PRINTED: 08/12/2022 OVED 8-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDICAID SERVICES						
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING <u>00</u>	COMPLETED		
	15G194	B. WING		07/14/2022		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD						

NAME OF	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD					
RES CARE COMMUNITY ALTERNATIVES SE IN		115 STONEGATE					
RES CA	RE COMMUNITY ALTERNATIVES SE IN	BEDFORD, IN 47421					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	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			
W 0000							
DI-I 00							
Bldg. 00	This visit was for the investigation of complaint #IN00383486.	W 0000					
	Complaint #IN00383486: Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W149, W155, W156 and W331.						
	Unrelated deficiency cited.						
	Survey Dates: July 11, 12, 13 and 14, 2022						
	Facility Number: 000724						
	Provider Number: 15G194						
	AIM Number: 100243320						
	These deficiencies also reflect state findings in						
	accordance with 460 IAC 9.						
	Quality Review of this report completed by #15068 on 7/27/22.						
W 0149	483.420(d)(1)						
	STAFF TREATMENT OF CLIENTS						
Bldg. 00	The facility must develop and implement						
	written policies and procedures that prohibit						
	mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 3	W 0149	To correct the deficient practice all	08/14/2022			
	clients in the sample (A, B and C) and 5 additional	W 0149	site staff have been re-trained on	06/14/2022			
	clients (D, E, F, G and H), the facility failed to		the ResCare ANE policy and				
	implement its policies and procedures to prevent		procedure, CPR, and on-call				
	abuse and neglect of the clients, prevent further		communication procedures. All				
	neglect while an investigation was in progress,		QA and administrative staff				
	ensure the results of investigations were reported		responsible for site have been				
	to the administrator within 5 working days, identify patterns related to injuries of unknown		re-trained on ensuring				
	origin and take appropriate corrective actions to		Investigations are completed within 5 business days,				
	address injuries of unknown origin in a timely		appropriate safety measures are				
	address injuries of unknown origin in a unicry		appropriate salety measures are				

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

TITLE

(X6) DATE

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

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15G194	B. W	ING		07/14/	/2022
		<u> </u>	<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			ONEGATE		
DES CVE		LTERNATIVES SE IN			RD, IN 47421		
NES CAP	VE COMMUNITY A	LILIMATIVES SE IIV		BEDFO			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	manner.				put in place timely, completing	1	
					recommendations timely, and		
	Findings include:				identifying/preventing patterns	5.	
					Additionally, the safety measu		
		AM, a review of the facility's			put in place for IUO patterns v	vill	
	_	ve reports was conducted and			remain in place. Additional		
	indicated the follow	ving:			monitoring will be achieved		
					through twice weekly		
		au of Developmental Disabilities			administrative observation to		
		ncident report indicated, "It was			ensure staff are following the		
		had been sleeping when he got			policy as well as identifying ar	ıy	
	*	om. While in the restroom			patterns or issues at the site.		
		f his wheelchair. Staff			Ongoing monitoring will be		
		I reported the incident, and			achieved through monthly site		
		alert. The nurse advised staff			reviews by ResCare administr	ative	
	-	ute checks and [client A]			staff.		
		Nurse was contacted and					
		tact EMS (Emergency Medical					
	· ·	rived and pronounced [client A]					
		death unknown currently.					
		ill and was scheduled to be					
	_	ce services at the request of					
	_	aving seen his physician the					
	day prior to his dea	th."					
		PM, a review of a Draft					
	_	nary, dated 6/17/22 to 7/11/22,					
	indicated in the Cor						
	-	nt A] saw his PCP (primary					
		6/16 who noted [client A] was					
		not resuscitate) and suggested					
		nission. Substantiated [client					
		ed [client A] to remain at the					
		antiated staff did not initiate					
	` .	nary Resuscitation).					
	Substantiated cause						
	cardiopulmonary ar	rest and Down Syndrome."					
	0 7/12/22 : 0.17	AM : CA 7/10/00					
		AM, a review of the 7/12/22					
	Investigative Sumn	nary was conducted. The	1				I

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STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI		
		15G194	B. W	ING		07/14	/2022	
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD	-		
NAME OF 1	PROVIDER OR SUPPLIEI	R			ONEGATE			
RES CA	RE COMMUNITY A	LTERNATIVES SE IN			PRD, IN 47421			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ated, "On 6/17 [client A] was						
		n by [staff #6] and was seated						
		when [staff #6] heard one of						
	_	nates get out of bed. [Staff #6]						
		g in the wheelchair to go attend						
		Staff #6] then heard a noise and						
	_	t A], finding him lying on the						
		sisted [client A] back into the						
		k [client A] back to his						
		red [client A] back to bed.						
		oonding to [staff #6] at that						
		empted to contact nurse with no						
		then contacted Program						
		reported the fall. PM told						
		ete 15-minute checks. [Staff #6]						
	_	and at approximately 6:53 AM						
	I	PM and reported [client A]						
	_	[staff #6] to help [client A] sit						
	_	[client A's] back was purple.						
		to call 911. EMS (Emergency						
		arrived at approximately 7:08						
		ent A] was deceased. Official						
		ardiopulmonary Arrest and						
	Down's Syndrome.	"						
	The Conclusion sec	ction indicated, "Substantiated						
		PCP on 6/16 who advised [client						
		and suggested nursing facility						
		ntiated [client A's] guardian						
		o remain at the group home.						
		did not initiate CPR.						
	Substantiated [clier							
		Arrest and Down Syndrome."						
		•						
		igation Peer Review indicated						
	the following:							
	"-Term [staff #6].							
	-Reinstate [staff #1							
		ent on directing staff to contact						
	911 in the event sta	aff are unable to reach nursing						

