hood under growth the hood under growth finished his breakfa for the finished his breakfa for the watched used to go to the gy. DSP #5 was interviand stated, "[Client verbal, so he can't to mostly just wanders for the finished his breakfa for the watched with the finished his breakfa for the watched with the hood under growth finished his breakfa for the watched with the hood under growth finished his breakfa for the watched with the hood under growth finished his breakfa for the watched with the hood under growth finished his breakfa for the watched with the hood under growth finished his breakfa for the finish	is chin. Staff did not prompt is shirt around. DSP #2 wo single serve containers of id Pop-Tarts. Client #19 was in the table. As client #19 ate, he with open. Cereal and milk in and onto his clothing and lid not prompt client #19 to it in the Pop-Tarts into large them to client #19 one at a she meal, DSP #2 did not for use gestures or signs to him. At 8:55 am, client #19 st and went into his bedroom. If you walked into the day room. It is sweatshirt was backwards this chin. Staff did not for turn his sweatshirt around. If you walked into the day room is sweatshirt was backwards this chin. Staff did not for turn his sweatshirt around. If you walked into the day room is sweatshirt was backwards this chin. Staff did not for turn his sweatshirt around. If you walk is the walk is so you walk is so yideos on his tablet. He is min, but he's lost interest." If you walk is the is nonell us what he likes to do. He is around." If you walk is the is nonell us what he likes to do. He is around." If you walk is the wa					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 48 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED	
		15G811	B. W	ING		04/21/	2021	
				STREET A	DDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER	ę.		1306 S	BLOOMINGTON STREET			
RES-CAF	RE INC				CASTLE, IN 46135			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	_	ked on any sign language with						
		assigned staff, I just try to						
	keep up with where	ever he goes."						
	DCD #12	. 1 4/7/01 + 0.24						
		viewed on 4/7/21 at 9:34 am						
	_	#19] wears briefs. They						
	-	ers for him. They still get what the purpose of those is.						
		inglet, but I wonder if that						
		l. He rips the brief out of his						
		ound with it. He can also take						
	_	uickly. A singlet would stop						
		etimes, I put his jeans on						
		an't get them off as quickly."						
	, , , , , , , , , , , , , , , , , , , ,	8						
	Client #19's record	was reviewed on 4/6/21 at						
	11:48 am. Client #	19's ISP dated 11/13/20						
	indicated the follow	ving:						
	"Needs:							
	Needs to improve n	noney skills.						
	Needs to initiate ow	vn activities.						
	Needs assistance w	hile toileting.						
	Needs assistance to	schedule and keep						
	appointments.							
	Needs supervision.							
		priate tone of voice when						
	speaking.							
	Needs to improve le							
	Needs to improve c	_						
	Needs to learn respo							
	Needs to improve k	-						
	Needs to learn shop							
	Needs to improve c	ommunication skills.						
	Needs to improve so							
	Needs to improve so							
	Needs to learn to us							
	Needs to learn abou	-						
		se banking facilities.						
	Needs to learn to bu							
	1.0000 10 100111 10 01	anger money.						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 49 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811			(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 04/21 /	ETED	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P.	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	women. Needs to learn to fil application. Needs to learn to in Needs to learn to per tools or machinery. Needs to learn to have tools or machinery. Needs to learn to in Needs to learn multing to learn multing tools to improve a needs to improve hearn to in the correctly." Client #19's ISP indicates: Self-medication addressed to improve hear while coping skills, social and reporting abuse. DSP #13 was intervant stated, "It's very some of them. It can and cause a behavior Noise and chaos is can't hear us when we tell the get upset." DSP #1 surgery on one of hear when we tell the get upset." DSP #1 surgery, he's sensiting stays in his room." clients] will sleep in them sleep in pajarn sleeping. Many of shoes. A lot of the the morning, they're clothes from the day in the sleep in the sleep in the sleep in the sleep in pajarn sleeping. Many of shoes. A lot of the the morning, they're clothes from the day in the sleep	opriate interaction with I out main items on an itiate tasks. erform a job requiring use of ave active interest in a hobby. itiate group activities. iplication and division. dding and subtracting skills. ow to use table ware ticated goals in the following ministration, dental hygiene, eating, laundry, bathing, interaction, sign language						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 50 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	ULTIPLE CO JILDING	00	COMPL		
		15G811	B. W	ING		04/21/	2021
NAME OF I	PROVIDER OR SUPPLIEF	t	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE		
RES-CAI	RE INC				BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	do."	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	do.						
		nterviewed on 4/7/21 at 10:00					
		s loud in here. When it gets					
	_	20] freaks out. He flips the ocus on doing things with all					
	1	can't hear what's going on.					
		only one who goes outside or					
		They don't have activities for					
	anyone else. They	all just sleep all day. It's not					
		t them help me, so they have					
	_	prompt some of them to eat					
		port staff don't do it. It's					
		er in here with the surveyors					
	than it usually is."	ere conducted at the facility on					
		M to 3:08 PM, 4/5/21 from					
		л, 4/6/21 from 7:25 AM to					
		om 10:23 AM to 12:05 PM,					
	i i	M to 3:00 PM, and 4/7/21					
	from 9:18 AM to 10	0:26 AM. During the					
	observations, the fo	llowing issues were noted:					
	1) On 4/5/21 from	1:27 PM to 3:08 PM, client					
		in the living room. Client #3					
		o engage in formal or					
		tment activities. Client #3					
	1	prompted to engage in					
		ff working in the facility.					
		ound a cookbook and ed in discussion with the					
		g his book. Client #3 went in					
		oom without an activity to					
	engage in.	, w					
	O., 4/5/21 C 4.2	O DM 4- C-22 DM 1' 4/2					
		0 PM to 6:32 PM, client #3 the living room. Client #3					
		o engage in formal or					
		tment activities. Client #3					
		prompted to engage in					
		· - 					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 51 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì í	ULTIPLE CO UILDING	00	(X3) DATE COMPL		
		15G811	B. W	ING		04/21/	2021
NAME OF I	PROVIDER OR SUPPLIER		•	1	ADDRESS, CITY, STATE, ZIP CODE		
RES-CAI	RE INC				BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	(X5) COMPLETION DATE
TAG	activities by the state Client #3 carried are occasionally engage surveyors regarding and out of his bedreengage in. On 4/6/21 from 7:22 was hanging out in was not prompted to informal active treat was not offered or pactivities by the state Client #3 carried are occasionally engage surveyors regarding and out of his bedreengage in. On 4/6/21 from 10:: #3 was hanging out was not prompted to informal active treat was not offered or pactivities by the state was not offered or pactivities by the state occasionally engage in.	or of working in the facility. The working in the facility.		TAG	DEFICIENCY		DATE
	Client #3 carried are occasionally engage surveyors regarding and out of his bedre engage in. On 4/6/21 from 2:15 sat on the front pore prompted to engage treatment activities. or prompted to engage working in the facil a cookbook and occ discussion with the	bound a cookbook and and in discussion with the set his book. Client #3 went in from without an activity to as PM to 3:00 PM, client #3 when the client #3 was not in formal or informal active. Client #3 was not offered age in activities by the staff ity. Client #3 carried around assionally engaged in surveyors regarding his book. Indicate the cook is a cook of the					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 52 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			l í	ULTIPLE CO. JILDING	NSTRUCTION 00	COMPL	
THAD TEXAL	or condition.	15G811	B. W		00	04/21/	
		100011		CTDEET A	ADDRESS, CITY, STATE, ZIP CODE	0 1/2 1/	2021
NAME OF I	PROVIDER OR SUPPLIER	₹		1	BLOOMINGTON STREET		
RES-CAI	RE INC				CASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	an activity to engag	ge in.					
	0 4/7/21 0 0 1	0 AM					
		8 AM to 10:26 AM, client in the living room. Client #3					
		o engage in formal or					
		tment activities. Client #3					
		prompted to engage in					
		ff working in the facility.					
	· ·	ound a cookbook and					
	occasionally engage	ed in discussion with the					
	surveyors regarding	g his book. Client #3 went in					
	and out of his bedro	oom without an activity to					
	engage in.						
	On 4/6/21 at 3:37 P	M, a review of client #3's					
		ed. Client #3's 12/18/20					
		Plan (ISP) indicated client #3					
	had the following n						
	Needs to improve n						
	Needs to initiate ow	vn activities.					
	Needs assistance to	schedule and keep					
	appointments.						
		priate tone of voice when					
	speaking.						
	Needs to improve le						
	Needs to improve c	_					
	Needs to learn response						
	Needs to improve k Needs to learn shop	•					
		ommunication skills.					
	Needs to improve s						
	Needs to learn response						
	Needs to improve s	-					
	Needs to learn to us						
	Needs to learn abou	-					
	Needs to learn to us	se banking facilities.					
	Needs to learn to bu	ıdget money.					
	Needs to improve s	ocial interaction.					
	Needs to learn appr	opriate interaction with					
	women.						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 53 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811			, ,	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/21/	ETED		
NAME OF F	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	application. Needs to learn to in Needs to learn to per tools or machinery. Needs to learn to have tools or machinery. Needs to learn to have to learn multiple to learn multi	erform a job requiring use of ave active interest in a hobby. itiate group activities. iplication and division. dding and subtracting skills. ow to use table ware dis formal goals included cup, naming two of his choice with the nurse, doing cheduled day, making change cheduled da							

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 54 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ì í	ULTIPLE CO. JILDING	NSTRUCTION 00	COMPL	
ANDILAN	or condition	15G811	B. W		00	04/21/	
		100011			PRESIDENCE COMMUNICATION OF THE COMMUNICATION OF TH	04/21/	2021
NAME OF I	PROVIDER OR SUPPLIER	8			DDRESS, CITY, STATE, ZIP CODE		
RES-CAI	RE INC				BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		I to prompted to engage in					
	activities by the star	ff working in the facility.					
		0 PM to 6:32 PM, client #20					
		ring the observation. Client					
		ted to engage in formal or					
		tment activities. Client #20 prompted to engage in					
	_	ff working in the facility.					
	activities by the sta	if working in the facility.					
	On 4/6/21 from 7:2	5 AM to 9:07 AM, client					
	#20 was in his roon	n during the observation.					
		prompted to engage in formal					
		reatment activities. Client					
		I to prompted to engage in					
	activities by the star	ff working in the facility.					
	On 4/6/21 from 10:	23 AM to 12:05 PM, client					
		appointment. He returned to					
	the facility at 11:12	AM. He went straight to his					
		stated, "that's a plus" meaning					
		ngage in physical aggression					
		s room. Client #20 was not					
	1	e in formal or informal active Client #20 was not offered					
		age in activities by the staff					
	working in the facil	-					
		8 PM to 3:00 PM, client #20					
		ring the observation. Client					
		ted to engage in formal or tment activities. Client #20					
		tment activities. Client #20 prompted to engage in					
	_	ff working in the facility.					
	activities by the sta						
	On 4/7/21 from 9:1	8 AM to 10:26 AM, client					
	#20 was in his roon	n during the observation.					
		prompted to engage in formal					
		reatment activities. Client					
	#20 was not offered	I to prompted to engage in					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 55 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		` ′	JILDING	nstruction 00	(X3) DATE : COMPL 04/21 /	ETED			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135						
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	During the observat was in his bedroom in. Client #20 did n computer, phone, be anything else to occexited his room his medications. He imbedroom after eatin medications. Client treatment. Client #2 treatment activities #20's peers moved a entered the common 2:48 PM, client #20 a snack. Client #20 peers. On 4/7/21 at 10:36 client #20's record with 1/19/21 ISP indicates referred to the ICF (due to the on-going self-regulation skills and independent lives capable of ambulating assistance. [Client point at the things the mixed success with communication. He place so that he can will happen during anticipate will help routine He works consistent routine as	mediately returned to his g or receiving his #20 did not engage in active 20 was not offered active to participate in. Client away from him when he a area to eat. At 4/6/21 at went to the dining room for sat at a table away from his AM, a focused review of vas conducted. Client #20's ed, "[Client #20] has been intermediate care facility) need for training in areas of s, coping skills, social skills, ing skills. [Client #20] is ng on his on without #20] is non-verbal, but can hat he is interested in. He has the use of pictures for e relies on schedules to be in have expectations as to what the day. Knowing what to him cope and adjust to the best when he has a had benefits from a structured he ISP indicated client #20 had is noney skills.							

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 56 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO UILDING	00	(X3) DATE COMPL				
		15G811	B. W	ING		04/21/	/2021		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE				
NAME OF F	NAME OF PROVIDER OR SUPPLIER			1306 S BLOOMINGTON STREET					
RES-CAF	RE INC			GREEN	ICASTLE, IN 46135				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE		
	Needs assistance to appointments.	schedule and keep							
	Needs supervision.								
	•	priate tone of voice when							
	speaking.								
	Needs to improve le	eisure skills.							
	Needs to improve c								
	Needs to learn respo	onsibility.							
	Needs to improve k	itchen safety skills.							
	Needs to learn shop								
	_	ommunication skills.							
	Needs to improve so								
	Needs to learn response	•							
	Needs to improve so								
	Needs to learn to us	-							
	Needs to learn abou								
		se banking facilities.							
	Needs to learn to but Needs to improve so	- ·							
	_	opriate interaction with							
	women.	opriate interaction with							
		ll out main items on an							
	application.								
	Needs to learn to in	itiate tasks.							
	Needs to learn to pe	erform a job requiring use of							
	tools or machinery.								
	Needs to learn to ha	ave active interest in a hobby.							
		itiate group activities.							
		ciplication and division.							
	-	dding and subtracting skills.							
	-	ow to use table ware							
	correctly.								
	The ISP indicated h	is formal goals included							
		ons, brushing his teeth in an							
	_	n, doing his laundry on his							
	-	ing daily, and demonstrating							
		ite ways to cope with anxiety							
	and/or stress.								
							l		

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 57 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/21/	ETED			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	indicated he should prompted to engage during the observation skills road trip, mean lunch, life skills act recreation activity, physical preparation for dimerecreation time. On 4/6/21 at 7:41 And surveyor, "you need client #20 entered the breakfast. Client #8 said was true. Staff On 4/6/21 at 2:30 P #20 was in his bedre client #20 would consider the state of the st	And the state of t							

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 58 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811			(X2) MULTIP A. BUILDIN B. WING		00	(X3) DATE COMPL 04/21/	ETED		
NAME OF P	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	she was not sure if engage him in activ								
	On 4/6/21 at 3:47 PM, staff #9 indicated client #20 did not have a plan to get him out of his room. Staff #9 stated it "worries me having him around you (surveyors) He needs to come								
	out I'm guilty of not taking the chance of him hurting someone." Staff #9 indicated he did not prompt client #9 to engage in activities with his peers due to his physical aggression. Staff #9								
	stated, "As a DSP (direct support professional), I'm struggling. Worried about his physical aggression." Staff #9 stated client #11 was "petrified" of client #20. Staff #9 stated client								
	hurt me, are you?" and #8 moved away	"You aren't going to let him Staff #9 indicated clients #4 7 from client #20 when he was ated client #5 was "scared of							
	injuries from client	cated there had been no major #20's aggression. Staff #9 client #20's aggression was							
	(RM) #2 stated he "interacting" with of	M, Residential Manager tried to get him (client #20) hers. Client #20 was prone to							
	common areas. RM behavior with loud	re were loud noises in the 1 #2 stated, "More prone to noises. Overactive sissues." RM #2 stated client							
	RM #2 indicated he had a goal for him t	much time in common areas." was not sure if client #20 o engage in activities out of ndicated he was not aware of overs fear of him.							
	On 4/6/21 at 5:27 P	M, staff #14 indicated client DVD player he listened to in							

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 59 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/21/	ETED			
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135						
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO		(X5) COMPLETION DATE		
	his room. Staff #14 broke about 2 week to do right now. Lie out He tends to b afraid of him." Staff nothing in his room Staff #14 indicated had a goal to join go indicated she was n included. On 4/7/21 at 10:42 (BC) stated client # for meals and snac ks." The BC staff the facility were #20, causing him chairs and become toward others. To client #20 exited a meal or snack a nurse's station fo BC indicated clien maladaptive behaviors seeme however there w did not seem to b indicated client # antecedents to al BC stated client away when he er unpredictable." engagement in ac was "very limited client #20 recent	es tated since the DVD player is ago, client #20 "had nothing es in bed. He doesn't come e violent There are clients if #14 stated client #20 "has in a bed, chair and bookcase." She was not sure if client #20 roup activities. Staff #14 of sure what his goals AM, the Behavior Consultant 20 "only leaves (his) room areas at "too noisy" for client in to flip tables, throw the physically aggressive in the BC indicated when this room, he went to eat and then straight to the in the medications. The cent #20 exhibited aviors during transitions. In the ent #20 exhibited are other times when it the noise related. The BC #20 did not exhibit the flip his behaviors. The #20's peers "will move							

