CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/06/2023	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET					
RES-CAI	RE INC			GREEN	NCASTLE, IN 46135			
(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)	ίΤΕ	(X5) COMPLETION DATE	
W 0000								
Bldg. 00	#IN00396047. Complaint #IN0039 and state deficiencion are cited at: W149 at Unrelated deficience	ies cited. 3/23, 1/4/23, 1/5/23 and 1/6/23. 3405 5G811	W	0000				
W 0149 Bldg. 00	These deficiencies is accordance with 410 Quality Review of to on 1/13/23. 483.420(d)(1) STAFF TREATME The facility must downwritten policies an mistreatment, neg Based on record revisampled clients (#1, clients (#6, #8, and implement its written prevent 4 incidents clients #1, #2, #3, # failed to complete the regarding allegation #2, #3, #6, #8 and #	effect state findings in DIAC 16.2-5. This report completed by #27547 ENT OF CLIENTS evelop and implement d procedures that prohibit lect or abuse of the client. Tiew and interview for 3 of 4 #2 and #3), plus 3 additional #21), the facility failed to en policy and procedures to of staff abuse regarding 6, #8 and #21. The facility morough investigations as of staff abuse of clients #1, 21 and failed to complete an If abuse of client #21 within 5	W	0149	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abus the client. Specifically, facility complete thorough investigation regarding allegations of staff a of clients and complete investigations of staff abuse with the complete investigation and the complete investigations of staff abuse with the complete investigation and the complete investigations of staff abuse with the complete investigation and the complete investigations of staff abuse with the complete investigation and the complete investigat	se of will ons abuse vithin	02/06/2023	

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

(X6) DATE

TITLE

Lisa Manista Operation Support Specialist 02/10/2023

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays 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) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	NG		01/06	/2023
				_			
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD		
					BLOOMINGTON STREET		
RES-CAI	RE INC			GREEN	ICASTLE, IN 46135		
(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		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
					Quality Assurance Manager of	r	
	Findings include:				Designee will maintain tracking		
	i munigs metade.				all investigations and assign to	-	
	The facilities BDDS (Bureau of Developmental				investigators while monitoring		
	Disabilities Services) reports and investigations were reviewed on 1/4/23 at 4:00 PM. The review				timeliness to ensure that they		
					completed in 5 business days.		
	indicated the following:				Investigators will be held	•	
	marcated the follow	· · · · · · · · · · · · · · · · · · · 			accountable with appropriate		
	1 Investigation sur	nmary dated 12/2/22 indicated			performance action for		
	the following:	mining dated 12/2/22 indicated			investigations that are not		
	and following.				completed in 5 business days.		
	"On November 26, 2022, during a behavior with				Completed in 5 business days.		
	-"On November 26, 2022, during a behavior with				Quality Assurance Manager o	r	
	[client #2], [RM (residential manager)#1] was observed by nursing to be conducting the YSIS				Designee will review the	I	
		afe) hold incorrectly, and she			investigation tracking with the		
		[RM #1] curse towards [client			_	delve	
	#2]."	[Kivi #1] curse towards [client			investigators no less than wee	KIY	
	#2].				to assure compliance.		
	"It is substantiated	that [client #2] sustained					
		ring his supine hold on					
	11/26/22."	ing ins supine noid on					
	11/20/22.						
	"It is substantiated	that [RM #1] cursed at [client					
	#2] during the supir	= = = = = = = = = = = = = = = = = = = =					
	#2] during the suph	ne on 11/20/22.					
	"It is substantiated	the [client #2] sustained the					
		by ½ inch and 4 inches by 1/2					
	-	-					
		s right clavicle/ armpit area,					
		n right side upper lip					
	underneath."						
	lite in more analysis of	iotod that IDM #111 4					
		iated that [RM #1] punched					
	[client #2] in the fa	ce.					
	IIIt in out the set of	1 the [DM #1] faile 1 to follows					
	- "It is substantiated the [RM #1] failed to follow						
	ResCare Policy and Procedures."						
		Summary dated 12/2/22 did not					
		ation of recommendations to					
	prevent recurrence	as a component of a thorough					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G811	A. BUI B. WIN	ILDING NG	00	01/06/	
			2		DDBECC CITY OTHER TRACE	31/00/	
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CAF	RE INC				CASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	COMPLETION DATE
TAG	investigation.	CESC IDENTIFTING INFORMATION	+	TAG			DATE
	investigation.						
	2. Investigation summary dated 11/8/22 indicated						
	the following:						
	- "On November 8,	2022 around 1:30 PM, [RM #2]					
		staff #2] entered the program					
		ice asking to talk with her. proceeded to tell [PM #1] that					
	1 -	aber 5, 2022 when [staff #3] had					
	1	ck up an employee who didn't					
	· ·	it was reported by two					
	1	ff #3] had stopped at a					
		d employees house [staff #4] mattended in the van while she					
	went inside to visit						
	1	neglect against [staff #3] is					
	substantiated based statements."	on consumer witness					
	statements.						
	The Investigation S	Summary dated 12/2/22 did not					
		tion of recommendations to					
	1 -	as a component of a thorough					
	investigation.						
	3. Investigation sun	nmary dated 10/28/22 indicated					
	the following:						
	- "On October 28. 2	2022, during a behavior with					
		5] was observed by staff with					
		client #21's] face while [client					
		lian and HRC approved YSIS					
	supine hold."						
	- "It is substantiated	d that [client #21] sustained					
	multiple injuries to his face during his supine hold						
	on 10/28/22."						
	- "It is substantiated	d that [staff #5] caused [client					