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	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 S	ADDRESS, CITY, STATE, ZIP CO TONEGATE ORD, IN 47421	DD
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LLSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORR. (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	DULD BE COMPLETION PROPRIATE
TAG	and there is a medical completion within 5 awaiting assessmental completion within 5 awaiting days. The results of the insubmitted to the administration of the regular facility failed to neglect while the infailing to immediate to the administration of the infailing to immediate to the administration of the infailing to immediate the infailing the infailin	n all staff. rsing chain of command. nange of condition procedure. nen to call 911/911 protocol. Nursing) to review se with state Nurse Manager etion for individuals who are t/intervention for Hospice. ty Assurance) on investigation to business days.	TAG	DEFICIENCY)	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 07/14/2022			
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	indicated staff #1 w neglect on 7/11/22. worked "several shi 6/17/22. The AED performed CPR. The took client A's vital investigation of clie actions should have working days. The review of the death however the events should be been invergented to the adm days. The AED starequirement for the On 7/12/22 at 2:28. Intellectual Disabilist "safety measures shimmediately." He is suspended on 7/11/2. He indicated the time results of an investi was 5 working days. On 7/11/22 at 3:53 spoke to staff #6 on however staff #6 disindications of a chanurse indicated staff information which is called. The nurse in called him about an told staff #6 to call A was at the doctor away.	PM, the QIDP (Qualified ties Professional) Lead stated ould have been implemented ndicated staff #1 was 22 but he was not sure why. neframe for reporting the gation to the administrator					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MUI A. BUI B. WIN	LDING	NSTRUCTION 00	(X3) DATE : COMPL 07/14/	ETED
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	•	115 STC	DDRESS, CITY, STATE, ZIP COD DNEGATE RD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	CPR when she arrivindicated when she he was pale and she dead. Staff #1 state "because it was obvitated the paramedi "had been gone for stated "don't think [Blood settled in his was dead for a whill first interviewed ab She indicated she was suspended 3-4 continued to work a days before being s On 7/12/22 at 9:40 was not assisting with physical limitations 6/17/22 during the (client A) stay in bedue to him not bein client A up at 5:30 wheelchair to take I client A put his han bear any weight so when to check on a thump and went to was on the bathroof forehead. He was reput client A back him to his room. He bed, got his oxygen He called the Area of the situation. He unable to get a hold trying to cook break check on client A.	first saw client A in his bed, immediately knew he was ad she did not initiate CPR rious he was dead." She cas indicated to her client A quite some time." Staff #1 staff #6] is telling the truth. (client A's) back Think he e." Staff #1 indicated she was out client A's death on 7/8/22. The staff #1 indicated staff #6 days after client A died and he at the home for a couple of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 07/14/2022		
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	A up. He did however client A's back was purple and he was unresponsive. He was instructed to 911. Staff #6 indicated staff #1 arrived right after he called 911. He said staff #1 saw him and said he looked bad. Paramedics arrived about 10 minutes later. He indicated he did not attempt CPR. He said he did not know client A needed it. He indicated staff #1 did not attempt CPR. The paramedics did not attempt CPR. He stated "they (paramedics) said he had been gone awhile." Staff #1 indicated client A was responding to him shortly before he called 911. He stated, "I checked on him and he seemed to be alive." Staff #1 indicated following client A's death, he worked Saturday and Sunday, attended a staff meeting on Monday, and then he was suspended on Wednesday. On 7/12/22 at 9:25 AM, the Quality Assurance Coordinator (QAC) stated, "The investigation may need an addendum. Currently in draft form." The QAC stated "thought we had longer than the 5 working days. Did first interviews, got initial information, reinterviewed as needed and then wrote the draft report." The QAC indicated the timeframe for reporting the results to the administrator was 5 working days. The QAC indicated staff #6 did not conduct CPR. The QAC indicated staff #1 did not conduct CPR. The QAC indicated staff #1 did not conduct CPR. The QAC indicated staff #1 was not breathing. The QAC indicated staff #1 did not conduct CPR. The QAC indicated staff #1 was obvious to her he was gone." The QAC indicated although client A had a physical therapy (PT) assessment the recommended home health PT was not completed due to PT being short staffed. When staff called to schedule appointments, they were told the PT was short staffed and did not have anyone to send. The QAC indicated she was not sure if there was documentation of staff calling to schedule an documentation of staff calling to schedule an					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		l í	JILDING	instruction 00	(X3) DATE COMPL 07/14 /	ETED	
	PROVIDER OR SUPPLIEI	LTERNATIVES SE IN		115 ST	NDDRESS, CITY, STATE, ZIP COD ONEGATE RD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE	(X5) COMPLETION DATE
TAG	appointment. The chave documented in didn't happen." The actions were not defined to be conducted actions being reconsultations. On 7/13/22 at 2:48 Disabilities Profess #6's termination no provide CPR for 20 He stated staff #6 ft "negligence." The investigation was not neglect was substituted in the control of the contr	QAC stated, "They should and the corrective termined yet. The peer review cted prior to the corrective termined. PM, the Qualified Intellectual ional (QIDP) Lead stated staff tice "will say he failed to minutes before EMS arrived." ailing to provide CPR was QIDP Lead indicated the ot conducted timely. The did have indicated whether or estantiated. PM, the Quality Assurance dicated staff #6 was terminated in to perform CPR. She stated in action. His actions or lack lifesaving measures was the did a change in his condition. In action." The QAM indicated eporting the results of eadministrator was 5 working dicated the investigation		TAG			DATE
	indicated the staff v	clear conclusion. The QAM were suspended once it was I not perform CPR. She stated ere was "no suspected					
	former staff #7 left at the group home v Investigative Sumn Manager/PM] recei Manager/RM] at 8:	allegation was made indicating clients A, B, C, D, E, F, G and H unsupervised. The 3/29/22 mary indicated, "[Program ved a call from [Residential 44 PM stating [staff #7] texted not at the group home and he					

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NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		ONEGATE PRD, IN 47421	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	k. [PM] went to the home to			
		ng into the driveway and			
	-	e. The 9PM staff was already			
		with [staff #7] and he admitted was placed on leave [Staff			
		hift at [group home] at 3/25/22			
		he front door was locked and			
		r at the door. [Staff #6] walked			
		the back door unlocked and			
		ns at the house but could not			
		6] called [RM] to inform her			
	and stated [staff #7]	and [PM] arrived at the home			
	around 8:50 PM"	Staff #7's statement in the			
	_	ted, "He worked at [name of			
		5/22 approximately 8:30 AM to			
		he left for an emergency			
		aving the clients unattended.			
		back around 8:50 PM." The			
		ction indicated, "[Staff #7]			
	-	or [RM] at 8:42 PM on 3/25/22 coup home. [Staff #6] arrived			
		t approximately 8:40 PM to			
		y at the home. [Staff #7] was			
	-	at the home around 8:50 PM by			
	_	. [Staff #7] admitted he left the			
		or approximately 20 minutes.			
		e clients are always to be			
	-	onclusion section indicated,			
	"It is substantiated [staff #7] left the [name of			
	group home] clients	s unsupervised on 3/25/22."			
	A 3/30/22 Correctiv	ve Action Form indicated, in			
	_	andards of Conduct 7.1,			
		Any acts of disrespect,			
		and/or neglect toward the			
		e. During a QA (Quality			
		ation you admitted to leaving			
		one while you left the premises.			
		tolerance policy for neglect,			
	due to your actions	we are terminating your			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		r í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 07/14/	ETED	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		115 ST	ODDRESS, CITY, STATE, ZIP COD DNEGATE RD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	unknown origin we undated Unknown I "During routine b small bruises were upper chest ½" (inc ½". Lower Right A Left Shin ½" Do recollection of how No, all home staff v could give an exact occurred. Some spene often bumps into (self injurious behamoved in his bedrowinto Not that any [Client E's] BSP (bs SIB and physical agroommates (sic) BS (Human Rights Corroom and staff wou even with the door execution of the commendations continue hourly room supervisor) and QID Disabilities Profess observations to ensure 3. Re-train staff on Staff #6 worked with being found. There was no docurt the investigation would administrator for results.	section indicated, "1. Staff will om checks. 2. The AS (Area DP (Qualified Intellectual ional) will complete routine are plans are being followed. completing daily body scans." th client E prior to the injuries mentation when the results of ere submitted to the view.					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED B. WING 07/14/2022				
		15G194	B. W			07/14	/2022
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
					ONEGATE BB IN 47404		
RES CARE COMMUNITY ALTERNATIVES SE IN			BEDFO	RD, IN 47421			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	4) On 2/13/22 (no t	time indicated), client H was					
		ch marks on his back. The					
		njury Investigation indicated,					
		upper back greater than 3					
	-	indicated, "No, all home					
	-	ed, and no one could give an					
		hy the mark occurred. Staff					
	*	was very possible [client H] while itching" The					
		section indicated, "1. All staff					
		H's] nails are routinely					
		f will continue hourly room					
	checks. 3. The AS	and QIDP will complete routine					
		are plans are being followed.					
	4. Re-train staff on	completing daily body scans."					
	Staff #6 wantad wit	the alient II maior to the injuries					
	being found.	th client H prior to the injuries					
	being found.						
	There was no docur	mentation when the results of					
	the investigation we	ere submitted to the					
	administrator for re-	view.					
		mentation the recommended					
	observations were c	onaucteu.					
	5) On 3/5/22 at 9:0	0 AM, staff #1 found scratches					
	· ·	nt H's back. The undated					
	Unknown Injury In	vestigation indicated, "[Staff					
	- , ,	tches across [client H's] back					
		ike fingernails and a bruise on					
		about a quarter size." The					
	_	ted, "All staff that worked					
		incident: [staff #6, #3, #5 and ow the marks could have					
	-	eported behaviors or seeing					
		rter [staff #1] noted that when					
		thes, she noticed [client H's]					
		tremely' long. [Staff #1]					
	-						1