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 60 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	IULTIPLE CO UILDING	00	(X3) DATE COMPL			
		15G811	B. W			04/21		
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIER		1306 S BLOOMINGTON STREET					
RES-CAI	RE INC				CASTLE, IN 46135			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
		his room Nothing in his						
		o do."On 4/7/21 at 1:38						
		Manager (PM) indicated						
	the former Quali							
		essional (QIDP) led a						
		2-15 clients daily. The						
		cility was "at half of the						
		taff are burned out. Not						
		ne." The PM indicated						
		not going out. The PM						
		"no joy left for the						
		e lack of community						
		stated a "big motivator						
		to the community." The						
		Life Skills groups were						
		cted however there were						
		ending the groups. The						
		taff should be engaging						
		PM stated the "lack of						
		was "due to the lack of						
	`	I indicated there was no						
		s could not take van rides.						
		ne "clients should be going						
	_	ood."C. Observations at the facility on 4/5/21						
		3:08 PM, from 4:20 PM						
		21 from 10:24 AM to						
		2:15 PM to 3:02 PM and						
		7 AM to 11:20 AM.						
		vations, the following						
	_	d:1) On 4/5/21 from						
		PM, client #16 remained						
		as lying in his bed.						
		ot prompted to engage in						
		al active treatment						
	101111ai 01 IIII0IIII	ar active treatment						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 61 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ	IULTIPLE CO UILDING	00	COMPI		
		15G811	B. W			04/21	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	BLOOMINGTON STREET		
RES-CAI	RE INC				CASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E RIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		t #16 was not offered or					
	1	age in activities by the					
	_	the facility. Client #16					
	1	m in his bed with his					
		ient #16 stayed in his					
		vithout an activity other					
		on to engage in. On 4/6/21					
		to 12:04 PM, client #16 snack at 10:37 AM and					
	_	oom. Client #16 was not					
	offered or prompted to engage in activities by the staff working in the facility. At						
	10:49 AM, client #16 asked staff #13 for						
	toothpaste. Staff #13 stated to client #16						
		him once someone else					
		day room". Client #16					
		oom until 10:56 AM. At					
		t #16 stepped into the					
		room and indicated					
		ck inside his room. Client					
		3's rooms were adjacent					
		Client #16 used his					
		ced client #8's bedroom					
	door open. Clien	t #16 stood in the					
	_	ke with client #8, as					
	client #8 thanked	l client #16 for opening					
	his bedroom doo	r. Client #16 then					
	returned and stay	ved in his room without an					
	activity other tha	n his television to engage					
	in.On 4/6/21 from	m 2:15 PM to 3:02 PM,					
	client #16 was no	ot prompted to engage in					
	formal or inform	al active treatment					
	activities. Client	t#16 was not offered or					
	prompted to enga	age in activities by the					
	staff working in	the facility. Client #16					
	•						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 62 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		r í	UILDING	nstruction <u>00</u>	(X3) DATE : COMPL 04/21/	ETED		
NAME OF I	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
RES-CAI (X4) ID PREFIX TAG	summary s (EACH DEFICIEN REGULATORY OR stayed in his roo television on. At asked about clier stated, "do laund Staff #9 indicate verbal prompting completion of hi Staff #9 stated, " or less". Staff #9 client #16 include	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) m, in his bed with his 2:22 PM, staff #9 was at #16's goals. Staff #9 ry, plugs for his ears". d client #16 required g as staff support for s goal and objectives. brushing his teeth with 2 stated other goals for ed "set the table twice a to clean. He wants to		GREEN ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	clean up afterwa party. They (clie (physical aggress destruction), if they can't eat with was asked if clie his room or the form out (resident trusted to go outs PM, client #16 croom. Client #16 to do. Client #16 phone trying to ce television. Staffer room and asked snack. Client #16 with the stated, "It's my form of the stated, "It's my form of the stated," It's my form of the stated, "It's my form of the stated," It's my form of the stated, "It's my form of the stated," It's my form of the stated, "It's my form of the stated," It's my form of the stated, "It's my form of the stated," It's my form of the stated, "It's my form of the stated," It's my form of the stated, "It's my form of the stated," It's my form of the stated, "It's my form of the stated," It's my form of the stated, "It's my form of the stated," It's my form of the stated what It's my form of the stated when the s	rds and earn his pizza nt #16) can't do PA sion) or PD (property ney do anything like that h the group". Staff #9 nt #16 would ever leave facility. Staff #9 stated, noes out. We have to let sial facility), but he can be side on his own". At 2:47 continued to remain in his was asked what he liked indicated he was on his connect the Internet to his #5 entered client #16's if he wanted to eat a 6 declined to eat and staff Client #16 was asked if the facility. Client #16 avorite place I've been ated his time spent at was "rough". Client #16 ne enjoyed doing. Client ching movies and this						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 63 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO UILDING	00	COMPL		
		15G811	B. W	ING		04/21/	/2021
NAME OF I	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE	1	
		•			BLOOMINGTON STREET		
RES-CAI	T			<u> </u>	ICASTLE, IN 46135		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	show about fire	engines". Client #16					
	stated he had a w	veekly shot of "Haldol					
	(treat psychotic of	disorders) every					
	Thursday" and in	ndicated the shots made					
	him tired. Client	#16 was asked if he ever					
	_	t #16 stated, "I got					
		#16 was asked if he went					
		nity or worked. Client #16					
		ed to start a job in the					
	· · ·	mom said don't start any					
	fights and I can get out of here. I'm on the						
	waiting list to get out of here". Client #16 indicated he spent time in his room to						
	avoid conflict wi						
		opportunity for moving.					
	· ·	f#13 was seated in a					
	_	ne day room. Staff #13					
		client #16. Staff #13					
		staying in his room" and					
		#16 does not like loud					
		stated, "He stays away					
	_	nd situations he (client					
		lp us (staff) if someone is					
		His shots make him tired. g time in his room					
		g time in ins room levision)". On 4/7/21					
		to 11:20 AM, client #16					
		in his bed. Client #16					
		d to engage in formal or					
		reatment activities.					
		not offered or prompted to					
		ies by the staff working in					
		ent #16 stayed in his room					
		ty to engage in.On 4/6/21					
		view of client #16's					
	<u> </u>						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 64 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15G811	B. W	ING		04/21/2021	
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					BLOOMINGTON STREET		
RES-CAI	RE INC			GREEN	CASTLE, IN 46135		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CV MUST BE PRECEDED BY ELLI I		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
		ucted. Client #16's					
		ort Plan (ISP) dated					
	4/1/21 indicated	` /					
	needs:"Needs to	improve money					
	skills.Needs to in	nitiate own					
	activities.Needs	assistance to schedule					
	and keep appoint	tments.Needs to use					
	appropriate tone	of voice when					
		to improve leisure					
	skills.Needs to in	-					
	skills.Needs to learn responsibility.						
	Needs to improve kitchen safety						
	skills.Needs to learn shopping						
		nprove communication					
		nprove socialization					
		earn responsibility.Needs					
	_	l skills.Needs to learn to					
	_	es.Needs to learn about					
		.Needs to learn to use					
	_	s.Needs to learn to budget					
	money.Needs to	-					
		s to learn appropriate					
		women.Needs to learn to					
	fill out main iten						
		ls to learn to initiate					
		earn to perform a job					
		tools or machinery.Needs					
		learn to initiate group					
	_	to learn multiplication					
		eds to improve adding and					
		s.Needs to improve how					
	_	correctly". The ISP					
	indicated client #	2					
	Objectives" as:"5	•					
	Cojectives as. I	Jon Michiganion					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 65 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì	ULTIPLE CO UILDING	00	(X3) DATE COMPL		
THIS TEXT	or conduction	15G811	B. W		00	04/21/	
		100011		CTREET	DDDECC OFFI CTATE ZID CODE	0 1/2 1/	2021
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET		
RES-CAI	RE INC				ICASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	SkillsOral Hygie						
	_	estic SkillsHygiene					
		RegulationSocial					
		lsAdaptive Equipment					
		's choice".Client #16's					
		schedule dated 10/27/20					
	indicated the foll	•					
		ay and Sunday: 6:00 am -					
	sleep, 7:00 am -	sleep, 8:00 am - AM					
	hygiene and brea	ıkfast, 9:00 am - clean up					
	and church (Sunday), 9:00 am - clean up						
	and schedule review (Saturday), 10:00 am						
	- life skills road trip, 11:00 am - leisure						
	time, 12:00 pm - lunch and meds						
	(medications), 1:	00 pm - clean up and					
	leisure time, 2:00) pm - community					
	integration, 3:00	pm - community					
	integration, 4:00	pm - physical life skill					
	activity, 5:00 pm	- meal prep					
	(preparation) and	l dinner, 6:00 pm - clean					
	up and goals, 7:0	0 pm - recreation time,					
	8:00 pm - evenin	g meds, 9:00 pm - pm					
	hygiene and leisu	are time, 10:00 pm - quiet					
	time and sleep, 1	1:00 pm - sleep.Monday,					
	Tuesday, Wedne	sday, Thursday, and					
	Friday - 6:00 am	- sleep, 7:00 am - sleep,					
	8:00 am - am hy	giene and breakfast, 9:00					
	am - room clean	up, 10:00 am - life skills					
	road trip, 11:00 a	nm - leisure time Meal					
	Prep, 12:00 pm -	lunch meds and clean up,					
	1:00 pm - life sk	ill activity on campus,					
	_	tion activity, 3:00 pm -					
	_	r, rec (recreation) room,					
	_	al life skill activity, 5:00					
		nd dinner, 6:00 pm -					
	I	*					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 66 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BUILDING B. WING	00	COMPLETED 04/21/2021	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE		
RES-CAF	RE INC			BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE	
W 0227 Bldg. 00	time, 8:00 pm - e pm hygiene and la quiet time and sle sleep". On 4/7/21 Manager (PM) windicated the clie (community outing should be engaging indicated a lack of the a result of a la Intellectual Disable (QIDP's) involved the 2 previous Qla from the facility. was no reason the van rides. The Physhold be going of 483.440(c)(4) INDIVIDUAL PRO The individual programmer objectives client's needs, as incomprehensive as paragraph (c)(3) on Based on observation failed to ensure clienthe time he spends of the time he spends of th	at 1:30 PM, the Program ras interviewed. The PM rus were not going out rugs). The PM stated, "staff rug the clients." The PM of active treatment could ruck of Qualified rollities Professionals ruent. The PM indicated rup's recently departed The PM indicated there rule clients could not take rule their food." GRAM PLAN rugram plan states the rucessary to meet the rucessary to meet the dentified by the rule sessment required by rung this section. rung, interview and record rung client (#20), the facility rung the program of the program rung the	W 0227	All staff will be in-serviced on specifics related to each individuals program plan. All staff will be in-serviced on to policy for active treatment. The will include, but is not limited to ensuring that all individuals are prompted at least every 15 minutes during waking hours to participate in active treatment, be encouraged to participate in formal and informal opportunities.	nis o, e o to n all	021

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 67 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

RES-CARE INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (REENCASTLE, IN 46135 FREETX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC DENTIFYING INFORMATION) From 9:18 AM to 10:26 AM. During the observations, the following issues were noted: On 4/5/21 from 1:27 PM to 3:08 PM, client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G811		r í	ILDING	onstruction 00	(X3) DATE : COMPL 04/21 /	ETED	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) from 9:18 AM to 10:26 AM. During the observations, the following issues were noted: On 4/5/21 from 1:27 PM to 3:08 PM, client #20 was in his room during the observation. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not adental appointment. He returned to the facility at 11:12 AM. He went straight to his bedroom. Staff #9 stated, "that's a plus" meaning client #20 did not engage in physical aggression prior to going to his room. Client #20 was not prompted to engage in informal active treatment activities. Client #20 was not offered to prompted to engage in informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in activities by the staff working in the facility. On 4/6/21 from 10:23 AM to 12:05 PM, client #20 was not offered to prompted to engage in informal active treatment activities by the staff working in the facility.					1306 S	BLOOMINGTON STREET		
from 9:18 AM to 10:26 AM. During the observations, the following issues were noted: On 4/5/21 from 1:27 PM to 3:08 PM, client #20 was in his room during the observation. Client #20 was not prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in activities by the staff working in the facility. On 4/5/21 from 4:20 PM to 6:32 PM, client #20 was not prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in activities by the staff working in the facility. On 4/6/21 from 7:25 AM to 9:07 AM, client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in physical aggression prior to going to his room. Client #20 was not prompted to engage in formal active treatment activities. Client #20 was not prompted to engage in formal active treatment activities. Client #20 was not offered to prompted to engage in activities oby the staff working in the facility. On 4/6/21 from 10:23 AM to 12:05 PM, client #20 was not offered to prompted to engage in physical aggression prior to going to his room. Client #20 was not offered to prompted to engage in activities by the staff working to first #20 was not offered to prompted to engage in formal active treatment activities. Client #20 was not offered to prompted to engage in offer	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
On 4/6/21 from 2:18 PM to 3:00 PM, client #20 was in his room during the observation. Client #20 was not prompted to engage in formal or informal active treatment activities. Client #20 was not offered to prompted to engage in		regulatory or from 9:18 AM to 10 observations, the for On 4/5/21 from 1:2 was in his room dur #20 was not prompt informal active trea was not offered to prove activities by the state on 4/5/21 from 4:20 was in his room dur #20 was not prompt informal active trea was not offered to prove activities by the state on 4/6/21 from 7:2 #20 was in his room Client #20 was not or informal active to reactivities by the state on 4/6/21 from 10:1 #20 was not offered activities by the state on 4/6/21 from 10:1 #20 was on a dental the facility at 11:12 bedroom. Staff #9 client #20 did not en prior to going to his prompted to engage treatment activities. To prompted to engage treatment activities. To prompted to engage working in the facility was not prompted in formal active treatment active treatment activities.	Discount of the state of the st			for active treatment. In regard specifically to client: — the IDT will meet to discuss proactive ways in which to acclimate him to his environm and encourage him to spend I time in his room. Since the survey some additions have be made to better support client number 20 including adding necancelling headphones, allowing him alternative times for med and dining and has met with the psychiatrist to adjust some medications. Two times per day, for at least administrators will conduct act treatment observations. The observations will be meant to active in nature to ensure that staff demonstrate competency active treatment and knowledge goals and objectives as written.	#20 ent ess een oise ng pass ne t 60, tive se all v in ge of	

