Patrick O'Heran

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

08/08/2023

AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)		TE	(X5) COMPLETION DATE
W 0000 Bldg. 00							
	This visit was for the pre-determined full recertification and state licensure survey. This visit included the investigation of complaint #IN00405103. This visit was done in conjunction with the PCR (Post Certification Revisit) to the investigation of complaint #IN00402349. Complaint #IN00405103: No deficiencies related to the allegation(s) are cited. Dates of Survey: 6/12/23, 6/13/23, 6/14/23, 6/15/23, 6/16/23, 6/19/23, 6/20/23 and 6/21/23. Facility Number: 013405 Provider Number: 15G811 AIMS Number: 201267570 These deficiencies also reflect state findings in accordance with 410 IAC 16.2-5. Quality Review of this report completed by #15068		W	0000			
W 0104 Bldg. 00		DY dy must exercise general d operating direction over					
	sample clients (#1, additional clients (# #13, #14, #15, #16, governing body fail budget, and operating ensure a sink in the	on and interview for 5 of 5 #2, #3, #4, and #5), plus 15 #6, #7, #8, #9, #10, #11, #12, #17, #18, #19, and #20), the ed to exercise general policy, and direction over the facility to common bathroom had a ants #10 and #15's shared	W	104	To correct the deficient practic staff have been re-trained to ensure the facility is kept clear an acceptable standard, and reporting maintenance issues immediately. The maintenance supervisor has been trained to ensure all reported issues are	n to	08/12/2023
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			3	TITLE		(X6) DATE	

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 XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF PRO	VIDER OR SUPPLIER		1306 5	ADDRESS, CITY, STATE, ZIP COD S BLOOMINGTON STREET NCASTLE, IN 46135	
(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)	(X5) COMPLETION DATE
bassled	athroom had a workhower rooms and publicates #1, #2, #3, #4 #12, #13, #14, #15, were clean. Sindings include: Observations were control of the facility of the facility throughout the facility of the facil	king sink, and common rivate bathrooms used by 4, #5, #6, #7, #8, #9, #10, #11, #16, #17, #18, #19, and #20 conducted in the facility on m to 3:30 pm and from 5:00 pm //13/23 from 8:00 am to 10:00 am to 12:30 pm. Clients #1, #2, #3, 9, #10, #11, #12, #13, #14, #15, and #20 were present in the he observation periods. com, the surveyor walked with Quality Assurance #17's shared bathroom, there	TAG	completed as soon as possible. The broken drainpipe and drain has been repaired. The facility been deep cleaned, and will be maintained by a daily cleaning for staff and Rm's. Additional oversight will be completed by QAC, PM, QIDP, or RM completing walk throughs five times a day and documenting the facility cleaning list. Any discrepancies found during the walk through will be addressed immediately. Ongoing monitor will be achieved by the QAC completing twice daily walk throughs of the facility to ensure the standard of cleanliness is achieved.	e. in / has e g list / the on e d

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF F	PROVIDER OR SUPPLIEI	R		1306 S I	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	the floor and wall of the tiles in the shador and walls met the floor and walls met the floor and walls. 5. In the bathroom bedrooms, the garb paper towels were dust and a yellow s and back of the toil. 6. In clients #7, #12 there was a strong of the toilet wash cloths on the wash cloths on the wash cloth in the back. In clients #13 and wash cloth in the back. In clients #13 and wash a puddle of uri and a strong odor. 9. In clients #5 and inside of the toilet the toilet was no drain pipe in had been pulled awof the toilet bowl was a white cream was no toilet paper were overflowing the floor.	between clients #1 and #19's page was overflowing, and on the floor. The toilet had substance built up on the seat let. 2, and #16's shared bathroom, odor. y shower room between clients oom and client #7's bedroom, id, a deodorant lid, and 4 wet floor. There was one wet					
		ve to ask for toilet paper when					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		06/21/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			BLOOMINGTON STREET		
RES-CAI	RF INC				ICASTLE, IN 46135		
	ı						
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	we need it."						
	A focused observation was conducted in clients						
		ed bathroom on 6/14/23 at 3:15					
	*	not been fixed, and the					
	bathroom had not b	een cleaned.					
	11 771 %	1 4 1 4 11 4 110					
	11. The community bathroom between clients #10 and #15's bedroom had the drain pipe under the						
	sink removed.						
	Direct Support Professional (DSD) #12 was						
	Direct Support Professional (DSP) #13 was interviewed on 6/14/23 at 12:43 pm and stated,						
	"We're constantly cleaning the day room. We try						
	_	g as clean as possible." DSP					
	-	writes up a list of what rooms					
		y to get the guys to clean up					
		#13 stated, "There is no					
	cleaning schedule th						
	8						
	RM #3 was intervie	ewed on 6/14/23 at 11:50 am and					
	stated, "In the morn	ning, we come in, and the					
	CNAs (Certified No	ursing Assistants) will make the					
	beds and clean the	rooms. Sometimes staff need					
	reminders of the ba	throoms. They forget about					
	them." RM #3 state	ed, "The staff are responsible					
	for checking the ba	throoms to make sure they're					
	clean."						
		(PM) was interviewed on					
	_	and stated, "The staff do have a					
	-	should be cleaning and					
		its to clean. They should be					
	going through at shift changes to make sure						
	everything is clean	from the shift before."					
	Onelity Assumer	Manager (QAM) was					
		4/23 at 4:10 pm and stated, with the clients to keep their					
		f notice a dirty bathroom it					
	should be addressed immediately."						

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NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, 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)	(X5) COMPLETION DATE		
W 0125	6/12/23 from 1:37 FPM to 6:09 PM, 6/16/13/23 from 11:38 from 4:03 PM to 4:00 observations, client bowl was covered in and on the toilet sear client #10's and clie covered in feces in a toilet seat. On 6/12/23 at 2:28 toilet was dirty and current condition du toilet. Client #17 st	#3's and client #17's toilet in feces in and around the rim it. During the observations, int #15's toilet bowl was and around the rim and on the PM, client #17 indicated his the did not want to use it in the tie to the feces in and on the ated it was "disgusting." If the feces was from the peer in with (client #3).					
Bldg. 00	PROTECTION OF The facility must enclients. Therefore encourage individurights as clients of citizens of the Unitright to file complar process. Based on observation interview for 1 of 5 additional client (#1) client #3's rights we	create the rights of all the facility must allow and the facility must allow and the facility, and as the states, including the the facility, and the right to due on, record review, and sample clients (#3), plus 1 6), the facility failed to ensure the renot infringed upon after equirements for an alternative	W 0125	To correct the deficient practic QIDP has been trained in ensonce an individual has met discharge criteria, other place is sought with the IDT's guidal	uring ment		
		nd to ensure client #16 had a rith making decisions and		and any client without a guard completes an informed conser assessment as well as making attempts to find the individual	nt 3		

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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 15G811		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/21/2023		
NAME OF I	PROVIDER OR SUPPLIEF	· ·		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(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)	TE	(X5) COMPLETION DATE
	Findings include: 1. Observations we 6/12/23 from 1:40 pto 6:00 pm and on and from 11:30 ampresent in the faciliperiods. On 6/12/23 client # appointment at 2:33 wheelchair to ambuindependently. Client wheelchair to he pm, client #3 had a staff assistance. At his bedroom and goremained in his bedroom and goremained in his bedroom and goremained in the demoved to a dining the served his evening pureed ravioli, garlidivided dish with a independently with Following his meal wedge cup. At 5:30 bedroom and got in returned to the day the end of the observed of from 8:00 client #3 transferred went into the day remiddle of th	re conducted in the facility on om to 3:30 pm and from 5:00 pm 6/13/23 from 8:00 am to 10:00 am to 12:30 pm. Client #3 was ty throughout the observation 3 arrived to the facility from an 5 pm. Client #3 used a date through the facility ent #3 transferred himself from is bed independently. At 2:45 snack at the dining table with 2:52 pm, client #3 went into bit into his bed. Client #3			guardian if the assessment indicates the need. On 7-17-2 client #3's IDT met to discuss their medical needs and altern placement needs. Client #3s I Guardians agreed to complete CIH waiver application and se alternate placement. The guar will work with BDDS on alternate placement. The QIDP will complete an informed consent assessment for Client #16. Cli #16's IDT continues to explore options for finding a legal guard Ongoing monitoring will be achieved by BDDS and Rescameeting monthly to discuss transition needs. The QIDP will complete informed consent assessments for clients without legal guardian during the 30-ditransition period.	ative egal the ek dian ative t ent ent dian.	
	van ride with his sta	aff and peers.					

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	OF CORRECTION OF CORRECTION 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF I	PROVIDER OR SUPPLIER	1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, 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 BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	COMPLETION	
	On 6/13/23 client #3 was sitting in his wheelchair in the day room from 11:30 am to 12:00 pm. At 12:00 pm, client #3 went to the dining table and was given hand sanitizer to sanitize his hands. At 12:17 pm, client #3 was served a pureed turkey sandwich, potato salad, and cucumbers. At 12:30 pm, client #3 went to his bedroom and got into his bed. Client #3's record was reviewed on 6/13/23 at 2:18 pm. Client #3's Individual Support Plan (ISP) dated 8/17/22 indicated the following: "Individual Profile: [Client #3's] [family members] are deceased. He is 1 of 4 siblings. His oldest [family member] is his guardian [Client #3] lacks the ability to clearly verbalize his needs and wants. He can express his wants by yelling, 'tea,' 'coffee,' 'coke,' 'snack,' and by grabbing staff to direct them to his desired location/item Discharge Criteria: The IDT (Interdisciplinary Team) agrees to review [client #3's] Discharge Criteria on a quarterly basis. - [Client #3] has refrained from the targeted behaviors of Verbal Aggression, Physical Aggression, Non-Compliance, Property Destruction, Bolting, Self-Injurious Behavior, Sexually Inappropriate Behavior, and Steal (sic)/Taking peer beverages for 3 consecutive months. - [Client #3] has no incidents of refusing medication or medical treatment for 3 consecutive months. - [Client #3] engages in daily life skill programming with 2 or less refusals per month for 3 consecutive months. - Attempts to reduce behavioral medication have been discussed/and or attempted with [client #3's] psychiatrist.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		UILDING	nstruction <u>00</u>	(X3) DATE COMPL 06/21/	ETED	
NAME OF F	PROVIDER OR SUPPLIEF	.	1306 S I	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL BLISC DEPUTIENT OF DEFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION
TAG		et discharge criteria at this	TAG	Ja Carett		DATE
	Services (BDDS) T dated 9/20/22 indic has very few behave consistent target be unattended coffee of behavior is infrequed consistent tea schedular van rides with his production of the producti	al Goals Related to Discharge: is very hesitant to talk about have not approved of [client ResCare. They are concerned to wander off, and they want using care available for him. pointments as needed: Met. ations PO (by mouth) as stable for community living: medications both behaviorally months: Met. ioral Criteria: 2 person advanced YSIS Met. IM PRN (medication injected				

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	PROVIDER OR SUPPLIE	R		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
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140	the last 6 months: Able to function sa Met. Able to safely utilize Would likely not be Barriers to Dischar Criteria: The guard type of discharge period safety related to be Discussion Notes: meeting with guard would not discuss a department was ser regarding discharge Quarterly meeting progress and to add An IDT meeting not following: "[Client #3] continuates does not require the (Intermediate Care participate in the meeting and following: "On February 28, 2 his room and was entered the dayroom for no apparent rea [client #5] engaged towards [client #3] in the led did not retaliate.	Met. Ifely in a home type setting: Ize chemicals with supervision: e able to use chemicals Ige Not Related to Discharge lian has not approved of any land due to the concerns for his liting and general health. Had quarterly/next steps lian/BDDS on 11/16/22. Family discharge. BDDS legal inding the guardian paperwork the but no updates at this time. is set for 2/15/23 to discuss literess transition concerns." Interest dated 5/10/23 indicated the ues to demonstrate that he the level of restriction at the ICF Facility). Guardian did not					

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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	COMPLETED	
		15G811	B. W	ING		06/21/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	3			BLOOMINGTON STREET		
RES-CAI	RE INC				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 CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		d without precursors [client					
		client #3] and engaged in					
	physical aggression by using both of his hands to push [client #3] effectively knocking him down.						
	[Client #3] landed on his buttocks and back. He						
	did not retaliate."						
	Direct Support Professional (DSP) #13 was						
	interviewed on 6/14/23 at 12:43 pm and stated,						
	"This is not an appropriate placement for [client						
	#3]." DSP #13 stated, "[Client #3] does not have						
	behaviors that are dangerous to himself and						
	others. The only behavior he has is over tea. He						
	sits in the dayroom and screams for tea. There is						
	no aggression."						
	Residential Manage	er (RM) #3 was interviewed on					
		and stated, "[Client #3] does					
		t behaviors that require this					
	setting. He only ste	_					
	Program Manager (PM) was interviewed on					
		and stated, "This placement is					
	_	[client #3]. He's not					
		der, and his health is					
		sn't need to be here." PM					
	I	in does not want to move him,					
		g on a letter. Their legal					
	department was inv	rolved. We can't move him					
	without BDDS plac	ement authority. We're waiting					
	on BDDS."						
	DDDG C 1' ·	. #1 11 1					
		#1 was interviewed by phone					
		om and stated, "[Client #3] has					
		discharge. The family has					
		Placement in this facility is not sabout behaviors, and he has					
		ria." BDDS Coordinator #1					
	_	ation has been given to the					
		department, and they were					
	central office legal	department, and mey were					