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	RE COMMUNITY A	TERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE ORD, IN 47421	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
140	speculated that [clich himself. [Staff #1] the only staff to trin the arm was undeter occurred." The Recindicated, "Recomm pattern of IUO (inju [client H], it should AS/RM/AED (Area Manager/Assistant ins during the week staff to be re-trained routinely. 3. All stabody assessments a minimum of 30 day determines it is need. Staff #6 worked with being found. There was no docur the investigation we administrator for reaction of the investigation was administrator for reaction. There was no docur observations were considered to the investigation was administrator for reaction of the investigation in the investigation indicated when I arrived, [state he found. We were happened. I do know E's) bathroom is brofrequently I broughter the investigation in the i	also noted she appears to be a his nails. The bruising on ramined as to how it could have commendations section mendations: 1. Due to the tries of unknown origin) with be recommended that the Supervisor/Residential Executive Director) do drop end between 7p and 6a. 2. All don completing nail trimmings off to be trained to complete full a every shift change for a se, and longer if the team ded." The client H prior to the injuries the submitted to the view. The commended that the supervisor/Residential to the view.	IAU		DATE

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194		UILDING	nstruction <u>00</u>	(X3) DATE COMPL 07/14 /	ETED	
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	(sic) a bruise on the seen anything that or There is a toilet sear uses that is loose and does masturbate a le caused" The Cor "After further revier concluded. [Client penis. There has be could have caused toilet seat that could staff indicated any sphysical abuse." 7) On 3/25/22 at 6: with scratches on hi Injury Investigation distressed noise con E's] room. Upon in clients up. [Client I [client E] was found his face. Two scratch is chin and one on inches in length Seratches occurred. noise he heard and to inspection. (Sic) The H's] toys and [client upset and struck [client E] could have the location of the mossible it was a structher review the form [Client E] in (sic) [client E] in (sic) [client E] in (sic) [client E] on. Staff heard monitor and responsitanding with a toy standing with a toy	tip of his penis. Have you ould have caused this? In the far bathroom that he dould have pinched. He of and could have also nelusion section indicated, we the following can be E] had a small bruise on his en no event reported that his. Staff did note a broken I have caused the injury. No suspicion of OO AM, staff #6 found client E is face. The 3/30/22 Unknown indicated, "Staff heard a ming from [client H's and client spection staff found both had a toy in his hand and it to have fresh scratches on ches were found - one under his lip. Both (sic) about two staff did not witness how the Staff speculates from the he situation he found upon at [client E] had one of [client						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/14/2022	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE ORD, IN 47421	
RES CAF (X4) ID PREFIX TAG	summary: (EACH DEFICIEN REGULATORY OR appeared to have ju scratches were treat occurred. Staff spe aggressed towards [(interdisciplinary te discuss potential ro options of supervisi injuries of unknown E and H]." Staff #6 worked wit being found. 8) On 4/23/22 (time found on client H's Unknown Injury In	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION st occurred. [Client E's] ed, and no further incidents culate that [client H] client E] over a toy The IDT am) should convene to commate changes or other on due to the pattern of a origins (sie) between [clients th client H prior to the injuries th client H prior to the injuries e not indicated), bruising was legs and back. The 4/29/22 vestigation indicated, "On	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	and back. Left thig inches All staff the of finding the mark could have been can have noted that [clic often bumps into the up with his PCP (probe is not anemic and After further review [client H] had sustaback sometime Frid (morning). Staff we could have occurred condition or bumping Recommendations: determine to medical bruising. 2. Admin weekly drop ins spen months"	as found on [client H's] legs th 4 inch (sic), and back about 2 that worked within a few days as had no recollection of what tasing the bruising. Most staff ent H] jumps into his bed and tings. Staff are also following timary care physician) to ensure d causing extreme bruising To it can be concluded that tined bruising to his leg and ay afternoon to Saturday AM ere unable to recall how that d. Speculations of a medical ting into things. 1. Follow up with PCP to al issues are causing increased distrative staff should do once therefore the staff should do once the staff should do o			

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	OF CORRECTION OF CORRECTION 15G194 X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 07/14/2022
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE RD, IN 47421	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	DBE COMPLETION
	There was no documentation the recommended observations were conducted.			
	9) The 5/13/22 Unknown Origin Investigation indicated, "During the (date and time not indicated) AM routine staff found multiple scratches on [client C's] upper left arm. Ranging for (sic) a half inch up to 4 inches in length." The investigation indicated, "[RM] stated that she believed the scratches to be self-inflicted due to [client C's] nails being long and staff witnessing him scratching. [RM] also stated he was laying (sic) on the zipper of his wedge pillow which also could have caused the scratches [Staff #1] found the scratches on Sunday 5-8-22. She assumed they were caused by [client C] scratching himself"			
	client G's left hip. The 6/10/22 Unknown Injury Investigation indicated, "On 6-5-22 during shower routines staff found a 5 inch bruise on [client G's] left hip. The bruise appeared to be fresh in color" The investigation indicated, "[Staff #1] stated [staff #5] found a bruise on [client G] on 6-5-22 during showers, between 9 am and 9:30 am. The bruise was on his left hip and was 5 inches long. [Staff #1] states the bruise looked as if [client G] had fell (sic) across something. It was blue and seemed 'fresh'. On 6-4-22 (sic) 7pm [client G] had an incident of smearing feces and she (staff #1) changed him. During that time, there were no injuries" The Conclusion indicated, "After further review [client G] sustained an injury to his hip causing a five-inch-long bruise across his hip. The cause of the bruise is undetermined. However, staff noted it looked as if he ran into something. [Client G] is unsteady in his gait and has a fall risk"			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 07/14/2022		
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE DRD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
	Staff #6 worked with being found.	th client H prior to the injuries				
	conducted. The ID meeting to address a doing the following -Random drop ins to Supervisor) and PM focus on overnight: [AS] will implement -Body observations and before bed, as well-read and before bed, as well-read and D], (and) [client -Door alarm will be Rights Committee) and E's] room. -Monitor in [client but will need anothe separated. Will need -Nail trim/check coon TAR (Treatment -Nail file and clipped-[Nurse] is getting of H] to place in medic findings related to in the control of the con	m (IDT) meeting was I indicated, "From today's unknown injuries, we are be be implemented by AS (Area I (Program Manager), with shifts, at least 2 per month. ited (sic) schedule. to be completed in morning well as a during toileting. tched, [AS] contacting and confirm they are in g at [clients H and B], [clients E				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		15G194	B. W	ING		07/14	/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF I	PROVIDER OR SUPPLIEF	3			ONEGATE		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			PRD, IN 47421		
	Г		1		· 		OV.5
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		etive actions for injuries of		IAU			DATE
		re implemented about 2 weeks					
		death. The RM indicated the					
	actions included clients E and H being separated						
	from sharing a room, daily skin assessments,						
	audio monitors in both client E's and H's						
	bedrooms, and daily observations by						
	administrative staff.						
	On 7/12/22 at 12:50 PM, staff #2 indicated she						
	worked at the group home Mondays, Tuesdays						
	and Wednesdays. Staff #2 indicated there were						
	no injuries of unknown injury when she left on						
	1	hen she returned to work on					
	I -	r about injuries. She					
		ne unknown injuries occurred					
		volving staff #5, #6 and former					
		tated the injuries of unknown					
	_	tely not client to client." Staff					
		E and H changed bedrooms					
	_	after client A's funeral, both					
		re an audio monitor, and daily					
	observations were b	•					
	administrative staff	just started.					
	On 7/12/22 at 12:50	PM, staff #3 stated she felt					
		unknown origin was "strange."					
	1	en asked if there was a pattern					
		known origin, "Absolutely."					
	· ·	uspected staff #5 or staff #6 of					
		. She indicated since staff #6					
		l, no injuries of unknown					
	_	und. She indicated daily body					
		mplemented recently, clients E					
		f their shared bedroom to split					
	them up, both clients E and H have audio						
		oms, and increased monitoring					
		ninistrative staff. She indicated					
	the corrective action	ns to address injuries of					
	unknown origin we	re implemented less than one					