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Event ID:

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	COMPLETED	
		15G811	B. W	ING		01/06/	2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIER	8			BLOOMINGTON STREET			
RES-CA	RE INC				ICASTLE, IN 46135			
	ı			L				
(X4) ID		STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CO			(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENC!		DATE	
	#21] injuries based	on witness statements."						
	- "It is substantiated	1 by [client #21's] statement be						
	- "It is substantiated by [client #21's] statement he was 'hit in the head' by 'that guy'.							
	was mem meaa	oy that gay.						
	- "It is substantiated	that [staff #5] failed to follow						
	ResCare Policy and							
	The Investigation S	ummary dated 11/2/22 did not						
	indicate documenta	tion of recommendations to						
	prevent recurrence	as a component of a thorough						
	investigation.							
	_	ed 11/2/22 indicated the						
	following:							
	"On November 1	2022, at 8:00 pm [client #1]						
	· ·	station to take his 8:00 PM						
		#1] had taken his meds, staff						
	_	vised him that he was done						
		I thanked him for taking them.						
	-	wn staff) was getting meds						
		lient, [client #1] grabbed the						
		longed to his peer, put the						
	medicine in his mor	uth, and swallowed them. Staff						
	(unknown staff) atto	empted to intervene but was						
	unsuccessful in stop	pping [client #1] from taking						
	them as he was too	quick in taking them. Staff						
		mediately called the nurse on						
		ructed staff to take [client #1]						
		ergency room]. The emergency						
		evaluation on [client #1] and						
		diagnosis: Accidental						
	- ·	ng. Discharge instructions						
		s tonight. Start back with						
		le in morning. Okay to eat and						
	drink overnight. Okay to sleep. Check vital signs few times thru night and get rechecked if feel							
		_						
	_	concerns. The medications he er are the following:						
	nau taken of his pee	er are the following:						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811			(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 00 COMPLET B. WING 01/06/20				ETED
NAME OF I	PROVIDER OR SUPPLIE	R	13	306 S I	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	II PRE		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	NTE.	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)	AIE.	DATE
	Haloperidol 5 mg (mcg (microgram), mg."	milligram), Levothyroxine 20 Olanzapine 20 mg, Topiramate 50					
	The review did not indicate documentation of an investigation.						
	Client #1's record v	was reviewed on 1/5/23 at 3:47					
	PM. Client #1's No	ovember 2022 physician's orders					
		ent #1 should receive					
		Levothyroxine 20 mcg,					
	Olanzapine 20 mg	and Topiramate 50 mg.					
	RM #3 was interviewed on 1/4/23 at 11:35 AM. RM #3 indicated client #1 should not have access to his peer's medication.						
	interviewed on 1/4	rsing assistant) #1 was /23 at 1:20 PM. CNA #1 should not have access to his					
	#1 indicated that cl to his peer's medicated which staff adminimated she did not involved in the admedication on 11/1 follow-up and provergarding which staincident. PM #1 into the investigated. Pl documentation avairecommendations of	or retraining. No additional ing which staff was involved					
		e abuse and neglect policy nted to prevent abuse and					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPL	
		15G811	B. WING			01/06/	ZUZ3
NAME OF F	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP COD		
RES-CAF	RE INC				BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)		DATE
	~	cated incidents of abuse and noroughly investigated with					
	_	o prevent recurrence					
		emented. PM #1 indicated					
	investigations should be completed in 5 business						
	days. PM #1 indica						
		on was complete and would be					
	_	ional documentation received.					
		egations of abuse and neglect					
		regarding clients #1, #2, #3,					
	#6, #8 and #21.						
	The facility's policy	and procedures were					
		at 3:45 PM. The facility's					
	Reporting and Inves	stigating Abuse, Neglect,					
	Exploitation, Mistre	eatment policy dated 7/10/2019					
	indicated the follow	ring:					
	"ResCare strictly no	ohibits abuse, neglect,					
		atment, or violation of an					
	_	These include but are not					
	_	e following: corporal					
	punishment i.e. force	eed physical activity, prone					
	_	nt exercise, hitting, pinching,					
		ain or noxious stimuli, the use					
		e infliction of physical pain,					
		which exit is prohibited, an					
		on is locking an individual in not allowing them to leave,					
		overcorrection, visual or					
		rbal abuse including					
	_	g, name-calling, belittling,					
	_	dual's self respect or dignity,					
	failure to follow ph	ysician's orders, denial of					
	1 -	drink, physical movement for					
		of time, medical treatment or					
	care or use of bathro	oom facilities."					
