PRINTED:	06/15/2021
FORM APP	PROVED

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 15G745 B. WING 05/11/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16611 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE. IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE TAG W 0000 Bldg. 00 This visit was for the investigation of complaint W 0000 #IN00349488. Complaint #IN00349488: Substantiated, no deficiencies related to the allegation(s) were cited. Unrelated deficiencies cited. Survey dates: 5/6/21, 5/7/21, 5/10/21 and 5/11/21 Facility Number: 011663 Provider Number: 15G745 AIMS Number: 200902020 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/26/21. 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 observation, record review and W 0149 06/10/2021 The Program Manager will 1. interview for 2 of 2 sampled clients (A and B) and ensure the Area Supervisor and 2 additional clients (C and D), the facility failed to Residential Manager retrain staff implement its policy and procedures for on the Abuse, Neglect and prohibiting abuse, neglect, exploitation, Exploitation Policy and mistreatment or violation of an individual's rights disciplinary action will be given if to prevent 1) alleged mistreatment of client A and the policy is not followed. client B, 2) a pattern of client-to-client physical 2. Area Supervisor and aggression between clients A and C and clients B Residential Manager will ensure and D, and 3) appropriate staffing supports for that the Abuse, Neglect and clients A, B and C according to their program Exploitation Policy is followed.

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

TITLE

Monitoring of Corrective

Action: The Program Manager,

(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.

plans.

3.