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	CON	TE SURVEY MPLETED 14/2022
NAME OF	PROVIDER OR SUPPLIE			ADDRESS, CITY, STATE, ZI	IP COD	
RES CA	ARE COMMUNITY A	LTERNATIVES SE IN		ONEGATE DRD, IN 47421		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TO DEFICIENCY	HE APPROPRIATE	COMPLETION DATE
Ind	month.	CESC IDENTIFICATION ORGANIZATION	1710			DATE
		PM, the Associate Executive				
	Director (AED) indicated, initially, all the injuries of unknown origin occurred in clients E and H's					
		ated none of the staff saw				
	anything. He initially indicated there was no pattern noted of a staff who worked prior to the					
	injuries being discovered. Later in the interview,					
	"	a pattern was noted involving				
	staff #6. The AED indicated none of the clients					
	have had injuries of	f unknown origin since staff #6				
	was suspended afte	r client A died on 6/17/22.				
		staff #6 was suspended on				
	6/20/22 after he got off work at 11:00 AM. The					
		facility implemented several				
		o address the injuries of				
	_	cluding daily observations,				
		ents, clients E and H changing				
		nt E having an audio monitor. The was not sure when the				
	corrective actions v					
	corrective actions v	vere implemented.				
		PM, the QIDP Lead indicated he				
	_	ated to the injuries of unknown				
		ered on the weekends. He				
		nvolved seemed to be staff #1,				
	J1 J	d the injuries, staff #5 and staff				
		e of the injuries "were a little				
		ed he asked during the off was doing the injuries and				
		ng. He indicated it was clear to				
	1	I were hitting each other. The				
		ed there was no documentation				
	1	oop ins on weekends were				
		ed, regarding the injuries of				
	1 -	Some were indicative of abuse."				
		commended observations were				
	conducted although	there was no documentation				
	of them being done	. He indicated the facility				
ı	1		I	1		I

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	ľ	UILDING	instruction 00	(X3) DATE SURVEY COMPLETED 07/14/2022	
	PROVIDER OR SUPPLIEI	R LTERNATIVES SE IN	•	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE RD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OI	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	implemented a root to split them up, au and H, door alarm of body scans. The Q corrective actions we past month. When were timely, he start (2022) were OK the measures." On 7/1 although the recome conducted by admit documentation to were found on the substantial worked. Us and #6] worked. Us and #6] worked. Us and #6] worked. Us and #6] worked on 7/12/22 at 10:00 staff #6 had been substantial of his assessment. On 7/12/22 at 10:00 staff #6 had been substantial worked (Thursday suspicious. All the bruises stopped simbruising found since On 7/12/22 at 5:00 2018 Change of Collidary Constantial, or psycholotic a nurse and revise to the state of the specific constantial constantia	m change with clients E and H dio monitors for both clients E on client E's bedroom, daily IDP Lead indicated the were implemented within the asked if the corrective actions ted "seems like April and May en implemented the safety 3/22 at 2:48 PM, the QIDP Lead mended observations were mistrative staff, there was no erify it. 7 AM, the nurse indicated he injuries of unknown origin weekends. The nurse stated d like it was when certain really around when [staff #5 ould have been a coincidence." I he conducted assessment of an origin but did not document atts. 8 AM, staff #1 indicated since uspended, there have been no of unknown origin. Staff #1 sure if there was a tated she "felt most were e weekends when [staff #6] to Saturday). Seems staff put it together that the ce he's been suspended. No e he's been off." PM, a review of the October andition policy indicated, ange in an individual's physical, origical status must be reported ewed/assessed timely. The					
	Tonowing are guide	elines intended for the review					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2022 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	l í	ILDING	nstruction 00	(X3) DATE : COMPL 07/14/	ETED
	PROVIDER OR SUPPLIER	TERNATIVES SE IN		115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE RD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	process On 7/12/22 at 5:00 deporting and Investigation, Mistree Individual's Rights process "ResCare strictly process and individual's rights." Ilmited to any of the punishment i.e. force restraints, continger the application of particle of electric shock, the seclusion in an area example of seclusion their bedroom and regative practice or facial screening, verscreaming, swearing damaging an individe or dignity, failure orders, denial of physical movement time, Medical tree bathroom facilities to complaint #IN 483.420(d)(3) STAFF TREATME The facility must probable above while the in Based on record revincident/investigative.	PM, a review of the 10/16/20 stigating Abuse, Neglect, atment or a Violation of policy indicated, in part, pohibits abuse, neglect, atment, or violation of an These include but are not a following: corporal ed physical activity, prone at exercise, hitting, pinching, ain or noxious stimuli, the use a infliction of physical pain, which exit is prohibited, an in is locking an individual in not allowing them to leave, overcorrection, visual or abal abuse including an ame-calling, belittling, dual's self-respect are to follow physician's sleep, shelter, food, drink, cent for prolonged periods of catment or care or use of es This federal tag relates 00383486.9-3-2(a)	W 0	TAG	To correct the deficient practical QA and administrative staff responsible for site have been	ce	
	potential abuse whil	e an investigation was in g the suspension of 2 staff			re-trained on ensuring appropriately. Additional monitoring vibe achieved by the QAM reviewall incident reports and assigni	riate ce vill wing	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETED	
		15G194	B. W	VING		07/14/2022	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L					
DEC OAF		TEDNIATIVES OF IN			ONEGATE		
RES CAP	RE COMMUNITY A	LTERNATIVES SE IN		BEDFO	RD, IN 47421		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X:	5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLE	ETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DAT	Е
					safety measures as needed.		
	On 7/11/22 at 11:31	AM, a review of the facility's			Ongoing monitoring will be		
	incident/investigative reports was conducted and				achieved quarterly through the	:	
	indicated the following:				quality and safety committee		
					reviewing all incidents for patt	erns	
	A 6/18/22 Bureau o	f Developmental Disabilities			and appropriate safety measu		
	Services (BDDS) incident report indicated, "It was						
	reported [client A] had been sleeping when he got						
	up to use the restroom. While in the restroom						
	[client A] fell out of his wheelchair. Staff						
	contacted nurse and reported the incident, and						
	that [client A] was alert. The nurse advised staff						
	to complete 15-minute checks and [client A]						
	became less alert. Nurse was contacted and						
		tact EMS (Emergency Medical					
		ived and pronounced [client A]					
	· ·	death unknown currently.					
		ill and was scheduled to be					
		ce services at the request of					
	_	aving seen his physician the					
	day prior to his deat						
	day prior to his deal	iii.					
	On 7/13/22 at 8:17	AM, a review of the 7/12/22					
		nary was conducted. The					
	_	ted, "On 6/17 [client A] was					
	_	by [staff #6] and was seated					
		hen [staff #6] heard one of					
		ates get out of bed. [Staff #6]					
	1	g in the wheelchair to go attend					
		taff #6] then heard a noise and					
		A], finding him lying on the					
	_	sisted [client A] back into the					
		[client A] back to his					
		ed [client A] back to bed.					
		onding to [staff #6] at that					
		ē : 1					
	time. [Staff #6] attempted to contact nurse with no answer. [Staff #6] then contacted Program						
		reported the fall. PM told					
		te 15-minute checks. [Staff #6]					
	completed checks a	nd at approximately 6:53 AM					