	"The Program Man	ager will assign an					
	I -	A full investigation will be					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA	î í	ULTIPLE CO	ONSTRUCTION OO	(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CURRECTION	IDENTIFICATION NUMBER 15G811	B. WI		00	01/06			
		-	<u> </u>	STDEET /	ADDRESS, CITY, STATE, ZIP COD		-		
NAME OF P	PROVIDER OR SUPPLIER			1306 S BLOOMINGTON STREET					
RES-CAF	RE INC		GREENCASTLE, IN 46135						
(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)	TE	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION tigators who have received		TAG	DEFICIENC!)		DATE		
		Relations Association and							
	_	procedures on investigations.							
	-	low for nepotism during the							
	conducting, directing, reviewing or other managerial activity of an investigation into an allegation of abuse, neglect, exploitation or mistreatment, by prohibiting friends and relatives								
		rator from engaging in these							
	managerial activities. One of the investigators will								
	-	investigative case summary							
		atements and other evidence							
	collected. The report will be maintained in a confidential, secured file at the office."								
		eer review committee chosen irector will meet to discuss the							
		estigation and to ensure that a							
		ion has been completed.							
		nmittee must include at least							
		tors, the Executive Director or							
		Manager for Supported Living,							
		urces representative."							
	This federal tag rela	ates to complaint #IN00396047.							
	5-1.2(24)(1)								
W 0154	483.420(d)(3)	TNT OF CLIENTS							
Bldg. 00	STAFF TREATME								
Diag. 00	-	nave evidence that all are thoroughly investigated.							
		riew and interview for 3 of 4	$ _{\mathbf{W}_0}$	154	The facility must develop and		02/06/2023		
		, #2 and #3), plus 3 additional	"	11.77	implement written policies and	1	02/00/2023		
		#21) the facility failed to			procedures that prohibit	-			
	· ·	investigations regarding			mistreatment, neglect, or abus	se of			
		abuse of clients #1, #2, #3, #6,			the client. Specifically, facility				
	#8 and #21.				complete thorough investigation				
	Findings include:				regarding allegations of staff				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		01/06	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEF	R			BLOOMINGTON STREET		
RES-CAF	RE INC		GREENCASTLE, IN 46135				
(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 OF	LSC IDENTIFYING INFORMATION		TAG DEFICIENCY)			DATE
					PREVENTION:		
	The facilities BDDS (Bureau of Developmental				All facility trained investigators	will	
		s) reports and investigations		be retrained to complete thorough			
		/4/23 at 4:00 PM. The review			investigations including all		
	indicated the follow	ving:			components of an investigatio	n	
	1. Investigation summary dated 12/2/22 indicated				and within 5 business days.		
	1. Investigation summary dated 12/2/22 indicated				l		
	the following:				All facility trained investigators		
	1	2022 1 1 1 1 1 1 1			be retrained that investigations	s are	
		, 2022, during a behavior with			to include documentation of		
	2. 2	sidential manager)#1] was			recommendations to prevent		
		g to be conducting the YSIS afe) hold incorrectly, and she			recurrence as a component of	а	
		[RM #1] curse towards [client			thorough investigation.		
	#2]."	[KWI #1] curse towards [client			All facility trained investigators	. will	
	#2].				All facility trained investigators be retrained on incidents that	VVIII	
	_"It is substantiated	that [client #2] sustained			require investigations		
		ring his supine hold on			require investigations		
	11/26/22."	ring ins supine note on			Quality Assurance Manager w	rill	
	11/20/22.				maintain tracking of all	1111	
	-"It is substantiated	that [RM #1] cursed at [client			investigations and assign to		
	#2] during the supir				investigators while monitoring	the	
	"2] daring the supi	10 011 11/20/22.			timeliness to ensure that they		
	-"It is substantiated	the [client #2] sustained the			completed in 5 business days.		
		by ½ inch and 4 inches by 1/2			Quality Assurance Manager of		
	-	s right clavicle/ armpit area,			Designee will maintain tracking		
		right side upper lip			all investigations and assign to	-	
	underneath."				investigators while monitoring		
					timeliness to ensure that they		
	- "It is not substanti	ated that [RM #1] punched			completed in 5 business days.		
	[client #2] in the fac	2 32			,		
	_				Investigators will be held		
	- "It is substantiated the [RM #1] failed to follow				accountable with appropriate		
	ResCare Policy and Procedures."				performance action for		
	The Investigation Summary dated 12/2/22 did not indicate documentation of recommendations to prevent recurrence as a component of a thorough				investigations that are not		
					completed in 5 business days.		
					Quality Assurance Manager of	r	
	investigation.				Designee will review the		
			1		investigation tracking with the		1