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G745	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 05/11/2021	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD		
RES CA	RE SOUTHEAST II	NDIANA		YVILLE, IN 47126		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	Findings include:			Area Supervisor and Resider		
				Manager will ensure all incide		
		7 AM, a review of the Bureau of		of possible abuse, neglect an		
	-	sabilities Services (BDDS)		exploitation are reported to th	ie QA	
	•	d accompanying Investigative		department.		
	Summaries was co	mpleted. The reports indicated:		4. The Behavior Clinician		
				QIDP will review ISP/BSP an		
	-	d 5/6/21 indicated, "It was		train facility staff on updated		
	-	unknown date, staff observed		to ensure appropriate suppor	ts are	
	-	5] holding on to the front of		included.		
		ith his face near [client B's] face. ervened and [staff #5] released		5. A member of the review		
	[client B] and left			team will observe the Facility	anu	
		the room.		report back to the IDT. 6. An IDT will meet weekly	, to	
	The review indicat	ed the investigation was in		review and report on issues a		
	process.	ed the investigation was in		the team will discuss and		
	process.			implement improvements.		
	BDDS report dated	1 5/5/21 indicated, "It was		7. The Facility will ensure		
	-	was talking to QIDP (Qualified		staffing is adequate to support	rt the	
		lities Professional) when he told		individuals and ensure prope		
		[#5] had hit him in the face near		implementation of plans.		
	his left eye.					
		ble to report the date of incident		Persons Responsible: Exect	utive	
		of days ago'. No injuries were		Director, Program Manager,		
	reported".	, , ,		Quality Assurance, Area		
	1			Supervisor, Director of Nursir	na,	
	The review indicat	ed the investigation was in		Nurse, Behavior Clinician, QI	DP,	
	process.			Residential Manager, and DS	SP.	
		5 AM, staff #3 was interviewed.				
		about the allegations regarding				
		C. Staff #3 stated, "It happened				
		nd, that Friday. [Staff #5] and				
		p that weekend. [Staff #2] was				
	-	nt B] asked who was coming in.				
		to his behaviors 'I don't want				
		we got him to calm and [staff #2]				
	-	(client B) was wigging out.				
		imself on the floor. [Staff #5]				
	salu everybody ou	t'. When I opened the door he	1			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G745	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/11/2021			
NAME OF	PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZIP COD 16611 SIMA GRAY RD					
RES CA	RE SOUTHEAST I	NDIANA	HENRY					
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)		
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETIO		
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
	(staff #5) had him	like this (both hands clinching						
	the front of her sh	irt). I told him (staff #5)						
	enough". Staff #3	was asked where this occurred.						
	Staff #3 stated, "In	n his (client B's) room. [Staff #5]						
	had him by the shi	irt after shutting the door. I told						
	him (staff #5) enor	ugh. [Staff #5] told me he						
	spanked [client B]	like he was his own kid. That						
		end when I worked with him						
	(staff #5). [Client	C] and [Client B] told me they						
	were mean. He (st	aff #5) told me he poured water						
	over [client B's] h	ead. They took a cup of water or						
		he sink. All I know was the						
		ney did that because he doesn't						
		im (client B) to do what they						
	-	n [area supervisor] and he didn't						
		s so embarrassed when I talked						
	with QA (Quality	Assurance). I didn't report that. I						
		vas a bully. They make [client C]						
		keep him busy. [Client C] has						
	-	hitting him. I've not seen that.						
		lient C] about telling the truth						
	-	g. [Client C] lies a lot. I'm not for						
		know they make him ride his						
	-	or an hour if he's aggravating						
		aid when I first started they						
		e retards. I remember talking to						
		at. He said we might say that						
		n't think this is the right job for						
		round the edges. All of that						
		over Easter weekend, the first						
		rked with them. [Staff #5] told						
		ient B] like he was 'my own son'.						
	_	and a 40 something grown man.						
		h QA, I was embarrassed that I						
		ner. [Staff #5] and [staff #4] are						
	_	They will cover, I was stuttering						
		was talking with QA. [Client C]						
		t or miss (telling the truth) with						