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 68 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		l í	JILDING	onstruction 00	(X3) DATE COMPL 04/21 /	ETED	
NAME OF	PROVIDER OR SUPPLIER			1306 S	NDDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	activities by the state On 4/7/21 from 9:1 #20 was in his room Client #20 was not or informal active to #20 was not offered activities by the state During the observation was in his bedroom in. Client #20 did recomputer, phone, be anything else to occevated his room his medications. He imbedroom after eatin medications. Client treatment. Client #treatment activities #20's peers moved a entered the common 2:48 PM, client #20 a snack. Client #20 a snack. Client #20 peers. On 4/7/21 at 10:36 client #20 referred to the ICF due to the on-going self-regulation skill and independent live capable of ambulation assistance. [Client point at the things to mixed success with communication. He place so that he can	ff working in the facility. 8 AM to 10:26 AM, client and during the observation. prompted to engage in formal reatment activities. Client at the prompted to engage in ff working in the facility. The facility of the faci					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 69 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BUILDING 00 B. WING			COMPLETED 04/21/2021	
NAME OF P	ROVIDER OR SUPPLIER		130	06 S BL	RESS, CITY, STATE, ZIP CODE OOMINGTON STREET ASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIENCE REGULATORY OR anticipate will help	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) him cope and adjust to the	ID PREF TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	routine He works consistent routine are environment" The the following needs: Needs to improve meds assistance to appointments. Needs assistance to appointments. Needs to use appropriate speaking. Needs to improve less to improve destended to learn to use Needs to learn to but Needs to learn to but Needs to learn to but Needs to learn to fil application. Needs to learn to fil application. Needs to learn to petools or machinery. Needs to learn to hat Needs to learn to init Needs to learn multiple destended to learn multiple	best when he has a and benefits from a structured at ISP indicated client #20 had attended skills. activities. schedule and keep briate tone of voice when assibility. attended skills. broking facilities. broking facilities. at welfare facilities. broking facilities and broking facilities and broking facilities. broking facilities and broking facilities and broking facilities and broking facilities. broking facilities and brok					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 70 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		, ,	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/21/	ETED	
NAME OF P	ROVIDER OR SUPPLIER		Ī	1306 S	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	The ISP indicated h taking his medication up and down motion scheduled day, bath with staff appropria and/or stress. On 4/6/21 at 2:56 P #20 came to have a him. Staff #5 indicasnacks depended on she was not sure if the engage him in active. On 4/6/21 at 3:47 P #20 did not have a proom. Staff #9 state around you (surveyout I'm guilty of hurting someone." prompt client #9 to peers due to his phystated, "As a DSP (the I'm struggling. Wording aggression." On 4/6/21 at 4:55 P (RM) #2 stated he interacting with other behaviors when the common areas. RM behavior with loud environments cause #20 did not "spend RM #2 indicated he	is formal goals included ons, brushing his teeth in an an, doing his laundry on his ing daily, and demonstrating the ways to cope with anxiety M, staff #5 indicated client snack after she prompted atted his participation in a his mood. Staff #5 indicated client #20 had a plan to be treatment. M, staff #9 indicated client colan to get him out of his ed it "worries me having him fors) He needs to come not taking the chance of him Staff #9 indicated he did not engage in activities with his resical aggression. Staff #9 direct support professional), tried about his physical M, Residential Manager tried to get him (client #20) hers. Client #20 was prone to be were loud noises in the fife stated, "More prone to		IAG	DEFICIENCY		DATE
		M, staff #14 indicated client OVD player he listened to in					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 71 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G811		r í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/21/	ETED		
NAME OF F	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	his room. Staff #14 broke about 2 week to do right now. Liout" Staff #14 st in his room. A bed, #14 indicated she w goal to join group a On 4/7/21 at 10:42 (BC) stated client # for meals and snack common areas at the client #20, causing chairs and become pothers. The BC indicated complete indicated there were to be noise related by times when it did not the BC indicated client #20's phe enters He's so stated as far as engagedient #20 was "very client #20 was "very client #20 recently by room. The BC stated activities in his room. Nothing to do." On indicated she was unclient #20. The BC plan" to address the his bedroom due to On 4/7/21 at 1:38 P (PM) indicated client.	s stated since the DVD player is ago, client #20 "had nothing is in bed. He doesn't come ated client #20 "has nothing is chair and bookcase." Staff it is not sure if client #20 had a ctivities. AM, the Behavior Consultant 20 "only leaves (his) room is." The BC stated the is facility were "too noisy" for him to flip tables, throw only is aggressive toward icated when client #20 exited to eat a meal or snack and then is station for his medications.						
1								

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 72 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	ı	JILDING	00	COMPL	
		15G811	B. Wl	NG		04/21/	/2021
NAME OF P	ROVIDER OR SUPPLIEI	R	STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	T	ID			(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE.	DATE
	· ·	vas "trying to maintain him." nt #20 "needs a goal at some					
W 0249	483.440(d)(1)						
	PROGRAM IMPL	EMENTATION					
Bldg. 00	formulated a client each client must reatment program interventions and number and frequachievement of the individual program. Based on observation interview for 2 of 4 #4) and 6 additional #19 and #20), the formulation in	on, record review and l clients in the sample (#3 and al clients (#5, #15, #16, #17, acility failed to ensure clients 6, #17, #19 and #20's	W	0249	All clients receive continuous active treatment. All staff will be in-serviced on topolicy for active treatment. The will include, but is not limited to ensuring that all individuals are prompted at least every 15	nis o,	05/21/2021
	Findings include:				minutes during waking hours t participate in active treatment, be encouraged		
	observation was co 6:12 PM, the client kitchen and placed	om 4:20 PM to 6:32 AM, an onducted at the facility. At its' food was brought out of the on tables. The food was ing bowls. Staff #7 served			All staff will be in-serviced on specifics related to each individuals program plan. All staff will be in-serviced on		
	clients #3, #4, #5, #	#15, #17 and #20's dinner			family style dining. This will		
	-	occoli and a piece of bread).			include encouraging individual		
		†7 served client #19's dinner.			participate in ISP goals as rela		
		s #3 and #5 were waiting for neir food in order to start			to meals and actively participa	ung	
	eating dinner.	ien 1000 in older to staft			in the meal time process. All staff will be in-serviced on t	he	
	caming annier.				policy for active treatment. The		
	not asked, prompte	#7, #15, #17, and #20 were do or provided the opportunity s from the serving bowls.			will include, but is not limited to ensuring that all individuals are prompted at least every 15 minutes during waking hours t	o, e	

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 73 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G811	` ′	ILDING	onstruction 00	(X3) DATE : COMPL 04/21 /	ETED
NAME OF I	PROVIDER OR SUPPLIER		•	1306 S	NDDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	On 4/7/21 at 1:38 P (PM) indicated the style." The PM stat themselves." 2) On 4/5/21 from #3 was hanging out was not prompted to informal active trea was not offered or pactivities by the stat Client #3 carried are occasionally engage surveyors regarding and out of his bedroengage in. On 4/5/21 from 4:20 was hanging out in was not prompted to informal active trea was not offered or pactivities by the stat Client #3 carried are occasionally engage surveyors regarding and out of his bedroengage in. On 4/6/21 from 7:2: was hanging out in was not prompted to informal active trea was not offered or pactivities by the stat Client #3 carried are occasionally engage surveyors regarding and out of fired or pactivities by the stat Client #3 carried are occasionally engages surveyors regarding surveyors regarding surveyors regarding surveyors regarding	M, the Program Manager meals should be "family ed the clients "should serve 1:27 PM to 3:08 PM, client in the living room. Client #3 or engage in formal or truent activities. Client #3 or ompted to engage in ff working in the facility. Found a cookbook and ed in discussion with the his book. Client #3 went in form without an activity to 10 PM to 6:32 PM, client #3 the living room. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or ompted to engage in ff working in the facility. Found a cookbook and ed in discussion with the his book. Client #3 went in form without an activity to 15 AM to 9:07 AM, client #3 the living room. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities. Client #3 or engage in formal or truent activities.			participate in active treatment, be encouraged to participate in formal and informal opportunition active treatment. Two times per day, for at least days, administrators will conduct active treatment observations. These observations will be ment to be active in nature to ensure that all staff demonstrate competency in active treatment and knowledge of goals and objectives as written in individual program plans including dietar and mealtime goals as well as family style dining. Individuals who are eligible to begin outside day service are already scheduled, or in the process of doing so. For individuals who are not eligito go to outside day service, the facility will ensure that no fewer than two life skills class opportunities are scheduled armade available to all individual living in the facility. Facility staff (PM, RM or BC) we conduct individual meetings with each client to discuss wants and needs in regards to accessing community. These will be not in an IDT meeting and incorporated into their program plans. Regular community outings have been re-instated prior to this correction date. As individuals will participate in community outings and also in workshop or day treatment as	n all ies 60 uct ant e at ual y gible ne er at us will ith and the ated at all ith all	

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 74 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		00	COMPLETED 04/21/2021
NAME OF	PROVIDER OR SUPPLIER RE INC	1306 S BL	DRESS, CITY, STATE, ZIP CODE LOOMINGTON STREET ASTLE, IN 46135	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION RIATE DATE
	On 4/6/21 from 10:23 AM to 12:05 PM, client #3 was hanging out in the living room. Client #3 was not prompted to engage in formal or informal active treatment activities. Client #3 was not offered or prompted to engage in activities by the staff working in the facility. Client #3 carried around a cookbook and occasionally engaged in discussion with the surveyors regarding his book. Client #3 went in and out of his bedroom without an activity to engage in. On 4/6/21 from 2:18 PM to 3:00 PM, client #3 sat on the front porch. Client #3 was not prompted to engage in formal or informal active treatment activities. Client #3 was not offered or prompted to engage in activities by the staff working in the facility. Client #3 carried around a cookbook and occasionally engaged in discussion with the surveyors regarding his book. Client #3 went in and out of his bedroom without an activity to engage in. On 4/7/21 from 9:18 AM to 10:26 AM, client #3 was hanging out in the living room. Client #3 was not prompted to engage in formal or informal active treatment activities. Client #3 was not offered or prompted to engage in activities by the staff working in the facility. Client #3 carried around a cookbook and occasionally engaged in discussion with the surveyors regarding his book. Client #3 went in and out of his bedroom without an activity to engage in. During the observations at the facility, client #3's goal and training objectives were not implemented.	PC dd E M re M a m Ir — pa a a ti s m n c h a p m A a c s A e w c c P ir p u to a	varranted in the individual program plan. Dutings will be scheduled an allocumented each day by the DSP staff and Residential Managers. These outings we viewed by the Program Manager to ensure completing and will be recorded on the monthly and quarterly reviewed in regard specifically to client the IDT will meet to discuss proactive ways in which to acclimate him to his environ and encourage him to spend and to better support client and the properties of the IDT will meet to discuss proactive ways in which to acclimate him to his environ and encourage him to spend and the properties of the IDT will meet to discuss proactive ways in which to acclimate him to his environ and encourage him to spend and the properties of the p	will be on ws. ht #20 ss ment d less been t noise wing d pass h the fitting n ovided ar clean e curate, on and ately

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	TED
		15G811	B. W	ING		04/21/2	2021
				CTDEET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			BLOOMINGTON STREET		
DEC CAE	DE INC						
RES-CAF	KE INC			GREEN	ICASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re I	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	On 4/6/21 at 3:37 P	M, a review of client #3's			New and complete inventories	of	
	record was conduct	ed. Client #3's 12/18/20			all client belongings, including	but	
	Individual Support	Plan (ISP) indicated client #3			not limited clothing will be		
	had the following n	eeds:			completed by the RM. The RI	М	
	Needs to improve n	noney skills.			will accurately document all		
	Needs to initiate ow				belongings, ensuring that thes	e	
	Needs assistance to				belongings are present, in goo		
	appointments.	•			repair and fitting and appropria		
		oriate tone of voice when			for the individual.		
	speaking.				The Program Manager will rev	iew,	
	Needs to improve le	eisure skills.			monthly, individual inventories		
	Needs to improve c	ooking skills.			ensure that they are present a		
	Needs to learn response	onsibility.			accurate.		
	Needs to improve k	itchen safety skills.			Administrative observations wi	11	
	Needs to learn shop	•			occur at least two times daily f	or	
	-	ommunication skills.			at least 60 days to ensure that		
	Needs to improve so				individuals are dressed in clea		
	Needs to learn respo				and well fitting clothing.		
	Needs to improve so	-					
	Needs to learn to us						
	Needs to learn abou	-					
	Needs to learn to us						
	Needs to learn to bu	_					
	Needs to improve so	ocial interaction.					
		opriate interaction with					
	women.	•					
	Needs to learn to fil	ll out main items on an					
	application.						
	Needs to learn to in	itiate tasks.					
	Needs to learn to pe	erform a job requiring use of					
	tools or machinery.	, ,					
		ave active interest in a hobby.					
		itiate group activities.					
		iplication and division.					
		dding and subtracting skills.					
	_	ow to use table ware					
	correctly.						
	The ISP indicated h	is formal goals included					
		cup, naming two of his					
		•					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 76 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BUILDING 00 B. WING			COMPLETED 04/21/2021	
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET		
RES-CAI	RE INC		GF	REEN	CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	TIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	his laundry on his so up to \$20 with staff, community location demonstrating with cope with anxiety as staff his safety proted daily, wearing his led of 12 hours, using heard wearing his glass. 3) On 4/5/21 from 1/20 was in his room Client #20 was in his room or informal active treated activities by the staff. On 4/5/21 from 4:20 was not prompt informal active treated was not offered to peactivities by the staff. On 4/6/21 from 7:25/4/20 was in his room Client #20 was not prompt informal active treated was not offered to peactivities by the staff. On 4/6/21 from 7:25/4/20 was not prompt or informal active treated was not offered activities by the staff. On 4/6/21 from 10:2/4/20 was on a dental the facility at 11:12 bedroom. Staff #9 section #20 did not exprior to going to his prompted to engage.	staff appropriate ways to nd/or stress, discussing with ocol to prevent falls twice or braces daily for a minimum is sippy cup during meals,					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 77 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF D AND PLAN OF COR		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G811	(X2) MUI A. BUI B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 04/21 /	ETED
NAME OF PROVID				1306 S E	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135		
· ·	EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	Р	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
_	ompted to enga ing in the facili	ge in activities by the staff ty.					
was inforwas inforwas activ On 4 #20 v Clier or in #20 v activ	in his room dur was not prompt mal active treat not offered to p ities by the staf /7/21 from 9:18 was in his room at #20 was not p formal active tr was not offered ities by the staf	ing the observation. Client ed to engage in formal or ment activities. Client #20 rompted to engage in ff working in the facility. 3 AM to 10:26 AM, client during the observation. For ompted to engage in formal eatment activities. Client to prompted to engage in ff working in the facility.					
in. Companythexite medial bedra medial treatment treatme	Client #20 did no puter, phone, because d his room his recations. He impoon after eating cations. Client #20 ment. Client #20 ment activities to peers moved a red the common PM, client #20 ck. Client #20 s. 1/7/21 at 10:36 At #20's record with the red to the ICF (to the on-going)	with no activities to engage of have a radio, television, pard games, craft activities or upy his time. Client #20 meals, snacks and mediately returned to his g or receiving his #20 did not engage in active to participate in. Client way from him when he area to eat. At 4/6/21 at went to the dining room for sat at a table away from his AM, a focused review of vas conducted. Client #20's ad, "[Client #20] has been intermediate care facility) need for training in areas of s, coping skills, social skills,					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 78 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	N OF CORRECTION IDENTIFICATION NUMBER: 15G811 A. BUILDING 00 B. WING			COMPLETED 04/21/2021		
NAME OF F	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE		
RES-CAF	RE INC			BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
	and independent livicapable of ambulatinassistance. [Client #point at the things the mixed success with communication. He place so that he can will happen during the anticipate will help froutine He works consistent routine are environment" The the following needs: Needs to improve meds assistance to appointments. Needs supervision. Needs to use appropriate to use appropriate to improve the Needs to learn responsed to learn to use Needs to learn to use Needs to learn to but Needs to learn to but Needs to learn to but Needs to learn appropriate to learn to fill application. Needs to learn to initiate of the needs to learn to initiate of	ing skills. [Client #20] is ing on his on without #20] is non-verbal, but can that he is interested in. He has the use of pictures for the relies on schedules to be in have expectations as to what the day. Knowing what to him cope and adjust to the best when he has a and benefits from a structured the ISP indicated client #20 had the indicated client #20 had the indicated and keep write tone of voice when the safety skills. The properties of the postal services. The postal services. The welfare facilities. The postal services. The welfare facilities of the postal interaction with The out main items on an				

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 79 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G811	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/21/2021
NAME OF F	PROVIDER OR SUPPLIEF		1306 S	ADDRESS, CITY, STATE, ZIP CODE B BLOOMINGTON STREET NCASTLE, IN 46135	3
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
	Needs to learn to in Needs to learn mult Needs to improve a Needs to improve h correctly.	ave active interest in a hobby. itiate group activities. iplication and division. dding and subtracting skills. ow to use table ware			
	up and down motionscheduled day, bath	ons, brushing his teeth in an n, doing his laundry on his ing daily, and demonstrating te ways to cope with anxiety			
	1	tions at the facility, client ing objectives were not			
	#20 was in his bedr client #20 would co She stated client #2 Stays in his room." hit staff #9 after bei	M, staff #2 indicated client oom. Staff #2 indicated ome out when he wanted to. 0 "does not join groups. She stated after client #20 ng asked to take his prompt anymore. Don't want			
	(RM) #3 indicated to client #20 involved.	M, Residential Manager the staff attempted to get RM #3 stated "Staff are rely joins group. Stays in his			
	#20 exited his bedro	#13 stated, "Other than that			
	On 4/6/21 at 2:56 P	M, staff #5 indicated client			