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPI A. BUILDIN B. WING		nstruction 00	(X3) DATE COMPL 01/06/	ETED	
NAME OF P	PROVIDER OR SUPPLIEF	- L			DDRESS, CITY, STATE, ZIP COD		
RES-CAF	RE INC				BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	.,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	·	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFI TAC		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	2. Investigation sun the following:	nmary dated 11/8/22 indicated			investigators no less than we to assure compliance.	ekly	
	- "On November 8, and [staff #1] and on Saturday Novem had permission to g didn't have a way to consumers that [staff formerly terminated and they were left to went inside to visit - "The allegation of substantiated based statements." The Investigation S indicate documental prevent recurrence investigation. 3. Investigation sum the following: - "On October 28, 2 [client #21], [staff # having his foot on [#21] was in a guard supine hold." - "It is substantiated multiple injuries to on 10/28/22." - "It is substantiated multiple injuries to on 10/28/22."	Ineglect against [staff #3] is on consumer witness ummary dated 12/2/22 did not tion of recommendations to as a component of a thorough mary dated 10/28/22 indicated 2022, during a behavior with the client #21's] face while [client tian and HRC approved YSIS] If that [client #21] sustained his face during his supine hold If that [staff #5] caused [client tian and HRC approved YSIS]			to assure compliance.		
	#21] injuries based	on witness statements."					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	SURVEY				
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. B	UILDING	00	COMPLETED	
		15G811	B. W	ING	_	01/06/	2023
NAME OF P	DROWNER OF GUIDNI 155		_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
	PROVIDER OR SUPPLIER				BLOOMINGTON STREET		
RES-CAF	RE INC			GREEN	ICASTLE, IN 46135		
(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	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		by [client #21's] statement he					
	was 'hit in the head'	by that guy.					
	- "It is substantiated	I that [staff #5] failed to follow					
	ResCare Policy and	= =					
	-						
	_	ummary dated 11/2/22 did not					
		tion of recommendations to					
	1 -	as a component of a thorough					
	investigation.						
	4. BDDS report date	ed 11/8/22 indicated the					
	following:						
	-						
		2022, at 8:00 pm [client #1]					
		station to take his 8:00 PM					
	_	#1] had taken his meds, staff					
		vised him that he was done					
	_	I thanked him for taking them.					
	1	wn staff) was getting meds					
	1 -	lient, [client #1] grabbed the					
		longed to his peer, put the					
		uth, and swallowed them. Staff					
		empted to intervene but was					
		oping [client #1] from taking					
		quick in taking them. Staff					
		mediately called the nurse on					
		ructed staff to take [client #1]					
		ergency room]. The emergency evaluation on [client #1] and					
	_	diagnosis: Accidental					
	_	ig. Discharge instructions					
		s tonight. Start back with					
		le in morning. Okay to eat and					
	•	ay to sleep. Check vital signs					
	_	t and get rechecked if feel					
	_	concerns. The medications he					
	had taken of his pee						
	_	milligram), Levothyroxine 20					
		Olanzapine 20 mg and					
	1 (1	J			