		e tells the truth and sometimes						
		know what I seen with [client B].						
	ne doesn't. I only i	know what i seen with [chefit b].						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G745	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/11/2021	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP C	OD	
RES CA	RE SOUTHEAST I	NDIANA		SIMA GRAY RD YVILLE, IN 47126		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	PECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	COMPLETIO
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		really complain about [staff #4]. say much. He's (client D) afraid against him".				
	Client D was asked Client D stated, "V and [staff #3] are H it's different". Clie feel. Client D state After [client B] state pick him up under room. Then they c on my side". Clien Client D stated, "[o staff". While askin working at the gro the question by state get, get. It's the att on his bike. When	5 AM, client D was interviewed. d how he felt he was treated. Vell, pretty good when [staff #2] nere, but [staff #5] and [staff #4] nt D was asked how it made him d, "Like I'm being mistreated. rted hitting and spitting they the arms and drag him into his ome back. Usually [staff #4] is t D was asked if he was ever hit. client B] (hits him), but not g about staff #4 and staff #5 up home, client D interrupted ting, "It's the issue. They say itude they have. With [client C] he (client C) comes out, they				
	On 5/10/21 at 11:1 interviewed. The A about alleged mist C. The Area Super (staff #5) was bein about [client B]. I suspended, and it's Supervisor was asl mistreatment. The would report it". On 5/10/21 at 2:03 interviewed. The in status of the invest C's alleged mistreat	(to ride his bike)". 8 AM, the Area Supervisor was Area Supervisor was asked reatment of client B and client visor stated, "They told me he g suspended. I didn't know just know he (staff #5) is being investigated." The Area ked if he was aware of any Area Supervisor stated, "No, I PM, the investigator was nvestigator was asked about the igations into client B and client ttment. The investigator dent had a separate				
	investigation ongo	ing and 4 people still needed to e investigator was asked about				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G745	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/11/2021				
NAME OF	PROVIDER OR SUPPLIE	ĒR			DRESS, CITY, STATE, ZIP COD					
	RES CARE SOUTHEAST INDIANA			16611 SIMA GRAY RD HENRYVILLE, IN 47126						
RES CA	RE SOUTHEAST I	NDIANA			ILLE, IN 47 120					
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	IĽ	)	PROVIDER'S PLAN OF CORREC		(X5)			
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	LD BE ROPRIATE	COMPLETIO			
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TA	G	DEFICIENCY)		DATE			
		ents for the incidents. The								
	-	, "I'm not sure of the timeline								
		reported having a black eye. I								
	-	s and there was no black eye".								
	-	vas asked about the timeline of								
		's incident. The investigator								
	-	. I just spoke with someone								
		ree weeks ago. I talked with her								
		t she reported, on the 5th (May								
		l me the first day she worked								
		ff #5] stated said he spanked him								
	· · · · · ·	ts him like he was his own son.								
		ock full responsibility for that								
		he investigator was asked if								
		D were interviewed. The								
	-	, "I did interview [client D]. He								
		ck [client B] on the butt". The								
	-	sked about the use of water to								
	-	nply to staff direction. The								
	-	, "She (staff #3) told me the								
		didn't see him do it. [Client C]								
		him multiple times with (open								
		er". The investigator was asked								
		ng directed to ride his bike. The								
	U	, "[Staff #3] said they (staff #5)								
		C) ride his bike. I've read narrative								
		ere they've noted he rides his								
		id he hasn't seen anything.								
	[Client D] did not	say anything about it (bike)".								
	2) On $5/7/21$ at 7.4	47 AM, a review of the Bureau of								
		sabilities Services (BDDS)								
	-	ad accompanying Investigative								
	-	ompleted. The reports indicated:								
	Summaries was et	impresed. The reports indicated.								
	BDDS report date	d 3/20/21 indicated, "It was								
	-	became agitated with [client C].								
		o hit [client C] then bit [client C]								
		n. [Client C] scratched [client A]								
		the face. Police were called for								