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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION [staff #6] contacted PM and reported [client A] was limp, PM told [staff #6] to help [client A] sit STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421 (X5) PREFIX CRACH CORRECTION EACH CORRECTION COMPLETION DATE		NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	1		NSTRUCTION	(X3) DATE	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION [staff #6] contacted PM and reported [client A] was limp, PM told [staff #6] to help [client A] sit STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (X5) COMPLETION DATE	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			00		
RES CARE COMMUNITY ALTERNATIVES SE IN (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION [staff #6] contacted PM and reported [client A] was limp, PM told [staff #6] to help [client A] sit 115 STONEGATE BEDFORD, IN 47421 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE			100 194				07/14/	/2022
RES CARE COMMUNITY ALTERNATIVES SE IN (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION [staff #6] contacted PM and reported [client A] Was limp, PM told [staff #6] to help [client A] sit BEDFORD, IN 47421 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (X5) COMPLETION DATE	NAME OF I	PROVIDER OR SUPPLIER						
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION [staff #6] contacted PM and reported [client A] was limp, PM told [staff #6] to help [client A] sit [X5) PREFIX PREFIX PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (X5) COMPLETION DATE	RES CAI	RE COMMUNITY A	LTERNATIVES SE IN					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION [staff #6] contacted PM and reported [client A] was limp, PM told [staff #6] to help [client A] sit (EACH DEFICIENCY) PREFIX COMPLETION TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG COMPLETION DATE		T					(X5)	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) [staff #6] contacted PM and reported [client A] was limp, PM told [staff #6] to help [client A] sit						(EACH CORRECTIVE ACTION SHOULD BE	TE	
was limp, PM told [staff #6] to help [client A] sit	TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	T	'AG	DEFICIENCY)	.15	DATE
up and he saw that [client A's] back was purple.		up and he saw that [client A's] back was purple. PM told [staff #6] to call 911. EMS (Emergency						
Medical Services) arrived at approximately 7:08								
(AM) and said [client A] was deceased. Official								
cause of death is Cardiopulmonary Arrest and								
Down's Syndrome."								
The Conclusion section indicated, "Substantiated		The Conclusion see						
[client A] saw his PCP on 6/16 who advised [client								
A] should be DNR and suggested nursing facility								
admission. Substantiated [client A's] guardian		admission. Substan	ntiated [client A's] guardian					
wanted [client A] to remain at the group home.		wanted [client A] to						
Substantiated staff did not initiate CPR.								
Substantiated [client A] died from		_	=					
Cardiopulmonary Arrest and Down Syndrome."		Cardiopulmonary A	Arrest and Down Syndrome."					
The facility failed to prevent further potential		The facility failed to	o prevent further potential					
neglect while the investigation was in progress by		neglect while the in	vestigation was in progress by					
failing to immediately suspend staff #1 and #6.		failing to immediate	ely suspend staff #1 and #6.					
On 7/12/22 at 12:31 PM, the Residential Manager		On 7/12/22 at 12:31	l PM, the Residential Manager					
(RM) indicated staff #6 was suspended on 6/22/22		(RM) indicated staf	If #6 was suspended on 6/22/22					
after client A passed away on 6/17/22. The RM								
indicated staff #6 should have been suspended								
immediately. She was not sure why there was a								
delay. The RM indicated staff #1 was suspended		_	-					
on 7/11/22 after working several shifts over the			orking several shifts over the					
past month.		past month.						
On 7/12/22 at 2:01 PM, the Associate Executive		On 7/12/22 at 2:01	PM, the Associate Executive					
Director (AED) indicated client A died on 6/17/22.		` ′						
The AED stated staff #6 was suspended due to			-					
"possible neglect" on 6/20/22. The AED indicated		1 .						
staff #6 worked on 6/18/22 and 6/19/22 prior to			•					
being suspended. The AED indicated staff #1								
was suspended due to possible neglect on		_	-					
7/11/22. The AED stated staff #1 worked "several shifts" since client A died on 6/17/22. The AED								

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	î ´		NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G194	A. BUI B. WIN	LDING IG	00	COMPL 07/14		
		100107	<i>D.</i> "I		PRINCE OF THE PR	07/14/		
NAME OF I	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD			
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN			RD, IN 47421			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE		
TAG		R LSC IDENTIFYING INFORMATION aff performed CPR. The AED		TAG	DEFICIENCE		DATE	
		aff took client A's vitals.						
		PM, the QIDP Lead stated tould have been implemented						
	immediately." He indicated staff #1 was suspended on 7/11/22 but he was not sure why.							
		PM, the nurse indicated he						
	*	6/17/22 after client A fell						
	however staff #6 did not communicate any indications of a change in client A's status. The nurse indicated staff #6 did not report any information which indicated the need for 911 to be called. The nurse indicated the Area Supervisor called him about an hour later and told him she							
		911. The nurse indicated client						
		the day before he passed						
	away.	, ,						
	On 7/12/22 at 8:24	AM, staff #1 indicated she just						
	got suspended on 7/	/11/22 due to not initiating						
		ved to the group home. Staff #1						
		first saw client A in his bed,						
	_	immediately knew he was						
		ed she did not initiate CPR						
		vious he was dead." She						
	_	cs indicated to her client A quite some time." Staff #1						
	_	quite some time." Staff #1 vas suspended 3-4 days after						
		e continued to work at the						
		of days before being						
	suspended.	and a colore come						
	_	ates to complaint #IN00383486.						
		же с соприне // 11100505400.						
	9-3-2(a)							
W 0156	483.420(d)(4) STAFF TREATME	ENT OF CLIENTS						

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 07/14/2022	
	ROVIDER OR SUPPLIER	_TERNATIVES SE IN	115 S	T ADDRESS, CITY, STATE, ZIP COD STONEGATE FORD, IN 47421	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
Bldg. 00	The results of all in reported to the addrepresentative or the accordance with Stays of the incider Based on record revincident/investigative clients A, E and H, results of investigative administrator within incident. Findings include: On 7/11/22 at 11:31 incident/investigative indicated the follow 1) A 6/18/22 Burea Services (BDDS) in reported [client A] full out of contacted nurse and that [client A] fell out of contacted nurse and that [client A] was at to complete 15-minimised staff to comfused staff to comfused staff to comfused staff to comfused staff to comfused. Cause of [Client A] had been evaluated for hospid his guardian after had ay prior to his deat On 7/11/22 at 5:56 Investigative Summindicated in the Comfused staff confused in the Comfused staff confused in the Comfused	AM, a review of the facility's reported the incident, and been sleeping when he got om. While in the restroom this wheelchair. Staff reported the incident, and alert. The nurse advised staff ute checks and [client A] Nurse was contacted and tact EMS (Emergency Medical ived and pronounced [client A] death unknown currently. ill and was scheduled to be the services at the request of aving seen his physician the h."	W 0156	To correct the deficient pract QA and administrative staff responsible for site have been re-trained on Investigations completed within 5 business days. Additional monitoring be achieved by the QAM revall incident reports and assignivestigations. The QAM will assign a deadline for all investigations to be completed submitted for peer review. Ongoing monitoring will be achieved quarterly through the quality and safety committee reviewing all incidents for parand appropriate safety means.	en are s will viewing gning I led and the eatterns

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G194	B. W	ING		07/14/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ONEGATE		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RD, IN 47421		
				<u> </u>			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		not resuscitate) and suggested					
		nission. Substantiated [client					
		ed [client A] to remain at the					
		antiated staff did not initiate					
		nary Resuscitation).					
	Substantiated cause						
	cardiopulmonary ar	rrest and Down Syndrome."					
	On 7/12/22 at 0:17	AM, a review of the 7/12/22					
		AIVI, a review of the 7/12/22 nary was conducted. The					
	-	ated, "On 6/17 [client A] was					
	-	= = =					
	assisted to restroom by [staff #6] and was seated in his wheelchair when [staff #6] heard one of						
	[client A's] housemates get out of bed. [Staff #6]						
	left [client A] sitting in the wheelchair to go attend						
		Staff #6] then heard a noise and					
		t A], finding him lying on the					
	_	sisted [client A] back into the					
		k [client A] back to his					
		ed [client A] back to bed.					
		onding to [staff #6] at that					
		empted to contact nurse with no					
		hen contacted Program					
	Manager (PM) and	reported the fall. PM told					
		ete 15-minute checks. [Staff #6]					
	completed checks a	and at approximately 6:53 AM					
	[staff #6] contacted	PM and reported [client A]					
	was limp, PM told	[staff #6] to help [client A] sit					
	up and he saw that	[client A's] back was purple.					
	PM told [staff #6] t	o call 911. EMS (Emergency					
	Medical Services) a	arrived at approximately 7:08					
	(AM) and said [clie	ent A] was deceased. Official					
	cause of death is Ca	ardiopulmonary Arrest and					
	Down's Syndrome.'	"					
		etion indicated, "Substantiated					
		PCP on 6/16 who advised [client					
	_	and suggested nursing facility					
		ntiated [client A's] guardian					
	wanted [client A] to	remain at the group home.					