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Event ID:

I12F11

Facility ID: 013405

If continuation sheet Page 10 of 20

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811			JILDING	00	COMPLETED 01/06/2023	
		136811	B. WI	NG		01/06/	2023
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CAF	RF INC				ICASTLE, IN 46135		
					I		715
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	Topiramate 50 mg."						
	-						
		indicate documentation of an					
	investigation.						
	Client #1's record w	vas reviewed on 1/5/23 at 3:47					
		vember 2022 physician's orders					
		nt #1 should receive					
		Levothyroxine 20 mcg,					
	Olanzapine 20 mg a	and Topiramate 50 mg.					
	PM #1 was interview	wed on 1/4/23 at 1:40 PM. PM					
		ent #1 should not have access					
	to his peer's medicar	tion. PM #1 was not sure					
	which staff adminis	tered the medications. PM #1					
		t know which staff were					
		inistration of client #1's					
		22. PM #1 indicated she would					
		de additional information					
		ff were involved in the icated the 11/1/22 incident was					
		#1 indicated there was not					
	documentation avail						
		r retraining. No additional					
		ng which staff was involved					
	was provided by PM	И#1.					
	DM #1 indicated in-	vestigations of abuse and					
		oroughly investigated with					
	recommendations to						
		emented. PM #1 indicated peer					
		on and recommendation was					
	complete and would	be provided. No additional					
	documentation rece	ived.					
	This federal tag rela	ites to complaint #IN00396047.					
	5-1.2(24)(1)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15G811	B. W	ING		01/06/	2023
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID	SUMMARY S	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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	483.420(d)(4) STAFF TREATME The results of all in reported to the addrepresentative or the accordance with Stages of the incider Based on record revelocities and investigate [client #21] was condays. The facilities BDDS Disabilities Services were reviewed on Lindicated the follow Investigation summing following: - "On October 28, 2 [client #21], [staff # having his foot on [washing	ENT OF CLIENTS Investigations must be ministrator or designated to other officials in the state law within five working ont. Triew and interview for 1 tient #21] the facility failed to ion regarding staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental staff abuse of impleted within 5 business So (Bureau of Developmental s	W		CORRECTION: The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abust the client. Specifically, investigations of allegations of abuse/neglect must be completed in 5 business days. PREVENTION: All facility trained investigators be retrained that investigations to be completed within 5 busined days. Quality Assurance Manager of Designee will maintain tracking all investigations and assign to investigators while monitoring timeliness to ensure that they completed in 5 business days. Quality Assurance Manager of Designee will maintain tracking all investigations and assign to investigators while monitoring timeliness to ensure that they completed in 5 business days.	se of seted swill sare ness r g of the are the are	
	ResCare Policy and	that [staff #5] failed to follow Procedures."			Investigators will be held accountable with appropriate performance action for		

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
	15G811		B. WING			01/06/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
TREG-0/ NAE INO				OKLLIN			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA*	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		ummary dated 11/8/22 did not			investigations that are not		
		tion of recommendations to			completed in 5 business days.		
	-	as a component of a thorough					
	investigation.				Quality Assurance Manager or	•	
					Designee will review the		
		wed on 1/4/23 at 1:40 PM.			investigation tracking with the		
		estigations should be			investigators no less than wee	kly	
	completed in 5 busin	ness days.			to assure compliance.		
	5 1 2(24)(1)						
	5-1.2(24)(1)						
W 0268	483.450(a)(1)(i)						'
	CONDUCT TOWA	ARD CLIENT					
Bldg. 00		d procedures must promote					
Ü	•	ppment and independence of					
	the client.						
		riew and interview for 1	l w c	268	CORRECTION:		02/06/2023
	additional client [#9	, the facility failed to ensure	'' '	_00	The facility must develop and		02/00/2028
		oted client #9's dignity.			implement written policies and		
	_				procedures that prohibit		
	Findings include:				mistreatment, neglect, or abus	e of	
					the client. Specifically, the faci	lity	
	The facilities BDDS	S (Bureau of Developmental			must follow all client behavior		
	Disabilities Services	s) reports and investigations			support plans to promote clien	t	
	were reviewed on 1/	/4/23 at 4:00 PM. The review			dignity.		
	indicated the follow	ring:					
					PREVENTION:		
	_	11/17/22 indicated, "On			All staff and residential manag	ers	
	· ·	at 10:52 am while in the day			will be trained on appropriate a	area	
	= =	ole staff's drink and proceeded			to keep their drinks during thei	r	
		bally redirected [client #9] to			shift.		
		couraged him to use coping					
		Client #6] was walking from			All staff and residential manag	ers	
		s hallway to the day room			will be retrained that no drinks		
		rted walking down Colts			should be on the floor within re	each	
	· ·	bedroom. On [client #9]'s way			or eyesight of clients.		
		engaged in client to client					
		is right arm to hit [client #6] in			ResCare Maintenance built a		
		nt #6] did not retaliate and			cabinet in the locked pantry for		
	continued walking t	o the day room and with			staff and residential managers	to	
					l .		