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	` ′		NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		15G811	B. W	ING		06/21/	2023
NAME OF F	PROVIDER OR SUPPLIER	t		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	-T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	DATE
	drafting a letter to the	he guardian. That was in					
		BDDS Coordinator #1 stated,					
		meetings with the guardians. I					
	bring it up at every meeting. They say we've						
	conversation."	already discussed it, and they shut down the					
	2. Client #16's record was reviewed on 6/19/23 at 11:30 AM. Client #16's BSP (Behavior Support						
		Plan) dated 5/18/23 indicated,					
	-"[Client #16, race, gender and age] who						
	transitioned to ResC						
	had previously been living at [another residential facility] since July 7, 2009 and he is his own legal guardian at this time. [Client #16] has frequent						
	_	ndmother [name], but his					
	_	and his father is not involved					
	in his life. [Client #	16] is diagnosed with Autistic					
		s extensive medical history					
	_	n 2005 and exposure to drugs					
		n utero. He is non-verbal and					
	and needs."	riately tell staff what he wants					
	una necas.						
	QIDP (Qualified In	tellectual Disabilities					
	Professional) #1 and	d QAM (Quality Assurance					
	· /	rviewed on 6/14/23 at 2:28 PM.					
		he was not sure if client #16					
	_	Formed consent. QIDP #1					
		did not have a guardian. ent #16's record did not include					
	documentation of a						
	assessment.						
	5-1.2(6)						
W 0126	483.420(a)(4)						
.		CLIENTS RIGHTS					
Bldg. 00		ensure the rights of all					
	clients. Therefore	, the facility must allow					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G811	B. W	ING		06/21/	/2023
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			BLOOMINGTON STREET		
DEC CAI	DE INC						
RES-CAI	RE INC			GREEN	NCASTLE, 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	.TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	individual clients to	o manage their financial					
	affairs and teach t	hem to do so to the extent					
	of their capabilities	S.					
	Based on record rev	view and interview for 3 of 5	W	0126	To correct the deficient practic	е	08/12/2023
	sampled clients (#1	, #3 and #5) and 1 additional			the PM no longer receives clie	ent	
	client (#9), the facil	ity failed to ensure clients #1,			checks made out to the PM. T	o	
	#3, #5 and #9 had o	pportunities to participate in			ensure clients are participating	g in	
	cashing their month	lly spending money checks.			their money management a ne	∍w	
					system has been put in place.		
	Findings include:				Individuals now use a Pcard		
					system to purchase items with	1	
	On 6/13/23 at 2:30 PM, the facility's finances were				their personal funds in the		
	reviewed and indicated the following:				community. QIDP will reasses	SS	
					each client ISCP to reflect the		
	1. Client #1's Resid	lent Funds Management			current system. The QIDP wil	ı	
	Service (RFMS) sta	tement from June 2022 to June			also assess individuals CFA to)	
	2023 was reviewed	and indicated the following			determine if banking is an		
	checks were made of	out to the Program Manager			appropriate goal in their curre	nt	
	(PM) and not client	#1:			development. ISP goals will b	e	
					created for those needing ban	king	
	_	ling money: \$40.00.			goals. Ongoing monitoring wi	ll be	
	7/18/22: Money for				achieved by the PM		
		ending money: \$40.00.			completing/reviewing client fin	ance	
		ending money: \$40.00.			records and QIDP reviewing g		
	10/7/22: Festival/H				for progress/appropriateness	at	
	-	pending money: \$60.00.			least monthly		
		ending money: \$40.00.					
	4/5/23: Weekly spe	nding money: \$40.00.					
		-					
		S statement from June 2022 to					
		ewed and indicated the					
	_	ere made out to the PM and					
	not client #3:						
	C/14/00 T	υ φ40.00					
	_	ling money: \$40.00.					
	7/18/22: weekly spending money: \$40.00. 8/31/22: new clothes: \$300.00.						
		nding money: \$40.00.					
		ending money: \$40.00.					
	10/27/22: winter clo	othes, coat: \$600.00.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	l í	JILDING	instruction 00	(X3) DATE : COMPL 06/21/	ETED
NAME OF PROVIDER OR SUPPLIE	R		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
11/29/22: weekly specified by specified specif	spending money: \$40.00. sothes, Christmas: \$500.00. sending money: \$40.00. sending money: \$		IAU			DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811			A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE	
	clients should be ab checks. On 6/14/23 at 9:00. (ED) and the Qualit were interviewed. The process is going to sliability there". The bank set up for clien checks. It never showay". The QAM at	AM, the Executive Director y Assurance Manager (QAM) The QAM stated, "That stop. There is too much be ED stated, "We just got a not to be able to cash their own bould have been done that and ED indicated clients should						
W 0130 Bldg. 00	483.420(a)(7) PROTECTION OF The facility must e clients. Therefore privacy during trea needs. Based on observation additional clients (# to provide clients # caring for their personal for their personal form of their personal for	conducted in the facility on m to 10:00 am. Clients #15 and the facility throughout the facility on the facility throughout the facility throughout the facility on th	W 0	130	To correct the deficient practice site staff have been trained in ensuring client privacy while car for personal needs and ensuring the bathroom/bedroom door is shut during activities that requiprivacy. The PM will purchase each client a robe to encourage modesty from the bathroom to individual's bedroom. Addition monitoring will be achieved by administrative staff completing times a week facility observation of one month. Ongoing monitoring will be achieved by the QAC, PM, and QIDP completing routine observations of the facility as a smonthly site reviews to be completed by ResCare	aring ng ired the nal the on	08/12/2023	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE C A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 06/21/2023			
NAME OF I	PROVIDER OR SUPPLIEI	₹	STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION imptoget dressed	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPLICATION OF THE APPLICA	TION (X5) LD BE ROPRIATE COMPLETION DATE			
	6/14/23 at 11:50 an frequently naked. In put him back in his being naked in the him to dress." RM naked in the hallward Qualified Intellectur (QIDP) #1 was interested and stated, "Staff's put clothes on. He QIDP #1 stated, "Coasked to go back in their bedrooms to put their bedrooms to put Quality Assurance interviewed on 6/14 "Staff's should promore the bathroom and 2. On 6/13/23 at 8:: bath in the common lying down in the beshower room door and #17 congregate at client #15. At 8: shower room and syou." QIDP #1 did client #15's lack of Coordinator (AC) with the common door and #3 was interviewed, "There should bathroom while [clied door is closed, but shower limited to the control of the correction of the coordinator while [clied oor is closed, but shower limited to the correction of the corre	er (RM) #3 was interviewed on an and stated, "[Client #16] is put myself in front of him and room to prevent him from day room. We should prompt #3 stated, "They shouldn't be		administration.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUF			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETI			ETED	
		15G811	B. WI	NG		06/21/	2023
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWINED'S DEAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE .	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
	bathroom and close privacy." PM was interviewed stated, "Staff should be in there with [clic privacy in the bathroom and stated, "If the deprompt the peers aw QAM was interview stated, "Staff should allow [client #15] his 483.420(d)(1) STAFF TREATME The facility must deprompt with the policies and mistreatment, neg Based on observation interview for 5 of 5 and #5) and 15 addit #10, #11, #12, #13, #20), the facility fair policy and procedure client to client aggree the aggressor and to	the door for [client #15's] d on 6/14/23 at 1:55 pm and l close the bathroom door and ent #15]. He should have boom." iewed on 6/14/23 at 2:28 pm boor is open, staff should vay and close the door." yed on 6/14/23 at 4:10 pm and l shut the bathroom door and is dignity."	W 0	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	e all ure tors the ents	
	incidents; to prevent regarding clients #1 complete the recom- regarding the incide ingesting non-edible and #16; to prevent abuse towards client	t an incident of neglect 3, #14, #15 and #17 and to mended corrective action nt; to prevent two incidents of e items regarding clients #8 substantiated staff physical t #4; to prevent additional			recommendations, reporting allegations to BDDS within 24 hours, and investigating all episodes of client to client. Clie #14 IDT will meet to discuss current patterns and further sa measures. The QA department	ent fety	
	clients #2, #4, #5, #	o client aggression regarding 13, #17, #20; to report an eeping on duty to the Bureau			will track all incoming incident reports to ensure BDDS report are completed within 24hrs. T		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		06/21	/2023
		l	I	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
INLO-CAI	VE IINO			GIVEEN			
(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	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	Disabilities Services (BDDS)			QAM will assign all investigation		
		to conduct thorough			and track on the IR spread she		
		ding incidents of client to			for timely completion. Addition		
	1	d an allegation of staff abuse			monitoring will be achieved by		
	of client #8.				administrative staff completing		
					times a week facility observati	on	
	Findings include:				for one month. To ensure no		
					others were affected the QAM	will	
		was conducted at the facility			review the last six months of		
		33 PM to 4:33 PM. Qualified			incidents and investigations to		
		ties Professional (QIDP) #1			ensure BDDS reports were		
		ents #10, #14 and #19 in the			completed timely and		
	1 -	the only staff present outside.			investigations were completed		
		ng at the picnic table while					
	1	s #10 and #14 walked around					
	the yard interacting	with each other.					
	0 (/12/22 + 2.20)	DM 1 (/12/22 4 9 00 AM					
		PM and on 6/13/23 at 8:00 AM,					
		lity's incident/investigative					
	following:	ted and indicated the					
	following.						
	1a) A 5/20/23 RDD	S report indicated, "On					
		PM, [client #14] for no apparent					
		precursors, [client #14]					
		aggression towards a peer					
		the peer in the back as he was					
		e day room. He was redirected					
	1	alm down and to use his					
		to Resolve: Staff will continue					
		4's] guardian and HRC (Human					
	_	approved BSP (Behavior					
		SP (Individual Support Plan)					
		d physical aggression, threats,					
		Staff will continue to educate					
	[client #14] on using his coping skills when he						
	becomes upset".						
	occomes upset .						
	A 5/25/23 Client to	Client Aggression					
		I) included the following					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	r í	JILDING	nstruction <u>00</u>	COMPL 06/21/	ETED
NAME OF I	PROVIDER OR SUPPLIER			1306 S I	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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)	ATE	(X5) COMPLETION DATE
	[client #10] for any continue to educate coping skills when respecting his peers to follow current Bt activities. Team wi on 5/30/23 on camp PRN (as needed) of behaviors) and a po will be trained on swhen [client #14] is The assigned staff vremaining between possible and encour keep peers safe". 1b) A 5/20/23 BDD at 3:20 pm, [client # and peers he was vi a peers (sic) (client person escort, so he calm down, use his continued PA (physthem several times (sic). They tried have again but he was un Nurse called [Psych 2nd PRN. PRN was will continue to foll HRC approved BSI physical aggression and coping skills. S [client #14] on usin becomes upset". A 5/25/23 CCAI in recommendations: 'client #9] for any follows.	Staff will continue to monitor further injuries. Staff will [client #14] on using his he becomes upset and a personal space. Will continue SP's (sic) and offer alternative II follow up with [Psychiatrist] bus to discuss the ineffective S'Haldol 5mg (milligrams/for ssible recommendation. Staff erving as an assigned staff and demonstrating precursors. Will be responsible for [client #14] and peers when raging separate programing to separate programing to separate programing to separate programing to separate (sic). He kicked #9) leg, he was placed in a two recould go to his room and coping skills (sic). He sical aggression) with staff hit and tried urinating on them wing him use his coping skills hable to calm himself down. Staff in permission to give a given. Plan to Resolve: Staff ow [client #14's] guardian and and ISP regarding verbal and threats (sic) PRN protocol taff will continue to educate g his coping skills when he cluded the following "Staff will continue to monitor further injuries. Staff will [client #14] on using his					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	ľ í	JILDING	nstruction 00	(X3) DATE : COMPL 06/21/	ETED	
NAME OF F	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
RES-CAF (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OF coping skills when respecting his peers to follow current Bi activities. Team wi on 5/30/23 on camp PRN of Haldol 5mg recommendation. Si as an assigned staff demonstrating precibe responsible for r and peers when pos separate programin. 1c) A 5/22/23 BDI 21, 2023 at 12:46 p were standing in the	when [client #14] is when [client #14] is wrsors. The assigned staff will emaining between [client #14] sible and encouraging g to keep peers safe". OS report indicated, "On May m [client #14] and [client #19] e front yard when [client #19]				ΝΤΕ	(X5) COMPLETION DATE	
	and pretending the at [client #14]. [Client #14]. [Client #14]. [Client #14] in the left side attempted to chase agitated at him for period [client #19] back in Staff educated both peers personal space education and retur [Client #19] did not and engaged in vertice by cussing at them continued to monito both clients and not further issues. Plant to follow [client #19] and HRC approved and physical aggress intervention, PRN period [client #19] clients report they for the state of th	client #14] by taking his ball (sic) he was going to throw it ent #14] became agitated and lient #19]. [Client #19] his right fist to punch [client of his face. [Client #14] then [client #19] due to being bunching him. Staff redirected side the residential building. clients on respecting their e. [Client #14] agreed with this ned to normal programming. agree with staffs education bal aggression towards them and shouting at them. Staff or [client #19]. Nurse assessed ed no injuries. There were no to Resolve: Staff will continue e. [Client #14] guardian BSP and ISP regarding verbal sion, threats, YSIS protocol and coping skills. Both eel safe and neither wished to aff will continue to educate						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. WI	NG		06/21/	/2023
		_		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R		1306 S	BLOOMINGTON STREET		
RES-CAF	RE INC			GREEN	CASTLE, 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 O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		lient #14] to talk with staff and					
	use coping skills w	hen he is upset".					
	Thora was no door	imentation indicating the					
		an investigation regarding the					
	client to client agg						
	enent to enent agg	ression.					
	On 6/14/23 at 10:0	0 AM, the Quality Assurance					
		vas interviewed and indicated					
	_	ould have been completed.					
		'It was not done. It was					
		QIDP #1) and he did not					
	complete them (in	vestigations)".					
	1d) A 5/22/23 BD	DS report indicated, "On May					
		n while in the dayroom, for no					
	_	d without precursors, [client					
		at at his peer [client #4]. [Client					
		up to [client #4] and engaged in					
	physical aggression	n towards [client #4] by using					
	his right hand to hi	it [client #4] in his left shoulder.					
		retaliate. Staff was able to					
		rected [client #14] away from his					
	_	a of the dayroom and educated					
		pecting his peers personal					
		seemed to agree with this					
		ients returned to normal					
		rse assessed both clients and There were no further issues.					
	1	taff will continue to follow					
		dian and HRC approved BSP					
		verbal and physical aggression					
	(sic) threats, YSIS						
		tervention) intervention, PRN					
		g skills. Both clients report					
		neither wished to file a					
	grievance. Staff wi	ill continue to educate [client					
	#14] on personal sp	pace and using his coping skills					
	when he is upset".						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPL	ETED
		15G811	B. WIN	1G		06/21/	/2023
		<u> </u>	' т	STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
	Г		$oldsymbol{\perp}$				
(X4) ID		STATEMENT OF DEFICIENCIE	_	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	F	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DETCIENC I)		DATE
		nentation indicating the n investigation regarding the					
	client to client aggre						
	chefit to effent aggi	ession.					
	On 6/14/23 at 10:00	AM, the QAM was					
		licated an investigation should					
		ed. The QAM stated, "It was					
	_	signed to the Q (QIDP #1) and	1				
		them (investigations)".					
	·	, ,					
		S report indicated, "On May 23,					
	2023 at 7:21 am [cl	ient #14] had just finished					
	eating breakfast and	l began to walk around the					
	dayroom. For no ap	parent reason and without					
	precursors [client #	14] began to target his peer					
		aging in verbal aggression					
	1	igating him and threatening					
		[client #14] on using kind					
	_	4] did not agree and engaged					
		on towards [client #10] by					
		to slap the right side of					
		nd then used both hands to					
	_	lient #10's] right leg. [Client					
	_	te. Staff was able to intervene					
	_	nt #14] away from his peer and					
	_	te dayroom. Staff also					
		f] on not engaging in physical					
		his peers. [Client #14] stated 'I ary person] did ([imaginary					
		person)'. He then returned to					
	-	dayroom without further					
		sed both clients and noted no					
		esolve: Staff will continue to					
	•	guardian and HRC approved	1				
	I	ling verbal and physical					
	_	YSIS intervention, PRN	1				
		g skills. Both clients report					
		either wished to file a	1				
	1 -	l continue to educate [client					
	_	ace and using his coping skills	1				
	' ' '	5 1 5					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		15G811	B. W	ING		06/21/2	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				BLOOMINGTON STREET		
RES-CAF	RE INC				CASTLE, IN 46135		
(V4) ID	CIDAMADV	ET A TEMENT OF DEFICIENCIE	1	ID		1	(V.E)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		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
IAG		pset. IDT (interdisciplinary		IAG			DATE
	l '	liscuss recent peer to peer					
	occurrences involvi						
	occurrences involvi	ing [enemt #11] .					
	There was no docur	nentation indicating the					
		n investigation regarding the					
	client to client aggre						
	On 6/14/23 at 10:00	AM, the QAM was					
	interviewed and ind	icated an investigation should					
	•	d. The QAM stated, "It was					
		signed to the Q (QIDP #1) and					
	he did not complete	them (investigations)".					
	1.0 1.5/0.//02 DDD						
		OS report indicated, "On May 25,					
	_	elient #11] and [client #14] were					
	· ·	no apparent reason and [client #14] engaged in verbal					
		vards [client #11] by					
		m. [Client #14] also got close					
	_	acted like he was going to hit					
		I him not to hurt his peer.					
		d staffs (sic) prompts and					
	1	aggression towards [client					
		ft hand to grab [client #11's]					
		to pinch him and dig his nails					
	1 -	ght arm. [Client #11] did not					
		able to intervene and separated					
		edirected [client #14] to					
		dayroom and educated him on					
		personal space and not					
	hurting them. He th	en walked to his bedroom.					
	Nurse assessed both	clients and noted no injuries					
	on [client #14]. Nur	se noted that the scab on					
		rm from a blood draw earlier in					
		ed off by [client #14] and					
		aned the area and bandaged it.					
		r injuries noted on [client #11].					
		d to normal programming					
	without further issu	es. Plan to Resolve: Staff will					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMI	E SURVEY PLETED 1/2023				
NAME OF I	PROVIDER OR SUPPLIEF		1306 S	STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE				
	approved BSP and physical aggression PRN protocol and oreport they feel safe file a grievance. Sta [client #14] on pers coping skills when recent peer to peer #14] and have put he psychiatrist on May a staff to keep an ey de-escalate when he A 5/31/23 CCAI in recommendations: [client #11] for any continue to educate coping skills when continue to follow alternative activities [Psychiatrist] to dis Haldol 5mg and a pwill be trained on swhen [client #14] is The assigned staff or remaining between possible and encounkeep peers safe". 1g) A 5/26/23 BDE 2023 at 3:29 pm [cl following around he aggression towards threatening them. Swalk with him to hiprogramming per hegan to walk with	client #14's] guardian and HRC ISP regarding verbal and threats, YSIS intervention, oping skills. Both clients and neither of them wished to aff will continue to educate onal space and using his the is upset. IDT met to discuss occurrences involving [client tim on a list to see the and an either of them wished to and regarding to the seed of the seed o								

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	î ´	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 06/21 /	ETED
	PROVIDER OR SUPPLIEF			1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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
	the dayroom, he entowards [client #11] if then spit on [client retaliate. Staff educe his peers personal swith him towards he when [client #14] pengaged in physical spitting on [client # to kick [client #5] in retaliated by using lection [client #14] and the then engaged in physical staff by using both their breasts. After engaging in physical walked with staff between the dayroom, [client #3] in his left #14] to his bedroom [client #1] in his left #14] to his bedroom request and walked where they were abdown. He returned issues. Nurse assessinguries. Plan to Refollow [client #14's BSP and ISP regard aggression, threats, protocol and coping feel safe and none of grievance. Staff will #14] on personal sputhen he is upset. If to peer occurrences have put him on a limit May 30, 2023 as well was staff will was staff will may 30, 2023 as well was staff will was staff will may 30, 2023 as well was staff will may 30, 2023 a	gaged in physical aggression] by using his left elbow to n his left elbow. [Client #14] #11's] face. [Client #11] did not ated [client #14] on respecting pace and continued walking is bedroom in Colt's hallway. bassed his peer [client #5], he laggression towards him by 5] and then using his right leg in his left leg. [Client #5] both of his hands to shove in ran to his room. [Client #14] bysical aggression towards hands to hit them and grab staff [educated him on not al aggression, [client #14] back to the dayroom. Once in it #14] engaged in physical his peer [client #1], who was he, by using his left foot to kick it shin. Staff redirected [client he was compliant with staff with them to his bedroom le to assist him in calming to the dayroom without further sed all clients and noted no solve: Staff will continue to gardian and HRC approved ling verbal and physical YSIS intervention, PRN g skills. All clients report they of them wished to file a l continue to educate [client ace and using his coping skills DT met to discuss recent peer involving [client #14] and ist to see the psychiatrist on lell as assigning a staff to keep 4] and help him de-escalate					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		06/21/	2023
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	R			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
1120 0711			1	L			
(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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	when he gets agitate	ed".					
	A 6/2/23 CCAI incl	_					
		"Staff will continue to monitor					
		#5] and [client #1] for any					
		aff will continue to educate					
		g his coping skills when he					
	_	respecting his peers personal					
	_	e to follow current BSP's (sic) e activities. Team will follow					
		st] to discuss the ineffective					
	PRN of Haldol 5mg	-					
	-	6/23. Staff will be trained on					
		ned staff when [client #14] is					
	-	ursors as of 6-1-23. The					
		be responsible for remaining					
	_	and peers when possible and					
	_	te programing to keep peers					
	safe".	to programming to moop poors					
	1h) A 5/29/23 BDD	OS report indicated, "On May 28,					
	2023 at 11:27 am [c	client #14] and his peer [client					
	#11] were in the kit	chen watching staff make lunch					
	when for no appare	nt reason and without					
	precursors, [client #	[‡] 14] engaged in physical					
	aggression towards	[client #11] by using both					
	hands to grab [clien	t #11's] left arm and then used					
	his right hand to hit	[client #11's] left side. Staff					
	redirected [client #1	[4] out of the kitchen but he					
	returned and used h	is right hand to pinch [client					
		ient #11] did not retaliate. Staff					
	-	[4] to his bedroom where they					
	_	te program him per his plan					
		using his coping skills (sic).					
		ssessed by nursing and no					
	-	. Both clients returned to					
	normal programming without further issues. Plan						
	to Resolve: Staff will continue to follow [client						
		HRC approved BSP and ISP					
	regarding physical	aggression and coping skills.					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023				
NAME OF P	ROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)) BE	(X5) COMPLETION DATE		
	wished to file a grie educate [client #14]	they feel safe and neither evance. Staff will continue to on personal space and using then he becomes upset".						
	[client #11] for any continue to educate coping skills when respecting his peers to follow current Bactivities. Team witto discuss the ineffera possible recommendation trained on serving a [client #14] is demonstrated for the assignment of the continuous formal for the continuous formal formal for the continuous formal formal for the continuous formal for the continuous formal for the continuous for the continuous formal formal for the continuous formal for the continuous formal for the continuous formal for the continuous formal formal for the continuous formal formal for the continuous formal for the continuous formal for the continuous formal for the continuous formal formal for the continuous formal formal for the continuous for the continuous formal formal for the continuous formal for the continuous formal for the continuous formal formal formal formal for the continuous formal forma	uded the following 'Staff will continue to monitor further injuries. Staff will [client #14] on using his he becomes upset and personal space. Will continue SP's (sic) and offer alternative Il follow up with [Psychiatrist] active PRN of Haldol 5mg and andation 6/6/23. Staff will be as an assigned staff when constrating precursors as of d staff will be responsible for [client #14] and peers when agging separate programing to						
	2023 at 8:40 am [cl walking around the up to [client #19] at space. [Client #19] hand to hit [client # did not retaliate. Sta separated both clier prompted [client #1 educated him on no aggression towards agitates him, and to seemed to agree with away. Both clients anoted no injuries. B programming without Resolve: Staff will	report indicated, "On June 5, ient #19] and [client #14] were dayroom. [Client #14] walked and go (sic) into his personal retaliated by using his right 14] in his mouth. [Client #14] aff was able to intervene and atts from each other. Staff 9] to leave his peers alone and tt engaging in physical them, walking away if a peer let a staff know. [Client #19] th this education and walked were assessed by nursing who oth clients returned to normal out further issues. Plan to continue to follow [client #19's]						
	programming without Resolve: Staff will	out further issues. Plan to						

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	 JILDING	instruction 00	(X3) DATE COMPL 06/21/	ETED
NAME OF F	PROVIDER OR SUPPLIER		1306 S	NDDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, 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)	λΤΕ	(X5) COMPLETION DATE
	physical aggression PRN protocol and creport they feel safe grievance. Staff wil #19] to talk with state is upset. IDT me #19] will see [Psych regarding possible regarding possible regarding possible resolved in the state of t	threats, YSIS intervention, oping skills. Both clients and neither wished to file a l continue to educate [client off and use coping skills when t and determined that [client niatrist] on June 6, 2023 med (medication) change to aggression".				

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		15G811	B. W	ING		06/21	/2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			BLOOMINGTON STREET		
RES-CA	DE INC				ICASTLE, IN 46135		
NE3-CA	NE INC			GNEEN			
(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	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	to himself in differ	ent accents. It has shown to be					
	beneficial for [clien	nt #14] to utilize other areas of					
	campus such as the	gym, courtyard, front porch,					
	etc. in order to take	a break from the residential					
	hall and [client #14] occasionally requires					
	programming outsi	de of the residential hall due to					
	continuous aggress	ion. Target behaviors for					
	[client #14] include	e verbal and physical					
	aggression, propert	y destruction, bolting,					
	non-compliance (re	efusing to engage in					
	programming), self	finjury, allegations of abuse					
	and neglect, sexual	ly inappropriate behaviors,					
	boundary violation	s/unwelcome touch, and					
	instigation"						
	"Physical Aggressi	on: Any occurrence or					
	attempts at hitting j	people, spitting on them,					
	kicking or scratching	ng at others, using objects as					
	weapons, pulling h	air, pinching, or behaviors that					
	produce or have the	e potential to produce an injury					
	to others. Spitting	on others occurred at a high					
	frequency at previo	ous placements. Historically,					
		ally aggressive to those who					
		ged' him. He can also be					
	1	ve when he is not getting what					
	he wants from othe	ers. He has a history of being					
		vard his mother and he has					
	_	iver during vehicle transports.					
		ed, he may attempt to engage					
	1	ggression toward peers					
	_	viors: Asking/approaching					
		time he asks appropriately for					
		et the items or attention that he					
	1	he uses his coping skills					
	instead of engaging	g in the target behavior"					
	"Restrictions: [Client #14] will have 1:1 staff for all						
		s and the 1:1 staff cannot be the					
		he furthest away from the driver					
	in the vehicle and will have staff seated next to						

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ľ í		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI		00	COMPLETED	
		15G811	B. WIN	IG		06/21/	/2023
NAME OF F	PROVIDER OR SUPPLIEF	· }			ADDRESS, CITY, STATE, ZIP COD		
					BLOOMINGTON STREET		
RES-CAI	RE INC			GREEN	ICASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		transports. If [client #14] is					
		, precursors, or has engaged in					
		to peers, an assigned staff					
		for the protection of other ed staff's responsibility is to					
	_	from being able to hit/kick/spit					
		e assigned staff should stay					
		and any peers that he may					
	_	aff can also encourage [client					
	_	e skills building for activity					
		away from his peers for their					
	safety"	amay non-mo peers for shen					
	"Precursors: Verbal	l aggression and instigation					
	could be identified	as precursors to other					
	behavioral issues. V	When he engages in this					
	behavior staff will:	See above restriction about					
	implementing an as	signed staff for [client #14].					
	Remain calm i	in tone and volume, do not react					
		tation. Ignore threats and					
		ot get into a back-and-forth					
		ne is engaging in instigation					
	-	nin between the two peers. Ask					
		elp. He is more likely to calm					
	_	oported and liked by his staff.					
		e are here to help him so that he					
	_	of being more independent. If					
	_	, with as little reaction that					
		that you want to help him but					
		o so if he is talking calmly. to resolve the problem or come					
	_	n as to how the problem or come					
		n for his input and compliance					
		d (i.e.: 'I know you're upset but					
		you for calming down so we					
	can talk about this' etc. If the verbal aggression continues, in a calm and neutral voice, suggest a						
	relaxation technique that he can use to calm down						
	_	eep breaths together, then if					
		talk'. A staff will encourage					
	l ´		I				I

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811		UILDING	nstruction <u>00</u>	(X3) DATE : COMPL 06/21/	ETED	
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	him to go with then his peers) for a wall a different area and aggressive, staff wi immediate area. Att upsetting him and a as best you can with creating an unsafe e aggression or instig refusing to leave a c to become a target t and safety, he can b safe area using YOU always beginning w measures" "Preventative Proce engaging in ongoing instigation, it has be to the life skills buil active without disrurestriction related to assigned staff when #14] should have of day to leave the resi yard/gym/etc. Give possible, he does be some control over he enjoys listening to reprovided for him". "[Client #14] and he along and staff shouthem away from on "Reactive Procedure plan. For Physical Destruction/Self Inj	in (in the opposite direction of a. If he does not begin to go to continues being verbally all redirect peers away from the tempt to find out what is a ttempt to resolve the problem in his input. If [client #14] is the environment due to his verbal action of peers, and he is the environment due to his verbal action of peers, for his own health the physically redirected to a current with the least restrictive to take him adding where he can yell or be the period of the environment due to fict the did the propertunities throughout the idential hall and go to the [client #14] choices whenever the est when he feels like he has the sits situation [Client #14] music and a tablet has been the properture of the environment of the						

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811		UILDING	nstruction <u>00</u>	(X3) DATE COMPL 06/21/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF	R	STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ment. Redirect him and/or		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	others to a different him to stop the behavior continuance and he is danger, implement (YSIS) beginning with the QAM with the QAM with the QAM with the Client to client aggression. RM #2 and the QAM with the Client to client aggression. RM #2 staff is with him to we can. He progration place recently". had many issues with (client #19) feeds it should step in betwie aggression) and verwas asked if and with RM #2 stated, "When the he gets assigned stawith him every sing Personally the continuing things out of dangerous environments. I was exhave him on 1 on 1 have someone with	area of the environment. Tell avior. If he stops the behavior, fe location and problem solve whim for doing this with us. If the ues, block all attempts of the placing himself or others in YOU'RE SAFE I'M SAFE with the least restrictive AM, Residential Manager (RM) ere interviewed. RM #2 has engaged in a pattern of the ession and his BSP has had the engaged in physical that the engaged in physical that the engaged in physical that the stated, "We always make sure avoid as many peer to peers as the separately a lot. It was put RM #2 stated client #14 has the client #19 because "he that it". RM #2 stated, "Staff the ento it". RM #2 stated, "Staff the ento prevent (physical bally redirect him". RM #2 then client #14 had 1:1 staffing. The ento it is becoming aggressive. For a while. It is assigned staff that aggression towards peers the state of the state of the client will have someone the second honestly I would. Intuous destroying his room, of his dresser, creating a then in his room, urinating on the able to prevent some of the client when we didn't have to the Each day passes he has to him. Multiple acts of bolting That is becoming an issue.						