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 80 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE (COMPL		
		15G811	B. W	ING		04/21/	2021
NAME OF P	PROVIDER OR SUPPLIER		•		DDRESS, CITY, STATE, ZIP CODE		
RES-CAF	RE INC				BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION) snack after she prompted		TAG	DEFICIENCY)		DATE
		ated his participation in					
	On 4/6/21 at 3:47 P me having him arou needs to come out (not taking the chance Staff #9 indicated here to engage in activition physical aggression (direct support profession (direct support profession) (direct support profess	M, staff #9 stated it "worries and you (surveyors) He of his room) I'm guilty of the of him hurting someone." He did not prompt client #20 hes with his peers due to his as Staff #9 stated, "As a DSP hessional), I'm struggling. Hysical aggression." M, Residential Manager thried to get him (client #20) hers. Client #20 was prone to the were loud noises in the staff #2 stated, "More prone to					
	On 4/7/21 at 10:42 (BC) stated client # for meals and snack	AM, the Behavior Consultant 20 "only leaves (his) room s." The BC stated the					
	client #20, causing chairs and become pothers. The BC ind	e facility were "too noisy" for him to flip tables, throw ohysically aggressive toward icated when client #20 exited to eat a meal or snack and then					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 81 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BUILDING 00 B. WING		COMPLETED 04/21/2021	
NAME OF I	PROVIDER OR SUPPLIER		1306	T ADDRESS, CITY, STATE, ZIP CODE S BLOOMINGTON STREET ENCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	The BC indicated climaladaptive behavior indicated there were to be noise related himes when it did not the BC stated as far treatment, client #20 indicated client #20 player in his room. "no activities in his Nothing to do." On 4/7/21 at 1:38 Pl (PM) stated "every moment." The PM should be implement anytime. B. Observations were 4/5/21 from 1:29 PM to 6:32 PM, 4/6 12:04 PM, from 2:1 4/7/21 from 10:37 A observations, the following	Is station for his medications. ient #20 exhibited ors during transitions. The BC of times his behaviors seemed cowever there were other of seem to be noise related. It as engagement in active of was "very limited." The BC recently broke his DVD The BC stated client #20 had room Nothing in his room. M, the Program Manager moment is a teachable indicated the clients' goals atted and could be completed indicated the clients' goals atted and could be completed indicated the stated and was long to the stated and was long to the state of the stat				

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 82 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		00	COMPLETED 04/21/2021	
NAME OF I	PROVIDER OR SUPPLIER	1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET NCASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) BE COMPLETION DATE	
	returned to his room. Client #16 was not offered or prompted to engage in activities by the staff working in the facility. At 10:49 AM, client #16 asked staff #13 for toothpaste. Staff #13 stated to client #16 she would assist him once someone else could "watch the day room". Client #16 returned to his room until 10:56 AM. At 10:56 AM, client #16 stepped into the hallway from his room and indicated client #8 was stuck inside his room. Client #16 and client #8's rooms were adjacent to one another. Client #16 used his shoulder and forced client #8's bedroom door open. Client #16 stood in the hallway and spoke with client #8, as client #8 thanked client #16 for opening his bedroom door. Client #16 then returned and stayed in his room without an activity other than his television to engage in. On 4/6/21 from 2:15 PM to 3:02 PM, client #16 was not prompted to engage in formal or informal active treatment activities. Client #16 was not offered or prompted to engage in activities by the staff working in the facility. Client #16 stayed in his room, in his bed with his television on. At 2:22 PM, staff #9 was asked about client #16's goals. Staff #9 stated, "do laundry, plugs for his ears". Staff #9 indicated client #16 required verbal prompting as staff support for completion of his goal and objectives. Staff #9 stated, "brushing his teeth with 2 or less". Staff #9 stated other goals for client #16 included "set the table twice a week" He wants to clean. He wants to clean up afterwards and earn his pizza party. They (client #16 included "set the table twice a week" He wants to clean up afterwards and earn his pizza party. They (client #16) can't do PA (physical aggression) or PD (property destruction), if they do anything like that they can't eat with the group". Staff #9 was asked if client #16 would ever leave his room or the facility. Staff #9 stated, "Sometimes he goes out. We have to let him out (residential facility),				

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 83 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUITABLE A. BUILDING 00 COMPLET				
AND TEAN	or condition.	15G811	B. W		00	04/21/	
		100011		CERTIFIE	DDDESS OF STATE OF SORE	0 1/2 1/	
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET		
RES-CAI	RE INC				CASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ed to go outside on his own".					
		#16 continued to remain in					
		6 was asked what he liked to					
		cated he was on his phone					
		e Internet to his television.					
	Staff #5 entered client #16's room and asked if						
	he wanted to eat a snack. Client #16 declined to						
	eat and staff #5 left his room. Client #16 was						
	asked if he liked living at the facility. Client #16						
	stated, "It's my favorite place I've been at". Client #16 stated his time spent at juvenile school was						
		was asked what he enjoyed					
	_	tated, "watching movies and					
	this show about fire engines". Client #16 stated						
	he had a weekly shot of "Haldol (treat psychotic						
	I	ursday" and indicated the					
		ed. Client #16 was asked if he					
		ent #16 stated, "I got movies".					
		ed if he went into the					
		xed. Client #16 stated, "They					
	tried to start a job in	n the community. My mom					
	said don't start any	fights and I can get out of					
	here. I'm on the wa	iting list to get out of here".					
		d he spent time in his room to					
		others and jeopardizing his					
		ving. At 2:56 PM, staff #13					
		ir watching the day room.					
		d about client #16. Staff #13					
	· ·	nying in his room" and					
		does not like loud noises.					
		le stays away from his peers					
	· ·	lient #16) wants to help us					
		s trying to hurt us. His shots likes spending time in his					
	room watching TV						
	100m watening I v	(television).					
	On 4/7/21 from 10:	37 AM to 11:20 AM, client					
		n in his bed. Client #16 was					
		gage in formal or informal					
		tivities. Client #16 was not					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 84 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ľ í	ULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		15G811	B. W	ING		04/21/	/2021
				STREET A	DDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R			BLOOMINGTON STREET		
RES-CAF	RE INC			GREEN	CASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		I to engage in activities by the facility. Client #16					
	_	without an activity to engage					
	in.						
		M, a review of client #16's					
		ed. Client #16's Individual					
		dated 4/1/21 indicated the					
	following needs: "Needs to improve	money skills					
	Needs to initiate ow	-					
	Needs assistance to schedule and keep						
	appointments.						
	Needs to use appropriate tone of voice when						
	speaking.						
	Needs to improve le						
	Needs to improve c	_					
	Needs to learn response to improve k	-					
	Needs to learn shop	-					
		ommunication skills.					
	Needs to improve s						
	Needs to learn respo	onsibility.					
	Needs to improve s	ocial skills.					
	Needs to learn to us						
	Needs to learn abou						
	Needs to learn to us Needs to learn to bu	se banking facilities.					
	Needs to learn to be Needs to improve s	0 ,					
	_	opriate interaction with					
	women.						
	Needs to learn to fil	ll out main items on an					
	application.						
	Needs to learn to in						
		erform a job requiring use of					
	tools or machinery.	ave active interest in a hobby.					
		itiate group activities.					
		iplication and division.					
		dding and subtracting skills.					
	<u> </u>	<u>-</u>					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 85 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G811		r í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/21/	ETED	
NAME OF P	PROVIDER OR SUPPLIER			1306 S	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135		
				L	O/10122, IIV 40100		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	_	ow to use table ware					
	correctly".						
	The ISP indicated cobjectives" as: "Self-Medication SI Oral Hygiene Skills Meal Preparation Domestic Skills Hygiene Skills Emotional Regulations of the self-self-self-self-self-self-self-self-	on Skills at (ear plugs) client's choice". Treatment schedule dated the following schedule: lay: 6:00 am - sleep, 7:00 am - M hygiene and breakfast, 9:00 hurch (Sunday), 9:00 am - alle review (Saturday), 10:00 trip, 11:00 am - leisure time, and meds (medications), 1:00 eisure time, 2:00 pm - ion, 3:00 pm - community a - physical life skill activity, b (preparation) and dinner, and goals, 7:00 pm - 0 pm - evening meds, 9:00 and leisure time, 10:00 pm -					
		00 pm - clean up and goals,					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 86 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		A. BUILDING B. WING	<u>00</u>	COMPLETED 04/21/2021	
NAME OF P	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE S BLOOMINGTON STREET	
RES-CAF	RE INC			ENCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIENG REGULATORY OR 7:00 pm - recreation	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Litime, 8:00 pm - evening	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	10:00 pm - quiet tim sleep".	hygiene and leisure time, ne and sleep, 11:00 pm -			
	(PM) was interview community outings and stated on "the 60 staff encouragement active treatment acti moment is a teachad done at any time. St clients". The PM incomment is a teachad done at any time. St clients". The PM incomplete the period of the perio	the client active treatment are conducted in the facility pm through 2:45 pm, from 60 pm, on 4/6/21 from 7:30 and from 2:30 pm through			
	3:00 pm, and on 4/7 11:15 am. Clients #	/21 from 9:15 am through :1, #10, #18, and #19 were y for the duration of the			
	throwing a football. (DSP) #9 was seated patio. 6 other client lying on the concret throwing a football.	D pm, client #1 was outside Direct Support Professional d in a chair on an outdoor s were sitting in chairs or e. At 1:53 pm, client #1 was DSP #9 stated, "I'm warning to here. Just come and sit			

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 87 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G811		ľ	UILDING	nstruction 00	(X3) DATE COMPI 04/21	ETED	
NAME OF F	PROVIDER OR SUPPLIER			1306 S	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135		
	SUMMARY S' (EACH DEFICIEN REGULATORY OR down." Client #1 c football. At 2:44 pr mattress on the floo were no sheets on th playing video game floor at the foot of t On 4/5/21 at 4:48 p kitchen and put on g prepare the evening #1's questions about foods. At 5:10 pm, day room. At 6:01 announcement for a Client #1 went to th #1 was served ham, bread. Client #1 ref prompt client #1 to On 4/6/21 at 7:30 at bedroom with the d #1 came out of his r kitchen. Client #1 g	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ontinued throwing the m, client #1 was lying on a r of his bedroom. There ne mattress. Client #1 was s on a television sitting on the he mattress. m, client #1 went into the gloves. Client #1 helped meal. Staff answered client t how to prepare the different client #1 went to sit in the pm, there was an ll clients to wash their hands. e table and sat down. Client potatoes, and a slice of fused broccoli. Staff did not		1306 S	BLOOMINGTON STREET	E	(X5) COMPLETION DATE
	and stated, "I've bee breakfast and lunch life skills. I haven't [social media] all da a shower or brush n on 2nd shift. I'm no clothes. I've been v Direct Support Prof interviewed on 4/6/	riewed on 4/6/21 at 2:38 pm en in bed all day. I got up for Staff didn't ask me to go to been sleeping, I've been on ay. They didn't ask me to take my teeth. I'll probably do that of sure when I last changed my vearing this for a while." Tessional (DSP) #2 was 21 at 2:56 pm. DSP #2 was any of client #1's goals or					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 88 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	PLETED
15G811 B. WING 04/2	
	21/2021
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 1306 S BLOOMINGTON STREET	
RES-CARE INC GREENCASTLE, IN 46135	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
Residential Manager (RM) #3 was interviewed	
on 4/6/21 at 9:15 am and stated, "I was trained on	
[client #1's] goals. He's supposed to shower	
daily, do his laundry, and brush his teeth. He'll	
start working soon. We have life skills at 9:30	
am and 3:00 pm, but he doesn't usually go."	
Client #1's record was reviewed on 4/6/21 at	
10:08 am. Client #1's Individual Support Plan	
(ISP) dated 8/31/20 indicated the following:	
"Needs:	
Needs to improve money skills.	
Needs assistance to schedule and keep	
appointments.	
Needs supervision.	
Needs to improve leisure skills.	
Needs to improve cooking skills.	
Needs to learn responsibility.	
Needs to improve kitchen safety skills.	
Needs to learn shopping skills.	
Needs to improve communication skills.	
Needs to improve socialization skills.	
Needs to learn responsibility.	
Needs to improve social skills.	
Needs to learn to use postal services.	
Needs to learn about welfare facilities.	
Needs to learn to use banking facilities.	
Needs to learn to budget money.	
Needs to improve social interaction.	
Needs to improve social interaction with peers.	
Needs to learn appropriate interaction with	
women.	
Needs to learn to fill out main items on an	
application.	
Needs to learn to initiate tasks.	
Needs to learn to perform a job requiring use of	
tools or machinery.	
Needs to learn to have active interest in a hobby.	
Needs to learn to initiate group activities.	
Needs to learn multiplication and division.	

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 89 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		î ´	ULTIPLE CO. JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15G811	B. W	ING		04/21/	2021
NAME OF F	PROVIDER OR SUPPLIER		<u>. I</u>	1306 S I	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135	<u> </u>	
	SUMMARY S' (EACH DEFICIEN REGULATORY OR Needs to improve a Needs to improve h correctly." Client #1's record ir objectives in the fol Self-medication adr laundry, bathing, co awareness, social in and cooking. 2. On 4/5/21 at 1:30 bedroom with the d remained in his roor period ending at 2:4 not attempt to engage On 4/5/21 at 4:20 p bedroom with the d was an announcement	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) dding and subtracting skills. ow to use tableware ddicated ISP goals and		1306 S I	BLOOMINGTON STREET	πE	(X5) COMPLETION DATE
	bedroom and sat at served ham, potatoe did not prompt clier After his evening m bedroom and shut the until the end of the pm. On 4/6/21 at 7:30 at bedroom with the diprompted client #10 Client #10 was weatie dye t-shirt he we evening. At 8:17 at dining table eating of #10 stated, "I'm goi I'm still wearing the I'll change when I ta	a dining table. Client #10 was a dining table. Client #10 was as, broccoli, and bread. Staff at #10 to serve himself. Leal, client #10 returned to his are door and remained there observation period at 6:30 In, client #10 was in his coor shut. At 8:13 am, staff to to take his medication. Tring the same jean shorts and one the previous afternoon and an, client #10 was seated at a coatmeal and Pop-Tarts. Clienting back to bed after breakfast. Esame clothes as yesterday. Lake a shower. I slept in my take off my belt or shoes."					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 90 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