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STATEMENT OF DEFICIENCIES X1) P		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. WI	NG		01/06/	2023
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF F	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD		
DEC CAI	DE INC				BLOOMINGTON STREET		
RES-CARE INC			GREEN	NCASTLE, IN 46135			
(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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	normal programm	ing. After hitting [client #6],			keep their drinks during their s	shift.	
	[client #9] continu	ed walking to his room. [Client					
	#9] then engaged i	in property destruction by			A Residential Manager, QA		
	slamming his door	multiple times. [Client #9] then			Coordinator or Program Mana	iger	
	lay in his bed with	out further issues."			will be present during no less	than	
					five days per week, on varied	shifts	
		ager) #1 was interviewed on			to assist with and monitor		
	1/4/23 at 1:40 PM	. PM #1 indicated client #9			implementation/compliance. F	or	
	should not have ac	ccess to staff drinks. PM #1			the next 30 days, members of	the	
	indicated staff drir	nks should be kept in the break			Operations Team (comprised	of	
	room or staff close	et out of the reach of clients.			the Executive Director, Progra	am	
	PM #1 indicated s	taff's interactions should			Managers, Quality Assurance		
	promote positive behavior outcomes.				Manager, QIDP, Quality		
					Assurance Coordinators,		
	· ·	anager) #3 was interviewed on			Residential Managers, and		
	1/4/23 at 11:35 AN	M. RM #3 indicated client #9			Designees will conduct		
		ccess to staff drinks. RM #3			administrative monitoring duri	ng	
		nks should be kept in the locked			varied shifts/times, no less that	an	
	pantry out of reach	n of clients.			three times weekly, until all sta		
					demonstrate competence. After	er	
		viewed on 1/4/23 at 11:45 AM.			this period of enhanced		
		client #9 should not have			administrative monitoring and		
		aks. Staff #6 indicated staff			support, the Executive Director		
		ept in the locked pantry out of			determine the level of ongoing	3	
	reach of clients.				support needed at the facility.		
	5-1.2(d)				Administrative Monitoring is		
					defined as follows:		
					· The role of the administra	ative	
					monitor is not simply to observ	ve &	
					Report.		
					· When opportunities for		
					training are observed, the mor	nitor	
					must step in and provide the		
					training and document it.		
					· Assuring the health and		
					safety of individuals receiving		
					supports at the time of the		
					observation is the top priority.		
					· Review all relevant		

02/23/2023 PRINTED: FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
15G811		B. WING		01/06/2023	
NAME OF PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF	FROVIDER OR SUFFEIEI	X.		BLOOMINGTON STREET	
RES-CARE INC		GREE	NCASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				documentation, providing	
				documented coaching and tra	ining
				as needed	
W 0367	483.460(k)				
	DRUG ADMINIST	TRATION			
Bldg. 00		nave an organized system			
J	-	ration that identifies each			
	_	int of administration.			
		view and interview for 1 of 3	W 0367	CORRECTION:	02/06/2023
	sampled clients [#1], the facility failed to ensure	1, 050,	The facility must implement	02/00/2023
		client #1's medications did not		written policies and procedure	es of
	pre-set his peer's m			proper use of the Medications	
				Administration Policy. Specific	
				facility will retrain all staff	,,
	Findings include:			administering medications to I	not
				pre-set individual's medication	
	BDDS report dated	111/2/22 was reviewed on		ľ	
	1/4/23 at 4:00 PM i	indicated the following:		PREVENTION:	
				All staff trained to administer	
	- "On November 1,	, 2022, at 8:00 pm [client #1]		medication will be retrained or	n the
	entered the nurse's	station to take his 8:00 PM		Medication Administration Pol	icy
	meds. After [client	#1] had taken his meds, staff		and specifically to not pre-sen	ıt 📗
	(unknown staff) ad	vised him that he was done		individual's medications.	
	taking his meds and	d thanked him for taking them.			
	While staff (unknown	wn staff) was getting meds		Administrative monitoring will	
	ready for the next of	elient, [client #1] grabbed the		occur to observe medication	
	cup of meds that be	elonged to his peer, put the		administration pass at varied	
		uth, and swallowed them. Staff		times to monitor implementation	
		empted to intervene but was		and compliance. For the next	
		pping [client #1] from taking		days, members of the Operati	
		quick in taking them. Staff		Team (comprised of the Exec	utive
	,	imediately called the nurse on		Director, Program Managers,	
		ructed staff to take [client #1]		Quality Assurance Manager,	
		ergency room]. The emergency		QIDP, Quality Assurance	
		evaluation on [client #1] and		Coordinators, Residential	
	made the following	g diagnosis: Accidental		Managers, and Designees wil	1