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/11/2021 15G745 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16611 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE assistance. [Client A] then left the group home with staff following. [Client A] was running toward the highway when police arrived and picked [client A] and staff up and returned them to group home. [Client C] stated he wanted to press charges. Police took report and stated report would be sent to prosecutor. [Client C] sustained a bite that broke the skin with a 3 1/2 inch bruise on his left forearm and a 1/4 inch scratch on the left side of his chest. [Client A] sustained a 1 inch and a 4 1/2 inch scratch on the left side of his face. [Client C] was transported to ER (emergency room) for treatment of injuries. [Client C] (sic) released prescription for Amoxicillin/Clavulanate Potassium (antibiotic) 875 mg two times daily for 7 days". Investigation summary dated 3/20/21 indicated, "Briefly describe the incident:... [Client A] got up and started hitting [client C]. Staff intervened and clients sat back down in their seats. [Client A] jumped up again and started swinging at [client C] and biting him on the arm ...7. Is there a pattern of occurrences between these two clients? Yes ...Recommendations: The team will meet to discuss options. Staff will continue to follow the BSP/ISP (Behavior Support Plan/Individual Support Plan) ... ". BDDS report dated 3/23/21 indicated, "It was reported [client A] became agitated with [client C]. Staff attempted to verbally redirect the two men. [Client A] then approached [client C] and [client C] made a fist at [client A]. [Client A] then hit [client C] in the left side of the face. Staff attempted to verbally redirect the two men and contacted police for assistance. Police arrived and had [client A] go to a different room. Police spoke to both men and calmed them. No injuries were reported". Event ID: HHH211 Facility ID: 011663 Page 6 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 15G745 B. WING 05/11/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16611 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Investigation summary dated 3/22/21 indicated, "Briefly describe the incident: Staff was getting medications and redirected [client C] several times to stop speaking to [client A] in a disrespectful manner. [Client A] then confronted [client C] in his room and [client C] balled his fists up at [client A]. [Client A] then punched [client C] in the face. Staff redirected the clients and called 911...7. Is there a pattern of occurrences between these two clients? Yes, there is a pattern ... Recommendations: Team met and discussed incidents. Team is going to seek transfer to another facility. The team is going to touch base with [name] and the psychiatric group [name] from [city] for assistance. There will be a third staff during medication times in the home". BDDS report dated 3/24/21 indicated, "It was reported [client B] was taking a dish to the sink when [client D] got hold of [client B's] arm. [Client B] then hit [client D] in the chest. Staff was able to verbally redirect the two men. No injuries were reported". Investigation summary dated 3/23/21 indicated, "Briefly describe the incident: [Client B] slapped [client D] in the chest after [client D] grabbed him by the arm. Staff immediately redirected [client B]... 7. Is there a pattern of occurrences between these two clients? Yes ...Recommendations: Team needs to meet to review pattern of client-to-client behaviors and discuss options to help reduce these occurrences". BDDS report dated 4/15/21 indicated, "It was reported [client B] came out of his bedroom and [client D] told [client B] to go back in his bedroom. [Client B] hit [client D] on the right side of the face. Staff verbally redirected both men. No Event ID: HHH211 Facility ID: 011663 Page 7 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G745	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/11/2021					
	NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 16611 SIMA GRAY RD HENRYVILLE, IN 47126						
RES CA		NDIANA		VILLE, IN 47 120						
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETIO DATE				
IAU	injuries were report	PR LSC IDENTIFYING INFORMATION rted".	IAG			DAIL				
	<ul> <li>"Briefly describe to of his room and [c his room. [Client I away. Staff verbal redirected [client I pattern of occurren Yes Recommend provide appropriate deter further opport incidents".</li> <li>BDDS report date reported [client D] dinner when [client the milk at the sam agitated and hit [c]</li> </ul>	mary dated 4/14/21 indicated, he incident: [Client B] came out lient D] told him to go back in B] slapped [client D] and walked ly (sic) there was no injury. Staff B] back to his room. 7. Is there a nees between these two clients? dations: Staff will continue to the supervision of the clients to rtunities for client-to-client d 5/6/21 indicated, "It was and [client B] were eating nt D] and [client B] reached for ne time. [Client B] became lient D] on the back. Staff was direct the two men. No injuries								
	process.	ted the investigation was in								
	3) Observation was conducted on 5/10 10:09 AM to 11:31 AM. Staff #2 answ door and completed the Covid-19 scret took the surveyor's temperature. Clien and D were in their rooms. While staff completed the Covid-19 screening wit surveyor, staff #3 was verbally promp about his morning snack and stated, "A ready for it"? Client D indicated he was returned to his room from the kitchen 10:19 AM, staff #2 was asked about s supports present at the home. Staff #2 only he and staff #3 were present at th 10:25 AM, staff #3 was being intervie incident history noted above. During to	1 AM. Staff #2 answered the ed the Covid-19 screening and s temperature. Clients A, B, C r rooms. While staff #2 vid-19 screening with the was verbally prompting client D snack and stated, "Are you nt D indicated he was not and m from the kitchen area. At 2 was asked about staffing t the home. Staff #2 indicated 43 were present at the home. At 3 was being interviewed about								