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	1 1	UILDING	nstruction <u>00</u>	(X3) DATE : COMPL 06/21 /	ETED	
	OF PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	possibly towards the RM #2 indicated claue to his plan not "When I see him so sure staff is right be prevent abuse and guys. He (client #1 will be walking without of nowhere. [Costomach earlier. I'm intervene until he costated, "Trying to go see him agitated. I many proactive me down here (gym ar some input. She is he responds better discussed 1:1 (for coand trying to come #14]. It's not usual is getting hurt. The him and [Psychiatr about the heavy hit indicated when pla written on a dry era indicating what pla responsible for revinservice form indicated when plandicating what pla responsible for revinservice form indicated when plandicating what plandicated when plandicated when plandicated when plandicated when plandicated when plandicated when plandicating what plandicatin	the transitioned off of it. It was the end of summer last year". ient #14 should have 1:1 staff being effective. RM #2 stated, treaming at peers, I try to make teside him. I do all I can to the the last transition of the last transition of the last transition of the last transition. I can't remember if we have the last things to help [client the lay anything serious. Nobody the IDT is working closely with tist]. Twice weekly IDTs we talk ters (client #14)". RM #2 the sare updated there is a note the serion of the last from the sum and signing the cating they reviewed the s. SAM, the Behavior Technician the last from the staff are the last from the staff are the last from the staff are the last from the l						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	l í	JILDING	nstruction 00	(X3) DATE COMPL 06/21/	ETED
NAME OF F	PROVIDER OR SUPPLIER	2		1306 S	NDDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
	SUMMARY (EACH DEFICIEN REGULATORY OF wasn't a restriction The BT indicated sl targeting client #14 should not be in pro indicated client #14 as written. On 6/13/23 at 11:25 Professional (DSP) was asked if client in DSP #11 stated, "It could really be any one of the main one staff should respond DSP #11 stated, "In something else before He is with assigned the c2cs (client to c #11 indicated when he should be progra client to client incid knows how [client in between him and hi client aggression)". On 6/14/23 at 8:52 The QAM indicated was abuse and the fi	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION addressed in client #14's BSP. The wasn't aware of client #19 and she wasn't aware they regramming together. The BT The BT The BSP should be implemented The BT The BSP should be implemented The		1306 S	BLOOMINGTON STREET	ATE	(X5) COMPLETION DATE
	QIDP #1 indicated meetings, Psychiatr client #14 and the cat preventing incide aggression. QIDP # concerning target be aggression. QIDP # precursors were hal	PM, QIDP #1 was interviewed. there have been many IDT ist visits and BSP changes for hanges haven't been effective ents of client to client #1 indicated client #14's most ehavior was physical #1 indicated client #14's lucinations, speaking to taring off and talking					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL		00	COMPL	
		15G811	B. WING	G		06/21/	2023
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
		•			BLOOMINGTON STREET		
RES-CAI	KE INC			GREEN	CASTLE, IN 46135		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		2 LSC IDENTIFYING INFORMATION 2 #1 stated, "I recognize his c2c		TAG	DEFICIENC!		DATE
		off the chart. Plans have not					
	,	DP #1 indicated clients #14					
		along very well. QIDP #1 was					
		14's BSP addressing client #14					
		eing in programming together. would have to double check.					
	7	c incidents. Based on past					
		t impression. When I first got					
	here that was somet	hing I was concerned about. I					
	_	#19] targeting [client #14]. I					
	_	#14] target [client #19] any					
	more than the other guys". QIDP #1 indicated plans should be implemented as written.						
	pians should be imp	memented as written.					
	2. A 5/31/23 BDDS	S report indicated, "On May 30,					
	_	elient #14] was on an outing at					
		of peers and staff. Staff was					
	assisting [client #14						
		ips when for no apparent					
		out precursors, [client #14]					
		cal aggression towards staff					
	'	nds to hit them as well as					
	1	sing at them. Staff prompted					
	1	se his coping skills and to					
	pick out his next	item when he engaged in					
	physical aggress	ion towards his peer [client					
	#17] by using bo	th hands to grab [client					
	#17's] left hand a	and squeezed and twisted it.					
	Staff was able to	intervene and separated					
	both clients. [Cli	ent #17] did not retaliate.					
	Staff and [client	#14] and his peers moved					
	on to get the nex	t item when [client #14]					
		e a baby from their (sic)					
	•	when he passed them. Staff					
	` ′	t #14] away immediately					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, 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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)				
	•	king up their items. At the						
	=	t #14] engaged in physical						
		ds his peer [client #13] by d to hit [client #13's] left						
	_	separated both clients,						
		ged in physical aggression						
		using both hands to attempt						
	_	n staff and clients got to the						
	van, [client #14]	spit in [client #13's] face.						
	Staff educated [c	elient #14] on respecting his						
	peers personal sp	pace. [Client #14] and his						
	peers made it bad	ck to residential without any						
	issues while on t	he van ride back. All clients						
	were assessed by	nursing and no injuries						
	were noted. All o	clients returned to normal						
		thout further issues. Plan to						
		ill continue to follow [client						
		and HRC approved BSP						
	_	g physical aggression and						
		l clients report they feel safe						
		to file a grievance. Staff						
		educate [client #14] on						
		nd using his coping skills						
		s upset. IDT will meet to						
		lent".A 6/5/23 CCAI						
		owing recommendations:						
		nue to monitor [client #17] &						
	_ =	ny further injuries. Staff will						
		ate [client #14] on using his en he becomes upset and						
		ers personal space. Will						
		w current BSP's (sic) and						
	commue to follo	w current DSF's (SIC) and						

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

Event ID:

KHZG11 Facility ID: 013405

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF I	PROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD S BLOOMINGTON STREET NCASTLE, IN 46135	•
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	BE COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	offer alternative	activities. IDT met to			
	discuss recent be	chavioral occurrences			
	involving [client	#14] and determined that he			
	1	trist] on June 6, 2023			
	regarding possib	le med changes. [Residential			
	Manager/RM #3] to receive a corrective			
	action for failing	to follow [client #14's] ISP			
	& BSP. [DSP #1	1] to receive corrective			
	action for falling	to follow [client #14's] ISP			
	& BSP. The IDT	met last week and the BC			
	(behavior clinicia	an) had no changes to the			
	BSP other than r	etraining staff on [client			
	#14's] BSP".The	re was no documentation			
	indicating the co	rrective action and retraining			
	were completed.	On 6/13/23 at 11:25 AM,			
	DSP #11 and the	QAM were interviewed.			
	DSP #11 indicate	ed she was the only staff			
	present during th	e outing. DSP #11			
	indicated she, cli	ent #14, client #13 and			
	client #17 transp	orted client #15 to a home			
	visit with his fan	nily and after they dropped			
	client #15 off the	e rest of them went to the			
	store. DSP #11 s	stated, "He (client #14)			
	was a perfect ang	gel all day, no behaviors".			
	DSP #11 indicate	ed client #14 became upset			
	when they didn't	have his preferred chips.			
	1	ked what the clients'			
	supervision level	ls were. DSP #11 stated,			
	client #14's supe	rvision level was "Assigned			
	_	nd 2:1 (2 staff) in public and			
	1	ne back seat away from the			
		ways been told they (clients			

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Event ID:

KHZG11 Facility ID: 013405

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		15G811	B. WI	NG		06/21/	/2023
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					BLOOMINGTON STREET		
RES-CAF	KE INC			GKEEN	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 LISC IDENTIFYING INFORMATION	1	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		7) are 3:1 (3 clients to 1		ING			DATE
		OSP #11 indicated she was					
	· · · · · · · · · · · · · · · · · · ·	e incident. DSP #11 was					
		ing was effective. DSP #11					
		100% sure. It is still					
	· ·	the 3:1. Training maybe					
		[Quality Assurance					
		ked it over with me after the					
	_	OAM stated, "[Client #17]					
	1	are not 1:1 in community.					
	-	sight. 2:1 for [client #14].					
		1 in community and the 1:1					
		e driver. There should have					
		ent. Training was not					
	_	#11 indicated the retraining					
		ling an inservice and signing					
		were trained on the					
		OSP #11 left the interview,					
		"I'm not sure if retraining					
		She (DSP #11) will be					
	getting a correcti	ive action. [RM #3] will					
	~ ~	corrective action because					
		outing. Staff are not					
		ervision levels. We just					
	created a cheat sl	heet so everyone knows					
		ls". On 6/14/23 at 8:52 AM,					
	•	terviewed. The QAM					
	_	o client aggression was					
	abuse and the fac	cility should prevent abuse					
		A 6/1/23 BDDS report					
		Iay 31, 2023 at 7:43 pm					
		[client #16] with a can of					
1	ı		1				1

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Event ID:

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023
RES-CAI	PROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
TAG	shaving cream. I shaving cream we evaluated [client control who info #16] plenty of fluction [Client #16's] vit range and he is neeffects. Plan to Rewill continue to report any issues met to discuss the [client #16] on line is outside of future similar incomplete in the intervention of the south of the	t is unknown how much ras ingested. Nursing #16] and called poison rmed them to give [client uids and to monitor him. rals have been within normal rot displaying any side resolve: Staff and nursing monitor [client #16] and to his treatment team. IDT is incident and has put ne of sight supervision when his bedroom to help prevent	TAG		
	1				

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

Event ID:

KHZG11 Facility ID: 013405

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		15G811	B. WI	NG		06/21/	2023
NAME OF P	PROVIDER OR SUPPLIER	t.			ADDRESS, CITY, STATE, ZIP COD		
RES-CAF	RE INC				BLOOMINGTON STREET ICASTLE, IN 46135		
	Г		1		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	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
	have no nutrition	nal value (paint, dirt, etc)					
	Target Behaviors	s and Goals: "Eating					
	non-food items:	Any time [client #16]					
	attempts or succe	eeds at eating a non-food					
	substance such as but not limited to soap,						
	lotion, toothpaste, deodorant, or any other						
	_	ntended to be an edible food					
	item. He has con	nsumed cleaning agents in					
	the past Rights	s Restrictions [Client					
	#16] will not hav	ve any cleaning agents,					
	shampoo, condit	ioner, or other cleaning					
	substances which	n can be consumed by					
	[client #16]. The	ese items will be stored for					
	him and will be j	provided as needed"On					
	6/14/23 at 8:52 A	AM, the QAM was					
	interviewed. The	e QAM indicated client #16					
	did not have acco	ess to his hygiene items at					
	the time of the ir	ncident, but he was able to					
	get client #15's s	having cream. The QAM					
	indicated client #	#16 has a history of PICA.					
	On 6/14/23 at 1:4	45 PM, DSP #13 was					
	interviewed. DS	P #13 indicated client #16					
	was restricted fro	om having access to his					
	hygiene items, b	ut he went into another					
	bedroom and too	ok shaving cream. DSP					
	#13 indicated hy	giene items were stored in a					
	latching box to p	revent further incidents and					
	chemicals are lo	cked. 4. A 6/3/23					
	BDDS report inc	licated, "On 06/02/23					
	[client #8] came	out of his bathroom with					
	Toilet Bowl clea	ner that he had ingested.					
	Staff immediatel	y took him to the ER					
	I						

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Event ID:

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15G811	B. WI	NG		06/21/	2023
NAME OF I	PROVIDER OR SUPPLIER	{			ADDRESS, CITY, STATE, ZIP COD		
DEC CAI	DE INC				BLOOMINGTON STREET		
RES-CAI	RE INC			GREEN	ICASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION DATE
1110		n) at [County] Hospital. At					5.112
	1 .	R] was given Geodon and					
	Benadryl to help him calm down. He was						
	given fliuds (sic) and food, they monitored						
	him for a couple of hours before sending him						
	home. They advised staff to keep monitoring						
	him and to lock up all chemicals. They						
		fluids, as of 6/3/23 he is					
	_	eating and drinking. The ED					
	1	ctor) was notified, [QAC]					
	and [PM] went to the facility to immediately						
	put safety measures in place. They did a						
	1 *	make sure all chemicals					
	1	nined staff that staff and RM					
	will do walk thro	oughs four times a day, 8a,					
		Plan to Resolve: IDT met					
		ety measures. There will be					
	a sign in/out she	et for all chemicals, this will					
	be reviewed by t	he RM. Added additional					
	facilty (sic) swee	eps at 11 a (am) and 4pm					
	that the PM will	do. QAC will also do twice					
	daily sweeps dur	ring the week. ED will					
	provide all client	ts with sealed boxes for					
	hygiene supplies	s for their rooms. The nurse					
	will do increased	d monitoring on [client #8]					
	for the next two	days". A 6/7/23					
	Investigative Sur	mmary included the following					
	conclusion: "It is	s unknown how Individual					
	[client #8] came	into possession of a bottle					
	of [brand name]	Toilet Bowl cleaner. It is					
	substantiated tha	at staff failed to provide					
	proper supervision	on for Individual [client #8].					
	I		1				

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Event ID:

KHZG11 Facility ID: 013405

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF F	PROVIDER OR SUPPLIER	•		ADDRESS, CITY, STATE, ZIP COD	-
RES-CAF				S BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	PRIATE
TAG		d that staff failed to follow	TAG	DEFICIENCE	DATE
		and Procedures".A 6/9/23			
	_				
	_	er Review included the			
	_	mendations: "Sweeps of the			
	I	a day and documented. All			
		be locked. HRC obtained			
		lock chemical (sic). Sign in			
		emicals. Re-train all staff on			
		ervision levels. [RM #2] to			
		ive action for failure to			
		ies. BC to review all			
	-	ls and create a spread sheet			
	_	vels for RMs to review".On			
		PM, a focused review of			
		l was conducted. Client			
		o indicated, "[Client #8]			
		ned staff due to needing			
		ommunication, toileting, and			
		Target Behaviors and			
	_	on-Food Items: Any time			
		pts or succeeds at eating a			
		nce such as but not limited			
	•	oothpaste, deodorant, or			
	-	at is not intended to be an			
		. [Client #8] may enter the			
		peers in an effort to look			
		he may look in the kitchen			
	_	. Restrictions: [Client #8]			
		gned staff across all shifts.			
	He will have 10	minute checks while he is in			
	his bedroom. The	e assigned staff is			
	responsible for the	ne following: Assisting [client			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/21/2023
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
RES-CA	RE INC			BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	LD BE COMPLETION
mo	 	rly toileting and hygiene (see	ing in		DATE
	_	sure he is not entering peer			
		en. Assisting with possible			
		barriers. Meal/snack			
	supervision. Pro	viding/offering walks around			
	campus (2x (tim	es) on 1st and 2nd shift). At			
	the end of the as	signed time, staff will check			
	[client #8's] room	n for fall hazards and will			
	assist with clean	ing up any messes that were			
	made" Me	dical records dated 6/2/23			
	indicated client	#8 was evaluated at the ER.			
	Client #8 was di	scharged from the ER with a			
	diagnosis of acc	idental ingestion of			
	chemicals. Or	n 6/14/23 at 8:52 AM, the			
	QAM was interv	viewed. The QAM stated,			
	"We had 2 incid	ents in 2 days. Sign in and			
	out sheets are cu	rrently being implemented,			
	sweeps 6 times a	a day and hygiene items are			
	locked in hygier	ne boxes. He was not			
	restricted from c	hemicals prior to the			
	incident. He is a	now". On 6/14/23 at 1:45			
	PM, DSP #13 w	as interviewed. DSP #13			
	stated, "We were	e still supposed to keep			
	everything (cher	nicals) locked up. No			
	chemicals lying	around due to him constantly			
	picking things u	p and putting them in his			
	mouth. He was	not restricted (from			
	chemicals) prior	to the incident. Currently			
	we have a sign i	n and out form for			
	chemicals. Chemicals.	micals are stored in the			
	janitor closet".	5. A			
	5/17/23 BDDS r	report indicated, "On May			

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPL	
		15G811	B. WI	NG		06/21/	2023
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
		•			BLOOMINGTON STREET		
RES-CAI	KE INC			GREEN	ICASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
TAG		pm [Client #20] and a	1	IAG			DATE
		rs were on a community van					
		•					
	ride. [Client #20] was listening to music when for no apparent reason and without						
	precursors he began to poke his peer [client						
	#17] who was sitting in the seat in front of						
	_	of his head. Staff prompted					
	· ·	spect his peers personal					
	_ =	0] did not agree with this					
	education and engaged in physical aggression towards [client #17] by using his						
	right hand to scratch and smack the left side						
	-	neck. [Client #17] did not					
	1 -	illed the company vehicle					
	1	s safe to do so that they					
		nts seating for their safety.					
		•					
		, when [client #20's] peer					
		t to exit the company vehicle					
		g, [client #20] engaged in					
	1	ion towards [client #13] by					
		s to grab [client #13's] right					
		nails in. [Client #13] pulled					
	1	t did not retaliate. After staff					
		back inside the vehicle with					
		nicle in motion, [client #20]					
	1	cal aggression towards the					
		ting next to him by using					
		and scratch staff as well as					
		kick them. Staff attempted					
	_	lient #20] by talking with					
		sic for him, and handing him					
	a ball as coping s	skills. [Client #20] threw the					

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Event ID:

KHZG11 Facility ID: 013405

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	ľ í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 06/21 /	ETED
NAME OF I	PROVIDER OR SUPPLIEF	· R			ADDRESS, CITY, STATE, ZIP COD		
RES-CAI	RE INC				BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID	SUMMARY	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		peer but did not hit him and		IAU			DATE
		physically aggressive					
		Then staff and clients were					
		e campus, staff walked with					
		is bedroom to assist him in					
	I = =	ef and pants as they were					
	wet. While staff	was assisting [client #20] in					
	changing his clo	thing and briefs, he engaged					
	in physical aggre	ession towards them by using					
	both hands to hit	t them. He then picked up a					
	shoe and threw i	t at staff. At this time,					
	trained staff initi	iated a guardian and HRC					
	approved 3 perso	on supine hold. Staff					
	assisted [client #	[20] in using his coping skills					
	and he was able	to calm himself down. He					
	was released from	m the hold. The hold lasted					
	12 minutes. Nurs	se assessed [client #20] and					
	noted no injuries	s. Nurse assessed [client					
	#13] and noted a	2.5 cm (centimeter) red					
	mark on his righ	t forearm with skin intact, no					
	bleeding, and no	bruising. Nurse assessed					
	[client #17] and	noted a 5 cm scratch mark					
	on the left side o	of the back of his neck.					
	Nursing cleaned	it and left it to air dry with					
	_	tion and no complaints of					
	pain. All consun	ners returned to normal					
	programming wi	ithout further issues. Plan to					
		vill continue to follow [client					
	#20's] guardian a	and HRC approved BSP					
	and ISP regardin	ng verbal and physical					
		ats, YSIS intervention, PRN					
	protocol and cop	oing skills. Staff will continue					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		15G811	B. WI	NG		06/21/	/2023
NAME OF P	PROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP COD		
					BLOOMINGTON STREET		
RES-CAF	KE INC			GKEEN	CASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		² 20] on using his coping		1110			DATE
	_	upset. [Client #20] is					
	non-verbal and was unable to answer						
		sumer incident questions					
		offering communication					
		3] and [client #17] stated					
	_	d did not wish to file a					
	· ·	will continue to monitor					
	•	[client #17] and report any					
	-	eatment team".A 5/24/23					
	CCAI included the following						
	recommendations: "Staff will continue to						
		413] and [client #17] for any					
	_	Staff will continue to					
	l	20] on using his coping					
	-	ecomes upset and respecting					
		al space. Will continue to					
		SP's (sic) and offer					
		ties. IDT will meet to discuss					
	recent peer to pe	er incidents involving [client					
	#20]".On 6/14/23	3 at 8:52 AM, the QAM					
	was interviewed.	. The QAM indicated client					
		ion was abuse and the					
		revent abuse of the clients.					
	1	DS report indicated, "On					
		om [client #2] was sitting at					
	_	a snack when a peer (client					
	1	e room, the peer picked up					
		threw it at [client #2]. [Client					
		I to the floor, he hit his head					
	_	sing a small laceration to the					
		. Staff called 911 and he					
1	ı		1				1