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	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING <u>00</u> COMPLETED		
15G194 B. WING 07/14/2022		
STREET ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER 115 STONEGATE		
RES CARE COMMUNITY ALTERNATIVES SE IN BEDFORD, IN 47421		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF CORRECTION (X5)		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETICATION CONTINUED TO THE APPROPRIATE COMPLETION CONTINUED TO THE APPROPRIATE CONTINUED TO THE APPROPRIA	ON	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE		
Substantiated staff did not initiate CPR.		
Substantiated [client A] died from		
Cardiopulmonary Arrest and Down Syndrome."		
The 7/12/22 Investigation Peer Review indicated		
the following:		
"-Term [staff #6].		
-Term [staff #0].		
-Remistate [staff #1]. -Retrain management on directing staff to contact		
911 in the event staff are unable to reach nursing		
and there is a medical concern.		
-CPR refresher with all staff.		
-Retrain staff on nursing chain of command.		
-Retrain staff on Change of condition procedure.		
-Retrain staff on when to call 911/911 protocol.		
-DON (Director of Nursing) to review		
protocols/procedures with state Nurse Manager		
regarding plan of action for individuals who are		
awaiting assessment/intervention for Hospice.		
-Retrain QA (Quality Assurance) on investigation		
completion within 5 business days.		
-Hourly bed checks on clients.		
-Client specific training completed with staff."		
The results of the investigation were not		
submitted to the administrator for review within 5		
working days.		
2) On 2/13/22 (no time indicated), bruises of an		
unknown origin were found on client E. The		
undated Unknown Injury Investigation indicated,		
"During routine body scans on 2-13-22 several		
small bruises were found on [client E]. Right upper chest ½" (inches). Right Calf ½". Left arm		
y''. Lower Right Arm ½". Upper Right arm >½".		
Left Shin ½" Does the staff have any		
recollection of how the injury may have occurred?		
No, all home staff were questioned, and no one		
could give an exact reason as to why the marks		
occurred. Some speculations from staff were that		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/14/2022	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD FONEGATE DRD, IN 47421	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY	BE COMPLETION
TAG	he often bumps into (self injurious behamoved in his bedroointo Not that any [Client E's] BSP (be SIB and physical agroommates (sic) BS (Human Rights Corroom and staff wou even with the door Recommendations continue hourly roo Supervisor) and QID Disabilities Profess observations to ensure 3. Re-train staff on There was no docur the investigation we administrator for readministrator for readministrat	section indicated, "1. Staff will om checks. 2. The AS (Area DP (Qualified Intellectual ional) will complete routine are plans are being followed. completing daily body scans." mentation when the results of cre submitted to the view. time indicated), client H was ch marks on his back. The injury Investigation indicated, apper back greater than 3 indicated, "No, all home ed, and no one could give an orby the mark occurred. Staff was very possible [client H] while itching" The section indicated, "1. All staff in H's] nails are routinely if will continue hourly room and QIDP will complete routine are plans are being followed. completing daily body scans."	TAG	DEFICIENCY	DATE

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2022 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		1 1	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 07/14 /	ETED		
		ROVIDER OR SUPPLIER	LTERNATIVES SE IN		115 STC	DDRESS, CITY, STATE, ZIP COD DNEGATE RD, IN 47421		
	(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
		and a bruise on clie Unknown Injury In #1] notice (sic) scra roughly 10 inches, the upper right arm investigation indica with in days of the HM] had no idea he occurred. No one rany falls. The reposhe found the scratce fingernails were 'exspeculated that [clie himself. [Staff #1] the only staff to trim the arm was undete occurred." The Recindicated, "Recompattern of IUO (inju [client H], it should AS/RM/AED (Area Manager/Assistant ins during the week staff to be re-trained routinely. 3. All stabody assessments a minimum of 30 day determines it is need. There was no docur the investigation we administrator for reconstruction.	mentation when the results of ere submitted to the					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 07/14/2022
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE DRD, IN 47421	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	surrounding client A investigated and the administrator within stated "still have a finvestigation." On 7/12/22 at 2:28 the timeframe for re-	30 days however the events A's death should be been e results reported to the n 5 working days. The AED five day requirement for the PM, the QIDP Lead indicated eporting the results of an administrator was 5 working			
	On 7/12/22 at 9:25 Coordinator (QAC) may need an addend The QAC stated "th 5 working days. Di information, reinter wrote the draft repo	AM, the Quality Assurance stated, "The investigation dum. Currently in draft form." lought we had longer than the d first interviews, got initial viewed as needed and then ort." The QAC indicated the ting the results to the working days.			
	Manager (QAM) in reporting the results administrator was 5	PM, the Quality Assurance dicated the timeframe for s of investigations to the working days. attes to complaint #IN00383486.			
	9-3-2(a)				
W 0157	483.420(d)(4) STAFF TREATME	ENT OF CLIENTS			
Bldg. 00	If the alleged viola corrective action r Based on record rev incident/investigativ clients C, E, G and implement correctiv	ntion is verified, appropriate nust be taken.	W 0157	To correct the deficient practi QA and administrative staff responsible for site have bee re-trained on ensuring all inci patterns are addressed timely	n dent

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STATEMENT OF DEFICIENCIES X1) PROVIDER/S		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETE	ED
		15G194	B. WING			22
			<u> </u>			
NAME OF P	PROVIDER OR SUPPLIEF	8		ET ADDRESS, CITY, STATE, ZIP	COD	
				STONEGATE		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	BED	FORD, IN 47421		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	APPECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		SHOULD BE CO	OMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	AFFROFRIATE	DATE
	origin and failed to	recognize and take appropriate		well as investigation		
	actions to address p	atterns related to injuries of		recommendations be	ing	
	unknown origin.			completed. Additiona	-	
				will be achieved by th	-	
	Findings include:			tracking all Group ho	me incidents	
				and reviewing for pat		
	On 7/11/22 at 11:31	AM, a review of the facility's		patterns of incidents		
		ve reports was conducted and		IDT will meet to put a		
	indicated the follow	ving:		measures in place. C		
				monitoring will be acl	nieved	
	1) On 2/13/22 (no	time indicated), bruises of an		quarterly through the	quality and	
	unknown origin we	re found on client E. The		safety committee rev	ewing all	
	undated Unknown Injury Investigation indicated,			incidents for patterns	and	
	"During routine b	ody scans on 2-13-22 several		appropriate safety me	easures.	
	small bruises were	found on [client E]. Right				
	upper chest 1/2" (inc	hes). Right Calf ½". Left arm				
	½". Lower Right A	rm ½". Upper Right arm >½".				
	Left Shin ½" Do	es the staff have any				
	recollection of how	the injury may have occurred?				
	No, all home staff v	vere questioned, and no one				
	could give an exact	reason as to why the marks				
	occurred. Some spe	eculations from staff were that				
	_	things, has a history of SIB				
		vior), and furniture has been				
		om that he could have ran (sic)				
		of the staff are aware of.				
		ehavior support plan) reflects				
		ggression as well as his				
	, ,	SP. However, there is an HRC				
	I '	nmittee) baby monitor in their				
		ld have heard an altercation				
	even with the door					
		section indicated, "1. Staff will				
	•	om checks. 2. The AS (Area				
		DP (Qualified Intellectual				
		ional) will complete routine				
		ure plans are being followed.				
	3. Re-train staff on	completing daily body scans."				
	Staff #6 worked with	th client E prior to the injuries				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/14/2022	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 S ⁻	ADDRESS, CITY, STATE, ZIP COD FONEGATE ORD, IN 47421	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION
	There was no docur observations were composervations were composervations were composervations are to ensure [client maintained. 2. Staf checks. 3. The AS	cime indicated), client H was ch marks on his back. The njury Investigation indicated, upper back greater than 3 indicated, "No, all home ed, and no one could give an only the mark occurred. Staff was very possible [client H] chile itching" The section indicated, "1. All staff H's] nails are routinely f will continue hourly room and QIDP will complete routine			
	observations to ensure plans are being followed. 4. Re-train staff on completing daily body scans." Staff #6 worked with client H prior to the injuries being found. There was no documentation the recommended observations were conducted.				
	3) On 3/5/22 at 9:0 and a bruise on clies. Unknown Injury Im #1] notice (sic) scra roughly 10 inches, I the upper right arm investigation indica with in days of the RM] had no idea he occurred. No one reany falls. The reposshe found the scratce	0 AM, staff #1 found scratches at H's back. The undated vestigation indicated, "[Staff tches across [client H's] back like fingernails and a bruise on about a quarter size." The ted, "All staff that worked ncident: [staff #6, #3, #5 and low the marks could have exported behaviors or seeing refer [staff #1] noted that when thes, she noticed [client H's] tremely' long. [Staff #1]			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/14/2022	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD FONEGATE ORD, IN 47421	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION GEACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE COMPLETION
TAG	speculated that [clie himself. [Staff #1] the only staff to trin the arm was undeter occurred." The Recindicated, "Recomm pattern of IUO (inju [client H], it should AS/RM/AED (Area Manager/Assistant ins during the week staff to be re-trained routinely. 3. All stabody assessments a minimum of 30 day determines it is need. Staff #6 worked with being found. There was no docur observations were considered as bruise on it. about a half inch investigation indicated When I arrived, [stabe found. We were happened. I do known is bruise on the seen anything that considered is a toilet sear a toilet sear.	th client H prior to the injuries	TAG	DEFICIENCY	DATE