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06/15/2021

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G745 05/11/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16611 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE separated, they're quick". The QAM indicated a pattern of client-to-client physical aggression had been identified. The QAM was asked about the staffing support levels at the home and the incidents that occurred on 2/7/21 and 3/22/21. The QAM stated, "There should be 3 staff during waking hours. We continue to question the ratio. We ask the staff (interview during investigation) and then check the timesheets". The QAM indicated staffing supports during the incidents on 2/7/21 and 3/22/21 were found through investigation to be not met. The QAM was asked about the implementation of the abuse, neglect, exploitation or mistreat and violation of an individual's rights (ANE) policy implementation during these above noted incidents. The QAM indicated the ANE policy should be implemented at all times and stated, "Yep". On 5/10/21 at 2:45 PM, the Interim Associate Director (IAD) was interviewed. The IAD was asked about the alleged mistreatment of clients B and C. The IAD stated, "I don't know the details on that". The IAD indicated an ongoing investigation into the allegations was being completed. The IAD was asked about the pattern of client-to-client physical aggression and staffing supports. The IAD indicated staffing supports were reviewed and changes in wage rate were forthcoming as way to attract and maintain staffing supports. The IAD stated, "It's 3 staff (during waking hours) and it's been a struggle". The IAD indicated staff supports were not met during the 2/7/21 and 3/22/21 incidents. The IAD indicated client A's placement was being reviewed and stated, "With [client A], we're looking at other services". The IAD indicated the client-to-client patten of physical aggression had been identified. The IAD indicated the ANE policy should be implemented at all times. HHH211 Facility ID: 011663 Page 11 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 15G745		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/11/2021	
	PROVIDER OR SUPPLIE RE SOUTHEAST I		1661	ET ADDRESS, CITY, STATE, ZIP COD I 1 SIMA GRAY RD IRYVILLE, IN 47126		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	D BE	(X5) COMPLETION DATE
W 0153 Bldg. 00	<ul> <li>was reviewed. The "ResCare strictly j exploitation, mistr Individual's rights</li> <li>9-3-2(a)</li> <li>483.420(d)(2)</li> <li>STAFF TREATM The facility must mistreatment, nei injuries of unknoi immediately to th officials in accord established proc Based on interview sampled clients, th alleged mistreatmare reported to the adding Findings include:</li> <li>1) On 5/7/21 at 7:: Developmental Dri incident reports ar Summaries was con BDDS report date reported that on an other staff [staff # [client B's] shirt w Reporting staff intig [client B] and left The review indica process.</li> </ul>	IENT OF CLIENTS ensure that all allegations of eglect or abuse, as well as wn source, are reported the administrator or to other dance with State law through edures. w and record review for 1 of 2 the facility failed to ensure ent of client B was immediately ministrator. 47 AM, a review of the Bureau of tabilities Services (BDDS) and accompanying Investigative completed. The reports indicated: d 5/6/21 indicated, "It was n unknown date, staff observed 5] holding on to the front of rith his face near [client B's] face. rervened and [staff #5] released	W 0153	<ol> <li>The facility must en all allegations of mistreatu neglect or abuse, as well injuries of unknown source reported immediately to the administrator or to other of accordance with State law established procedures.</li> <li>The facility will retration on the requirement of immediately to the allegations of mistreatme reporting to ensure all alle allegations of mistreatme reported as required by state federal and company polition the Reporting Standard.</li> <li>Program Manager ensure the Area Supervise Residential Manager retration care staff on the Abuse, Mand Exploitation Policy. If follow policy will result in</li> </ol>	ment, as e, are he officials in v through in staff nediate eged nt are tate, cy. r will he BDDS will or and ain direct leglect	06/10/202