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Event ID:

KHZG11 Facility ID: 013405

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD		
RES-CAF	RE INC			BLOOMINGTON STREET NCASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE	
TAG		y ambulance and taken to	TAG		DATE	
		al Emergency Room. The				
		ran tests and evaluated				
		ests came back with good				
	= =	ated the laceration with skin				
	-	t #2] home at 11:03 pm with				
	his discharge ins	tructions. Plan to Resolve:				
	Staff will continu	ue to monitor [client #2] and				
	report any chang	es to his treatment team.				
	Staff and nursing	g will follow all discharge				
	instructions prov	ided by the hospital". There				
	was no documen	tation indicating the client to				
	client aggression	was investigated. On				
	6/14/23 at 4:00 F	PM, client #2's record was				
	reviewed. Medic	cal records dated 5/20/23				
		[‡] 2 was evaluated at the ER				
		tion. The record indicated				
		on was closed with skin glue				
		s discharged. On 6/14/23				
		QAM was interviewed.				
	-	ated client to client				
		buse and the facility should				
	•	the clients. The QAM				
		ident should have been				
		A 5/2/23 BDDS report				
	· ·	Tay 2, 2023, at 6:15 AM,				
		is peer (client #1) began				
		I forth in the dayroom. Staff				
	-	pally redirect both				
		arguing but both were				
	_	with the request. At this time,				
	[client #4] attem	pted to lunge towards peer,				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023
	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET	
RES-CAF	RE INC		GREEN	NCASTLE, IN 46135	
(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)	DATE DATE
	but staff were ab	le to physically redirect			
	[client #4] before	e making contact. At this			
	time, [client #4]	became upset and			
	attempted to hit	staff; trained staff initiated a			
	_	C approved supine hold.			
		d [client #4] was prompted			
		se his coping skills. Nursing			
	-	4] and administered him a			
		(as needed medication for			
	· -	t #4] was able to calm			
		d was released from the			
		d 6 minutes. [Client #4] was			
	-	ing staff who reported no			
	_	44] went to his room with no			
		fter the supine (behavioral			
		s finished, it was reported			
	that staff [Forme	r Waiver Site			
	•	S] performed the supine			
		SS] has been suspended			
		ation. Plan to Resolve: Staff			
		follow [client #4's] guardian			
		ed BSP and ISP regarding			
		cal aggression, threats,			
		n, PRN protocol and			
		lient #4] was offered			
		onal support".A 5/4/23			
	_	nmary included the following			
		t is substantiated that			
		sically abusive towards			
		is substantiated that			
		follow approved YSIS			
	techniques durin	g the incident on			

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	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· /		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G811	A. BU B. WI	JILDING NG	00	COMPI 06/21	
		100011	D. W1			00/21/	12020
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CAI	RE INC				ICASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE	COMPLETION DATE
IAU		/23 Investigation Peer		IAU			DATE
		d, "Recommendation:					
		SS's] employment due to					
	substantiated physical abuse". 8. A 5/11/23						
	BDDS report indicated, "On May 10, 2023						
	at 7:19 pm [client #17] was sitting at the						
	table in the dayroom eating a snack when his						
	l -	walked up to him and					
	1	#17] of grabbing his					
	headphones (upon review of the cameras,						
	[client #17] was not anywhere close to						
	[client #4] and d	lid not grab his headphones).					
	[Client #4] then	engaged in physical					
	aggression towa	rds [client #17] by using his					
	right hand to sla	p [client #17] on his head					
	multiple times. S	Staff was able to intervene					
	and separated bo	oth clients by redirecting					
	[client #4] to his	s room where staff could					
	assist him in usi	ng his coping skills to calm					
	down. [Client #4	4] was compliant with staff					
	assistance and w	vas able to calm himself					
	down. Both clien	nts were assessed by nursing					
	who noted no in	juries. Both clients returned					
	to normal progra	amming without further					
	issues. Plan to I	Resolve: Staff will continue					
	to follow [client	#4's] guardian and HRC					
	approved BSP a	nd ISP regarding verbal					
	and physical agg	gression, threats, YSIS					
	intervention, PR	N protocol and coping					
	skills. Both clier	nts report they feel safe and					
	neither wished to	o filed (sic) a grievance. Staff					
	will continue to	educate [client #4] on					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811 A. BUILDING 00 B. WING			COMPLETED 06/21/2023		
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET	
RES-CAI	RE INC		GREEN	ICASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	personal space as	nd physical aggression. An			
	IDT meeting wil	l convene to discuss relevant			
	peer to peer incidents". There was no				
	documentation in	ndicating the client to client			
	aggression was is	nvestigated. On 6/14/23 at			
	8:52 AM, the QA	AM was interviewed. The			
	QAM indicated of	client to client aggression			
	was abuse and th	e facility should prevent			
	abuse of the clien	nts. The QAM indicated			
	the incident shou	ald have been investigated.			
	9. A 5/26/23 Inv	estigative Summary			
	indicated, "On M	[18] [18] [18] [18] [18] [18] [18] [18]			
	notified [PM] that	at she had observed [DSP			
	#1] asleep while	in the dayroom on 3rd shift,			
	she stated she pro	ompted him to wake up			
	and assist with c	leaning. An investigation			
	was initiated.[DS	SP #1] was suspended			
	pending investig	ation Conclusion: 1. It is			
	not substantiated	that [DSP #1] was asleep			
	while on duty. 2	. It is not substantiated that			
	[DSP #1] failed t	to maintain proper			
	supervision to th	e consumers. 3. It is			
	substantiated tha	t [DSP #1] failed to			
	complete job dut	ies as assigned. 4. It is not			
	substantiated tha	t [DSP #1] failed to follow			
	ResCare Policy a	and Procedure". This			
	affected clients #	£1, #2, #3, #4, #5, #6, #7,			
	#8, #9, #10, #11,	#12, #13, #14, #15, #16,			
	#17, #18, #19 an				
		er Review included the			
		mendations: "[DSP #1]			
	should return to	work. Corrective action for			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	r í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 06/21 /	ETED
NAME OF I	PROVIDER OR SUPPLIEF	<u> </u>	•		ADDRESS, CITY, STATE, ZIP COD	•	
RES-CAI	RE INC				BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		ete lob duties. Review Code					
	of conduct. Rand	dom Administrative					
	monitoring durir	ng [DSP #1's] shifts".					
	There was no do	cumentation indicating the					
	incident was rep	orted to BDDS. On					
	6/14/23 at 8:52 A	AM, the QAM was					
	interviewed. Th	e QAM stated, "We didn't					
	do one (BDDS r	eport) because we didn't					
	think it was negl	ect since other staff were on					
	duty". The QAN	A indicated an allegation of					
	neglect should b	e reported then investigated					
	to rule out negle	ct. The QAM indicated the					
	allegation should	l have been reported to					
	BDDS. On 6	5/13/23 at 8:38 AM, the					
	Quality Assuran	ce Manager (QAM)					
	indicated the clie	ent to client investigations					
	were to determin	ne whether or not staff					
	followed the plan	ns, were within the required					
	proximity based	on the clients' plans,					
	whether or not th	ne clients' plans needed to					
	be adjusted, iden	tify patterns and ensure the					
	interdisciplinary	team convened to discuss.					
	The QAM indica	ated client #14 was found to					
	have a majority	of his client to client					
	aggression about	t one hour before mealtimes.					
	The QAM indica	ated staff received training					
	on the clients' pl	ans and when the plans were					
		facility's BDDS and					
	Investigations w	ere reviewed on 6/12/23 at					
	2:35 PM. The re	view indicated the					
	following:Invest	igation Summary dated					
	4/13/23 indicated	d the following:-"On April					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
RES-CAF	RE INC			BLOOMINGTON STREET NCASTLE, IN 46135	
(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 APPROPRI DEFICIENCY)	
TAG		pm, Greencastle CRMNF	TAG	BERTOLENOTY	DATE
		stration received a report			
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ehavior consultant) #2] that			
	= '	OSP (Direct Support			
	_	6] aggressively grab			
		t #8's] hands to wipe them			
	-	messy from snack. The [BC			
		that she witnessed [DSP			
		around [client #8's] back			
		to his bedroom in Pacer's			
		shut the door. She stated			
	-	ened the door to enter the			
	_	re everything was okay, she			
	overheard [DSP	#16] say 'Who the			
	[expletive] is cor	ning in?' The [BC			
	#2]immediately	reported the incident to the			
	administration. [DSP #16] was immediately			
	asked to leave th	e floor and was suspended			
	pending investig	ation."-"Conclusion1. It is			
	substantiated tha	t [DSP #16] was physically			
	forceful towards	[client #8].2. It is			
	substantiated tha	t [DSP #16] used profane			
	language in the p	presence of [client #8].3. It is			
	substantiated tha	t [DSP #16] failed to follow			
	ResCare Policy a	and Procedures."The review			
	did not indicate of	documentation of the			
	4/10/23 allegatio	n of DSP #16's			
	abuse/mistreatme	ent of client #8 was			
	reported to BDD	S. QAM (Quality			
	Assurance Mana	ger) was interviewed on			
	6/12/23 at 1:41 P	PM. QAM indicated the			
	facility's ANE (A	Abuse, Neglect,			

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF I	PROVIDER OR SUPPLIER	₹		ADDRESS, CITY, STATE, ZIP COL		
RES-CA	RE INC			BLOOMINGTON STREET NCASTLE, IN 46135		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE COMPLETION ROPRIATE	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	1	licy should be written to				
	1 *	nd neglect of clients. QAM				
		gations of ANE should be				
		orted to the facility				
		d to BDDS within 24 hours				
	_	cident. QAM indicated all				
	_	ld thoroughly investigated				
		ne investigation reported to				
	1	nistrator within 5 business				
		am Manager) was				
		6/13/23 at 3:40 PM. PM				
		tive measures to prevent				
		egations of ANE should be				
	•	mplemented. ED (Executive				
	1 '	AM were interviewed on				
		PM. QAM indicated some				
	BDDS reports w	ere missing. QAM				
		nvestigations should have				
		ompleted. QAM indicated				
	he would send/e	mail any Peer Reviews he				
		AM indicated there were				
	allegations of Al	NE without investigations.				
	The facility's Po	licy and Procedures were				
	reviewed on 6/12	2/23 at 2:33 PM. The				
	facility's Reporti	ing and Investigating Abuse,				
	Neglect, Exploit	ation, Mistreatment or a				
	Violation of Ind	ividual's Rights Policy dated				
	5/5/21 indicated	the following:-"ResCare				
	staff actively adv	vocate for the rights and				
	safety of all indi	viduals. All allegations or				
	occurrences of a	buse, neglect, exploitation,				
	mistreatment or	violation of an Individual's				
	I		1			

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING		(X3) DATE SURVEY COMPLETED 06/21/2023				
NAME OF I	PROVIDER OR SUPPLIER	₹	•		ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET	-	
RES-CAI	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		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		eported to the appropriate		IAG			DATE
		gh the appropriate					
		nnels and will be thoroughly					
	investigated under the policies of ResCare,						
	local, state and f						
		sCare strictly prohibits					
		exploitation, mistreatment, or					
		ndividual's rights."-"The					
	Quality Assuran	ce Manager will assign an					
	investigative tea	m. A full investigation will be					
	conducted by in	vestigators who have					
	received training	g from Labor Relations					
	Association and	ResCare's internal					
	procedures on in	vestigations."-"One of the					
	investigators wil	l complete a detailed					
	investigative cas	se summary based on witness					
	statements and o	other evidence					
	collected."-"An	investigative peer review					
		en by the Executive Director					
	will meet to disc	euss the outcome of the					
	_	d to ensure that a thorough					
		s been completed. Members					
		e must include at least one of					
	_	, the Executive Director or					
		m Manager, and a Human					
144.04.50	_	sentative." 5-1.2(v)(2)(5)					
W 0153	483.420(d)(2)	ENT OF CLIENTS					
Bldg. 00		ensure that all allegations of					
-	mistreatment, neg	glect or abuse, as well as					
	•	n source, are reported					
		e administrator or to other ance with State law through					
	established proce						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		15G811	B. WI	NG		06/21/	2023
				CTREET	ADDRESS OF A STATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DEC 045	DE INO				BLOOMINGTON STREET		
RES-CAF	RE INC			GREEN	ICASTLE, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Based on record rev	view and interview for 5 of 5	W	153	To correct the deficient practic	e all	08/12/2023
	sampled clients (#1,	, #2, #3, #4 and #5) and 15			staff responsible for BDDS rep	orts	
	additional clients (#	6, #7, #8, #9, #10, #11, #12,			will be re-trained to complete t	he	
	#13, #14, #15, #16,	#17, #18, #19 and #20), the			reporting of allegations to BDD)S	
	facility failed to rep	ort an allegation of staff			within 24 hours as well as all		
	sleeping while on sl	nift and an allegation of staff			allegations of ANEM are to be		
	abuse of client #8 to	the Bureau of Developmental			reported to BDDS. The QAM v	vill	
	Disabilities Services	s (BDDS) within 24 hours, in			be re-trained on ensuring all		
	accordance with sta	te law.			allegations of ANEM are repor	ted	
					to BDDS within 24hrs to be		
	Findings include:				completed by the regional sup	port	
					specialist. Additional monitorii	ng	
	1. On 6/12/23 at 2:30 PM and on 6/13/23 at 8:00				will be achieved by the QAM		
	AM, a review of the	e facility's			reviewing all incidents to ensu	re	
	incident/investigative	ve reports was conducted.			staff are assigned to report an	y	
					needed BDDS reports within 2	4	
	A 5/26/23 Investiga	tive Summary indicated, "On			hours as well as reporting to the	ne	
	May 24, 2023, [Dire	ect Support Professional/DSP			ED weekly for review of incide	nts.	
	#4] notified [PM/Pr	ogram Manager] that she had			Ongoing monitoring will be		
	observed [DSP #1]	asleep while in the dayroom on			achieved through IR tracking,	and	
		she prompted him to wake up			all IR's being reviewed by the		
		ning. An investigation was			quality and safety committee for	or	
		was suspended pending			reporting and patterns.		
	investigation Cor						
		OSP #1] was asleep while on					
	1	ostantiated that [DSP #1]					
		roper supervision to the					
		substantiated that [DSP #1]					
		ob duties as assigned. 4. It is					
		at [DSP #1] failed to follow					
	1	Procedure". This affected					
		4, #5, #6, #7, #8, #9, #10, #11,					
	#12, #13, #14, #15,	#16, #17, #18, #19 and #20.					
	_	tion Peer Review included the					
	I -	ndations: "[DSP #1] should					
		rective action for failure to					
		. Review Code of conduct.					
		ative monitoring during [DSP					
	#1's] shifts".						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	ì í	JILDING	nstruction <u>00</u>	(X3) DATE (COMPL 06/21/	ETED
NAME OF I	PROVIDER OR SUPPLIEF	2		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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)	TE	(X5) COMPLETION DATE
	allegation of neglect On 6/14/23 at 8:52 Manager (QAM) w stated, "We didn't d we didn't think it w were on duty". The of neglect should be rule out neglect. The allegation should has 2. The facility's BD reviewed on 6/12/2 indicated the follow Investigation Summe the following: -"On April 10, 2022 CRMNF (agency) as from the [BC (behas witnessed [DSP (Diaggressively grab in wipe them off due to [BC #2] also report #16] put his arm are force him into his b then shut the door to opened the door to everything was oka say 'Who the [expless #2] immediately rej administration. [DS to leave the floor ar investigation."	nary dated 4/13/23 indicated B, at 3:00 pm, Greencastle administration received a report vior consultant) #2] that she irect Support Professional) #16] adividual [client #8's] hands to to being messy from snack. The ed that she witnessed [DSP bound [client #8's] back and redroom in Pacer's hallway and She stated that when she enter the room to make sure y, she overheard [DSP #16] tive] is coming in?' The [BC ported the incident to the EP #16] was immediately asked and was suspended pending					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. I		(X2) MULTIPLE CO A. BUILDING B. WING			
NAME OF P	ROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	4/10/23 allegation of abuse/mistreatment BDDS. QAM (Quality Asso- interviewed on 6/12 all allegations of Al- reported to the facil within 24 hours of t	of client #8 was reported to urance Manager) was /23 at 1:41 PM. QAM indicated NE should be immediately ity administrator and to BDDS he alleged incident.			
W 0154 Bldg. 00	interviewed on 6/14 some BDDS reports 5-1.2(v)(2)(5) 483.420(d)(3) STAFF TREATME The facility must h alleged violations Based on record rev allegations of abuse reviewed, the facilit investigations for in aggression regardin #17 and #19. Findings include: On 6/12/23 at 2:30 a review of the facil reports was conduct	·	W 0154	To correct the deficient practic staff responsible for completir investigations have been re-tr on timely completion. The QA will be re-trained on ensuring allegations of ANEM are repo investigated to be completed the regional support specialist The Investigations have been completed.	rained M all rted by
	following:				

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	r í	JILDING	nstruction 00	(X3) DATE : COMPL 06/21/	ETED
NAME OF I	PROVIDER OR SUPPLIER			1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	Services (BDDS) re 2023 at 12:46 pm [o standing in the fron to instigate [client # pretending the (sic) [client #14]. [Client began to shout at [c retaliated by using I #14] in the left side attempted to chase agitated at him for p [client #19] back in Staff educated both peers personal space education and return [Client #19] did not and engaged in vertice by cussing at them accontinued to monitor both clients and not further issues. Plant to follow [client #19] and HRC (Human I BSP (behavior supproport plan) regard aggression, threats, behavioral intervenneeded medication coping skills. Both and neither wished continue to educate talk with staff and upset". There was no docur facility conducted a client to client aggression to color to client aggression.	au of Developmental Disabilities apport indicated, "On May 21, client #14] and [client #19] were the tyard when [client #19] began with the tyard when [client #19] began with the was going to throw it at a with the was going to throw it at with the was going to the with the with the was going to the with the with the with the was going to the with the with the was going to the with the wi					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 15G811 B. WING			(X3) DATE COMPL 06/21 /	ETED		
NAME OF P	ROVIDER OR SUPPLIER	3	1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	an investigation sho The QAM stated, " assigned to the Q (O Disabilities Profess complete them (inv	-				
	2023 at 3:25pm wh apparent reason and #14] began to shou #14] then walked u physical aggression	S report indicated, "On May 21, ile in the dayroom, for no d without precursors, [client t at his peer [client #4]. [Client p to [client #4] and engaged in a towards [client #4] by using t [client #4] in his left shoulder.				
	[Client #4] did not intervene and redire peer to another area [client #14] on resp space. [Client #14] education. Both client	retaliate. Staff was able to ected [client #14] away from his a of the dayroom and educated ecting his peers personal seemed to agree with this ents returned to normal				
	noted no injuries. Plan to Resolve: St [client #14's] guard and ISP regarding v (sic) threats, YSIS	se assessed both clients and There were no further issues. aff will continue to follow ian and HRC approved BSP verbal and physical aggression intervention, PRN protocol and				
	and neither wished continue to educate and using his copin	clients report they feel safe to file a grievance. Staff will [client #14] on personal space g skills when he is upset". mentation indicating the				
		nn investigation regarding the				
	interviewed and inc have been complete not done. It was as	O AM, the QAM was dicated an investigation should ed. The QAM stated, "It was signed to the Q (QIDP #1) and them (investigations)".				