l é		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	UILDING	00	COMPL	ETED
		15G811	B. W	ING		04/21/	2021
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹		1306 S	BLOOMINGTON STREET		
RES-CAF	RE INC				CASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
		ent #10 returned to his					
	bedroom with the door shut. He remained there						
	until the end of the observation period at 9:00						
	am.						
	On 4/6/21 at 2:41 p	m, client #10 was in his					
	bedroom with the door shut. Client #10 stated,						
	"I've been sleeping	all day. I slept through lunch.					
	I don't know if staff	f tried to wake me up for life					
	skills or lunch. I w	as sleeping."					
	- Throughout the observation periods, staff did not make attempts to engage client #10 in any						
	activities.						
	att						
		rviewed on 4/5/21 at 6:28 pm					
	-	leep and watch TV (television)					
	-	thing to do with the workshop					
		for that to open, so I can get don't have activities for me					
	to do."	don't have activities for the					
	to do.						
	DSP #2 was intervi	ewed on 4/6/21 at 2:56 pm					
		know what goals [client #10]					
	is supposed to be w						
	RM #3 was intervie	ewed on 4/6/21 at 2:24 pm and					
	_] doesn't need to be prompted					
		st let's us know when he's					
	finished something.	. He's usually in his					
	bedroom."						
		was reviewed on 4/6/21 at					
	-	0's ISP dated 12/8/20					
	indicated the follow	ving:					
	"Needs:	1.11					
	Needs to improve n						
		to structure time and					
	activities. Needs to initiate ow	en activities					
	inecus to ilitiate ov	vii activities.					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 91 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		ľ	ILDING	nstruction 00	(X3) DATE : COMPL 04/21 /	ETED		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Needs assistance to	schedule and keep						
	appointments.							
	Needs supervision.	priate tone of voice when						
	speaking.	orrate tone of voice when						
	Needs to improve le	eisure skills.						
	Needs to improve c							
	Needs to learn respo	_						
	Needs to improve k	itchen safety skills.						
	Needs to improve b	asic education skills.						
	Needs to improve v							
	Needs to learn shopping skills.							
	Needs to improve communication skills.							
	Needs to improve socialization skills.							
	Needs to learn respo							
	Needs to improve so Needs to learn about							
	Needs to learn to us							
	Needs to learn to but	_						
	Needs to improve so	-						
	-	opriate interaction with						
	women.							
	Needs to learn to fil	l out main items on an						
	application.							
	Needs to learn to in	itiate tasks.						
	Needs to learn to pe	erform a job requiring use of						
	tools or machinery.							
		we active interest in a hobby.						
		itiate group activities.						
		iplication and division.						
	Needs to learn oral Needs to learn pede	• •						
	_	ey management skills.						
	Needs to learn hygi	· ·						
		dding and subtracting skills.						
	•	in Reporting Abuse Skills.						
	-	in Adaptive Equipment Skills.						
		exual responsibility.						
	Needs to improve sa	afe electronic skills."						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 92 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		(X2) MULTI A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE COMPL 04/21/	ETED	
NAME OF P	ROVIDER OR SUPPLIER	2	13	806 S E	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TA	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
TAG	Client #10's ISP incorrects areas: Self-medication addiaundry, bathing, occommunity awarence 3. On 4/5/21 at 1:30 bedroom with the duntil the end of the pm. On 4/5/21 at 4:20 p bedroom with the dwas an announcement hands for dinner. Obedroom and sat at served ham, potatored did not prompt client After his evening medical bedroom, shut the did the end of the obsertion of the obsertion. On 4/6/21 at 7:39 at Pop-Tarts at a dining wearing the same years before. At 7:43 am he had brushed his client #18 stated, "Let's do his bedroom to get the door shut, where the observation periods." Client #18 was integed and stated, "I sleep nothing else to do. planned for us. We	ministration, oral hygiene, oping skills, cooking, ess, and money management. D pm, client #18 was in his oor shut and remained there observation period at 2:45 m, client #18 was in his oor shut. At 6:01 pm, there ent for clients to wash their client #18 came out of his a dining table. Client #18 was es, broccoli, and bread. Staff and #18 to serve himself. The eal, client #18 returned to his door, and remained there until evation period at 6:30 pm. m, client #18 was eating ag table. Client #18 was ellow t-shirt he wore the day, DSP #2 asked client #18 if teeth or washed his laundry. Not yet. I want to wait." DSP it now." Client #18 went into his laundry. #10 was in his bedroom with the he remained until the end of itod at 9:00 am. rviewed on 4/6/21 at 7:39 am most of the day. There's Staff don't have anything the can go to the gym, the	TA		DEFICIENCY)		DATE
	library, or outside.	We have to come up with an					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 93 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G811			UILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/21/	ETED	
	PROVIDER OR SUPPLIER		•	1306 S	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET		
RES-CAF	RE INC			GREEN	CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
		take us. They don't come up					
	DSP #2 was intervied and stated, "[Client I don't know what he is the continuous state and goal. He rides and learn he places."Client #18 on 4/6/21 at 3:16 dated 10/9/20 incomplete following: "Need money skills. Need activities. Needs and keep appoint supervision. Need of voice when spleisure skills. Needs to improve kitchelearn shopping sl	is supposed to brush his every day. He has a e's supposed to go on van ow to get to 8's record was reviewed pm. Client #18's ISP dicated the seNeeds to improve eds to initiate own assistance to schedule ements. Needs disto use appropriate tone eaking. Needs to improve eds to					
	responsibility.Ne skills.Needs to le services.Needs to facilities.Needs t	eeds to improve social earn to use postal o learn about welfare o learn to use banking					
	money.Needs to interaction.Need	o learn to budget improve social s to learn appropriate women.Needs to learn to					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 94 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ì	ULTIPLE CO UILDING	NSTRUCTION 00	(X3) DATE COMPI		
		15G811	B. W		00	04/21	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				BLOOMINGTON STREET		
RES-CAI	RE INC				CASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	ſ	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	fill out main iten						
		ls to learn to initiate arn to perform a job					
		tools or machinery.Needs					
		active interest in a					
		learn to initiate group					
	_	to learn multiplication					
		eds to improve adding and					
		Needs to improve how					
		correctly.Client #18's					
	ISP indicated goals in the following						
	areas:Self- medication administration,						
	oral hygiene, coo	oking, laundry, cleaning					
	his bedroom, bat	hing, coping skills,					
	recognizing pers	onal space and reporting					
	abuse and negled	et, 4. On 4/5/21 at 1:30					
	pm, client #19 w	as running through the					
		nping up and down. DSP					
	_	behind client #19,					
		ep up with him. At 1:49					
	-	n toward the kitchen.					
		t to client #19 and					
		n entering the kitchen. At					
		19 attempted to go into					
	1	n. DSP #13 stated, "You					
	_	We can't have you					
		Client #19 continued to					
		bb throughout the group nd of the observation					
	-	n.On 4/5/21 at 4:20 pm, tting on a sofa in the day					
		9's 1 to 1 staff was					
		him. Client #19 sat on the					
		ening meal was served at					
		21 at 7:30 am, client #19					
	3.00 piii.01 1/0/.						<u> </u>

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 95 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 15G811			UILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/21	ETED		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
	SUMMARY S' (EACH DEFICIEN REGULATORY OR was lying in his seleping. At 8:4 at a dining table. inside out and bavisible under his prompt client #1 DSP #2 brought serve containers Pop-Tarts. Clier to the table. As a with his mouth of his mouth the floor. DSP # #19 to turn towar with his mouth of Pop-Tarts into lathem to client #1 Throughout the respeak to client # signs to communication.	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Deed and appeared to be 8 am, client #19 sat down Client #19's shirt was tekwards. The tag was chin. Staff did not 9 to turn his shirt around. client #19 two single of cereal with milk and at #19 was turned parallel client #19 ate, he chewed pen. Cereal and milk fell and onto his clothing and 2 did not prompt client red the table or to chew losed. DSP #2 broke rge pieces and handed 9 one at a time. meal, DSP #2 did not 19 or use gestures or nicate with him. At 8:55		1306 S	BLOOMINGTON STREET	3	(X5) COMPLETION DATE	
	went into his bed #19 walked into #19's hooded sw with the hood un prompt client #1' around.DSP #7 v 4/5/21 at 5:04 pm #19] likes to go of watches videos of go to the gym, bu #5 was interview and stated, "[Click is non verbal, so	hished his breakfast and droom. At 9:04 am, client the day room. Client eatshirt was backwards der his chin. Staff did not 9 to turn his sweatshirt was interviewed on an and stated, "[Client on walks outside. He on his tablet. He used to at he's lost interest."DSP red on 4/5/21 at 5:10 pm ent #19] likes walks. He he can't tell us what he mostly just wanders						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 96 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	00	(X3) DATE COMPL			
		15G811	B. W	ING		04/21	/2021	
NAME OF I	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP CODE			
RES-CA		•	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
	1	TATEMENT OF DEFICIENCIES		<u> </u>	10A31EE, IN 40133		(7/5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE	
	around."DSP #1:	5 was interviewed on						
	4/6/21 at 7:55 an	n and stated, "I'm fluent in						
	sign language. V	We're trying to work on						
	sign language wi	ith [client #19]. He can						
	talk, but he choo	ses not to. He won't sit						
	and do activities	. We have to make						
	everything a gan	ne for him. We're mostly						
	trying to get him	to communicate."DSP #3						
	was interviewed	on 4/6/21 at 8:36 am and						
	stated, "I can't th	ink of any goals for						
	-	aven't worked on any sign						
		m. When I'm his assigned						
		keep up with wherever						
		3 was interviewed on						
		n and stated, "[Client						
	_	s. They ordered special						
		They still get wet, so I'm						
		e purpose of those is. He						
		nglet, but I wonder if that						
		cial. He rips the brief out						
		walks around with it. He						
		pants off very quickly. A						
	singlet would sto	•						
		t his jeans on backwards,						
	_	em off as quickly."Client						
		reviewed on 4/6/21 at						
	11:48 am. Clien	t #19's ISP dated						
	_	s:Needs to improve eds to initiate own						
	activities.Needs							
		assistance withe assistance to schedule and						
	keep appointmer							
		ds to use appropriate tone						
	_	peaking.Needs to improve						
	or voice when sp	caking.reeds to improve						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 97 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		î ´	LDING	nstruction <u>00</u>	(X3) DATE : COMPL 04/21/	ETED		
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	leisure skills.Needs to let to improve kitch learn shopping stommunication socialization skill responsibility.Net skills.Needs to leservices.Needs to facilities.Needs to facilities.Needs to interaction.Need interaction.Need interaction with fill out main iten application.Need tasks.Needs to le requiring use of to learn to have a hobby.Needs to activities.Needs and division.Need subtracting skills to use table ware ISP indicated go areas:Self-medic dental hygiene, ulaundry, bathing interaction, sign abuse and neglection interviewed on 4 stated, "It's very some of them. It #20] and cause a sign and cause a skills to use table ware laundry and learn to have a subtracting skills to use table ware ISP indicated go areas:Self-medic dental hygiene, ulaundry, bathing interaction, sign abuse and neglections and neglections are sign and cause a sign and	eds to improve cooking carn responsibility. Needs en safety skills. Needs to skills. Needs to improve skills. Needs to improve disconsisted to improve social carn to use postal to learn about welfare to learn to budget improve social so to learn appropriate women. Needs to learn to initiate arn to perform a job tools or machinery. Needs to improve adding and an earn to initiate group to learn multiplication disto improve adding and an earn to interest in a learn to improve how correctly. "Client #19's als in the following ation administration, using utensils while eating, coping skills, social language and reporting						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 98 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811			UILDING	onstruction 00	(X3) DATE COMPL 04/21/	ETED		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
W 0250 Bldg. 00	good for learning when we prompt when we tell ther They get upset." #16] had surgery fall. Since his su the noise. That's room." DSP #13 clients] will sleep few of them sleep only for sleeping jeans, belts, and when I come to verthey're still wears the day before." bored sitting in he to do. "Custodian 4/7/21 at 10:00 a in here. When it #20] freaks out. can't focus on do noise. They can' [Client #19] is thoutside or gets an have activities for just sleep all day let them help me to do. I prompt so when the support actually a lot qui surveyors than it 483.440(d)(2) PROGRAM IMPLE The facility must desired.	them. They can't hear us them. They can't hear m they're doing well. DSP #13 stated, "[Client on one of his ears in the argery, he's sensitive to why he stays in his stated, "A lot of [the or in their clothing. Very or in pajamas or clothes. Many of them sleep in shoes. A lot of the time, work in the morning, and the same clothes from DSP #13 stated, "I get ere all day with nothing #1 was interviewed on m and stated, "It is loud gets really bad, [client He flips the tables. They ing things with all of the thear what's going on. e only one who goes by exercise. They don't are anyone else. They all anyone else. They all a staff don't do it. It's eter in here with the usually is."						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 99 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	NG		04/21/	/2021
				CERTEE	ADDRESS STEV STATE STRESSE		-
NAME OF I	PROVIDER OR SUPPLIEF	t			ADDRESS, CITY, STATE, ZIP CODE		
					BLOOMINGTON STREET		
RES-CA	RE INC			GREEN	NCASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	1.5	DATE
	treatment progran	n and that is readily					
	available for review by relevant staff.				W250 The facility develops an		
	Based on observation, record review and		W (250			05/21/2021
	interview for 2 of 4	clients in the sample (#1 and			active treatment schedule that		
	#3) and 2 additional clients (#16 and #20), the				outlines the current active		
	facility failed to ensure clients #1, #3, #16 and				treatment program and that is		
	#20's active treatme	ent schedules were			readily available for review by		
	individualized.				relevant staff.		
					Facility PM and QIPD's will be	:	
	Findings include:				in-serviced to ensure that all		
					active treatment schedules are	Э	
	A. Observations we	ere conducted at the facility on			individualized to meet the nee	ds of	
	4/5/21 from 1:27 Pl	M to 3:08 PM, 4/5/21 from			each individual living in the		
	4:20 PM to 6:32 PM	1, 4/6/21 from 7:25 AM to			facility.		
	9:07 AM, 4/6/21 fro	om 10:23 AM to 12:05 PM,			All Active treatment schedules	will	
	4/6/21 from 2:18 Pl	M to 3:00 PM, and 4/7/21			be updated to ensure that they	y are	
	from 9:18 AM to 10	0:26 AM. During the			individualized for the needs, w	ants/	
	observations, the fo	llowing issues were noted:			and schedules of each individ	ual	
					person.		
		rvations at the facility, client			Active treatment schedules wi		
		in the living room. Client #3			reviewed at least, at the quart	-	
		o engage in active treatment			meetings to ensure the sched		
		3 was not offered or			continue to meet the needs of	the	
		e in activities by the staff			individuals.		
	_	ity. Client #3 carried around			Active treatment schedules wi		
		casionally engaged in			posted and available for all sta		
		surveyors regarding his book.			including direct support staff to	b be	
		nd out of his bedroom without			able to access at any time.		
	an activity to engag	ge in.			Two times per day, for at least		
					administrators will conduct act		
		M, a review of client #3's			treatment observations. Thes		
		ed. Client #3's 10/26/20			observations will be meant to		
		nedule indicated he should			active in nature to ensure that		
	have been engaged or prompted to engage in the				staff demonstrate competency		
	following activities during the observations:				active treatment and knowledge		
	room clean up, life skills road trip, meal				goals and objectives as written		
	preparation, clean up from lunch, life skills				individual program plans. The		
	activity at the facility, recreation activity,				observations will include obse	rving	
		creation room activity,			access to active treatment		
	physical life skill a	ctivity, meal preparation for			observations and ensuring that	ıt	