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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
		15G194	B. W	ING		07/14/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			ONEGATE		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RD, IN 47421		
	ı			<u> </u>			ı
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
		ot and could have also					
		nclusion section indicated,					
		w the following can be					
	_	E] had a small bruise on his een no event reported that					
	_	his. Staff did note a broken					
		d have caused the injury. No					
	staff indicated any	ş 3					
	physical abuse."	suspicion or					
	physical abuse.						
	5) On 3/25/22 at 6:	00 AM, staff #6 found client E					
	with scratches on his face. The 3/30/22 Unknown						
	Injury Investigation indicated, "Staff heard a						
	distressed noise coming from [client H's and client						
	E's] room. Upon inspection staff found both						
	clients up. [Client]	H] had a toy in his hand and					
	[client E] was found	d to have fresh scratches on					
	his face. Two scrat	ches were found - one under					
	his chin and one on	his lip. Both (sic) about two					
	inches in length S	Staff did not witness how the					
		Staff speculates from the					
		the situation he found upon					
		at [client E] had one of [client					
	H's] toys and [clien						
		ient E]. Staff also noted that					
		re scratched himself, but due to					
		marks. (Sic) It seems more					
		rike from [client H]. After					
		following can be concluded.					
		client H] were in their shared					
		oor shot (sic) and the HRC					
		nmittee) approved audio					
		eard a noise over the baby					
	_	ded. Staff found [client H]					
		and [client E] sitting on his					
		arks on [client E's] face that					
	* *	st occurred. [Client E's] ted, and no further incidents					
	_	culate that [client H]					
	aggressed towards	[client E] over a toy The IDT					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/14/2022	
	RE COMMUNITY A	LTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE ORD, IN 47421	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	discuss potential rooptions of supervisi	am) should convene to commate changes or other on due to the pattern of a origins (sic) between [clients			
	Staff #6 worked wind being found.	th client E prior to the injuries			
	found on client H's Unknown Injury In 4-23-22 bruising wa and back. Left thig inches All staff th of finding the mark could have been can have noted that [clie often bumps into th up with his PCP (pr he is not anemic an After further review [client H] had susta back sometime Frid (morning). Staff we could have occurred condition or bumpin Recommendations: determine to medical bruising. 2. Admin	legs and back. The 4/29/22 vestigation indicated, "On as found on [client H's] legs h 4 inch (sic), and back about 2 nat worked within a few days s had no recollection of what using the bruising. Most staff ent H] jumps into his bed and ings. Staff are also following imary care physician) to ensure d causing extreme bruising v it can be concluded that ined bruising to his leg and lay afternoon to Saturday AM ere unable to recall how that d. Speculations of a medical ng into things. 1. Follow up with PCP to al issues are causing increased istrative staff should do once excifically on the weekends for 2			
	Staff #6 worked 4/2 to 8:00 AM.	1/22 and 4/22/22 from 9:00 PM			
	There was no docur observations were c	mentation the recommended conducted.			
	7) The 5/13/22 Unl	known Origin Investigation			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPP.		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G194	B. W	ING		07/14/	2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	t .			ONEGATE		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			RD, IN 47421		
1120 0/11	(L GOIMMONT 17)			DEDI O	110, III 47421		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		the (date and time not					
		ine staff found multiple					
	_	C's] upper left arm. Ranging					
		up to 4 inches in length." The					
	investigation indica	= =					
		ved the scratches to be					
		[client C's] nails being long					
		g him scratching. [RM] also					
		g (sic) on the zipper of his					
		a also could have caused the					
	_	[1] found the scratches on					
	Sunday 5-8-22. She assumed they were caused by						
	[client C] scratching himself"						
	8) On 6/5/22 at 9:00 AM, a bruise was found on						
	· /						
	-	The 6/10/22 Unknown Injury					
	-	ated, "On 6-5-22 during					
		ff found a 5 inch bruise on					
		The bruise appeared to be					
		he investigation indicated,					
		taff #5] found a bruise on 2 during showers, between 9 am					
	and 9:30 am.	during showers, between 9 am					
		nis left hip and was 5 inches					
		tes the bruise looked as if					
		sic) across something. It was					
	,	esh'. On 6-4-22 (sic) 7pm					
		cident of smearing feces and					
		ged him. During that time,					
		es" The Conclusion					
	-	rther review [client G]					
	sustained an injury						
		se across his hip. The cause of					
		rmined. However, staff noted					
		n into something. [Client G] is					
		and has a fall risk"					
	and a sure of the sure						
	Staff #6 worked wit	th client G prior to the injuries					
	being found.	1					
	<i>5</i>						

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CO A. BUILDING B. WING	E SURVEY PLETED 4/2022			
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP (COD	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		ONEGATE PRD, IN 47421		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION
	(EACH DEFICIEN REGULATORY OR On 7/12/22 at 3:08 interdisciplinary tea conducted. The ID meeting to address doing the following -Random drop ins to Supervisor) and PM focus on overnight: [AS] will implement -Body observations and before bed, as well-are as we	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION PM, a review of an Im (IDT) meeting was I indicated, "From today's Inknown injuries, we are to be implemented by AS (Area I (Program Manager), with Shifts, at least 2 per month. Ited (sic) schedule. It obe completed in morning Iteled, [AS] contacting		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	
	_	death. The RM indicated the ents E and H being separated				

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PRINTED: 08/12/2022 FORM APPROVED

ENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			ON	MB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 07/14/2022	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE DRD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	_	-				
	worked at the grou and Wednesdays. no injuries of unkn Wednesdays and w Mondays, she'd he indicated most of t on the weekends in staff #7. Staff #2 s origin were "defini #2 indicated clients about 3 weeks ago clients E and H hav	o PM, staff #2 indicated she p home Mondays, Tuesdays Staff #2 indicated there were nown injury when she left on when she returned to work on ar about injuries. She he unknown injuries occurred avolving staff #5, #6 and former stated the injuries of unknown itely not client to client." Staff is E and H changed bedrooms after client A's funeral, both we an audio monitor, and daily being conducted by if just started.				
	client G's injury of Staff #3 stated, wh to the injuries of us She indicated she seausing the injuries had been suspende origin have been for assessments were in and H moved out of them up, both clien monitors in their recoff the home by addithe corrective action.	9 PM, staff #3 stated she felt cunknown origin was "strange." en asked if there was a pattern aknown origin, "Absolutely." suspected staff #5 or staff #6 of s. She indicated since staff #6 d, no injuries of unknown bund. She indicated daily body mplemented recently, clients E of their shared bedroom to split hats E and H have audio boms, and increased monitoring ministrative staff. She indicated ons to address injuries of ere implemented less than one				