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	ATION NUMBER A. BUILDING <u>00</u>		(X3) DATE SURVEY COMPLETED 06/21/2023		
	OF PROVIDER OR SUPPLIED	₹		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(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)	TE	(X5) COMPLETION DATE
	2023 at 7:21 am [cleating breakfast and dayroom. For no apprecursors [client # [client #10] by eng towards him by ins him. Staff educated words but [client # in physical aggress using his right hand [client #10's] face a push a chair into [client #10] did not retalia and redirected [client of another part of the educated [client #1 aggression towards didn't do it, [imagin person] is not a rea walking around the issues. Nurse asses injuries. Plan to Refollow [client #14's BSP and ISP regard aggression, threats, protocol and coping they feel safe and magrievance. Staff wi #14] on personal specific when he becomes used team) will meet to occurrences involved.	mentation indicating the an investigation regarding the					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023		
NAME OF F	PROVIDER OR SUPPLIEF		1306 S	ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET NCASTLE, IN 46135		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION
TAG	interviewed and ind have been complete not done. It was as he did not complete 4) A 5/21/23 BDD at 9:07 pm [client # a snack when a peer room, the peer pick at [client #2]. [Clien he hit his head on the laceration to the bas and he was picked to [County] Hospital Hemergency room ra #2]. All tests came treated the laceration #2] home at 11:03 prinstructions. Plan to monitor [client # his treatment team. discharge instruction to client aggression On 6/14/23 at 4:00 reviewed. Medical indicated client #2 to (emergency room) record indicated the with skin glue and conditional for the clients. The should have been in the should have been in the stream of the clients. The should have been in the shou	PM, client #2's record was records dated 5/20/23 was evaluated at the ER for a head laceration. The head laceration was closed client #2 was discharged. AM, the QAM was interviewed. I client to client aggression facility should prevent abuse QAM indicated the incident	TAG	DEFICIENCE		DATE

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	ì í	UILDING	onstruction 00	(X3) DATE COMPL 06/21/	ETED	
NAME OF P	PROVIDER OR SUPPLIEF	3	STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE	
	2023 at 7:19 pm [cli in the dayroom eati [client #4] walked w #17] of grabbing hi the cameras, [client to [client #4] and di [Client #4] then eng towards [client #17] on was able to interver by redirecting [client was able to interver and was Both clients were a no injuries. Both clients were a no injuries. Both clients were and injuries. Both clients was able to filed (sie continue to educate and physical aggres convene to discuss incidents". There was no document to client aggression on 6/14/23 at 8:52. The QAM indicated was abuse and the file of the properties of th	client #17] was sitting at the table ing a snack when his peer up to him and accused [client is headphones (upon review of it #17] was not anywhere close id not grab his headphones). It is gaged in physical aggression is gaged in physical aggression is gaged in physical aggression is head multiple times. Staff the and separated both clients in the separated both client in the separated both client #4's] approved BSP and ISP is approved BSP and ISP is approved BSP and representation in the separated both client #4's] and present in the separated both client in the separated both clients in the separated both clients in the separated						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPI A. BUILDIN B. WING	le construction ng <u>00</u>	COMP	E SURVEY LETED 1/2023
NAME OF F	PROVIDER OR SUPPLIER		130	EET ADDRESS, CITY, STATE, ZIP CO 06 S BLOOMINGTON STREE REENCASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFI TAC	CROSS-REFERENCED TO THE A	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
W 0157	483.420(d)(4) STAFF TREATME	ENT OF CLIENTS				
Bldg. 00	If the alleged viola corrective action r Based on observation interview for 4 addi and #17), the facilit implement effective client #14's pattern and to ensure the re to address neglect owhile on a communindicated. Findings include: 1. An observation of 6/13/23 from 4:00 Intellectual Disability was supervising clied yard. QIDP #1 was Client #19 was sitting QIDP #1 and clients the yard interacting On 6/12/23 at 2:30 a review of the facility reports was conducted following: 1a) A 5/20/23 Burea Disabilities Service 05/19/2023 at 3:10 reason and without engaged in physical (client #10). He hit walking through the to his bedroom to excepting skills. Plan	tion is verified, appropriate nust be taken. on, record review and tional clients (#13, #14, #15 y failed to develop and corrective measures regarding of client to client aggression commended corrective action f clients #13, #14, #15 and #17 ity outing was implemented as was conducted at the facility of the professional (QIDP) #1 ents #10, #14 and #19 in the the only staff present outside. In at the picnic table while is #10 and #14 walked around with each other. PM and on 6/13/23 at 8:00 AM, hity's incident/investigative and indicated the end of Developmental is (BDDS) report indicated, "On PM, [client #14] for no apparent precursors, [client #14] aggression towards a peer the peer in the back as he was a day room. He was redirected alm down and to use his to Resolve: Staff will continue	W 0157	To correct the deficient site staff have been tra Client #14's current BS ensuring staff are in be agitated individual and prevent client to client. supervisory staff and in have been trained in er IDT meets the needs of to prevent patterns of client and ensuring all recommendations are colient #14's IDT will mediscuss current patterns further safety measures will monitor and track a behaviors and patterns convene the IDT if a parafound. The QAC will trainvestigation recommen completion. Additional will be achieved by the administrative staff contimes a week facility ob for one month. Ongoin monitoring will be achieved by the administrative staff contimes a week facility ob for one month. Ongoin monitoring will be achieved by the administrative staff contimes a week facility ob for one month. Ongoin monitoring will be achieved by the administrative staff continues a week facility obtained by the administrative staff continues as well as the administrative weekly to any issues in the facility determine if the IDT neand address.	ined on P, and tween an others to All vestigators asuring the f the clients lient to completed. eet to s and s. The BC Il targeted . BC will attern is ack all adations for monitoring appleting five servation g eved by the completing the facility rative team of discuss y to	08/12/2023
	to follow [client #14	4's] guardian and HRC (Human				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 06/21/2023			
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, 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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)			
IAU	Rights Committee) Support Plan) and I regarding verbal and (sic) coping skills. So [client #14] on using becomes upset". A 5/25/23 Client to Investigation (CCA recommendations: 'client #10] for any continue to educate coping skills when be respecting his peers to follow current Boundard activities. Team with on 5/30/23 on camp PRN (as needed) of behaviors) and a powill be trained on so when [client #14] is The assigned staff or remaining between possible and encount keep peers safe". 1b) A 5/20/23 BDD at 3:20 pm, [client #14] and peers he was vitable and peers he was vitable and peers (sic) (client person escort, so he calm down, use his continued PA (physthem several times (sic). They tried have again but he was un Nurse called [Psychappen].	approved BSP (Behavior SP (Individual Support Plan) d physical aggression, threats, Staff will continue to educate g his coping skills when he	IAG		DATE		
	1 **	2 2	1		ĺ		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G811	B. W	/ING		06/21/	2023
				STDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	8			BLOOMINGTON STREET		
RES-CAF	DE INC				CASTLE, IN 46135		
KES-CAI	KE IING			GREEN	CASTLE, IN 40133		
(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 OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		, threats (sic) PRN protocol					
		taff will continue to educate					
	[client #14] on usin	g his coping skills when he					
	becomes upset".						
		cluded the following					
		"Staff will continue to monitor					
		urther injuries. Staff will					
		[client #14] on using his					
		he becomes upset and					
		s personal space. Will continue					
		SP's (sic) and offer alternative					
		ill follow up with [Psychiatrist]					
		ous to discuss the ineffective					
	PRN of Haldol 5mg	-					
		Staff will be trained on serving					
	-	when [client #14] is					
		ursors. The assigned staff will					
	-	emaining between [client #14]					
		sible and encouraging					
	separate programing	g to keep peers safe".					
	1) + 5/00/00 DDF	20					
		OS report indicated, "On May					
	_	m [client #14] and [client #19]					
	_	e front yard when [client #19]					
		client #14] by taking his ball					
		(sic) he was going to throw it					
		ent #14] became agitated and					
		lient #19]. [Client #19]					
		his right fist to punch [client					
	_	of his face. [Client #14] then					
	-	[client #19] due to being					
	-	punching him. Staff redirected					
		side the residential building. clients on respecting their					
		, ,					
		e. [Client #14] agreed with this					
	education and returned to normal programming. [Client #19] did not agree with staffs education						
	-	_					
		oal aggression towards them					
	by cussing at them	and shouting at them. Staff					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	ľ í	JILDING	nstruction 00	(X3) DATE COMPL 06/21 /	ETED
NAME OF I	PROVIDER OR SUPPLIEF			1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(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
	both clients and not further issues. Plan to follow [client #19] and HRC approved and physical aggres intervention, PRN proclients report they file a grievance. Sta [client #19] and [client #14] began to shout #14] then walked uphysical aggression his right hand to hit [Client #4] did not intervene and redire peer to another area [client #14] on resp space. [Client #14] education. Both client #14] education. Both client #14's] guard and ISP regarding with the protocol and coping they feel safe and ningrievance. Staff will #14] on personal sp when he is upset". 1e) A 5/24/23 BDD	protocol and coping skills. Both deel safe and neither wished to aff will continue to educate then #14] to talk with staff and men he is upset". DS report indicated, "On May while in the dayroom, for no at without precursors, [client at his peer [client #4]. [Client proto [client #4] and engaged in towards [client #4] by using [client #4] in his left shoulder. The retaliate. Staff was able to exted [client #14] away from his at of the dayroom and educated ecting his peers personal seemed to agree with this ents returned to normal see assessed both clients and of the continue to follow ian and HRC approved BSP verbal and physical aggression					

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	OF CORRECTION	IDENTIFICATION NUMBER 15G811	A. BU	A. BUILDING <u>00</u> B. WING			COMPLETED 06/21/2023	
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET			
RES-CAI	RE INC				ICASTLE, IN 46135			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION I began to walk around the	-	TAG	Difficience 17		DATE	
	_	parent reason and without						
		14] began to target his peer						
		aging in verbal aggression						
		tigating him and threatening						
	1	[client #14] on using kind						
		[4] did not agree and engaged						
	_	ion towards [client #10] by						
		I to slap the right side of						
		nd then used both hands to						
		lient #10's] right leg. [Client						
	_	te. Staff was able to intervene						
	_	nt #14] away from his peer and						
	_	ne dayroom. Staff also						
	_	4] on not engaging in physical						
	_	his peers. [Client #14] stated 'I						
		nary person] did ([imaginary						
	person] is not a real	person)'. He then returned to						
	walking around the	dayroom without further						
	issues. Nurse assess	sed both clients and noted no						
	injuries. Plan to Re	esolve: Staff will continue to						
	follow [client #14's]	guardian and HRC approved						
	BSP and ISP regard	ling verbal and physical						
	00	YSIS intervention, PRN						
		g skills. Both clients report						
		either wished to file a						
	l -	l continue to educate [client						
		ace and using his coping skills						
		pset. IDT (interdisciplinary						
	· /	discuss recent peer to peer						
	occurrences involvi	ing [client #14]".						
	16) A 5/07/20 DDD	OS mamoust in diserted NO. 34 . 25						
		OS report indicated, "On May 25,						
		client #11] and [client #14] were no apparent reason and						
		[client #14] engaged in verbal						
		wards [client #11] by						
		m. [Client #14] also got close						
		acted like he was going to hit						
		d him not to hurt his peer.						
	min. Sum prompted	a min not to nurt ms peer.						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811		UILDING	nstruction <u>00</u>	(X3) DATE : COMPL 06/21 /	ETED	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(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 BE CROSS-REFERENCED TO THE APPROPRIA	.TE	(X5) COMPLETION	
PREFIX TAG	REGULATORY OR [Client #14] ignored engaged in physical #11] by using his le right arm and begar into [client #11's] ri retaliate. Staff was a both clients. Staff re another area of the crespecting his peers hurting them. He th Nurse assessed both on [client #14]. Nur [client #14]. Nur [client #11's] right at the day was scratch bleeding. Nurse cleated bleeding. Nurse cleated bleeding. Nurse cleated bleeding. Staff was a continue to follow [approved BSP and Inphysical aggression PRN protocol and creport they feel safe file a grievance. Staff ile a grievance. Staff ile a grievance without further is sure coping skills when in the staff to keep an ey de-escalate when he staff to keep an ey de-escalate when he staff to recommendations: [client #11] for any	d staffs (sic) prompts and aggression towards [client ft hand to grab [client #11's] to pinch him and dig his nails ght arm. [Client #11] did not able to intervene and separated edirected [client #14] to dayroom and educated him on personal space and not en walked to his bedroom. In clients and noted no injuries are noted that the scab on the area and bandaged it. In injuries noted on [client #14] and aned the area and bandaged it. In injuries noted on [client #11]. It do normal programming es. Plan to Resolve: Staff will client #14's] guardian and HRC (SP regarding verbal and threats, YSIS intervention, oping skills. Both clients and neither of them wished to ff will continue to educate onal space and using his the is upset. IDT met to discuss occurrences involving [client im on a list to see the 30, 2023 as well as assigning the on [client #14] and help him		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	TE .	COMPLETION DATE	
	continue to follow of alternative activities	the becomes upset. Will burrent BSP's (sic) and offer s. Team will follow up with cuss the ineffective PRN of						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	COMPLETED	
		15G811	B. W	ING		06/21/	/2023	
				·				
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP COD			
DE0 044	DE 1110				BLOOMINGTON STREET			
RES-CA	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 CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
	Haldol 5mg and a p	possible recommendation. Staff						
	will be trained on s	erving as an assigned staff						
	when [client #14] is	s demonstrating precursors.						
	The assigned staff	will be responsible for						
	remaining between	[client #14] and peers when						
	possible and encou	raging separate programing to						
	keep peers safe".							
	1g) A 5/26/23 BDI	OS report indicated, "On May 25.						
	2023 at 3:29 pm [cl	lient #14] was in Pacer's hallway						
	following around h	is QIDP (QIDP #1) when for no						
	apparent reason he	began to engage in verbal						
	aggression towards	staff and his peers by						
	threatening them. S	staff prompted [client #14] to						
	walk with him to hi	is bedroom for separate						
	programming per h	is plan. He was compliant and						
	began to walk with	staff. As [client #14] walked						
	past his peer [client	t#11], who was walking around						
	the dayroom, he en	gaged in physical aggression						
	towards [client #11] by using his left elbow to						
	elbow [client #11]	in his left elbow. [Client #14]						
	then spit on [client	#11's] face. [Client #11] did not						
		eated [client #14] on respecting						
		space and continued walking						
		is bedroom in Colt's hallway.						
		passed his peer [client #5], he						
		l aggression towards him by						
		[5] and then using his right leg						
		n his left leg. [Client #5]						
	, ,	both of his hands to shove						
		en ran to his room. [Client #14]						
		ysical aggression towards						
		hands to hit them and grab						
		staff educated him on not						
		al aggression, [client #14]						
		ack to the dayroom. Once in						
		t #14] engaged in physical						
		his peer [client #1], who was						
		ne, by using his left foot to kick						
	[client #1] in his le	ft shin. Staff redirected [client						

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Event ID:

KHZG11 Facility ID: 013405

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811		UILDING	onstruction 00	(X3) DATE COMPL 06/21 /	ETED	
NAME OF F	PROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	-	n. He was compliant with staff						
	-	with them to his bedroom le to assist him in calming						
	-	to the dayroom without further						
		sed all clients and noted no						
		esolve: Staff will continue to						
		guardian and HRC approved						
	_	ling verbal and physical						
	aggression, threats,	YSIS intervention, PRN						
		g skills. All clients report they						
		of them wished to file a						
	-	Il continue to educate [client						
		pace and using his coping skills						
	-	OT met to discuss recent peer						
	-	involving [client #14] and ist to see the psychiatrist on						
	-	ell as assigning a staff to keep						
		4] and help him de-escalate						
	when he gets agitat	-						
	A 6/2/23 CCAI inc							
		"Staff will continue to monitor						
		#5] and [client #1] for any						
	-	aff will continue to educate						
		ig his coping skills when he						
	_	respecting his peers personal e to follow current BSP's (sic)						
	-	e activities. Team will follow						
		st] to discuss the ineffective						
	PRN of Haldol 5mg	=						
		6/23. Staff will be trained on						
	serving as an assign	ned staff when [client #14] is						
	demonstrating prec	ursors as of 6-1-23. The						
	_	be responsible for remaining						
	_	and peers when possible and						
	encouraging separa safe".	te programing to keep peers						
		OS report indicated, "On May 28, client #14] and his peer [client						
	2020 at 11.27 am [t	The state of the poor fortent						

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KHZG11 Facility ID: 013405

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 00		(X3) DATE S COMPL 06/21/	ETED
NAME OF P	PROVIDER OR SUPPLIER		130	ET ADDRESS, CITY 6 S BLOOMING EENCASTLE, IN	TON STREET		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF #11] were in the kit	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION chen watching staff make lunch	ID PREFIZ TAG	(EACH CORR	DER'S PLAN OF CORRECTION LECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	when for no apparer precursors, [client # aggression towards hands to grab [client his right hand to hit redirected [client # I returned and used h # 11's] left side. [Cli redirected [client # I were able to separar and assisted him in Both clients were as injuries were noted. normal programmir to Resolve: Staff wi # 14's] guardian and regarding physical a Both clients report wished to file a grie educate [client # 14] his coping skills when a coping skills when respecting his peers to follow current Bactivities. Team with to discuss the ineffer a possible recommendation serving a [client # 14] is demoted.	ant reason and without [14] engaged in physical [client #11] by using both t #11's] left arm and then used [client #11's] left side. Staff 4] out of the kitchen but he is right hand to pinch [client ent #11] did not retaliate. Staff 4] to his bedroom where they the program him per his plan using his coping skills (sic). The sessed by nursing and no Both clients returned to the gwithout further issues. Plan all continue to follow [client HRC approved BSP and ISP the aggression and coping skills. They feel safe and neither the vance. Staff will continue to on personal space and using the safe and using the safe and using the becomes upset".					
I							

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Event ID:

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Facility ID: 013405

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023
NAME OF F	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CO BLOOMINGTON STREE	
RES-CAF	RE INC			NCASTLE, IN 46135	:1
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	OULD BE COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		report indicated, "On June 5,			
	_	ient #19] and [client #14] were dayroom. [Client #14] walked			
	~	nd go (sic) into his personal			
		retaliated by using his right			
		14] in his mouth. [Client #14]			
	_	aff was able to intervene and			
		its from each other. Staff			
	prompted [client #1	9] to leave his peers alone and			
	educated him on no	t engaging in physical			
		them, walking away if a peer			
	_	let a staff know. [Client #19]			
	I -	th this education and walked			
		were assessed by nursing who			
	1	oth clients returned to normal			
		out further issues. Plan to			
		continue to follow [client #19's]			
		and ISP regarding verbal and			
		, threats, YSIS intervention, oping skills. Both clients			
	_	and neither wished to file a			
		l continue to educate [client			
	_	aff and use coping skills when			
	_	t and determined that [client			
		niatrist] on June 6, 2023			
	regarding possible i	med (medication) change to			
	assist in decreasing	aggression".			
	A 6/9/23 CCAI incl	e e			
		'Staff will continue to monitor			
		further injuries. Staff will			
		[client #19] on using his			
		he becomes upset. Staff will			
		[client #14] on respecting his sic). Will continue to follow			
		The team met 6-8-23 and			
		t #14] having an assigned staff			
		s room combined with an			
		(Haldol, 10mg currently) that			
		s [Psychiatrist] on 6-8-23".			