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multi-drug poisoning. Discharge instructions

state: No more meds tonight. Start back with

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conduct administrative monitoring

during varied shifts/times, no less

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STATEMENT OF DEFICIENCIES X1) PF		X1) PROVIDER/SUPPLIER/CLIA	` ′		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00			COMPLETED	
		15G811	B. WING		01/0		/2023
NAME OF I	DROWNER OF CURPLIES			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C		1306 S	BLOOMINGTON STREET		
RES-CAI	RE INC			GREEN	NCASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	_	le in morning. Okay to eat and ay to sleep. Check vital signs			than three times weekly, until		
	_	t and get rechecked if feel			staff demonstrate competence After this period of enhanced) .	
	_	concerns. The medications he			administrative monitoring and		
	_	ers are the following:			support, the Executive Director	r will	
	_	milligram), Levothyroxine 20			determine the level of ongoing		
		Olanzapine 20 mg, and			support needed at the facility.	,	
	Topiramate 50 mg.'	-			, permitted at the resulting.		
					Administrative Monitoring is		
		vas reviewed on 1/5/23 at 3:47			defined as follows:		
		wember 2022 physician's orders			· The role of the administra	ative	
		ent #1 should receive			monitor is not simply to observ	/e &	
	Haloperidol 5 mg, Levothyroxine 20 mcg,				Report.		
	Olanzapine 20 mg a	and Topiramate 50 mg.			· When opportunities for		
					training are observed, the mor	nitor	
		ewed on 11/4/23 at 11:35 AM.			must step in and provide the		
		ient #1 should not have access			training and document it.		
	to his peer's medica	tion.			· Assuring the health and		
					safety of individuals receiving		
	· ·	sing assistant) #1 was			supports at the time of the		
		23 at 1:20 PM. CNA #1			observation is the top priority.		
		should not have access to his			· Review all relevant		
	peer's medication.				documentation, providing	:	
	DM #1 was intervia	wed on 1/4/23 at 1:40 PM. PM			documented coaching and tra	ınıng	
		#1 should not have access to			as needed		
	his peer's medication						
	ms peer s medicatio	11.					
	LPN (licensed pract	tical nurse) #1 was interviewed					
		M. LPN #1 indicated client #1					
		ess to his peer's medication.					
		lients are brought to the					
		dividually and medication is					
	dispensed at the tim	ne of administration of					
	_	ions. LPN #1 indicated					
	medications should	not be preset prior to					
	dispensing.						
	1	ation policy and procedures					
l	I dated 7/25/22 were	reviewed on 1/4/23 at 3:45 PM.	1		Ī		I

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 15G811		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/06/2023
NAME OF F	PROVIDER OR SUPPLIER	2	1306 S	ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET	
RES-CAI	RE INC		GREE	NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	"It is the policy of t accurate, prompt, a medication. Deviate deviation from the Administration. Ina consumer medication medications droppe medications in the l treated as negligent Disciplinary action	this operation to ensure the end efficient administration of tion from a physician and or Rights of Medication appropriate handling of the ons, i.e., excessive number of end, failure to properly secure all locked cabinet, etc. may be a performance of duties. In may follow that of policy. The ences and severity may be taken			
W 9999					
Bldg. 00	Facilities for Person Disabilities rules w 410 IAC 16.2-5-4 F Authority: IC 16-28 Affected: IC 16-28-(e) The administration provision of resider ordered by the residual supervised by a lice on call as follows: (Health services 3-1-7; IC 16-28-1-12 -5-1 ion of medications and the natial nursing care shall be as dent's physician and shall be ensed nurse on the premises or (1) Medication shall be ensed nursing personnel or	W 9999	CORRECTION: The facility must implement appropriate procedures for Medications Administration. Specifically, facility will ensure that all medications shall be administered by licensed nursi personnel or Qualified Medicat Aides (QMA). PREVENTION: The facility will ensure that all medications are administered by licensed nursing personnel or qualified medication aide. RESPONSIBLE PARTIES: QIE Residential Managers, Program	py DP,