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On 7/12/22 at 2:01 PM, the Associate Executive Director (AED) indicated, initially, all the injuries

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED						
		15G194	B. W	ING		07/14	/2022		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	•			
				115 STONEGATE					
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		BEDFO	PRD, IN 47421				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	· ·		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		ATE	COMPLETION			
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
		occurred in clients E and H's							
		eated none of the staff saw							
		ally indicated there was no							
	1 ~	taff who worked prior to the							
	1 -	overed. Later in the interview,							
		a pattern was noted involving							
		indicated none of the clients							
	· ·	f unknown origin since staff #6							
		er client A died on 6/17/22.							
		l staff #6 was suspended on							
	_	t off work at 11:00 AM. The							
	AED indicated the facility implemented several corrective actions to address the injuries of								
	_	cluding daily observations,							
	1 -	ents, clients E and H changing							
		nt E having an audio monitor. I he was not sure when the							
	corrective actions v	were implemented.							
	On 7/12/22 at 2:28	PM, the QIDP Lead indicated he							
	found a pattern rela	ated to the injuries of unknown							
		vered on the weekends. He							
		involved seemed to be staff #1,							
		d the injuries, staff #5 and staff							
	#6. He stated some	e of the injuries "were a little							
		ed he asked during the							
	_	aff was doing the injuries and							
	no one said anythir	ng. He indicated it was clear to							
	him clients E and I	H were hitting each other. The							
	-	ed there was no documentation							
	the recommended p	oop ins on weekends were							
	completed. He stated, regarding the injuries of								
		Some were indicative of abuse."							
	He indicated the re	commended observations were							
	conducted although	there was no documentation							
	of them being done	e. He indicated the facility							
	implemented a room	m change with clients E and H							
	to split them up, au	dio monitors for both clients E							
	and H, door alarm	on client E's bedroom, daily							
	body scans. The QIDP Lead indicated the								

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 07/14/2022			LETED			
	NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	(X5) COMPLETION DATE	
140	corrective actions we past month. When were timely, he stat (2022) were OK the measures." On 7/12 although the recome conducted by admind documentation to volumentation to volu	were implemented within the asked if the corrective actions and "seems like April and May en implemented the safety 3/22 at 2:48 PM, the QIDP Lead mended observations were instrative staff, there was no erify it. 7 AM, the nurse indicated he injuries of unknown origin weekends. The nurse stated I like it was when certain ually around when [staff #5 ould have been a coincidence." 8 AM, staff #1 indicated since ispended, there have been no of unknown origin. Staff #1 sure if there was a stated she "felt most were e weekends when [staff #6] to Saturday). Seems staff put it together that the ce he's been suspended. No		140			DATE	
W 0331	483.460(c) NURSING SERVI	CES						
Bldg. 00	Based on record rev clients in the sampl services failed to er	provide clients with nursing lance with their needs. View and interview for 1 of 3 or (A), the facility's nursing assure client A had a physical at his home as recommended crapist.	W	0331	To correct the deficient practic staff responsible for appointm have been trained to ensure a recommendations are follower on timely as well as documentall conversations with doctors offices. Additional monitoring	ents ill d up ting	08/14/2022	

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 07/14/2022				
	NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
	On 7/11/22 at 11:31 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) A 6/18/22 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "It was reported [client A] had been sleeping when he got up to use the restroom. While in the restroom [client A] fell out of his wheelchair. Staff contacted nurse and reported the incident, and that [client A] was alert. The nurse advised staff to complete 15-minute checks and [client A] became less alert. Nurse was contacted and advised staff to contact EMS (Emergency Medical Services). EMS arrived and pronounced [client A] deceased. Cause of death unknown currently. [Client A] had been ill and was scheduled to be evaluated for hospice services at the request of his guardian after having seen his physician the day prior to his death." 2) A 6/6/22 BDDS report indicated on 6/5/22 at 7:00 AM, "Staff reported [client A] became weak in his legs and dropped to the floor, on three occasions on 6/5. Staff assisted [client A] and helped him into a chair. Staff noted an abrasion to his right knee, dime sized, after the last incident" 3) On 3/16/22 (no time indicated), the undated Consumer Falls Investigation indicated, "On 3-17-22 [staff #8] was assisting [client A] out of bed for morning routines. During the transfer [client A] sat down on the ground and refused to get up. [Staff #1] came in shortly after and assisted [staff #8] with getting [client A] off the floor. No injuries were sustained"		be achieved by a weekly reviet all appointments needed to be completed by the site nurse. The surrence of the surrence of the surrence all appointments to ensure recommendations in the been completed. Ongoing monitoring will be completed through quarterly review of all medical needs for each client.	Γο d the ents		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194			ì í	JILDING	instruction 00	(X3) DATE : COMPL 07/14/	ETED
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			•	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE RD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
4) CC A Was he W to R CO ev re 5) CC A i ou an Or A CC Fa "N tra di Pl "R ev hc A di hc Or tes sc	On 2/17/22 (no tonsumer Falls Involved alk towards the baselp another client with the ground from the ground from the ground alk towards the ground from the ground from the ground from the ground from the ground alluation per nurse commendations On 1/31/22 (no tonsumer Falls Involved alluation for in the ground fall to the grand checked for injuring an article of the ground falling at home." The obvious physical ansfers/walking if rections/cooperatingsician/Consultant Recommend Home are to determine in 4/26/22 Nurse As donot address the rome PT evaluation. In 7/13/22 at 3:23 for an article of the ground falling in home." In 7/13/22 at 2:49 for a falliation for the ground fall in home."	ime indicated, the undated estigation indicated, "[Client f bed by staff and started to throom. Staff then went to while [client A] transitioned. E back [client A] had dropped his walker" The ection indicated, "Complete al Therapy/Physical Therapy) and follow any " ime indicated), the undated estigation indicated, "[Client he dining room and slipped round. He was assisted up hary. No injury was found" PM, a focused review of client fucted. A 3/24/22 Medical cated, "Reason for Visit: he Results section indicated, al limitations. Can perform following we." The following the at Orders section indicated, the Health Physical Therapy rapy would be beneficial at f cause of falls is behavioral." sessment and Review Report ecommendations for an in					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/S		(X2) MULTIPLE CO A. BUILDING B. WING	TE SURVEY MPLETED 14/2022			
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZI ONEGATE ORD, IN 47421	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	indicated the staff a appointment however staff to send to the lathere was "nothing indicating they atter appointments. He is attempted to schedul document anything QIDP Lead indicated programming quarter evaluation. On 7/14/22 at 8:23. A had a PT evaluation recommended an in RM called to schedul to they did not has indicated the RM caspointment. The redocument it. The number of the RM documenter appointment. The redocument everythin on 7/12/22 at 9:25. Coordinator (QAC) ordered but not combe had an evaluation recommended home when staff called to staff was told the Prot have anyone to was not sure if there ResCare staff calling She indicated staff attempts to make an stated, "if it's not documents appointment of the staff attempts to make an stated, "if it's not documents appointment of the staff attempts to make an stated, "if it's not documents appointment of the staff attempts to make an stated, "if it's not documents appointment of the staff attempts to make an stated, "if it's not documents appointment of the staff attempts to make an stated, "if it's not documents appointment of the staff attempts to make an stated, "if it's not documents appointment of the staff attempts to make an stated, "if it's not documents appointment of the staff appoi	AM, the nurse indicated client on at their office. The PT home evaluation. When the ule the appointment, she was we enough staff. The nurse indicated he did not turse indicated he did not think ther attempts to schedule the nurse stated, "I need to				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/12/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	VIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2)			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		15G194	B. WING			07/14/2022	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	REGULATORY OR LSC IDENTIFYING INFORMATION			DEFICIENCY)		DATE
	9-3-6(a)						

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