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PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	r í	JILDING	nstruction <u>00</u>	(X3) DATE (COMPL 06/21/	ETED
	DF PROVIDER OR SUPPLIED	3		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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)	TE	(X5) COMPLETION DATE
	On 6/14/23 at 12:0. reviewed.	5 PM, client #14's record was					
	be very aggressive of his behaviors ap warning. He spits of he may engage in the knowing why he is acts of physical aggression [Clier and friendly to three without clear envirous be observed to be yhaving 'arguments' present, punching at to himself in different beneficial for [clier campus such as the etc. in order to take hall and [client #14] programming outsic continuous aggress [client #14] include aggression, propert non-compliance (reprogramming), self and neglect, sexual boundary violation instigation" "Physical Aggressi attempts at hitting physical Aggressis attempts at hitting physical or scratchin weapons, pulling hiproduce or have the to others. Spitting	BSP indicated, "[Client #14] can with peers and staff and some pear to take place without on others when he is upset and his behavior without others upset. Due to his numerous pression toward peers, he has then he is demonstrating at #14] can switch from pleasant atening and aggressive commental triggers. He can often relling at no one in particular, with people who are not and fighting the air, or talking ent accents. It has shown to be at #14] to utilize other areas of gym, courtyard, front porch, a break from the residential cocasionally requires de of the residential hall due to ion. Target behaviors for everbal and physical y destruction, bolting, fusing to engage in rinjury, allegations of abuse ly inappropriate behaviors, solumwelcome touch, and					

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		06/21/	2023
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			BLOOMINGTON STREET		
RES-CAI	DE INC				ICASTLE, IN 46135		
RES-CAI	RE INC			GREEN	ICASTLE, IN 40133		
(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		TAG	DEFICIENCY)		DATE
	he has been physica	ally aggressive to those who					
		ged' him. He can also be					
		ve when he is not getting what					
		rs. He has a history of being					
		vard his mother and he has					
	_	iver during vehicle transports.					
		ed, he may attempt to engage					
		ggression toward peers					
	•	viors: Asking/approaching					
		time he asks appropriately for					
		t the items or attention that he					
	· ·	he uses his coping skills					
	instead of engaging	in the target behavior"					
	"Doctrictions: [Clic	nt #14] will have 1:1 staff for all					
	_	and the 1:1 staff cannot be the					
		he furthest away from the driver					
		vill have staff seated next to					
		transports. If [client #14] is					
		, precursors, or has engaged in					
		to peers, an assigned staff					
		for the protection of other					
		ed staff's responsibility is to					
	_	from being able to hit/kick/spit					
		e assigned staff should stay					
		and any peers that he may					
	_	aff can also encourage [client					
		e skills building for activity					
		away from his peers for their					
	safety"						
	-						
	"Precursors: Verbal	aggression and instigation					
	could be identified	as precursors to other					
	behavioral issues. V	When he engages in this					
	behavior staff will:	See above restriction about					
	implementing an as	signed staff for [client #14].					
	Remain calm i	in tone and volume, do not react					
	with emotion or irri	tation. Ignore threats and					
		ot get into a back-and-forth					
	power struggle. If h	ne is engaging in instigation					
	I		1				

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	WING 06/21/2023			2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	R			BLOOMINGTON STREET		
RES-CAI	RE INC				ICASTLE, IN 46135		
				OI (EE)			
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
	-	nin between the two peers. Ask					
		elp. He is more likely to calm					
	_	pported and liked by his staff.					
		e are here to help him so that he					
	_	of being more independent. If , with as little reaction that					
		that you want to help him but					
		o so if he is talking calmly.					
		to resolve the problem or come					
	_	n as to how the problem can be					
		n for his input and compliance					
		d (i.e.: 'I know you're upset but					
		you for calming down so we					
	• •	etc. If the verbal aggression					
		and neutral voice, suggest a					
		e that he can use to calm down					
	_	eep breaths together, then if					
	you're calm, we car	n talk'. A staff will encourage					
	him to go with then	n (in the opposite direction of					
	his peers) for a wall	k. If he does not begin to go to					
	a different area and	continues being verbally					
		ll redirect peers away from the					
		tempt to find out what is					
		attempt to resolve the problem					
		h his input. If [client #14] is					
	_	environment due to his verbal					
		ration of peers, and he is					
	_	common area, thus causing him					
	_	to his peers, for his own health					
		be physically redirected to a					
		U'RE SAFE I'M SAFE (YSIS)					
	always beginning w	vith the least restrictive					
	incasures						
	"Preventative Proce	edures: If [client #14] is					
		g verbal aggression or					
		een helpful to offer to take him					
	to the life skills building where he can yell or be active without disrupting his peers. See above						
		o [client #14] having an					
		. , 0					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		06/21/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER				BLOOMINGTON STREET		
RES-CAF	RES-CARE INC				ICASTLE, IN 46135		
1120-071	NE IIVO			OKEEK	10/10/12/2, 114 40/100		
(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		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	showing precursors. [Client					
		pportunities throughout the					
	-	dential hall and go to the					
		[client #14] choices whenever					
	-	est when he feels like he has					
		is situation [Client #14]					
		nusic and a tablet has been					
	provided for him".						
	"[Cliont #1.4]	g noon foliant #101 do					
	-	s peer, [client #19] do not get ald make an effort to program					
	-	e another when possible."					
	them away from on	e another when possible.					
	"Reactive Procedur	es: For Verbal Aggression: See					
		in 'precursor' section of this					
	-	Aggression/Property					
		urious Behaviors: Immediately					
		d safety of everybody in the					
		nent. Redirect him and/or					
		area of the environment. Tell					
		avior. If he stops the behavior,					
	-	e location and problem solve					
		him for doing this with us. If					
	the behavior continu	ues, block all attempts of					
	aggression and atter	npt to redirect, if the behavior					
	continues and he is	placing himself or others in					
	danger, implement	YOU'RE SAFE I'M SAFE					
	(YSIS) beginning w	rith the least restrictive					
	measures"						
		AM, Residential Manager (RM)					
	`	ere interviewed. RM #2					
		has engaged in a pattern of					
		ession and his BSP has had					
	many updates. RM #2 indicated client #14 had						
	assigned staff when he engaged in physical						
	aggression. RM #2 stated, "We always make sure						
	staff is with him to avoid as many peer to peers as						
		ns separately a lot. It was put					
	in place recently".	RM #2 stated client #14 has					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF I	PROVIDER OR SUPPLIER	.			ADDRESS, CITY, STATE, ZIP COD		
RES-CAI	RE INC				BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIE	.TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		th client #19 because "he nto it". RM #2 stated, "Staff					
	should step in betw	een to prevent (physical					
	aggression) and ver	bally redirect him". RM #2					
		hen client #14 had 1:1 staffing.					
		en he is becoming aggressive.					
		for a while. It is assigned staff					
		as aggression towards peers					
		ff. If I could have someone					
		gle second honestly I would.					
	· ·	inuous destroying his room,					
		f his dresser, creating a					
	"	nent in his room, urinating on					
	1 -	be able to prevent some of the					
		cited when we didn't have to					
		Each day passes he has to					
		him. Multiple acts of bolting That is becoming an issue.					
		he transitioned off of it. It was					
		e end of summer last year".					
		ient #14 should have 1:1 staff					
		being effective. RM #2 stated,					
	_	reaming at peers, I try to make					
		eside him. I do all I can to					
	_	neglect at all times towards the					
	1 ~	4) pops up at random times. He					
		h a basketball and he'll throw it					
		lient #19] took 2 balls to the					
	stomach earlier. I'm	not going to proactively					
	intervene until he d	oes something". The QAM					
	stated, "Trying to g	et in between people when we					
	see him agitated. T	he IDT tried to come up with					
	many proactive mea	asures for him. We bring him					
		ea). [RM #2] just gave me					
		suggesting 1:1 and male staff					
		o. I can't remember if we have					
		lient #14). Everyone is aware					
		up with things to help [client					
	_	ly anything serious. Nobody					
	is getting hurt. The	IDT is working closely with					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 15G811 B. WING			(X3) DATE COMPL 06/21/	ETED	
NAME OF I	PROVIDER OR SUPPLIEI	3	1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TO DEFICIENCY		ON SHOULD BE COMINE COM	
TAG	him and [Psychiatria about the heavy hit indicated when plan written on a dry era indicating what pla responsible for revi inservice form indicatings to the plan On 6/13/23 at 10:3: (BT) was interview an incident this motrying to bolt from the library. The BT staff with client #14	5 AM, the Behavior Technician red. The BT indicated there was rning where client #14 was the group when they were in a indicated she was the only 1, client #19 and client #1. The	TAG	DEFICIENCY)		DATE
	BT indicated she had to close the door and sit by the door to prevent client #14 from bolting from the room. The BT indicated closing the door wasn't a restriction addressed in client #14's BSP. The BT indicated she wasn't aware of client #19 targeting client #14 and she wasn't aware they should not be in programming together. The BT indicated client #14's BSP should be implemented as written.					
	Professional (DSP) was asked if client DSP #11 stated, "It could really be any one of the main one staff should respon- DSP #11 stated, "Ir something else before He is with assigned the c2cs (client to c #11 indicated when he should be progra client to client incice	#11 was interviewed. DSP #11 #14 targets any of his peers. just depends on his mood. It of the clients. [Client #19] is es". DSP #11 was asked how d to client #14's behaviors. Itervene, redirect him to pre something else happens. Iters so we can try to prevent lients) from happening". DSP is client #14 displays precursors ammed by himself to prevent lents. DSP stated, "Everyone #14] is, you have to stay in				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		06/21/	/2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	3			BLOOMINGTON STREET		
RES-CAI	RE INC				ICASTLE, IN 46135		
	1	OTA TEL CENT OF DEPLOYENCE		<u> </u>	,		OV.C.)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	DATE
IAU		is peers to prevent (client to		IAU			DATE
	client aggression)".						
	enent aggression).						
	On 6/14/23 at 2:28	PM, QIDP #1 was interviewed.					
	QIDP #1 indicated	there have been many IDT					
	meetings, Psychiatr	rist visits and BSP changes for					
	client #14 and the c	hanges haven't been effective					
		ents of client to client					
		#1 indicated client #14's most					
		ehavior was physical					
		#1 indicated client #14's					
	_	llucinations, speaking to					
		staring off and talking					
		P #1 stated, "I recognize his c2c					
		off the chart. Plans have not					
	-	IDP #1 indicated clients #14					
	_	along very well. QIDP #1 was					
		#14's BSP addressing client #14					
		being in programming together. would have to double check.					
		c incidents. Based on past					
		t impression. When I first got					
		thing I was concerned about. I					
		#19] targeting [client #14]. I					
	_	#14] target [client #19] any					
	-	guys". QIDP #1 indicated					
		olemented as written.					
	2. A 5/31/23 BDDS	S report indicated, "On May 30,					
	2023 at 10:55 am [c	client #14] was on an outing at					
		of peers and staff. Staff was					
		1] in getting his chips when for					
		and without precursors,					
		d in physical aggression					
		ing both hands to hit them as					
		d cussing at them. Staff					
	prompted [client #14] to use his coping skills and						
	_	item when he engaged in					
		towards his peer [client #17]					
	by using both hands	s to grab [client #17's] left					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF	PROVIDER OR SUPPLIEI	₹	•	1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	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
	hand and squeezed to intervene and set #17] did not retalia peers moved on to #14] attempted to to moms (sic) arms wore redirected [client # finished picking up [client #14] engage towards his peer [chand to hit [client # separated both client physical aggression hands to attempt to clients got to the variation #13's] face. Staff erespecting his peers and his peers made any issues while on were assessed by noted. All clients rewithout further issue continue to follow approved BSP and aggression and cop they feel safe and most Staff will continue personal space and he becomes upset. Finitely incident. A 6/5/23 CCAI increcommendations: [client #17] & [client	and twisted it. Staff was able parated both clients. [Client te. Staff and [client #14] and his get the next item when [client ake a baby from their (sic) then he passed them. Staff [14] away immediately and their items. At the check out, d in physical aggression lient #13] by using his left [413's] left arm. After staff ants, [client #14] engaged in a towards staff by using both hit them. When staff and an, [client #14] spit in [client ducated [client #14] on a personal space. [Client #14] it back to residential without at the van ride back. All clients arrived to normal programming test. Plan to Resolve: Staff will [client #14's] guardian and HRC ISP regarding physical ing skills. All clients report sone wished to file a grievance. To educate [client #14] on using his coping skills when a little with the following "Staff will continue to monitor using his coping skills when a little will continue to monitor using his coping skills when a little will continue to monitor using his coping skills when a little will continue to monitor using his coping skills when a little will continue to monitor using his coping skills when a little will continue to monitor using his coping skills when a little will continue to monitor using his coping skills when a little will continue to monitor using his coping skills when a little will continue to monitor using his coping skills when using his coping skills wh					

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Event ID:

KHZG11 Facility ID: 013405

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		r í	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 06/21/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF			1306 S	NDDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, 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 APPROPRIA DEFICIENCY)	ΙΤΕ	(X5) COMPLETION DATE
	offer alternative discuss recent be involving [client will see [Psychia regarding possib Manager/RM #3 action for failing & BSP. [DSP #1 action for falling & BSP. The IDT (behavior clinici BSP other than r #14's] BSP". The indicating the reaction and retrain 6/13/23 at 11:25 QAM were interindicated she was during the outing client #14, client transported client his family and at off the rest of the #11 stated, "He (angel all day, no indicated client # didn't have his p was asked what levels were. DS supervision level facility and 2:1 (activities. IDT met to chavioral occurrences #14] and determined that he atrist] on June 6, 2023 le med changes. [Residential] to receive a corrective to follow [client #14's] ISP 1] to receive corrective to follow [client #14's] ISP 2 met last week and the BC an) had no changes to the retraining staff on [client re was no documentation commended corrective ming were completed. On AM, DSP #11 and the viewed. DSP #11 sthe only staff present g. DSP #11 indicated she, at #13 and client #17 and the first they dropped client #15 to a home visit with the free they dropped client #15 to a					

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Event ID:

KHZG11 Facility ID: 013405

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BUILDING <u>00</u> COM			(X3) DATE COMPL 06/21	ETED	
NAME OF F	PROVIDER OR SUPPLIEF		•	1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135	•	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE		ATE	(X5) COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	I have always be	en told they (clients #15,					
	#13 and #17) are	e 3:1 (3 clients to 1 staff) in					
	ratio". DSP #11	indicated she was retrained					
	after the incident	t. DSP #11 was asked if the					
	training was effe	ective. DSP #11 stated, "I					
	wasn't 100% sur	e. It is still confusing to me,					
	the 3:1. Training	g maybe wasn't effective.					
	[Quality Assurar	nce Coordinator] talked it					
	over with me aft	er the incident". The QAM					
	stated, "[Client #	⁴ 17] and [client #13] are not					
	1:1 in communit	y. They are line of sight. 2:1					
	for [client #14].	[Client #15] is 1:1 in					
	community and	the 1:1 should not be the					
	driver. There sh	ould have been 4 staff					
	present. Trainin	g was not effective". DSP					
	_	e retraining consisted of					
		vice and signing it indicating					
	_	d on the changes. After					
		interview, QAM #1 stated,					
		etraining has been done.					
		vill be getting a corrective					
		will also be getting a					
		because she approved the					
		not aware of the					
		ls. We just created a cheat					
	_	e knows supervision levels".					
	5-1.2(v)(2)(5)	•					
W 0159	483.430(a) QIDP						
Bldg. 00		e treatment program must					
	be integrated, coo	rdinated and monitored by					
		tual disability professional					
	who-						

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BUILDING B. WING	00	COMPLETED 06/21/2023
NAME OF PROVIDER OF RES-CARE INC	R SUPPLIER	STREET A 1306 S GREEN		
PREFIX (EACH TAG REGUL	SUMMARY STATEMENT OF DEFICIENCIE H DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112
for 5 of 5 and 15 ad #12, #13, the facilit Profession #5 and #9 cards, to a implement supervision client rati #8, #10, # to ensure competent and to ensure and to ensure and to ensure direct caraclient #14 to ensure invited to meetings, identified addressed (ISP), to #14, #15, (ISPs) and implement #8, #16 at individua clients #3 #20's dignensure state the phone behaviors		W 0159	To correct the deficient practice the QIDP has been trained in coordinating, monitoring, and integrating for all client needs. The QIDP will also be completed the QIDP certification program with ResCare Quality supports team. The QIDP duties will be monitored by completing a we meeting to ensure all duties at complete with the QAM and EAdditional monitoring will be achieved by the administrative staff completing five times a wear facility observation for one monogoing monitoring will be achieved by the QIDP completed in the QAM and ED to ensure all duties are completed.	ting n s ekly re D. evek onth. ting cility

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Event ID:

KHZG11 Facility ID: 013405

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		l í	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 06/21/	ETED	
NAME OF F	PROVIDER OR SUPPLIER	2		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	discovered clients # money checks from	ring the review process it was £1, #3, #5 and #9's spending their bank accounts were gram Manager (PM) and not t.					
	The PM indicated v requests for the clie to her and not the cl how it always was l	PM, the PM was interviewed. when she completes check nts, the checks are made out lient. The PM stated, "That is perfore I came. The clients Ds (state identification					
		PM, current ID cards for clients ere requested from the Quality (QAM).					
	The QAM indicated ID cards, but he wa	PM, the QAM was interviewed. If he was unable to locate the still looking. The QAM d be in the safe and copies in					
	The QAM stated, "	AM, the QAM was interviewed. [Client #9's] ID expired in indicated he was unable to its #1, #3 and #5.					
	(ED) and the QAM QAM indicated the cards. The ED state	AM, the Executive Director were interviewed. The ED and clients should have current ID ed, "They are all going to have to they can do their own					
	Disabilities Profess interviewed. QIDP	PM, Qualified Intellectual ional (QIDP) #1 was #1 indicated he was uring clients have current state					

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KHZG11 Facility ID: 013405

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		UILDING	nstruction 00	(X3) DATE COMPL 06/21	ETED
NAME OF F	PROVIDER OR SUPPLIEF		1306 S I	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE	
	ID cards. QIDP #1 their IDs and they so other personal docucurrent". 2. The QIDP failed staff to implement a supervision needs a client ratios for clie #8, #10, #11, #12, # Please see W186. 3. The QIDP failed Technician received conduct restraints a Professional (DSP) regarding clients #1 ratios while particip Please see W189. 4. The QIDP failed invited to and particip meetings. Please see 5. The QIDP failed guardian were invit #14's IDT meetings 6. The QIDP failed #20's identified conformally addressed Plan (ISP). Please see 7. The QIDP failed #12, #13, #14, #15, Support Plans (ISPs) were implemented the see W249.	stated, "They should have hould be kept in our safe with ments. They should all be to ensure sufficient direct care clients #9, #16, and #20's 1:1 and to meet minimum staff to ints #1, #2, #3, #4, #5, #6, #7, #13, #14, #15, #17, #18, and #20. to ensure the Behavior of competency based training to ind to ensure Direct Support in the sum of the staffing parting in community outings. to ensure direct care staff were clipated in client #14's IDT in the weather with the weather with the staffing in community outings. to ensure client #14 and/or his in the second in client in the second				DATE

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED B. WING 06/21/2023				
		15G811	B. WI	NG		06/21/	2023
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CAF	RE INC		GREENCASTLE, IN 46135				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL DESCRIPTION OF AGE IN STREET AND ACTION OF THE PROPERTY OF THE PR		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX				PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION eir personal needs. Please see		TAG	DEFICIENCY		DATE
	W250.	eir personal needs. Please see					
	9. The QIDP failed	to promote clients #3, #5, #8,					
		#19, and #20's dignity in					
	regards to their appearance. Please see W268.						
	-	to ensure staff did not restrict					
		the phone in order to behaviors. Please see W288.					
	prevent maiadaptive	JUCHAVIOIS. I ICASC SEC W 200.					
W 0186	483.430(d)(1-2)						
	DIRECT CARE STAFF						
Bldg. 00		rovide sufficient direct care					
	_	nd supervise clients in					
	plans.	neir individual program					
	piaris.						
	Direct care staff a	re defined as the present					
		lated over all shifts in a					
	-	each defined residential					
	living unit.						
		on, record review, and	W^0	186	To correct the deficient practic	e all	08/12/2023
		sample clients (#1, #2, #3, #4, litional clients (#6, #7, #8, #9,			staff have been trained to	ho	
		#14, #15, #16, #17, #18, #19,			implement plans as written. T RMs and PM have been traine		
		failed to provide sufficient			ensure the expected ratio is in		
	· · · · · · · · · · · · · · · · · · ·	mplement clients #9, #16, and			place at all times. The		
		n needs and to meet minimum			administrative team will review	the	
	staff to client ratios	for clients #1, #2, #3, #4, #5,			current ratio needs for the curr	ent	
	#6, #7, #8, #10, #11	, #12, #13, #14, #15, #17, #18,			clients admitted to the facility.		
	and #20.				The team will develop a ratio p		
	Findings in the 4.				and inform the RMs of the ratio)	
	Findings include:				that will be implemented.		
	1. Observations wer	re conducted in the facility on			Additional monitoring will be achieved by the administrative	1	
		om to 3:30 pm and from 5:00 pm			staff completing five times a w		
	-	3/13/23 from 8:00 am to 10:00 am			facility observation for one mo		
	-	to 12:30 pm. Clients #3, #4, #8,			to ensure the appropriate ratio		
		ere in the facility throughout			in place, and plans are		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		15G811	B. WING 06/21/2023			2023	
				CTD FFT A	DDDFGG CITY CTATE TIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DEC OAF	DE INO				BLOOMINGTON STREET		
RES-CAF	KE INC			GREEN	ICASTLE, IN 46135		
(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 APPROPRIAT DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	_	DATE
	the observation peri	ods.			implemented as written. Ongo	ing	
					monitoring will be achieved by	the	
	On 6/12/23 at 1:45	pm, Residential Manager (RM)			administrative team meeting tv	vice	
	#2 indicated clients	#9 and #20 had dedicated 1:1			weekly to discuss the needs of	f	
	staff.				the facility including what the		
					appropriate ratio is with the cu	rrent	
	At 2:30 pm, clients	#1, #12, #20, #2, #15, #8, and			clients.		
	#19 were in the day	room. RM #2 was the only					
	staff in the day roon	n. Clients #1, #12, #20, #2,					
		ere not engaged in meaningful					
	activities and were i	not encouraged to do so.					
	Client #1 sat at the dining table with a board game						
	_	ked RM #2 to play the game					
		[‡] 2 stated, "I can't leave [client					
		pproached the surveyor and					
	-	one. Client #19 stated, "I can					
	-	day. Staff get the phone from					
		The surveyor encouraged					
		staff for assistance. Client					
		he could use the phone, and					
		n't leave my one on one." At					
		ssurance Coordinator was					
	_	down the hallway and was					
		eep his clothing on. Client #8					
		n and knocked over a rack of					
		At 2:45 pm, Direct Support					
	, , ,	#11 was following client #8 up					
	and down the hallw	-					
	_	assisted client #3 with his					
	•	ning table. Client #15 was					
		the day room and in and out					
		nt #2 was sitting on a sofa in					
		nt #19 jumped up and down on					
	_	perched on the arm of the					
	•	pted client #19 to get off of the					
	chair. Client #19 stood on the arm of the chair then jumped off. Client #8 walked through the						
		nto his pants, and ripped off					
		P #11 prompted client #8 to his					
	bedroom to put on a	new brief. At 2:52 pm, client					