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		, ,	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/21 /	ETED		
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	dinner, clean up fro time.	m dinner, and recreation			staff are aware of their location and understand how to use the			
	#20 was in his bedremeal, snack or receiful #20 was not prompt treatment activities. activities to engage facility. Client #20 activities, crafts, tel	evations at the facility, client com unless he was eating a siving medications. Client sed to engage in active Client #20 was not offered in by the staff working in the is room did not have any evision, radio, computer, books for him to occupy his						
	client #20's record v 1/19/21 active treats should have been er in the following act observations: room meal preparation, cl activity at the facilit library/computer/re- physical life skill ac	AM, a focused review of was conducted. Client #20's ment schedule indicated he ngaged or prompted to engage ivities during the clean up, life skills road trip, ean up from lunch, life skills try, recreation activity, creation room activity, entivity, meal preparation for m dinner, and recreation						
	contained the same	s active treatment schedules information. Client #3's and reatment schedules were not						
		AM, staff #9 indicated the been at the Life Skills group tle.						
	facility was "so sho	AM, staff #13 stated the rt staffed" they "should be ule" but "can't when there isn't						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 101 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO. UILDING	NSTRUCTION 00	(X3) DATE COMPL			
		15G811	B. W	ING		04/21/	2021	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
	<u> </u>	TA TEL CIVIT OF DEPLOYENCIES		<u> </u>			(M2)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	4/5/21 from 1:30 pr 4:20 pm through 6:3 am through 9:00 am 3:00 pm, and on 4/7 11:15 am. Clients # for the duration of t On 4/5/21 at 1:30 pt throwing a football. (DSP) #9 was seate patio. 6 other client lying on the concret throwing a football. you. If a ball hits u down." Client #1 c football. At 2:44 pt mattress on the floot were no sheets on th playing video game floor at the foot of t On 4/5/21 at 4:48 pt kitchen and put on g prepare the evening #1's questions about foods. At 5:10 pm, day room. At 6:01 announcement for at Client #1 went to th #1 was served ham, bread. Client #1 ret prompt client #1 to On 4/6/21 at 7:30 at bedroom with the d #1 came out of his r kitchen. Client #1 g	m, client #1 went into the gloves. Client #1 helped meal. Staff answered client thow to prepare the different client #1 went to sit in the pm, there was an ll clients to wash their hands. e table and sat down. Client potatoes, and a slice of fused broccoli. Staff did not						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 102 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		r í	ULTIPLE CO. UILDING	NSTRUCTION 00	COMPL			
		15G811	B. W	ING		04/21/	2021	
				STREET A	DDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER		1306 S BLOOMINGTON STREET					
RES-CAI	RE INC			GREEN	CASTLE, IN 46135			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY		DATE	
	same clothing as the	e day before.						
	Client #1 was interv	viewed on 4/6/21 at 2:38 pm						
	and stated, "I've bee	en in bed all day. I got up for						
	breakfast and lunch	. Staff didn't ask me to go to						
	life skills. I haven't	been sleeping, I've been on						
		ay. They didn't ask me to take						
		ny teeth. I'll probably do that						
		ot sure when I last changed my						
	clothes. I've been v	vearing this for a while."						
	Residential Manage	er (RM) #3 was interviewed						
	_	n and stated, "I was trained on						
		He's supposed to shower						
		y, and brush his teeth. He'll						
		We have life skills at 9:30						
	_	t he doesn't usually go."						
	G1:	. 1 4/6/01						
	Client #1's record w	vas reviewed on 4/6/21 at						
		eatment schedule dated						
		the following schedule:						
		y: 6:00 am - sleep, 7:00 am -						
	-	giene and breakfast, 9:00 am -						
		(Sunday), 9:00 am - clean up						
	-	v (Saturday), 10:00 am - life						
	skills road trip, 11:0	00 am - leisure time, 12:00						
	pm - lunch and med	ls (medications), 1:00 pm -						
	-	time, 2:00 pm - community						
	-	n - community integration,						
		life skill activity, 5:00 pm -						
		er, 6:00 pm - clean up and						
	-	reation time, 8:00 pm -						
	-	pm - pm hygiene and leisure						
		iet time and sleep, 11:00 pm						
	- sleep.	W 1 1 TH 1 1						
		Wednesday, Thursday, and						
	•	leep, 7:00 am - sleep, 8:00						
		d breakfast, 9:00 am - room - life skills road trip, 11:00						
	cican up, 10:00 am	- me skins road trip, 11:00						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 103 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		1 1	ILDING	nstruction 00	(X3) DATE : COMPL 04/21 /	ETED		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	clean up, 1:00 pm - 2:00 pm - recreation computer, rec (recrephysical life skill act and dinner, 6:00 pm pm - recreation time 9:00 pm - hygiene a quiet time and sleep Client #1's active traindividualized to his C. Observations we 4/5/21 from 1:29 PM to 6:32 PM, 4/6 12:04 PM, from 2:1 4/7/21 from 10:37 A observations, the formula of the following the facilia asked staff #13 for the facilia following the facilia asked staff #13 for the facilia asked staff #13 for the facilia asked staff #13 for the facilia following the facilia asked staff #13 for the facilia following the facilia asked staff #13 for the facilia asked staff #1	2:00 pm - lunch meds and life skill activity on campus, a activity, 3:00 pm - library, eation) room, 4:00 pm - ctivity, 5:00 pm - meal prep a - clean up and goals, 7:00 e, 8:00 pm evening meds, and leisure time, 10:00 pm - e, 11:00 pm - sleep. The conducted at the facility on the spersonal needs and goals. The conducted at the facility on the signal of the signal						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 104 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		15G811	B. W	ING		04/21/	2021
			-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					BLOOMINGTON STREET		
RES-CAF	RF INC				ICASTLE, IN 46135		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY		DATE
		client #8 was stuck inside his					
		d client #8's rooms were					
		ther. Client #16 used his					
		client #8's bedroom door					
	-	ood in the hallway and spoke					
		ient #8 thanked client #16					
		room door. Client #16 then					
		in his room without an is television to engage in.					
	activity other than h	is television to engage in.					
	On 4/6/21 from 2:1:	5 PM to 3:02 PM, client #16					
		o engage in formal or					
		tment activities. Client #16					
		prompted to engage in					
		ff working in the facility.					
	-	his room, in his bed with his					
	-	22 PM, staff #9 was asked					
		oals. Staff #9 stated, "do					
	_	is ears". Staff #9 indicated					
		verbal prompting as staff					
	support for complet						
		stated, "brushing his teeth					
	with 2 or less". Staf	f #9 stated other goals for					
	client #16 included	"set the table twice a week"					
	He wants to clean. I	He wants to clean up					
	afterwards and earn	his pizza party. They (client					
		hysical aggression) or PD					
		n), if they do anything like					
		ith the group". Staff #9 was					
		would ever leave his room or					
	•	stated, "Sometimes he goes					
		him out (residential facility),					
		d to go outside on his own".					
		#16 continued to remain in					
		6 was asked what he liked to					
		ated he was on his phone					
		e Internet to his television.					
		ent #16's room and asked if					
		nack. Client #16 declined to					
	eat and staff #5 left	his room. Client #16 was					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 105 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811			A. BUILDING 00 B. WING			COMPLETED 04/21/2021	
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RES-CAF	RE INC				BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)	ГЕ	COMPLETION DATE
IAG		ing at the facility. Client #16		IAG	DEFICE CO.		DATE
		rite place I've been at". Client					
	-	spent at juvenile school was					
		was asked what he enjoyed					
	-	ated, "watching movies and					
	-	engines". Client #16 stated					
		ot of "Haldol (treat psychotic					
		ursday" and indicated the					
		d. Client #16 was asked if he					
		nt #16 stated, "I got movies".					
	-	d if he went into the					
		ed. Client #16 stated, "They					
		the community. My mom					
	-	ights and I can get out of					
	-	ting list to get out of here".					
		he spent time in his room to					
		others and jeopardizing his					
		ring. At 2:56 PM, staff #13					
		r watching the day room.					
		about client #16. Staff #13					
		ying in his room" and					
		does not like loud noises.					
	Staff #13 stated, "H	e stays away from his peers					
	and situations he (cl	ient #16) wants to help us					
	(staff) if someone is	trying to hurt us. His shots					
	make him tired. He	likes spending time in his					
	room watching TV	(television)".					
	On 4/7/21 from 10:3	37 AM to 11:20 AM, client					
		in his bed. Client #16 was					
		age in formal or informal					
		ivities. Client #16 was not					
		to engage in activities by					
		the facility. Client #16					
		vithout an activity to engage					
	in.						
	On 4/6/21 at 3:30 P	M, a review of client #16's					
		ed. Client #16's Individual					
		dated 4/1/21 indicated the					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 106 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLI	ETED
		15G811	B. W	ING		04/21/2	2021
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			BLOOMINGTON STREET		
RES-CAI	DE INC				CASTLE, IN 46135		
RES-CAI	KE INC			GREEN	CASTLE, IN 40133		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	following needs:						
	"Needs to improve money skills.						
	Needs to initiate own activities.						
	Needs assistance to schedule and keep						
	appointments.						
	Needs to use approp	priate tone of voice when					
	speaking.						
	Needs to improve le	eisure skills.					
	Needs to improve c	cooking skills.					
	Needs to learn resp	onsibility.					
	Needs to improve k	ritchen safety skills.					
	Needs to learn shop	pping skills.					
	Needs to improve c	communication skills.					
	Needs to improve s	ocialization skills.					
	Needs to learn resp	onsibility.					
	Needs to improve s	ocial skills.					
	Needs to learn to us	se postal services.					
	Needs to learn abou	ut welfare facilities.					
	Needs to learn to us	se banking facilities.					
	Needs to learn to bu	udget money.					
	Needs to improve s	ocial interaction.					
	Needs to learn appr	opriate interaction with					
	women.						
	Needs to learn to fi	ll out main items on an					
	application.						
	Needs to learn to in						
		erform a job requiring use of					
	tools or machinery.						
		ave active interest in a hobby.					
		itiate group activities.					
		tiplication and division.					
	_	dding and subtracting skills.					
	_	now to use table ware					
	correctly".						
	-	treatment schedule dated					
		the following schedule:					
	1	day: 6:00 am - sleep, 7:00 am -					
	1 -	M hygiene and breakfast, 9:00					
	am - clean up and c	church (Sunday), 9:00 am -					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 107 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	00	(X3) DATE COMPL		
		15G811	B. W	ING		04/21/	2021
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RES-CAF	RE INC				BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION) ale review (Saturday), 10:00		TAG	DEFICIENCY)		DATE
	*	trip, 11:00 am - leisure time,					
		nd meds (medications), 1:00					
		eisure time, 2:00 pm -					
	• •	ion, 3:00 pm - community					
		n - physical life skill activity,					
		o (preparation) and dinner, and goals, 7:00 pm -					
		0 pm - evening meds, 9:00					
		nd leisure time, 10:00 pm -					
	quiet time and sleep	•					
	• • • • • • • • • • • • • • • • • • • •	Wednesday, Thursday, and					
	•	leep, 7:00 am - sleep, 8:00					
		d breakfast, 9:00 am - room					
	* '	- life skills road trip, 11:00					
		eal Prep, 12:00 pm - lunch 1:00 pm - life skill activity on					
	-	recreation activity, 3:00 pm -					
		ec (recreation) room, 4:00					
		kill activity, 5:00 pm - meal					
	prep and dinner, 6:0	00 pm - clean up and goals,					
	-	n time, 8:00 pm - evening					
		hygiene and leisure time,					
		ne and sleep, 11:00 pm -					
	sleep".						
	On 4/7/21 at 1:30 P	M, the Program Manager					
	(PM) was interview	red. The PM indicated					
	, ,	had recently started back up					
		th". The PM was asked about					
	_	t for the participation in					
		ivities. The PM stated, "Every ble moment. Goals can be					
		taff should be engaging the					
		dicated a lack of active					
		a result of a lack of Qualified					
		ties Professionals (QIDP's)					
		M stated the 2 previous					
		parted from the facility's					
	employment in the	month of "February" and the					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 108 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		A. BUILDING B. WING	00	COMPLETED 04/21/2021	
NAME OF I	PROVIDER OR SUPPLIER RE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
W 0268	second QIDP's last day was on "3/19/21". The PM indicated further review of the implementation of the client active treatment was needed. 483.450(a)(1)(i)				
Bldg. 00	CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client.				
	Based on observation, record review and interview for 2 of 4 sampled clients (#1 and #3) and 6 additional clients (#10, #11, #12, #13, #15 and #18), the facility failed to ensure clients #1, #3, #10, #11, #12, #13, #15 and #18 were provided and encouraged to wear clothing in good repair and clean clothes. Findings include: A. Observations were conducted at the facility on 4/5/21 from 1:27 PM to 3:08 PM, 4/5/21 from 4:20 PM to 6:32 PM, 4/6/21 from 7:25 AM to 9:07 AM, 4/6/21 from 10:23 AM to 12:05 PM, 4/6/21 from 2:18 PM to 3:00 PM, and 4/7/21 from 9:18 AM to 10:26 AM. During the observations at the facility, the following issues were noted: 1) Client #17 wore the same clothes (dark jeans with rips and tears on the legs and dark, short-sleeve shirt) throughout the observations. 2) On 4/5/21 from 1:27 PM to 3:08 PM, client #12's pants were too tight and could not be buckled and zipped. At 2:20 PM, client #12 needed assistance to pull his pants up due to them falling down. Nurse #1 unbuckled client #12's pants, pulled them up and buckled his belt. The nurse was unable to buckle the button and zip	W 0268	Policies and procedures prome the growth, development, and independence of the client. All individuals will have appropriate, clean and well-fitt clothing in good repair and in sufficient supply. All staff will be in-serviced to enure that all clients are provid with and encouraged to wear clothing in good repair and cle clothes. All staff will be in-serviced to ensure understanding of individignity. PM, QIDP's and RM's will be in-serviced to ensure that personal inventories are accur updated in a real time fashion to ensure a system to accurate account for client's personal possessions. New and complete inventories all client belongings, including not limited clothing will be completed by the RM. The R will accurately document all belongings, ensuring that thes belongings are present, in good repair and fitting and appropria	ing ded an dual rate, and ely of but M e	

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 109 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION	(X3) DATE			
AND PLAN	OF CORRECTION		B. WI	ILDING	00	COMPL		
		15G811	D. WII	<u> </u>		04/21/	2021	
NAME OF F	PROVIDER OR SUPPLIEF	}		STREET A	ADDRESS, CITY, STATE, ZIP CODE			
550.04	75 W.O				BLOOMINGTON STREET			
RES-CAF	RE INC			GREEN	CASTLE, IN 46135			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	N SHOULD BE COMPLETION HE APPROPRIATE		
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE	
	1 -	At 2:24 PM, client #12 left			for the individual.			
		to use the restroom. When PM, nurse #1 had to assist			The Program Manager will revented monthly, individual inventories			
		e to his pants falling down. At			ensure that they are present a			
	_	2 asked staff for assistance			accurate.			
	with his belt.				Administrative observations w	ill		
					occur at least two times daily t	for		
	3) On 4/5/21 at 2:5	2 PM, client #11 was			at least 60 days to ensure that			
	wearing two right s	hoes.			individuals are dressed in clea	n		
	4) 0 4/5/21 4.5.0	O DM 1' 4 //121 1			and well-fitting clothing.			
4) On 4/5/21 at 5:00 PM, client #13's shoes were on the wrong feet.								
	were on the wrong	ieet.						
5) On 4/6/21 at 7:42 AM, client #3 was wearing								
		lue shorts and a gray shirt)						
	from 4/5/21.B. Obs	ervations were conducted in						
		1 from 1:30 pm through						
	_	pm through 6:30 pm, on						
		n through 9:00 am and from						
		00 pm, and on 4/7/21 from						
	1	:15 am. Clients #1, #10, vere present in the facility for						
	the duration of the	-						
		r seed and						
	On 4/6/21 at 7:30 a	m, client #1 was in his						
		oor shut. At 8:58 am, client						
		room and went into the						
	١ ،	got Pop-Tarts and sat at a						
	_	Client #1 was wearing the						
	breakfast, client #1	e day before. After eating his						
		apt client #1 to put on clean						
	clothing.	promoner to par on clean						
		viewed on 4/6/21 at 2:38 pm						
		en in bed all day. I got up for						
		. Staff didn't ask me to go to						
İ		been sleeping, I've been on						
	-	ay. They didn't ask me to take						
	a snower or brush n	ny teeth. I'll probably do that						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 110 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED	
		15G811	B. W	ING		04/21/	2021	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	ROVIDER OR SUPPLIEF	8			BLOOMINGTON STREET			
RES-CAF	RE INC				ICASTLE, IN 46135			
				OILLIN				
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		TE	COMPLETION	
TAG	· · · · · · · · · · · · · · · · · · ·			TAG	DEFICIENCY)		DATE	
		ot sure when I last changed my						
	clothes. I've been v	vearing this for a while."						
	10:08 am. Client #1's Individu	vas reviewed on 4/6/21 at ual Support Plan (ISP) dated lient #1 had a goal to bathe						
	daily.							
		am, client #10 was in his						
		oor shut. At 8:13 am, staff						
	prompted client #10 to take his medication.							
		ring the same jean shorts and ore the previous afternoon and						
		m, client #10 was seated at a						
	-	oatmeal and Pop-Tarts. Client						
		ng back to bed after breakfast.						
	_	e same clothes as yesterday.						
	_	ake a shower. I slept in my						
	_	take off my belt or shoes."						
	-	ent #10 returned to his						
	·	oor shut. He remained there						
	until the end of the	observation period at 9:00						
	am.							
		was reviewed on 4/6/21 at						
	3:22 pm.							
		ted 12/8/20 indicated client						
	#1 had a goal to bat	the daily.						
	2.0 4/6/01 : 7.00	1. 4.//10						
		9 am, client #18 was eating						
	_	g table. Client #18 was ellow t-shirt he wore the day						
		, DSP #2 asked client #18 if						
		teeth or washed his laundry.						
		Not yet. I want to wait." DSP						
		it now." Client #18 went into						
	his bedroom to get							
	5 5	,						
	At 8:07 am, client #	‡10 was in his bedroom with						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 111 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER RES-CARE INC STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) The door shut, where he remained until the end of (EACH CORRECTION (EACH CORRECTION ASSOCIATED ASSOCIA	(X5) PLETION ATE
the door shut, where he remained until the end of the observation period at 9:00 am. Client #18 was interviewed on 4/6/21 at 7:39 am and stated, "I've wom this shirt for a few days. It's my favorite shirt." RM #3 was interviewed on 4/6/21 at 2:24 pm and stated, "[Client #18] is supposed to brush his teeth and shower every day. He has a laundry goal. He's supposed to go on van rides and learn how to get to places." Client #18's record was reviewed on 4/6/21 at 3:16 pm. Client #18's 1SP dated 10:9/21 indicated client #18 had a goal to bathe daily. 4. On 4/6/21 at 7:30 am, client #19 was lying in his bed and appeared to be sleeping. At 8:48 am, client #19 sat down at a dining table. Client #19's shirt was inside out and backwards. The tag was visible under his chim. Staff did not prompt client #19 to turn his shirt around. DSP #2 brought client #19 two single serve containers of cereal with milk and Pop-Tarts. Client #19 was turned parallel to the table. As client #19 was turned parallel to the table. As client #19 to turn toward the table or to chew with his mouth open. Cereal and milk fell out of his mouth and onto his clothing and the floor. DSP #2 did not prompt client #19 to turn toward the table or to chew with his mouth closed. DSP #2 brough client #19 to the communicate with him. At 8:55 am, client #19 finished his breakfast and went into his bedroom. At 9:04 am, client #19 walked into the day room. Client #19's hooded sweatshirt was backwards with the hood under his chin. Staff did not speak to the finish #19 walked into the day room. Client #19's hooded sweatshirt was backwards with the hood under his chin. Staff did not speak with the med. Lient #19 was turned parallel to the table or to chew with his mouth was backwards with the hood under his chin. Staff did not speak to client #19 walked into the day room.	