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G745	A. BL	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/11/2021	
NAME OF	PROVIDER OR SUPPLIE	ĒR			ADDRESS, CITY, STATE, ZIP COI	)	
					SIMA GRAY RD		
RES CA	RE SOUTHEAST I	NDIANA		HENRY	YVILLE, IN 47126		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
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TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	l about mistreatment of client B.			disciplinary action up to a	and	
		happened over Easter			including termination.		
		lay. [Staff #5] and [staff #4]					
		ekend. [Staff #2] was still here			Persons Responsible: C		
		ed who was coming in. [Client B]			Manager, QA Coordinato		
		viors 'I don't want [staff #5]'. I			Residential Manager, Are		
	-	to calm and [staff #2] left. One			Supervisor, DSP and Pro	ogram	
		was wigging out. [Client B]			Manager.		
		he floor. [Staff #5] said					
		Then I opened the door he (staff					
		his (both hands clinching the					
		I told him (staff #5) enough". I where this occurred. Staff #3					
		ent B's) room. [Staff #5] had him					
		hutting the door. I told him					
	-	[Staff #5] told me he spanked					
		vas his own kid. That was the					
		n I worked with him (staff #5).					
		ient B] told me they were mean.					
		me he poured water over [client					
		ok a cup of water or the sprayer					
		I know was the couch was wet.					
	They did that so b	ecause he doesn't like it and to					
	get him (client B)	to do what they want. I talked					
	with [area supervi	sor] and he didn't seem to care. I					
	was so embarrasse	ed when I talked with QA					
	(Quality Assurance	e). I didn't report that".					
	On 5/10/21 at 11:1	18 AM, the Area Supervisor was					
		Area Supervisor was asked					
	e	mistreatment of client B and					
		Supervisor stated, "They told					
		as being suspended. I didn't					
		t B]. I just know he (staff #5) is					
		s being investigated. The Area					
	-	ked if he was aware of any					
	mistreatment. The would report it".	Area Supervisor stated, "No, I					
	On 5/10/21 at 2:03	3 PM, the Investigator was					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 15G745 B. WING 05/11/2021 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16611 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE interviewed. The investigator was asked about the status of the investigations into client B's alleged mistreatment and timeline of events. The investigator stated, "I can't say. I just spoke with someone who said two or three weeks ago. I talked with her (staff #3) the night she reported, on the 5th (May 2021). She did tell me the first day she worked with him that [staff #5] stated said he spanked him (client B) and treats him like he was his own son. She told me she took full responsibility for that (not reporting)". On 5/10/21 at 1:14 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the reporting of the alleged mistreatment of client B. The QAM indicated suspected abuse, neglect, mistreatment should be reported immediately to the administrator. The QAM indicated staff have been trained and further follow up was needed. On 5/10/21 at 2:45 PM, the Interim Associate Director (IAD) was interviewed. The IAD was asked about the reporting of the alleged mistreatment of client B. The IAD stated, "We've done a lot of training on reporting. They've seen the repercussions of that". The IAD indicated the alleged mistreatment of client B should have been immediately reported to the administrator and further follow up was needed. 9-3-2(a) W 0186 483.430(d)(1-2) DIRECT CARE STAFF Bldg. 00 The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Event ID: HHH211 Facility ID: 011663 Page 14 of 19 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G745	î, î	LDING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/11/2021	
	PROVIDER OR SUPPLIE			16611	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD		
RES CP	RE SOUTHEAST I	INDIANA		HENRYVILLE, IN 47126			
(X4) ID PREFIX	(EACH DEFICIE	EFICIENCY MUST DE DECEDED DY FILLI DEFENY (EACH CORRECTIVE ACTIO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFLICIENCY)	E	(X5) COMPLETION	
TAG	Direct care staff a on-duty staff calc 24-hour period for living unit. Based on observat interview for 2 of 1 1 additional client there was sufficient and supervise client their program plant Findings include: Observation was c AM to 11:31 AM. completed the Cov surveyor's temperat were in their room Covid-19 screenin was verbally prom morning snack and Client D indicated room from the kito was asked about st home. Staff #2 ind present at the hom being interviewed above. During the entered the home a screening at 10:35 staffed with only s AM to 10:35 AM entered. On 5/7/21 at 7:47 . Developmental Di incident reports, in	are defined as the present culated over all shifts in a or each defined residential ion, record review and 2 sampled clients (A and B), and (C), the facility failed to ensure at direct care staff to manage ints A, B and C according to is. onducted on 5/10/21 from 10:09 Staff #2 answered the door and rid-19 screening and took the ature. Clients A, B, C and D is. While staff #2 completed the g with the surveyor, staff #3 pting client D about his d stated, "Are you ready for it"? he was not and returned to his chen area. At 10:19 AM, staff #2 taffing supports present at the licated only he and staff #3 was about incident history noted interview, the Area Supervisor and completed his Covid-19 AM. The group home was taff #2 and staff #3 from 10:09 until the Area Supervisor AM, a review of the Bureau of sabilities Services (BDDS) aternal incidents reports and estigative Summaries was	W 01		<ol> <li>The Program Manager conduct a weekly meeting to project needs and plan cover for open shifts. All Area Supervisors in the New Alba Program and All ESN Direct Support Leads, will attend if available.</li> <li>ResCare New Albany Operation has brought in sta out of town and, increased w for DSPs outside of the ESN System including paid travel bonuses, and mileage.</li> <li>ResCare New Albany increased DSP hourly base to \$15.00 and \$15.60 based DSP selection of benefits. A \$2000.00 sign on bonus is b offered to all new hires effect June 1, 2021 and a \$2000.00 referral bonus is being offere existing staff to assist in rect qualified DSPs.</li> <li>Human Resources has made filling ESN Open shifts priority, this will continue uni- vacancies are filled.</li> <li>The Area Supervisor w coordinate with ESN Direct Support Leads to ensure sh coverage. All unfilled shift w reported to the Program Ma 6. DSP Base pay has be increased for all ESN Staff f help fill staffing vacancies,</li> </ol>	any aff from vages l time has vages l time has vages on veing tive 0 ed to ruiting s s a til vill ift ill be nager. en	06/10/2021