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	OF CORRECTION OF CORRECTION 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/21/2023
NAME OF I	PROVIDER OR SUPPLIER	1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	#3 went into his bedroom and laid down in his bed. At 2:54 pm, RM #2 called client #19 to the day room, so he could make a phone call. At 2:55 pm, client #2 wandered in and out of the kitchen. Client #15 followed the surveyor around the facility repeating his mother was coming to see him. Staff did not provide meaningful activities. At 3:00 pm, Program Manager was in the Qualified Intellectual Disabilities Professionals (QIDPS) office with client #16. The gym, consumer room, and music rooms were empty. Client #14 was in a staff office with Activities Coordinator (AC). Client #14 was talking to himself and others not visibly present in the room. AC stated, "[Client #14] is being separately programmed, so he can't target people. He's being aggressive today." Clients #13 and #17 were in the art room playing bingo with Behavior Technician (BT). Client #18 was in the movie room with Quality Assurance Coordinator (QAC). On 6/12/23 at 5:00 pm, client #14 and AC were in the recreation building kitchen. From 5:00 pm to 6:00 pm, client #4 paced through the day room. Client #4 indicated he was going on an outing and would eat in the community. Client #4 was not provided with an activity while he was waiting. There were no other clients participating in activities in the recreation building. At 4:57 pm, clients #3, #7, #1, #16, #8, #20, and #4 were in the dayroom with client #20's one to one staff. Clients #19, #9, #17, and #2 were in the kitchen. At 5:07 pm, RM #2 indicated DSP #13 was assigned as client #9's one to one staff. At 5:13 pm, DSP #11 stated, "I think [client #5] is in his room." DSP #10 asked DSP #13 to prompt client #5 for dinner. DSP #13 left client #9 in the day			

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Event ID:

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	MENT OF DEFICIENCIES AN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/21/2023	
	OF PROVIDER OR SUPPLIES	R		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
	5:15 pm, DSP #13 room. DSP #13 se #16 was walking th pudding cup. Client and was scooping to with his fingers. A walking through the green beans. Client and poured the greet the bowl. At 5:23 hands and was pact Client #16 went into client #16 to leave hand, and RM #2 ge Client #16 bit down stated, "He bit me! #16 to the end of the to the facility. RM bedroom and sat in RM #2 sat on the cephone. DSP #10 we client #20 went into take something from physically blocked sit on the sofa in the his bedroom and la lights off. Client #16 hallways with his help with the door shut. DSF in bed. I have no ce Client #1 was seate tablet. Client #5 we DSP #13. Client #	and client #5 returned to the day reved client #5 his meal. Client arough the day room with a and #16 did not have a spoon the pudding into his mouth the 5:18 pm, client #16 was a day room with a bowl of the #16 gave his spoon to QAC are beans into his mouth from pm, client #16 was biting his ang around the day room. To the kitchen. RM #2 prompted the kitchen. Client #16 bit his rabbed client #16's hand. In on his hand again, and RM #2 are ballway by the main entrance #2 followed client #9 to his a chair outside of his room. The hair and was typing on her cell was talking to another staff, and to the kitchen and attempted to me the garbage can. DSP #10 client #20 and prompted him to be day room. Client #3 went to id down in his bed with the swas pacing up and down the stand inside the front of pants. am, client #3 was in his bed with #2 indicated client #3 had ast at 6:30 am and had been in the entity at the did had been in the stand inside the front of pants. am, client #3 was in his bed with #2 indicated client #4 is still lue if he's eaten breakfast." and at the dining table with his as seated at a dining table with 5 had a full pizza and milkshake. If he would like to go to the					

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

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. BUILDING <u>00</u>			COMPLETED	
		15G811	B. WING 06/21/2023			2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	8			BLOOMINGTON STREET		
RES-CAI	RF INC				ICASTLE, IN 46135		
	Т						
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY		DATE
		novie. Client #1 indicated he					
		deo game. BT left the					
	_	with client #1. At 8:15 am,					
		the day room. Client #2 was					
	_	table and indicated he was					
	1	tivities planned for the day.					
		#2, #3, #4, and #5 were in their					
		am, client #8 was walking					
	1	vearing one white sock and one eet. Client #8 had a black sock					
		up to his elbow. Client #10					
		nd pulled it off of client #8's					
	1 -	AC. AC stated, "It's ok." DSP					
		t #10 to assist with putting the					
		Client #10 complied. At 8:45					
		eated in a chair in the day room.					
		#5 were in their bedrooms.					
		ng up and down the halls, and					
	_	ng him. RM #2 stated, "We					
		ensory toys for him." At 9:00					
		#4 were in their bedrooms.					
	1	ling in the hallway, and client					
		the day room. At 9:06 am,					
		a piece of toast from client					
		a bite. DSP #11 grabbed the					
		0's hand and threw it into the					
	garbage. Client #20	oran to the sofa and put the					
	toast left in his hand	d into his mouth. DSP #11					
	stood over client #2	0, leaning over his shoulder,					
	and attempted to tal	ke the toast from his hand and					
	mouth. DSP #11 st	ated, "Spit it out. Spit it out."					
	At 9:06 am, client #	\$\frac{1}{2}\$ went into the day room.					
	Client #2 was lying	in his bed with the lights off.					
	At 9:30 am, client #	48 went into the day room with a					
	pink cup in his hand	d. Client #8 drank the contents					
	of the cup, coughed	, then put the cup on the					
	table. Client #7 we	nt into the day room, took the					
	cup, and stated, "Th	nat's mine! Stay out of my					
		and #5 were in their bedrooms.					
	Client #2 was sittin	g in a chair in the day room.					
	l		1				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF E	PROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET NCASTLE, IN 46135	•
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
	Client #4 was engage his peers. At 9:45 a wheelchair in the datea. Client #11 wal stated, "It's so loud! verbal aggression were not engaged in am, client #4 was p saying, "F***," rep clients #12 and #16 into the kitchen and banana. Client #12 stated, "Hold on. Go asked AC to play a stated, "Hold on. Go can't leave the day in on a special diet." (hallway to the dayrestaff. Client #8 were AC directed him out kitchen without his the surveyor asked AC stated, "Me." Aday room. Clients #4 were in the day room other staff in the but knowledge." At 10 the gym, recreation room, consumer room. Clients #14, movie room with B training. On 6/13/23 at 11:30 gym, recreation bui movie room, consumer of com. Clients #14, movie room, consumer of com. Clients #13,	ging in verbal aggression with am, client #3 was sitting in his any room and was yelling for ked through the dayroom and "Client #4 was engaging in with his peers. Clients #11, #9, #4 were in the day room and a meaningful activity. At 9:48 acing through the day room eatedly. Client #8 went into 's bedroom. Client #8 went got a banana. Client #7 got a asked for a banana, and AC give me a minute." Client #4 card game with him. AC Client #12] wants a banana. I groom to get it for him, and he's Client #9 walked down the boom without his one to one and into client #15's bedroom. It. Client #9 went into the one to one staff. At 9:56 am, who was assigned to client #9. AC was the only staff in the #15, #7, #6, #12, #8, and #9 m. When asked if there were ilding, AC stated, "Not to my :00 am, there were no clients in building kitchen, sensory om, library, music room, or art #19, #1, and #20 were in the T, DSP #11, and a staff in			
		room with QAC. PM was smoking. When PM saw the			

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE (A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 06/21/2023			
NAME OF I	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(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 CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	ULD BE COMPLETION			
	room to assist QAC and #14 were in the staff in the day room preparing lunch. Q assigned one to one were in their bedrood At 11:51 am, AC to Clients #3 and #15 staff. Client #8 were the sofa. At 11:54 room without his on stated, "We need to lunch. This can't be pile of art supplies top of a cabinet. Client #8 back to the screamed and pushed "We can't have you redirect client #8 to alone in the dining assigned staff was, idea." At 11:58 am stomping his feet, a "We can't act this way to deal with it. #8 to another activity and #5 were in their closed. At 12:05 proom. At 12:11 pm and laid down on the staff was not prompted for were sitting at the swas monitoring bot asked BT to sit with	art room, she went into the art and common and and sat on an and client #9 removed a from the table and put them on ient #8 walked down the 2 followed him. RM #2 directed a day room. Client #8 and activity. Client #9 was room. When asked who is client #9 was room. When asked who is client #9 stated, "I have no an activity. Client #9 was room. When asked who is client #9 stated, "I have no activity. Client #9 was room. When asked who is client #9 stated, "I have no activity. Client #9 stated, "I have no activity. Client #9 stated, "I have no activity. Client #9 was room. When asked who is client #8 was biting his hands, and yelling. RM #2 stated, "ay. You need to find another "RM #2 did not direct client the did not an activity. Client #9 was room. When asked who is client #9 stated, "I have no activity. Client #9 was room. When asked who is client #9 stated, "I have no activity. Client #9 was room. When asked who is client #9 stated, "I have no activity. Client #9 was room. When asked who is client #9 stated, "I have no activity. Client #9 was room. When asked who is client #9 stated, "I have no activity. Client #9 was room. When asked who is client #9 stated, "I have no activity. Client #9 was room. When asked who is client #9 stated, "I have no activity. Client #9 was room. When asked who is client #2 was biting his hands, and yelling. RM #2 stated, "I have no activity. Client #10 pm, clients #2, #4, and #10 pm, clients #2, #4, and #10 pm, clients #2, #4, and #10 pm, client #2 went to the day room was sofa. RM #2 stated, "[Client appreciate it if you would sit not move. At 12:17 pm, lunch #5 was in his bedroom and wor lunch. Clients #3 and #20 ame table. AC indicated she hof them. At 12:21 pm, AC in client #3, and she did. Client in onto the table with his spoon						

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	l í	JILDING	nstruction 00	(X3) DATE : COMPL 06/21/	ETED
NAME OF F	PROVIDER OR SUPPLIER			1306 S	NDDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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)	ATE	(X5) COMPLETION DATE
	did not redirect clie provide him with a up the spilled food walking down the h from its wrapper. A eating, went to this At 12:30 pm, RM # you get that shirt?" #6's] shirt." RM #2 [client #6's] clothes "Everyone is done of #5 had been prompt [client #5] have his stated, "We tried to other building for h went to client #5's r like to eat in the day guess," and followed 12:36 pm, client #4 outside, so he could now. I'm watching into his bedroom and PM was interviewed stated, "Staff should every 15 minutes." Quality Assurance interviewed on 6/14 "Plans and schedule written. Staff should activities." 1a. On 6/13/23 at 90 on a community var #13 indicated he and only staff going on	d on 6/14/23 at 1:55 pm and d be prompting for activity Manager (QAM) was 4/23 at 4:10 pm and stated, es should be followed as d be providing choices and 4/48 am, DSP #13 took client #3 in ride with 4 other clients. DSP d a staff in training were the					

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	OF CORRECTION	IDENTIFICATION NUMBER 15G811	A. BUILDING B. WING	00 00	COMPI 06/21	LETED
NAME OF I	PROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
	dated 8/17/22 indicated lidentify medication positioning in bed, positioning in bed, positioning, pedestrian when dining, using when he needs help activities. - Throughout the obwas not encouraged goals and objectives. Client #3's Behavio 6/1/23 indicated cliestaff when in the co-Client #3 was not when he participate. DSP #13 was intervand stated, "Due towheelchair now, he goes on outings." If the staff with 5 client 6/13/23. DSP #13 is client #3's supervisic community. RM #2 was interviewed stated, "[Client #3] when he's in the corp. PM was interviewed stated, "[Client #3] he's on outings. The implemented." 1b. Client #8's recorp. 10:40 am. Client #8'	r Support Plan (BSP) dated ent #3 required a one to one mmunity. provided a one to one staff d in a community outing. riewed on 6/14/23 at 12:43 pm the fact [client #3] has a might be one to one when he DSP #13 indicated he was only not son a community outing on ndicated he was not aware of on level when in the wed on 6/14/23 at 11:50 am and has 2 staff assigned to him				

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MUL A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE (COMPL 06/21/	ETED
NAME OF I	PROVIDER OR SUPPLIEF	2		1306 S E	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	тЕ	(X5) COMPLETION DATE
	in his bedroom. The for the following: hourly toileting and not entering peer be with possible comm Meal/snack superviaround campus (two the end of the assig [client #8's] room for with cleaning up and the end of the assig [client #8's] room for with cleaning up and the end of the assig going into his peers. DSP #13 was intervated and stated, "[Client at all times. Once we specific hall, we veet toward the day room toward the day room and common staff there to redirect the end of his room and common staff there to redirect to keep an eye on he constantly being (signorms, attempting to history of eating not the end of t	sion. Providing/offering walks ice on first and 2nd shift). At ned time, staff will check or fall hazards and will assist by messes that were made." servation periods, client #8 igned staff to prevent him from it rooms and the kitchen. Viewed on 6/14/23 at 12:43 pm #8] is line of sight supervision we notice him going down a rebally prompt him to go back m." Ewed on 6/14/23 at 11:50 am and is line of sight supervision is room. He doesn't have him, he's always in the day areas, and there are always et him." d on 6/14/23 at 1:55 pm and is 15 minute checks in his ned staff when out of it. When a, we have to assign someone im and watch him. He's c) in and out of people's o get into things. He has a					

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		15G811	B. W	ING		06/21/	2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIER	L			BLOOMINGTON STREET			
RES-CAF	RE INC				CASTLE, IN 46135			
77.0.75			-	<u> </u>	,			
(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		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		a LSC IDENTIFYING INFORMATION onitoring him. We need to		TAG	DEFICIENCE?		DATE	
		ed staff means. The RM						
	_	e responsible for [client #8] at						
	· ·	tated, "If a person is one to						
		else, they cannot be an						
	assigned staff for [c							
	assigned stair for [c	nent noj.						
l	1c. Client #9's recor	rd was reviewed on 6/14/23 at						
		9's BSP dated 6/6/23 indicated						
		ent #9] has a history of						
		ate behaviors and he has been						
	charged with rape o	n more than one occasion in						
	the past. Sexual agg	gression has taken place with						
	both male and fema	le clients at previous						
	placements and [cli-	ent #9] is capable of careful						
	and thorough plann	ing in order to sexually assault						
	another person. He	engages in 'grooming'						
	behaviors where he	will try to win over the trust of						
	_	ning behaviors serve the						
		setting up circumstances so						
		sexually act out or victimize						
	1	overly nice to others, flirt with						
	_	items in an effort to have the						
		owe' [client #9] sexual favors.						
		ming examples can be found in						
	_	definition for grooming.						
		orically engaged in sexual						
		n his bedroom without the						
	_	It is imperative that [client #9]						
	_	ervised with any client or while						
	1	s there is a risk for others to be #9] must have 1:1 staff						
	_	nis opportunist nature and due						
		nce (sic). [Client #9] has						
		s providers that the only						
	_	ot sexually acted out with						
		use he is deterred by his 1:1						
İ		neras that were in place."						
		e observation periods, client						
	_	ne to one staff assigned to						
		5 .						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023
NAME OF	PROVIDER OR SUPPLIER	1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, 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 CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	him, and his one to one staff left him to assist other clients.			
	DSP #13 was interviewed on 6/14/23 at 12:43 pm and indicated client #9 required a one to one staff at all times.			
	PM was interviewed on 6/14/23 at 1:55 pm and indicated client #9 required a one to one staff at all times.			
	QAM was interviewed on 6/14/23 at 4:10 pm and indicated client #9 required a one to one staff at all times.			
	1d. On 6/13/23 at 8:36 am, client #15 was in the bathtub in the community shower room. The bathroom door was open, and there were no staff in the area. Clients #10, #13, and #17 stood in the bathroom doorway and pointed at client #15. At 8:43 pm, QIDP #1 looked into the bathroom and stated, "I was just checking on you." QIDP #1 did not close the door or address client #15's lack of privacy. At 8:45 am, AC was standing outside the bathroom door, and the door was closed.			
	Client #15's record was reviewed on 6/14/23 at 10:36 am. Client #15's BSP dated 6/1/23 indicated client #15 should have stand by assistance while showering and bathing due to a history of seizures and overflowing the bathtub.			
	DSP #13 was interviewed on 6/14/23 at 12:43 pm and stated, "I don't think [client #15] requires any supervision while he's in the bathtub."			
	RM #2 was interviewed on 6/14/23 at 11:50 am and stated, "There should be a staff outside the bathroom while [client #15] is in the bath or shower. The door is closed, but we check on him.			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		15G811	B. W	ING		06/21/	2023
				CTREET	DDBECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
DEC CAE	DE INC				BLOOMINGTON STREET		
RES-CAF	KE INC			GREEN	CASTLE, 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	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	He likes to flood the	e bathtub. We have to be right					
	there to make sure h	ne doesn't overflow it. He also					
	has a history of seiz	zures."					
	PM was interviewed	d on 6/14/23 at 1:55 pm and					
	stated, "[Client #15]] does have supervision in the					
	bath due to a history	y of seizures. Staff should					
	close the door and b	be in there with him."					
	QIDP #1 was interv	viewed on 6/14/23 at 2:28 pm					
	and stated, "[Client	#15] should be monitored					
	when he's in the bat	thtub due to seizures."					
	QAM was interview	ved on 6/14/23 at 4:10 pm and					
	stated, "Staff should	d implement the plan as					
	written."						
	DSP #13 was interv	viewed on 6/14/23 at 12:43 pm					
	and stated, "We nee	ed at least 9 staff. The staff we					
		afficient to implement					
	everyone's plans. If	f we had holds, behaviors, or					
	outings, having 9 st	aff would allow for 3 to					
	address the behavio	r and still have 6 to do					
	everything else. It's	s rare that we have 7. With 7					
	or 8, things run pret	tty smoothly." DSP #13 stated,					
	"We have run with	less than 5 staff." DSP #13					
	stated, "There shoul	ld be a person in the day room					
		going on. The day room					
		be a one to one for [clients #9					
	and #20]."	- -					
	RM #2 was intervie	ewed on 6/14/23 at 11:50 am and					
	stated, "We need on	ne staff for each of the 2 one					
	to ones, and the rati	o is 3 clients to one staff. We					
	need 8 staff to provi	ide direct care on the day shift					
	-	nt. Today we have 6 staff, but					
	2 of them are off ca	-					
	PM was interviewed	d on 6/14/23 at 1:55 pm and					
	stated, "We have 6	staff here today.					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	TIPLE CONSTRUCTION X		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED	
		15G811	B. W	ING		06/21	/2023	
NAME OF A	DROLLIDED OF GLIDBLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEI	R		1306 S	BLOOMINGTON STREET			
RES-CAI	RE INC			GREEN	ICASTLE, IN 46135			
(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 APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE	
		f step in as direct care staff if . We need 8 staff during the						
	_	' PM stated, "We have 2 one						
	to one clients [#9 and #20]. [Client #8] has an assigned staff. [Client #14] has an assigned staff							
	_	g peers. [Client #5] has an						
		he's out of his bedroom."						
	_	is enough to do program and						
	activities."	aga to do program and						
	QIDP #1 was interv	viewed on 6/14/23 at 2:28 pm						
	and stated, "The ideal number of staff would be							
	6."							
		wed on 6/14/23 at 4:10 pm and						
		ld be staff in the day room.						
		ot be one to one with [clients						
	_	ing waking hours, we need						
		aff. [Client #5] is one to one						
		s room, and [client #16] is one						
		ore and an hour after meals."						
		fing ratios should be						
	•	itten in the clients' plans."2. On						
		M, a focused review of client onducted. Client #16's 6/8/23						
		Plan (BSP) indicated, "At this						
		as 1:1 approximately arms-reach						
		all meals and snacks since						
		when he struggles the most.						
		his 1:1 will be with him for the						
	_	hour after the meal. For						
	example, lunch is a	t 12:00pm so [client #16] would						
	_	m 11:00am - 1:00pm. During the						
		responsible for taking [client						
		nd campus in addition to						
	_	lient #16] doesn't steal food						
		es or eat food from the floor"						
		7 AM, a focused review of client						
	#20's record was co	onducted. Client #20's 6/8/23						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COMP	E SURVEY PLETED 1/2023
NAME OF I	PROVIDER OR SUPPLIEF	· · · · · · · · · · · · · · · · · · ·	1306 S	ADDRESS, CITY, STATE, ZIP COI B BLOOMINGTON STREE 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 CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	#20] will have a 1:1 during all waking have 5 minute cheer out as frequently as of the 1:1 staff inchall daily living task bathing (including clean) and providing Supervising all means food is cut up approsed in the provided with a staff at from his peers during the provided with a utensils can be used independently. The from taking food its [client #20] for any try to eat/drink, ince does not drink from #20] so that he does On 6/14/23 at 12:42 Professional (DSP) "short staffed." DS needed "at least 9 s stated, "Fewer than times we only have On 6/14/23 at the times we only have on 6/14/23 at the times decive treatment. On 6/14/23 at 10:12 Clients."	Plan (BSP) indicated, "[Client approximately arm's reach staff ours. When sleeping, he will ks. Staff should be switched necessary. Responsibilities ade: Assisting [client #20] with so including toileting and assisting with keeping his feet gractive treatment options. Als/snacks and making sure all opriately (see below). Due to peer's plates, [client #20] will sit a table or couch/chair awaying meals and snacks. He will TV tray for his meal. Alternate at the help [client #20] eat to help [client #20] eat to help [client #20] eat the facility luding making sure that he he is that he may potentially luding making sure that he is not take items from others" By PM, Direct Support #13 stated the facility was P #13 stated the facility taff" during waking hours. He 9 isn't enough. There are 4 staff." AM, Residential Manager there should be 8-9 staff during #3 indicated there were 6 staff me of her interview. RM #3 on't have enough staff to do often have 4-5 staff for all 20				
	Indicated there shot	and de d dum per diffit duming				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		15G811	B. W	NG		06/21/	2023
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
(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	ΓE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	waking hours and 7	during the overnight shift.					
	0 (114/02 + 0.20)						
		PM, the Qualified Intellectual					
		ional #1 indicated he had					
		ty for 3 weeks. He stated, ot fewer staff' than 6-7 he					
		ed to provide supervision to					
		2/23 at 2:30 PM and on 6/13/23					
	at 8:00 AM, a revie						
		we reports was conducted and					
	indicated the follow	•					
	A 5/31/23 Bureau o	f Developmental Disabilities					
		cated, "On May 30, 2023 at					
		4] was on an outing at [store]					
	_	rs and staff. Staff was					
	assisting [client #14] in getting his chips when for					
	no apparent reason	and without precursors,					
	[client #14] engage	d in physical aggression					
	towards staff by usi	ng both hands to hit them as					
	well as shouting and	d cussing at them. Staff					
		4] to use his coping skills and					
	•	item when he engaged in					
		towards his peer [client #17]					
		s to grab [client #17's] left					
	-	and twisted it. Staff was able					
		parated both clients. [Client					
	_	re. Staff and [client #14] and his					
		get the next item when [client					
		ake a baby from their (sic)					
	1 1	nen he passed them. Staff [4] away immediately and					
	-	their items. At the check out,					
		d in physical aggression					
		ient #13] by using his left					
		13's] left arm. After staff					
	_	its, [client #14] engaged in					
	*	towards staff by using both					
		hit them. When staff and					
	_	n, [client #14] spit in [client					
	Silvino got to the va	, t-ment 1 . J opit in tenent					