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 112 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			survey eted 2021	
NAME OF F	PROVIDER OR SUPPLIER			1306 S	NDDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	DSP #13 was intervand stated, "[Client ordered special box wet, so I'm not sure He doesn't wear a si would be beneficial pants and walks aro his pants off very quboth of those. Sombackwards, so he catclient #19's record 11:48 am. Client #19's ISP dat bathing goal. 5. On 4/5/21 at 2:20 jeans with a belt and Professional (DSP) adjust his belt. Who up, his pants were to zipped or buttoned a -DSP #13 did not phis pants. DSP #13 was intervand stated, "[Client keep noticing him we clothes. I don't kno His stuff has just vaon 3rd shift. There' They're way too sme Program Manager (4/7/21 at 1:55 pm and pants should fit him	rompt client #12 to change riewed on 4/5/21 at 2:22 pm #12] needs new clothes. I vearing other peoples' w where any of his shorts are. nished. Staff do his laundry s no way those are his pants. all." PM) #1 was interviewed on nd stated, "[Client #12's] I. I wonder if those weren't clients will take other					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 113 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		15G811	B. WING		04/21/2021	
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	a green t-shirt with a it and blue jogging properties of the thighs. On 4/6/21 at 8:00 at green t-shirt with blue in the substant of the thighs. On 4/7/21 at 10:13 at green t-shirt with blue in the substant of the thighs. On 4/7/21 at 10:50 at there were two laun Client #15 dumped through them. There baskets. Client #15 drawers and hanging additional pants in contact in the substant in the su	n, client #15 was wearing a				
W 0289 Bldg. 00	BEHAVIOR The use of system manage inapproprise incorporated in program plan, in a §483.440(c)(4) and Based on observation interview for 4 of 4 #3, and #4), the facing systematic intervent	d (5) of this subpart. on, record review and clients in the sample (#1, #2, lity failed to ensure the ion of locking the laundry rporated into clients #1, #2,	W 0289	The facility ensures the use of systemic interventions to maninappropriate client behavior. The Behavior Consultant and Program Manager will be in-serviced to ensure understanding that all intervenused to manage client behavious are incorporated into program	age	

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 114 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IULTIPLE CO UILDING	00	(X3) DATE COMPL		
		15G811	B. W		00	04/21/	
				STREET A	ADDRESS CITY STATE ZIR CODE		
NAME OF F	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET				
RES-CAI	RE INC				ICASTLE, IN 46135		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
		ere conducted at the facility on			plans, for any client effected. Restrictive interventions will b	•	
		M to 3:08 PM, 4/5/21 from A, 4/6/21 from 7:25 AM to			written into program plans and		
		om 10:23 AM to 12:05 PM,			approved by guardians as well as the HRC.		
	i i	M to 3:00 PM, and 4/7/21					
		0:26 AM. During the			All interventions will be review	ed	
	observations at the	facility, the laundry room			for relevancy by the IDT at ea	ch	
ı		d locked. This affected			quarterly meeting and revised	as	
	clients #1, #2, #3 ar	nd #4.			needed.		
	O., 4/C/21 -+ 2.27 D	M					
		M, a review of client #3's					
	record was conducted. Client #3's 12/18/20 Individual Support Plan and 3/25/21 Behavior						
	Support Plan did not indicate the need for the						
	* *	to be locked.On 4/6/21 at					
	4:08 PM, a review of	of client #4's record was					
	conducted. Client #	#4's 11/1/20 Individual					
		25/21 Behavior Support Plan					
		need for the laundry room					
	door to be locked.						
	On 4/7/21 at 1:30 P	M, the Program Manager					
	, ,	ents just have to ask the staff"					
		ne locked laundry room door.					
		he locked laundry room door					
	needed to be part of	-					
		re conducted in the group m 1:30 pm through 2:45 pm,					
		igh 6:30 pm, on 4/6/21 from					
	*	00 am and from 2:30 pm					
		nd on 4/7/21 from 9:15 am					
		Clients #1, #2, #3, and #4					
		group home for the duration					
	of the observation p	period.					
	Throughout the obs	ervation period, the laundry					
	room was locked.	-					
	1. Client #1's record	d was reviewed on 4/6/21 at					
	10:08 am.						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 115 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	(X3) DATE SURVEY COMPLETED			
THE TELL	51 CG14LEC11G11	15G811	B. WING	00	04/21/2021		
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
W 0331 Bldg. 00	Direct Support Profesinterviewed on 4/5/2 "[Client #15] will the behavior he has. He and do it with other why it's locked." Behavior Specialist 4/7/21 at 11:30 am as is kept locked. Some steal clothing. All of client can use it when have to go through a restriction in their pinkinghts Committee) at 483.460(c) NURSING SERVIO The facility must professed on observation (#13), the facility's reduced in accordance (#13), the facility's recurrence. Findings include: On 4/5/21 from 4:20 observation was conditionally from the table and bedroom. Client #1 closed door and fell assisted client #13 urestroom.	essional (DSP) #9 was 21 at 2:27 pm and stated, arow clothing away. That's a b'll go into the laundry room people's clothes, too. That's (BS) #1 was interviewed on and stated, "The laundry room are of the clients will go in and of the staff have a key. Any enever they want, but they a staff. It should be listed as a lans. It needs HRC (Human and guardian approval."	W 0331	The facility provides clients winursing services in accordance with their needs. All individuals will be assesse upon admission and ongoing any high risk care plan needs including factors that may lear falls. The DON will investigate all facorder to assess the root cause and need for intervention, and prevention of further falls and potential injury. All staff will be in-serviced on each individual high risk plans how to intervene to ensure clisafety.	d on , d to alls in e d		
		,	1	'			

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 116 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15G811	B. W	ING		04/21/2021	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET		
RES-CAI	RE INC			GREEN	CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
	since February 202 thought there was a and a loss of bowel "We're tracking it." was currently going medication changes #13's primary care p Trazodone for troub indicated when she #13's psychiatrist w indicated after the T #13's sleep worsene #13's Thorazine was time. Observations were 4:20 PM to 6:32 AM AM to 12:04 PM, 2 6:02 PM to 6:59 PM indicated the follow Observation on 4/5/ -At 6:00 PM, an am radios stated, "time the table". Client #1 dining room for the At 6:20 PM, client #1 and ran through the bedroom. As client bedroom, he hit his which caused him to Staff #7 assisted client Observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations on 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations of 4/6 -At 10:26 AM, client of the caused him to Staff #7 assisted client observations of 4/6 -At 10:26 AM, client of the caused him to	21: nouncement over the staff to wash hands and come to 3 then joined his peer at the evening meal. #13 stood up from the table day room toward his #13 attempted to enter his door and lost his balance o fall onto his bedroom floor. ent #13 up from the floor.					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 117 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BU	A. BUILDING 00 B. WING		COMPLETED 04/21/2021	
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET		
RES-CAF	RE INC				CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
		ding near the entryway to the was making a vocalization.					
	toward a sofa in the	se #1 followed client #13 day room as Residential tated, "[Client #13], I would u sit down".					
	the day room and ar bedroom. Client #13 ambulated to his bed his bathroom inside did not turn on the l bathroom. No staff a	at #13 stood from the sofa in inhulated on his own to his 3 was unsteady as he droom. Client #13 entered his bedroom unassisted and ight as he entered his assisted client #13 while he day room into his bathroom					
	bedroom. Client #13 staff #9 stated to client	f #9 entered client #13's 3 was lying on his bed when ent #13, "Get up, we're going uting client #13 had a medical and.					
	-At 2:20 PM, staff # from his outing.	⁴ 9 returned with client #13					
		#13 entered his bedroom . Staff #9 asked for Nurse #1 3's bedroom.					
	#13's ambulation whis medical appoints (client #13) used a way prompt med (medicathe ER (emergency with a UTI (Urinary was asked what trea	was asked about client hile on his outing and during ment. Staff #13 stated, "He wheelchair. We went to al) first and were then sent to room). He was diagnosed Tract Infection)". Staff #9 stated, pointment. Staff #9 stated,					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 118 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I .	ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE COMPL		
		15G811	B. W	ING		04/21/2021	
NAME OF PRO	OVIDER OR SUPPLIER		<u>I</u>	1306 S	DDDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135	<u> </u>	
RES-CARE (X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENCE REGULATORY OR "They gave us an an culture. Orders for Le [name] the PCP (pri more comfortable we once he was in prore wheelchair." Staff # a pattern of recent fa up (incidents reports he fell on [staff #2]. (March 2021). They Trazodone 200 mg (Trazodone was for se was asked if client # gait belt or other ada ambulation. Staff #9 belt. I've suggested is order. The last 6 more and the second of the second was a suggested filling out paperwork while client #13 lay how client #13 was (client #13) had anowent to get up from into the arm of the second of the se	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) Intibiotic and doing a blood abs, they might send those to mary care physician). I felt with him in the wheelchair. Inpt care, they used the 9 was asked if client #13 had alls. Staff #9 stated, "I wrote s) 3. He got 4 staples when I think it was the 23rd wid a decrease in his (milligrams) to 100 mg. The sleeping at night". Staff #9 #13 had been assessed for a aptive supports for his 0 stated, "I've not seen a gait it. That has to be a doctor's with swe've noticed a change". Pential Manager (RM #2) was k in client #13's bedroom on his bed. RM #2 was asked doing. RM #2 stated, "He ther fall in the day room. He the couch and fell forward ofa. He landed on his right I. [Nurse #1] was notified und out today he (client #13)		1306 S	BLOOMINGTON STREET	TE	(X5) COMPLETION DATE
; (#13 with ambulation dining room table. F	n from his bedroom to the RM #2 stood to the right side and placed his left arm under oulder as client #13					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 119 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l í	ULTIPLE CO JILDING	NSTRUCTION	COMPL		
ANDILAN	OF CORRECTION	15G811	B. W		00	04/21/	
		136611	5			04/21/	2021
NAME OF F	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
RES-CAF	RE INC				BLOOMINGTON STREET CASTLE, IN 46135		
		TATEL OF REFIGIENCIES		<u> </u>	10710122, 111 10100		975)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ATE	DATE
1710		#13 had finished eating and		mo			Ditte
		ay room while in his dining					
		3 physically prompted client					
		e table and redirected client					
	#13 to eat his choco	plate pudding.					
		#13 stood up from the table. ne RM #3 verbally redirected					
		k down. Client #13 sat to the					
		oom chair, leaned to his left					
	_	k of his chair and faced out					
	-	n rather than the dining room					
	table.						
		#3 verbally prompted client					
	#13 to stay seated a	t the dining room table.					
	-At 6:43 PM. RM #	2 physically assisted client					
		g room table to his bedroom.					
		ed his arm under client #13's					
	shoulder and walke	d to the side of client #13 as					
		gh the day room to his					
		de client #13's bedroom, RM					
		13 to sit down on his bed and					
		elient #13's bathroom. While away, client #13 stood up					
		egan to lose his balance and					
		ard and reached out with his					
	1	rt to gain his balance. Client					
	_	ch his wardrobe with his right					
	_	nce and then spun to his left					
	and plopped down	onto his bed.					
	On 4/7/21 at 1:05 D	M a raviany of the Duran of					
		M, a review of the Bureau of abilities Services (BDDS)					
	-	internal incident reports with					
		stigation summaries was					
	completed. The rep						
	•						
	-BDDS Report date	ed 3/24/21 indicated, "On					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 120 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		A. BU	A. BUILDING 00 B. WING		COMPLETED 04/21/2021		
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
RES-CAI	RE INC				BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	with client [client # room. [Client #13] s balance. Staff attem from falling but both the floor with [clien against the tub. The and noted a laceratic (centimeters) X 0.5 dressing applied to a the [name of hospita assessed and received -Post Fall Investigatindicated, "Individu 3/23/21 Location: The investigation fur "Peer Review" section: Laceration, ER (Em "Recommendation/" the investigation sun to further action to reoccurrence of furt -Internal Incident Resident action in the investigation sun to further action to reoccurrence of furt -Internal Incident Resident #13] Descent #13] Descent #13] Descent #13] showe mat down prior to sl staff assisted [client #13's] showe mat down prior to sl staff assisted [client #13] up. Staff was up. [Client #13] up. Staff was up. [Client #13] was fall #13's] fall. On the webumped his head on	cm. The wound cleaned and a and [client #13] was taken to all by staff were (sic) he ed 4 staples". sion Summary dated 3/23/21 al: [Client #13]. Date of Fall: Pacer Hall bathroom", rther indicated under the on, "Brief Description: Fall, ergency Room)". The Changes to plan" section of mmary was blank and listed prevent client #13 from the her falls. seport dated 3/26/21 ar: Colt's shower room Client: cribe the incident: On PM, staff was finishing r. Staff had placed the floor howering [client #13]. When #13] out of the shower to sient #13] lost his balance. were wet and slid down and attempted to hold [client mable to hold [client #13] up. ling and staff guided [client ray down, [client #13] the shower wallDescribe up notified, RM (Residential					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 121 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING	00	COMPL	
		15G811	B. W	ING		04/21/	2021
NAME OF I	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	KOVIDEK OK SOLI EIEN				BLOOMINGTON STREET		
RES-CAI	RE INC			GREEN	ICASTLE, IN 46135		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-Post Fall Investigatindicated, "Individual 3/26/21 Location investigation further titled "Nurse Managand indicated, "Clie 3/26/21 Falls in the Gait/Balance: (circl standing or walking with towel before granding or undicated: 4 PM Location: Da Describe the incircle [client #13] was find began to run to his lattempted to slow drawent to fall forward fall to where [client [Client #13] was assignated further issues. RM (notified, Nurse asset of the properties of the properti	tion Summary dated 3/26/21 tal: [Client #13]. Date of Fall: : Colt's shower". The r included documentation ger (or Admin) to Complete" ent: [Client #13]. Date of Fall: the past 3 months: Yes ed) Balance problems while g Recommendations: Only etting out of tub". eport dated 4/5/21 indicated, //5/21. Time of Incident: 6:21 tyroom/Bedroom [Client #13] dent: On said date and time, ished eating dinner when he bedroom. Staff began to (sic) own [client #13] when he l. Staff broke [client #13's] #13] fell on his bottom. sessed by nursing with no [Residential Manager] ssed". tion Summary dated 4/5/21 Fall: 4/5/21. Time: 6:20 PM m 7. Describe footwear a factor in the fall: N/A. 8. vioral issues that may have fall: rushing to use the envestigation further included d "Nurse Manager (or Admin) adicated, "Client: not filled of filled out Falls in the past ait/Balance: (x) balance					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 122 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	NSTRUCTION 00	COMPL		
		15G811	B. W	ING		04/21/	/2021
NAME OF F	PROVIDER OR SUPPLIER			1306 S	ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135	•	
	SUMMARY S' (EACH DEFICIEN REGULATORY OR On 4/7/21 at 9:35 A client #13's record v indicated the follow -Individual Support indicated, "Individu the ability to clearly wants [Client #13 use the restroom an with little to no assi requires assistance close supervision w Living) tasks to ens -Fall Risk Plan date #13's] safety will be Actions: 1. Staff to with ambulation (w living as needed a assistance when ent needed. 3. Staff to r hazards. 4. Encoura and take his time if -Physical Therapy (indicated, "Reason (evaluation). Result Altered gait Impa standing balance in instructions. Diagno balance. Recommen unable to participate inability to follow in to face significant in (outpatient) therapy	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) M, a focused review of vas completed. The record ring: Plan (ISP) dated 8/31/20 al Profile: [Client #13] lacks verbalize his needs and B] can recognize when he must d is able to complete the task stance. However, showering from staff He requires ith other ADL (Adult Daily ure completion". d 9/2/2020 indicated, "[Client e maintained through 9-2021. provide assistance or support alking) and activities of daily 2. Staff to provide hands-on ering and exiting vehicles as monitor for environmental ge [client #13] to slow down he appears to be rushing". PT) consult dated 11/25/20 for Visit: PT Eval s/Findings of Examination: aired static and dynamic ability to follow single step basis: Altered gait, impaired adations: Pt (Patient) was the in therapy secondary to anstructions. Pt is anticipated mpediment in attending OP . He (client #13) might mealth therapy for training and				ATE	(X5) COMPLETION DATE
	Interdisciplinary Te	am Meeting (IDT) dated					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 123 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BUILDING 00 B. WING		COMPL: 04/21/	ETED
NAME OF P	ROVIDER OR SUPPLIER		1306	ET ADDRESS, CITY, STATE, ZIP CODE S S BLOOMINGTON STREET ENCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIENCE REGULATORY OR 3/24/21 indicated, "C	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) On Tuesday, March 23, 2021	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	IATE	(X5) COMPLETION DATE
	at 10:50 AM, staff v the Pacer Hall Show to undress and lost h to keep [client #13] #13] and staff fell to striking his head aga assessed [client #13] the scalp 4 cm (cent Recommendations: continue to monitor safety reporting all i nursing manager and Intellectual Disabilit follow all doctor rec - Emergency Room indicated, "Event: F Lac (laceration) Y by [Name of Physic conditions: Lacerat On 47/21 at 1:40 PN reviewed. The 3/19/ following: "Name: [Client #13] - Friday 3/5/21 at 2: dayroom stumbled v Possible bruising. - Friday 3/5/21 at 7: from his room and s No injuries. - Monday 3/8/21 at prompted for lunch out and had urinated him to the bathroom him fall when comin	vas with client [client #13] in ver room. [Client #13] stood his balance. Staff attempted from falling but both [client to the floor with [client #13] hainst the tub. The nurse and noted a laceration to imeters) X 0.5 cm The IDT agrees Staff will [client #13's] health and his QIDP (Qualified ties Professional). Staff will commendations as needed". (ER) consult dated 3/23/21 all Chief Complaint: Head You have been evaluated today ian] for the following				
	injuries reported.	<i>y</i>				