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This State rule was not met as evidenced by:

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Director, Direct Support Staff,

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
15G811		B. W	ING		01/06	/2023	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			BLOOMINGTON STREET		
RES-CARE INC					ICASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Operations Team		
		view and interview for 4 of 4					
	• `	, #2, #3 and #4), plus 17					
		#5, #6, #7, #8, #9, #10, #11, #12,					
		, #17, #18, #19, #20 and #21), the					
	· ·	lize QMAs for medication					
	administration.						
	Findings include:						
	i manigo metade.						
	The facilities BDD	S (Bureau of Developmental					
	Disabilities Service	es) reports and investigations					
	were reviewed on 1/4/23 at 4:00 PM. The review						
	indicated the following:						
		ed 11/2/22 indicated, "On					
		at 8:00 pm [client #1] entered					
		o take his 8:00 PM meds. After					
		en his meds, staff (unknown					
	· ·	that he was done taking his					
		him for taking them. While staff					
	,	as getting meds ready for the					
	_	#1] grabbed the cup of meds					
	_	s peer, put the medicine in his					
		wed them. Staff (unknown staff)					
	_	ene but was unsuccessful in					
		from taking them as he was them. Staff (unknown staff)					
		the nurse on call. The nurse					
	1	ake [client #1] to the [hospital					
		The emergency room performed					
		lient #1] and made the					
	_	s: Accidental multi-drug					
		_					
	poisoning. Discharge instructions state: No more meds tonight. Start back with regular med						
	_	g. Okay to eat and drink					
		sleep. Check vital signs few					
		d get rechecked if feel					
		concerns. The medications he					
	_	er are the following:					

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Fac

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
	15G811		B. W	ING		01/06	/2023
),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	NOVEMBER OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			BLOOMINGTON STREET		
RES-CARE INC				ICASTLE, IN 46135			
(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 APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		milligram), Levothyroxine 20 Olanzapine 20 mg, and					
	Topiramate 50 mg.						
	Tophamate 30 mg.						
	The review indicate	ed an unspecified direct care					
		client #1's medications.					
		vas reviewed on 1/5/23 at 3:47					
		ovember 2022 physician's orders					
		ent #1 should receive					
		Levothyroxine 20 mcg,					
	Olanzapine 20 mg,	and Topiramate 50 mg.					
	RM (residential ma	mager) #3 was interviewed on					
	`	M. RM #3 indicated he had					
	received medication	n administration training. RM					
	#3 indicated the fac	cility had trained RMs to					
	administer clients #	41, #2, #3, #4, #5, #6, #7, #8, #9,					
		#14, #15, #16, #17, #18, #19,					
		cations when nursing staff was					
		#3 indicated he was not a					
	QMA.						
	CNA (certified nurs	sing assistant) #1 was					
	· ·	23 at 1:20 PM. CNA indicated					
		ned RMs to administer clients					
	I	#6, #7, #8, #9, #10, #11, #12, #13,					
	#14, #15, #16, #17,	#18, #19, #20 and #21's					
	medications when r	nursing staff was not available.					
	DM (non-						
		ger) #1 was interviewed on PM #1 indicated the facility					
		administer clients #1, #2, #3,					
		#9, #10, #11, #12, #13, #14, #15,					
		#20 and #21's medications					
	when nursing staff						
		tical nurse) #1 was interviewed					
		M. LPN #1 indicated the facility					
	had trained RMs to	administer clients #1, #2, #3,					

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

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE COMPI 01/06	
NAME OF PROVIDER OR SUPPLIER RES-CARE INC			1306	T ADDRESS, CITY, STATE, ZIP COD S BLOOMINGTON STREET ENCASTLE, IN 46135		
(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 APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	#4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20 and #21's medications when nursing staff was not available. ED (Executive Director) was interviewed 1/5/23 at 3PM. ED indicated the facility had trained RM level staff to administer clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20 and #21's medications due to nursing staff shortages. ED indicated the agency did not have QMAs available to administer medication in the absence of nursing staff. ED indicated the agency did not have a waiver or approval from BDDS regarding the use of RMs for medication administration. 16.2-5-4(e)					

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