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G745	(X2) MULTIPLE ( A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 05/11/2021	
NAME OF	PROVIDER OR SUPPLIE	R		t address, city, state, zip co 1 SIMA GRAY RD	OD	
RES CA	RE SOUTHEAST I	NDIANA		RYVILLE, IN 47126		
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TAG	Internal incident re "What happened d (client B) ran to ba (neighboring home basketball court ar room because I ha was watching out a Investigation summ "Briefly describe t injury if any? Lead (medicines) and as the side door; a fee the door and onto stood in the doorw called another hom and got [client B] there sufficient sta There was only on the incident. Staff Recommendations staffing ratios are a ensure the radio sy functioning correce needed". BDDS report dated reported [client A] Staff attempted to [Client A] then ap C] made a fist at [c [client C] in the le attempted to verba contacted police for had [client A] go t to both men and ca reported".	R LSC IDENTIFYING INFORMATION eport dated 2/7/21 indicated, uring the incident? Client isketball court. I called ESN 1 e). [Staff #9] ran down to ad got him back inside into his d to stay with other clients. I the door". mary dated 2/7/21 indicated, he incident and any sustained d staff had given meds is this staff exited the home out w minutes later [client B] ran out the basketball court. Staff ay watching [client B] and he and the Lead staff came back to come back inside 10. Was ff at the time of the incident? e staff working at the time of from ESN 1 assisted. : Team needs to ensure required in place. Team also needs to vstem for assistance is in place, tly and being used when d 3/23/21 indicated, "It was became agitated with [client C]. verbally redirect the two men. proached [client C] and [client client A]. [Client A] then hit ft side of the face. Staff lly redirect the two men and or assistance. Police arrived and o a different room. Police spoke almed them. No injuries were	TAG	additional bonuses are provided for qualified si 7. A weekly report is provided to the hiring m will identify open position forecast staff gains and Persons Responsible: I Manager, Human Reso Quality Assurance, Are Supervisor, Behavior C QIDP, Residential Man DSP.	taff. s being nanager that ons and I losses. Program ource, sa Slinician,	DATE

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G745	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/11/2021		
NAME OF	PROVIDER OR SUPPLI	ER	_		DDRESS, CITY, STATE, ZIP C	OD	
	RE SOUTHEAST I				SIMA GRAY RD VILLE, IN 47126		
RES CA	RE 3001HEA311	NDIANA			VILLE, IN 47 120		<u>.</u>
(X4) ID		Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
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TAG		DR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		edirected [client C] several times					
		c[client A] in a disrespectful					
	-	] then confronted [client C] in nt C] balled his fists up at [client					
	-	n punched [client C] in the face.					
		e clients and called 911 8. Was					
		aff at the time of the incident?					
		uty. Recommendations: Team					
	met and discussed	incidents. Team is going to					
	seek transfer to an	other facility. The team is going					
		[name] and the psychiatric					
		n [city] for assistance. There will					
		ring medication times in the					
	home".						
		9 AM, client A's record was ord indicated the following:					
		rt Plan (ISP) dated 10/2/20					
		rge Plan: The interdisciplinary					
		that he (client A) have					
	-	participating in community is not acquired safe pedestrian					
		equires structure for leisure time					
		erdisciplinary team has reviewed					
		e assessments and determined					
	-	, due to the level of needs and					
		and his inability to transfer some					
		ironments or setting, [Client A]					
	•	lacement and active treatment					
	services".						
	On 5/7/21 at 11:5:	5 AM, client B's record was					
		ord indicated the following:					
		-					
		rt Plan (ISP) dated 3/25/21					
		rge Plan: [Client B] requires					
	-	ure basic ADL's (adult daily					
		ompleted The interdisciplinary					
	team recommends	that [client B] have supervision					