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 124 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		A. BUII	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/21/2021	
NAME OF I	PROVIDER OR SUPPLIER			1306 S E	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	P	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	λΤΕ	(X5) COMPLETION
TAG	- Sunday 3/14/21 at around and tripped fell. He was assessed were reported Re continue to monitor report all issues and and his treatment te has bed rails to assist none (sic) slip sock lessen the likelihood of the likelihoo			TAG	DEFICIENCY)		DATE

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 125 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	NSTRUCTION 00	(X3) DATE (COMPL		
		15G811	B. W	ING		04/21/	2021
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET		
RES-CAI	RE INC			GREEN	CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	#1 was asked if clie nursing services. No Nurse completes the would be high risk of Nurse #1 indicated decrease in Trazodo #1 stated the higher could have made client #13 had about staff commune #13's ambulation su "[Nurse Manager] recommend the RM's about one". On 4/7/21 at 12:05 (NM) was interviewed client #13's history #13 had been assess Physician (PCP) and PCP] could not find recommend anythin meeting to review a client #13's falls. Not discussed him going NM indicated the ted did not support a transport of the light was asked what determined by the I falls. NM stated, "Vehange to drop his to be the cause of the light with evaluation, not with him getting up believe that correlate the Neurologist (Net that through Behavit	to [Nurse Manager]". Nurse nt #13 was assessed by urse #1 stated, "Yes. The at quarterly. [Client #13] or moderate at the least". client #13 had a recent one (treat depression). Nurse prescription of Trazodone tent #13 have "more falls or rated he did not know how a UTI. Nurse #1 was asked dication for changes to client pports. Nurse #1 stated, nakes the in-services, but I him being staffed one to PM, the Nurse Manager red. The NM was asked about of falls. NM indicated client sed by his Primary Care d PT. NM stated, "[Name of anything. Therapy did not anything. Therapy did not anything. Therapy did not g". NM was asked about IDT nd address the history of M stated, "Yes, we've even g to a Nursing Home". The sam had met, but the family unsition to a nursing home. t supports had been DT to address client #13's Ve've had a med (medication) Trazodone in half. That could UTI. With the falls, we started haslip socks. We had an issue and in some urgency. I don't ed. That's why we sent him to uro). [Behaviorist] tracks or. We sent him to Neuro, but thing". NM was asked if client					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 126 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO UILDING	00	COMPI		
ANDILAN	OF CORRECTION	15G811	B. W		00	04/21	
		15G611	В. W			04/21/	2021
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
RES-CAI	DE INC				BLOOMINGTON STREET CASTLE, IN 46135		
				GKEEN	CASTLE, IN 40133		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E RIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ified adaptive support needs.					
	· ·	ls, rails on his bed, in the					
	_	ocks and since he fell twice					
		staff on him. We're at a point					
		nd anything. Personally, I					
		mentia". NM was asked about					
		assessments. NM stated,					
		and taken to nursing. We do a					
	_	ly and every time someone					
	-	nto things all the time. His					
		him stand and sit down on					
		. NM was asked about client					
	_	NM stated, "If they have a					
	pattern of falls it's been updated". NM was asked if client #13 fall risk plan had been updated. NM						
		know, that one is good until					
		sked what the nursing staff do s is updated. NM stated, "A					
	_	staff". The NM was asked					
		d on updated fall risk plans.					
		verybody (Direct Support Staff					
		nagers) has to go through a					
		ay in the break room and					
		oody has a list of names.					
		ve to take a test". The NM was					
	-	fall risk plan had been					
		his fall history and the					
	_	nich required staples due to a					
		ed, "If something were to					
		update". The NM was asked					
	_	nosis. NM stated, "Probably, I					
		a risk plan for the UTI. The					
		have been updated with the					
	_	even if temporary". NM was					
		l last assessed client #13 due					
	to his history of inc	reased falls. NM stated, "I've					
	-	the last 48 hours, no". NM					
	was asked if concer	ns had been reported about					
	client #13 falls and	being unsteady. NM stated,					
		ed what had been reported.					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 127 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		A. BU	A. BUILDING 00 B. WING			survey eted 2021	
NAME OF I	PROVIDER OR SUPPLIER			1306 S	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
	NM stated, "He fell we meet". The NM had meet were "[Be Manager]". NM state additional staff was assessment was not asked about staff su ambulation. NM state and holding his standing to the side assisted person and observation of clien bed on 4/6/21, taking out with his right ar wardrobe to gain his previous falls on 4/6" If he was that unstate a gait belt. I also rechis room when they was asked if staff si bedroom had been a stated, "No, that was the NM indicated of a hurry (when ambuwas needed. The NI work came back negin fection). On 4/7/21 at 1:30 P interviewed. The PM #13's IDT meetings client #13's falls. PM which occurred on a had not been compliand was done on 3/client #13's fall risk address client #13's PM stated, "At this been a change. He's	and then fell again. As a team stated the team members who haviorist] and [Program ted, "The recommendation of based on the UTI. The based on falls". NM was pports during client #13's ted, "Staff would be to the wrist". NM demonstrated with her arm under the holding their wrist. The tr #13 standing up from his gr 3 steps backward reaching mand placing it on his sablance after having 2 to 5/21 was shared. NM stated, eady, I would want them to use commended staff sit outside watched the hallways". NM titing next to client #13's added to his fall risk plan. NM as just my recommendation". Heient #13 had always been in the diating but more assessment of indicated client #13's blood grative for being septic (blood was asked about client to address the history of mindicated IDTs for falls 3/5/21, 3/8/21 and 3/14/21 teted until his return to work 19/21. The PM was asked if plan had been updated to increased history of falls. point I don't think there has (client #13) been assessed looking at it as a medical					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 128 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 15G811	A. BUILDING 00 B. WING		COMPLETED 04/21/2021	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET		
RES-CAF	RE INC			NCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
	[Nurse #1] called [N suspected a Kidney him firsthand, disoristaff should physical ambulation. PM state hold that can be use #13 standing up from steps backward react and placing it on his after having 2 previous Manager state past 48 hours was slided in the state of the state	2M, a review of client #13's n was completed. The recording: 4/7/21 indicated, "Ensure ne event of an emergency, #13] FIRST then notify let (i.e., nurse, supervisor)". plan indicated the following Staffing until further notice UTI currently with possible a result. elt as needed for unsteady have rubber sole shoes on non-skid socks on while in bed				

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 129 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G811		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/21/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W 0441 Bldg. 00	use for safety. 5. Encourage [clienthis time if he appea 6. Should fall occur immediately - with 7. Should fall occur determine if an inju and complete an Injund a Post Fall Inveocurs 8. Nurse to notify deneeded". 483.470(i)(1) EVACUATION DETHE facility must have varied conditions. Based on record reversity 20 clients living in 185, #6, #7, #8, #9, #15, #16, #17, #18, failed to conduct ever conditions for cliented facility may be conditioned for cliented facility. Findings include: On 4/5/21 at 3:44 Prevacuation drills we evacuation drills we evacuated for the times of this affected clients 18, #9, #10, #11, #1 #18, #19 and #20.	NOTIFY the nurse or without injury. perform assessment, to ry occurred, document fall ury/Illness Report if injured stigation form. If INJURY octor or send to ER as RILLS old evacuation drills under view and interview for 20 of the facility (#1, #2, #3, #4, #10, #11, #12, #13, #14, #19 and #20), the facility acuation drills under varied its (#1, #2, #3, #4, #5, #6, #7, 2, #13, #14, #15, #16, #17, M, a review of the facility's as conducted and indicated the inducted during the night shift AM) were not varied in the drills were conducted. St. #1, #2, #3, #4, #5, #6, #7, 2, #13, #14, #15, #16, #17, what shift evacuation drill was get shift evacuation drill was	W)441	The facility holds evacuation of under varied conditions The Program Manager will be in-serviced on the policy for emergency evacuation drills. Evacuation drills will be sched each month at a variety of time. The PM will complete a sched for the year, of evacuation drill include the range of acceptable times to conduct the drills. Evacuation drills will be review at each quarterly safety committee review for adherence to the policy.	uled es. ule, ls to e	05/21/2021

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 130 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/21/2021		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	-On 6/25/20, the night shift evacuation drill was conducted at 6:51 AM.					
	-On 9/27/20, the night shift evacuation drill was conducted at 7:31 AM.					
	-On 12/31/20, the night shift evacuation drill was conducted at 7:08 AM.					
	-On 3/17/21, the night shift evacuation drill was conducted at 7:40 AM.					
	On 4/5/21 at 3:50 PM, the Program Manager indicated the evacuation drills needed to be varied in regard to the time conducted. The PM indicated the night shift drills needed to be conducted throughout the night shift.					
W 0455	483.470(I)(1) INFECTION CONTROL					
Bldg. 00	There must be an active program for the prevention, control, and investigation of infection and communicable diseases.					
	Based on observation, record review and interview for 20 of 20 clients living in the facility (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20), the facility failed to ensure high-touch areas (door knobs, arms of chairs, tables, chairs and couches) were cleaned and disinfected throughout the shift. Findings include: 1. Observations were conducted at the facility on 4/5/21 from 1:27 PM to 3:08 PM, 4/5/21 from 4:20 PM to 6:32 PM, 4/6/21 from 7:25 AM to 9:07 AM, 4/6/21 from 10:23 AM to 12:05 PM,	W 0455	All staff will in serviced on polifor infection control. Staff will ensure that all surfactor are disinfected, per policy multimes a day. In addition the custodian will do a deep cleant of surfaces each day. Individuals will be prompted to assist in cleaning all surfaces assisting with infection control well. Administrative observations we occur at least two times daily fat least 60 days to ensure adherence to infection control	ees tiple iing and as iill for		
	9:07 AM, 4/6/21 from 10:23 AM to 12:05 PM, 4/6/21 from 2:18 PM to 3:00 PM, and 4/7/21		policy.			

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 131 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		l í	ILDING	nstruction 00	(X3) DATE : COMPL 04/21/	ETED	
NAME OF F	PROVIDER OR SUPPLIER			1306 S	DDRESS, CITY, STATE, ZIP CODE BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	from 9:18 AM to 10 observations at the swere not observed thigh-touch areas. T #3, #4, #5, #6, #7, #14, #15, #16, #17, -On 4/5/21 from 1:2 Residential Manage mouth but not his not at the swere soiled with for The tables were not eating their snacks a client #4 set the table silverware. The table breakfast and the smooth but not his not at the silverware of the silverware of the silverware. The table breakfast and the smooth but not his not on 4/6/21 at 2:37 P indicated there was completed for each on 4/6/21 at 2:44 P was a cleaning completing of the carbon shift related to regarding completing on 4/7/21 at 1:38 P (PM) indicated the staff was cleaning was "conditated the staff was "con	2:26 AM. During the facility, the clients and staff of clean and disinfect the chis affected clients #1, #2, #8, #9, #10, #11, #12, #13, #18, #19 and #20. 27 PM to 3:08 PM, cr #5's mask covered his ose. AM, the dining room tables and debris and dried liquids. cleaned prior to the clients at the tables. At 11:30 AM, les with cups, plates and les were not cleaned after acks at 10:35 AM 223 AM to 12:05 PM, cr (RM) #5's mask covered his					

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 132 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 15G811		ILDING 00		COMPLETED 04/21/2021		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
RES-CARE INC				1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	REFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		-	IAG	BEFELECTI		DATE	
	the global pandemic related to Covid-19.							
	On 4/8/21 at 1:41 Pi	M, a review of the facility's						
		nd Disinfection procedure was						
	_	edure indicated, "Following						
	_	ing and disinfection of						
	-	most critical thing you can						
		e transmission of illness,						
	including COVID-19. Current evidence suggests							
	that COVID-19 may remain viable for hours to							
	days on surfaces ma	de from a variety of						
	materials. Cleaning visibly dirty surfaces							
	followed by disinfed	ction is a best practice						
	measure for prevent	ion of COVID-19 and other						
	viral respiratory illn	esses in households and						
	community settings.	The CDC (Centers for						
	Disease Control) has	s released best practices for						
	cleaning and disinfe	ection, but first definitions:						
	Cleaning refers to the	ne removal of germs, dirt, and						
	-	faces. Cleaning does not kill						
		ving them, it lowers their						
		k of spreading infection.						
		o using chemicals to kill						
	germs on surfaces. This process does not							
	necessarily clean dirty surfaces or remove							
	germs, but by killing germs on a surface after							
	cleaning, it can further lower the risk of							
	spreading infection. Encourage our staff, clients,							
	patients, and family members to follow these guidelines. Practice routine cleaning of							
	_							
		surfaces (for example: tables,						
		itches, handles, desks, toilets,						
	_	sinks) with household egistered disinfectants that						
		he surface, following label						
	instructions Surfaces should be cleaned and disinfected several times each day. For our							
		•						
	residential homes, at least at the start of each shift.							
		e conducted at the facility on						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet Page 133 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G811		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/21/2021		
NAME OF PROVIDER OR SUPPLIER RES-CARE INC			STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULL CROSS-REFERENCED TO THE APPRO DEFICIENCY) TAG		BE COMPLETION		
	4/5/21 from 1:29 PP PM to 6:32 PM, 4/6 12:04 PM, from 2:1 6:02 PM to 6:59 PM to 11:20 AM. During the observat and staff were not of the high-touch areas #2, #3, #4, #5, #6, #13, #14, #15, #16, On 4/6/21 at 10:37 #12, #13, #14, #15, at the dining room to finis prompted client #12 his hands before ret snack. At 10:49 AM their snacks. Clients their bedrooms. Client #15 lingered in prompted the client tables, chairs or swe staff #2 began prep: #8 entered the kitch prompted client #8 and stated, "put you client #15 entered the #3. Staff #2 verball #15 to leave the kitch sit down. Watch ou staff #2 used a dish trays in the kitchen plastic drinking glasted for the noon in drinking glasses upsurface of the glasses.	M to 3:08 PM, from 4:20 1/21 from 10:24 AM to 5 PM to 3:02 PM, from 6 and 4/7/21 from 10:37 AM 1/21 from 10:37 AM 1/22 from 10:37 AM 1/23 from 10:37 AM 1/24 from 10:37 AM 1/25 from 10:37 AM 1/26 from 10:37 AM 1/27 from 10:37 AM 1/27 from 10:37 AM 1/27 from 10:37 AM 1/28 from 10:37 AM 1/29 from 10:37 AM 1/20 from 10:37 AM 1/21 from 10:37 AM 1/21 from 10:37 AM 1/22 from 10:37 AM 1/23 from 10:37 AM 1/24 from 10:37 AM 1/25 from 10:37 AM 1/26 from 10:37 AM 1/27 from						

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 134 of 135

PRINTED: 05/17/2021 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 15G811		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/21/2021		
NAME OF PROVIDER OR SUPPLIER RES-CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	from where glasses had sat during previous meals and snacks from the morning. The tables and chairs had not been cleaned or sanitized and the floor had not been swept. At 11:33 AM, client #4 began to slide the drinking surface of the glasses against the table surfaces as he set the glasses around the tables. At 11:34 AM, client #4 smiled, laughed, and stated, "I'm making squeaky noises". The tables, chairs and floor under the dining room tables had not been cleaned or sanitized prior to clients #4 and #8 setting the tables for the noon meal. On 4/7/21 at 1:30 PM, the Program Manager (PM) was interviewed. The PM was asked about infection control and cleaning schedules. The PM stated, "Daily per shift, 3 times a day". The PM indicated the cleaning and disinfecting schedules three times a day should include sweeping the floors, door handles, counters, tables, and chairs.								

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

Event ID:

FAZ411

Facility ID: 013405

If continuation sheet

Page 135 of 135