	R MEDICARE & MEDIC					OMB NO. 0938-0	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	· ,	TE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00		APLETED
		15G745	B. W	B. WING		05/11/2021	
NAME OF	PROVIDER OR SUPPLIEF		-		DDRESS, CITY, STATE, ZIP C	OD	
RES CA	RE SOUTHEAST IN	IDIANA		HENRY	VILLE, IN 47126		-
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
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TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		in community activities The					
		m has reviewed the					
	-	essments and determined that					
		the level of needs and training					
	•	ty to transfer some skills to					
		or setting, [client B] is in need IR (Intermediate Care Facility					
		Intellectual Disabilities)					
		ve treatment services".					
	placement and activ	e treatment services					
	On 5/7/21 at 12:15	PM, client C's record was					
		rd indicated the following:					
		8					
	-Individual Support	Plan (ISP) dated 2/25/21					
		ge Plan: The interdisciplinary					
	team recommends t	hat he (client C) have					
	supervision while p	articipating in community					
	activities, as he has	not acquired safe pedestrian					
		quires structure for leisure time					
		disciplinary team has reviewed					
	<u>^</u>	assessments and determined					
	-	o the level of needs and					
		d his unwillingness to transfer					
		environments or settings.					
		ntinued placement and active					
	treatment services	• •					
	On 5/10/21 at 1:14	PM, the Quality Assurance					
		as interviewed. The QAM was					
	asked about the staf	fing support levels at the					
	home and the incide	ents that occurred on 2/7/21					
	and 3/22/21. The Q	AM stated, "There should be 3					
	staff during waking	hours. We continue to					
	question the ratio. V	We ask the staff (interviews					
		ns) and then check the					
	-	AM indicated staffing					
		incidents on 2/7/21 and					
		through investigation to not					
	be met.						
	1						

STATEMENT OF DEFICIE AND PLAN OF CORRECTI		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING	(X3) DATE SURVEY COMPLETED 05/11/2021
NAME OF PROVIDER OR		STREET ADDRESS, CITY, STATE 16611 SIMA GRAY RD HENRYVILLE, IN 47126	, ZIP COD
PREFIX(EACHTAGREGULAOn 5/10/21Director (Iasked abouand C. Theon that". Tinvestigationcompleted.supports. Twere revierforthcominestaffing supports. Twere revierforthcominestaff on the	MMARY STATEMENT OF DEFICIENCIE DEFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION at 2:45 PM, the Interim Associate AD) was interviewed. The IAD was t the alleged mistreatment of clients B IAD stated, "I don't know the details ne IAD indicated an ongoing on into the allegations was being The IAD was asked about staffing he IAD indicated staffing supports wed and changes in wage rate were g as way to attract and maintain oports. The IAD stated, "It's 3 staff king hours) and it's been a struggle". dicated staff supports were not met 2/7/21 and 3/22/21 incidents. at 3:20 PM, the undated ment Guidelines for the 24 hour Support Needs Residences were The record indicated, "Individuals sidences under this category must be at all times and the staffing pattern at y should be a minimum of: three (3) day shift; three (3) staff on the ft; and two (2) staff on the night shift".	ID PREFIX TAG PROVIDER'S PLAN (EACH CORRECTIVE AC CROSS-REFERENCED DEFICIENT DEFICIENT PROVIDER'S PLAN (EACH CORRECTIVE AC CROSS-REFERENCE DEFICIENT DEFICIENT PROVIDER'S PLAN (EACH CORRECTIVE AC CROSS-REFERENCE DEFICIENT PROVIDER'S PLAN (EACH CORRECTIVE AC DEFICIENT DEFICIENT DEFICIENT PROVIDER'S PLAN (EACH CORRECTIVE AC DEFICIENT DEFICIENT PROVIDER'S PLAN (EACH CORRECTIVE AC DEFICIENT PROVIDER'S PLAN (EACH CORRECTIVE AC DEFICIENT (EACH C	CTION SHOULD BE COMPLETION

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