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Event ID:

KHZG11 Facility ID: 013405

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	ľ	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 06/21/	ETED
NAME OF I	PROVIDER OR SUPPLIEF			1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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 APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	respecting his peers and his peers made any issues while on were assessed by moted. All clients rewithout further issue continue to follow [Human Rights Con (behavior support property support plan) regard coping skills. All clients without further issue continue to follow [client # using his coping skills. All client with the coping skills are commendations: A 6/5/23 CCAI (Cl. Investigation) inclured in the commendations: [client #17] & [client # [cl	'Staff will continue to monitor int #13] for any further injuries. to educate [client #14] on using men he becomes upset and a personal space. Will continue SP's (sic) and offer alternative to discuss recent behavioral ing [client #14] and determined vichiatrist] on June 6, 2023 med changes. [Residential or receive a corrective action for ient #14's] ISP & BSP. [DSP receive action for falling to action for falling to graph of the properties					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF F	PROVIDER OR SUPPLIEI	.		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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
	· · · · · · · · · · · · · · · · · · ·	ghts Restrictions: Line of sight putings (target behavior: gression)".					
	#14's record was co BSP indicated, "Re 1:1 staff for all con staff cannot be the away from the driv staff seated next to If [client #14] is ex has engaged in phy assigned staff will be protection of other responsibility is to able to hit/kick/spit staff should stay be peers that he may he encourage [client #	5 PM, a focused review of client and orducted. Client #14's 6/1/23 strictions: [Client #14] will have annunity outings and the 1:1 driver. He will sit the furthest er in the vehicle and will have him during outings/transports. The hibiting agitation, precursors, or sical aggression to peers, an one put in place for the clients. The assigned staff's prevent [client #14] from being at other clients. The assigned tween [client #14] and any it. The assigned staff can also 14] to go to the life skills of where he would be away from afety"					
	#15's record was co BSP indicated, "Re outings, he will hav the 1:1 staff cannot	PM, a focused review of client onducted. Client #15's 6/11/23 strictions: For community we a 1:1 (one to one) staff and be the driver due to a history moving vehicles/aggression					
	#17's record was co BSP indicated, "Su Assigned staff for a	PM, a focused review of client onducted. Client #17's 6/7/23 pervision Restrictions: all community access due to a target behavior: bolting)".					
	were interviewed.	5 AM, DSP #11 and the QAM DSP #11 indicated she was the uring the outing. DSP #11					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G811	B. W	/ING		06/21/	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	2			BLOOMINGTON STREET		
RES-CAF	RE INC				CASTLE, IN 46135		
(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	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		t #14, client #13 and client #17					
	•	15 to a home visit with his					
	-	y dropped client #15 off the					
		the store. DSP #11 stated, s a perfect angel all day, no					
		11 indicated client #14 became					
		In't have his preferred chips.					
		what the clients' supervision					
		11 stated, client #14's					
		as "Assigned staff at facility					
	•	public and he has to sit in the					
	back seat away from	n the driver. I have always					
	been told they (clien	nts #15, #13 and #17) are 3:1 (3					
	clients to 1 staff) in	ratio". DSP #11 indicated she					
		the incident. DSP #11 was					
	-	was effective. DSP #11					
		0% sure. It is still confusing to					
		ng maybe wasn't effective.					
		Coordinator] talked it over					
		cident". The QAM stated,					
		client #13] are not 1:1 in					
		re line of sight. 2:1 for [client					
		is 1:1 in community and the 1:1 river. There should have been					
		ining was not effective". DSP					
	-	training consisted of reading					
		ning it indicating we were					
		ges. After DSP #11 left the					
		stated, "I'm not sure if					
		done. She (DSP #11) will be					
	_	action. [RM #3] will also be					
	getting a						
		because she approved the					
		not aware of the					
	_						
	supervision levels. We just created a cheat						
	sheet so everyone knows supervision levels".						
	4. Observations	were conducted on 6/13/23					
	from 2:00 PM th	rough 2:51 PM. At 2:00					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF F	PROVIDER OR SUPPLIER		1306 \$	ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF	LD BE COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	1	seated outside of client			
		nile he lay in his bed. Client			
		g the unit hallway where			
		ed. Client #14 was verbally			
		ds visitors on the hallway			
		pting to invade the visitors			
		touch and grab them. No			
	1	present on the hall and RM			
	_	ting client #14 while			
	providing client	#9 1:1 (staff to client) ratio			
	supervision. Clie	ent #14 continued verbal			
	aggression and a	ttempting to grab the			
	visitors and RM	#2 had to physically prompt			
	and redirect clien	nt #14 from the hallway to			
	the unit dayroom	and leave client #9 in his			
	room without 1:1	1 supervision. At 2:08 PM,			
	the PM (Program	n Manager) arrived on the			
	unit and assisted	redirection with client #14			
	while RM #2 ret	urned to 1:1 supervision			
		M #2 was interviewed on			
		PM indicated client #9 was			
		on. RM #2 indicated there			
	_	staff on the unit to supervise			
		viors and maintain client			
		ion. PM (Program			
	_	terviewed on 6/13/23 at			
		dicated the facility should			
		nad 2 no call no shows.			
	5-1.4(b)				
W 0189	483.430(e)(1)				
	STAFF TRAINING	PROGRAM			
Bldg. 00		rovide each employee with ng training that enables the			

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PRINTED: 08/11/2023 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						ON	1B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPI	LETED
		15G811	B. W	ING		06/21	/2023
NAME OF I	PROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(TE	DATE
	effectively, efficier Based on observation review for 20 of 20 #2, #3, #4, #5, #6, # #14, #15, #16, #17, failed to ensure the competency based to and to ensure Direct #11 was competent #13, #14, #15 and # participating in com Findings include: 1. On 6/12/23 at 2:3 AM, a review of the incident/investigative indicated the follow A 5/31/23 Bureau of (BDDS) report indi 10:55 am [client #1 with a group of pee assisting [client #14 no apparent reason [client #14] engage towards staff by usin well as shouting and prompted [client #1 to pick out his next physical aggression by using both hands hand and squeezed to intervene and sep #17] did not retaliant peers moved on to g #14] attempted to ta moms (sic) arms who	30 PM and on 6/13/23 at 8:00 e facility's we reports was conducted and	W	0189	To correct the deficient practic the Behavior Technician has received competency-based training to conduct restraints. DSP #11 has been competent trained regarding staffing ratic All staff have been trained in appropriate staff ratios. The Idepartment and Supervisory shave been trained by the ED ensure all staff receive competency-based training provide working alone. BC created a community outings for staff to quickly reference. Additional monitoring will be achieved by HR department reviewing new training completion weekly as as the administrative team reviewing all staff training neet wice weekly. Ongoing monit will be achieved by the HR department conducting rando monthly audits of employee fit to ensure all needed training completed.	tly os. HR staff to rior to ratio nd y the v hire well eds oring m les	08/12/2023

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	 UILDING	nstruction <u>00</u>	(X3) DATE : COMPL 06/21 /	ETED
NAME OF F	PROVIDER OR SUPPLIER		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LEG IDENTIFYING DIFFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	(X5) COMPLETION
TAG	finished picking up [client #14] engaged towards his peer [cl hand to hit [client # separated both client physical aggression hands to attempt to clients got to the variation #13's] face. Staff edgrespecting his peers and his peers made any issues while on were assessed by number of the work o	their items. At the check out, d in physical aggression ient #13] by using his left 13's] left arm. After staff its, [client #14] engaged in towards staff by using both hit them. When staff and in, [client #14] spit in [client ucated [client #14] on personal space. [Client #14] it back to residential without the van ride back. All clients ursing and no injuries were turned to normal programming es. Plan to Resolve: Staff will client #14's] guardian and HRC inmittee) approved BSP lan) and ISP (individual ling physical aggression and ients report they feel safe and a grievance. Staff will continue [14] on personal space and lls when he becomes upset. They team) will meet to discuss the following staff will continue to monitor int #13] for any further injuries. The deducate [client #14] on using the he becomes upset and personal space. Will continue SP's (sic) and offer alternative to discuss recent behavioral ing [client #14] and determined rechiatrist] on June 6, 2023 and changes. [Residential preceive a corrective action for ient #14's] ISP & BSP. [DSP]	TAG			DATE

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 06/21/2023					
NAME OF F	ROVIDER OR SUPPLIER	₹		1306 S	NDDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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
	follow [client #14's week and the BC (b	rective action for falling to] ISP & BSP. The IDT met last pehavior clinician) had no other than retraining staff on					
	#13's record was co BSP indicated, "Rig	PM, a focused review of client onducted. Client #13's 4/10/23 ghts Restrictions: Line of sight outings (target behavior: agression)".					
	#14's record was co BSP indicated, "Re 1:1 staff for all con staff cannot be the away from the driv staff seated next to	5 PM, a focused review of client onducted. Client #14's 6/1/23 strictions: [Client #14] will have numerity outings and the 1:1 driver. He will sit the furthest er in the vehicle and will have him during outings/transports. hibiting agitation, precursors, or					
	assigned staff will I protection of other responsibility is to able to hit/kick/spit staff should stay be peers that he may h encourage [client #	sical aggression to peers, an be put in place for the clients. The assigned staff's prevent [client #14] from being at other clients. The assigned tween [client #14] and any it. The assigned staff can also 14] to go to the life skills y where he would be away from					
	#15's record was co BSP indicated, "Re outings, he will hav the 1:1 staff cannot	PM, a focused review of client onducted. Client #15's 6/11/23 strictions: For community we a 1:1 (one to one) staff and be the driver due to a history moving vehicles/aggression					
	On 6/20/23 at 4:20	PM, a focused review of client					

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF I	PROVIDER OR SUPPLIEI	8		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	#17's record was co	onducted. Client #17's 6/7/23					
	BSP indicated, "Su	pervision Restrictions:					
	Assigned staff for a	all community access due to a					
	history of bolting (target behavior: bolting)".						
	On 6/13/23 at 11:25 AM, DSP #11 and the QAM						
		DSP #11 indicated she was the					
		uring the outing. DSP #11					
		t #14, client #13 and client #17					
	_	15 to a home visit with his					
		ey dropped client #15 off the					
		o the store. DSP #11 stated,					
		as a perfect angel all day, no					
		11 indicated client #14 became					
		dn't have his preferred chips.					
		d what the clients' supervision #11 stated, client #14's					
		ras "Assigned staff at facility					
		public and he has to sit in the					
		n the driver. I have always					
	1	nts #15, #13 and #17) are 3:1 (3					
		ratio". DSP #11 indicated she					
	· /	the incident. DSP #11 was					
		g was effective. DSP #11					
		0% sure. It is still confusing to					
	· ·	ng maybe wasn't effective.					
		Coordinator] talked it over					
		ncident". The QAM stated,					
		client #13] are not 1:1 in					
		are line of sight. 2:1 for [client					
		is 1:1 in community and the 1:1					
		river. There should have been					
		ining was not effective". DSP					
	_	etraining consisted of reading					
		gning it indicating we were					
	trained on the chan	ges. After DSP #11 left the					
	interview, QAM #1	stated, "I'm not sure if					
	retraining has been	done. She (DSP #11) will be					
		action. [RM #3] will also be					
		action because she approved					

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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	
		15G811	B. W	ING		06/21/	/2023	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	3			BLOOMINGTON STREET			
RES-CAI	RE INC				ICASTLE, IN 46135			
	ı		1	<u> </u>	,			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
IAG		e not aware of the supervision	+	TAG	DEFICIENCE!		DATE	
	_	ated a cheat sheet so everyone						
	_	levels". The QAM indicated						
	_							
	staff needed to be retrained on supervision levels. 2. On 6/13/23 from 8:51 AM to 9:54 AM, an							
		nducted at the facility. At 9:50						
		eyor opened the door to the						
		or swung into the Behavior						
		s sitting in a chair blocking the						
		Clients #1, #14, #19 and #20						
		room at the time. Client #1 was						
		ne. Client #14 was standing						
	1	ng a basketball. Client #19 was						
		Client #20 was standing toward						
	the back of the roor	•						
		nician) and QAM (Quality						
	· ·	r) were interviewed on 6/13/23						
	at 10:35 AM. BT in	ndicated she had worked at the						
	agency for less than	2 months. BT indicated her						
	daily role included	engaging clients in activities.						
	BT indicated she ha	nd been working independently						
	before the interview	w with clients #19, #1 and #14						
	in the movie room.	BT indicated she had not been						
	trained on the imple	ementation of YSIS (You're						
		ysical restraint procedures) and						
		ients #19 and #14's targeting						
	behaviors.							
		1 (12/22 + 2.22 72 5						
		ved on 6/13/23 at 3:28 PM.						
	`	had been scheduled to						
	_	ning on 6/2/23. QAM indicated						
		department had listed BT's						
	_	impleted on 6/2/23 as a clerical						
		ed BT had not completed YSIS						
		not be working independently the completed the training.						
	with chents until sh	ie completed the training.						
	PM was interviewe	d on 6/13/23 at 3:40 PM. PM						
		ning should be completed						
		ependently with clients to						
	before working ind	ependentry with elicitis to						

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		15G811	B. W	B. WING			2023
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			BLOOMINGTON STREET		
RES-CAI	DE INC				ICASTLE, IN 46135		
NES-CAI	NE INC			GKEEN	1CASTLE, IN 40133		
(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		TAG	DEFICIENCY)		DATE
	manage client behar	viors. PM indicated the facility					
	did not currently ha	we a YSIS certified trainer but					
		in the process of obtaining the					
		to ensure staff were trained on					
	YSIS.						
		d was reviewed on 6/20/23 at					
	3:08 PM. Client #1'	's BSP dated 5/4/23 indicated					
		gnosed with intermittent					
	_	which can be characterized by					
	_	impulsive, aggressive					
		rerbal outbursts that seem					
		the situation. For example, he					
		y or physically aggressive					
		uch as prompts about portion					
		s. These sudden acts of					
		quently take place in the					
	_	ery minor educational					
		ff such as 'we have to let the					
		g' or 'that dishwasher is already					
	I	cult to tell what will set [client					
	_	-confrontational statements					
		sion. [Client #1] can be quite					
		and has yelled at staff or peers					
		when he doesn't want them					
		so sometimes demand that he be					
	1	ess different activities on					
	_	ng the movie room, etc.					
		get behaviors have included					
		physical aggression, property					
		urious behaviors, instigation,					
		of abuse/neglect/exploitation,					
	sexually inappropri	ate behaviors, and					
	non-compliance."						
	, ,	ression Self-Injurious					
		perty Destruction. Immediately					
		nd safety of everybody in the					
	immediate environr	nent					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF I	PROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET 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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION
IAU	o Calmly but firmly and redirect him and of the environment. -If he stops the behad location and problem him for doing this was aggression or self had the behavior continuor others in danger, SAFE (YSIS) begins measures. o One person YSIS o Two person YSIS o Two person Supin -"YOU'RE SAFE, I OF TECHNIQUES Listed in order of le restrictive. Basic Moves -Personal Space/Predictive and body at 45 degration of the standard body at 45 degration of the standard body at 45 degration of the standard sweep in the syour outside forearred the syour outside forearred with your forearms, avoid head butts, losafe area, release hor kicks: move away one side to the person side side to the person side side to the person side side side side side side side side	tell him to stop the behavior d/or others to a different area avior, redirect him to a safe in solve with him and praise with us. Itinues' block all attempts of arm and attempt to redirect, if are and he is placing himself implement YOU'RE SAFE I'M inning with the least restrictive TM SAFE (YSIS) SUMMARY ast restrictive to most Spared Stance: maintain visual, ray, feet shoulder width apart	IAG		DATE

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	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 15G811 B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023			
NAME OF I	PROVIDER OR SUPPLIEI	R	•	1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	hand, quickly roll of	out arm toward the individual's					
	thumb, resume prep	pared stance. Two-Handed					
	Wrist Release: clos	e hand, quickly roll out arm					
	toward the individu	al's thumbs (use your other					
	hand on your close	d fist for leverage if					
	necessary), resume	prepared stance.					
	Hair Pull Release:	Front Hair Pull: raise shoulders					
	to protect your necl	k, press the individual's hands					
	to your head to loo	sen grip, apply downward					
		ding and stepping back, block					
	•	sume prepared stance. Back					
		ulders to protect your neck,					
	l ~	l's hands to your head to					
	loosen grip, bend, pivot, step back and block with						
	other hand, resume						
		r Pull: raise shoulders to					
	1 -	secure hair and individual's					
	I	nead, flatten hand against your					
		ance, step away while bending					
		nt peels the individual's hand					
		ky finger with their thumb,					
	resume prepared st						
	_	Front or Side: trap the					
		lose to body with open hand,					
	~ ~	ar the individual's hand, pull					
		ep back and pull clothing out					
		repared stance. Back: secure					
		possible in front, quickly spin,					
	resume prepared st						
		way, anchor the individual's body part being bitten into the					
		ess down while rolling out					
		on, resume prepared stance.					
		on, resume prepared stance. ont or Back Choke: tuck chin,					
		straight up, quickly turn away					
		gain visual contact, resume					
		all Choke (headlock): tuck chin					
		s elbow, step behind					
		dividual's wrist with one hand					
		dual's elbow with the other					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE (A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF P	ROVIDER OR SUPPLIEF		1306	F ADDRESS, CITY, STATE, ZIP COD S BLOOMINGTON STREET ENCASTLE, IN 46135	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	OPRIATE COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	individual, resume	n, pull out and away from			
		elease: with open palms, place			
		idual's forearms/wrists, have			
		urn head to side, bend at knees			
		erson's hands over your head,			
	step away and resur	_			
		telease: move one leg forward			
	_	grasp fatty part of the			
	individual's thumbs	and roll in an outward motion,			
	release, step away a	and face individual and resume			
	prepared stance.				
	Advanced Moves				
		ng Restraint/Escort: approach			
		arm across the back to grasp			
	-	t forearm in an overhand grip,			
	_	oss your own body to grasp			
		n in an underhand grip; can			
	_	safety or away from a			
	reinforcing situation	ing Restraint/Escort: one staff			
		side with one taking the			
		across the individual's back to			
		l's outside forearm using an			
		h across your own body to			
		l's wrist closest to you with an			
		taff may instead grab the			
		with outside hand and grab			
		vith their inside hand). Hips			
	should be snug for	stability. Draw the person's			
		d secure snugly over your hip;			
	•	n to safety or away from a			
		n. If the person attempts to			
	. •	e closer knee while maintaining			
	arm position.				
		l Restraint: one staff approach			
		one taking the leading role,			
		lividual's back to grasp the			
	individual's outside	forearm using an overhand			

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	T OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023		
NAME OF I	PROVIDER OR SUPPLIE	R	1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	16	DATE
		our own body to grasp the losest to you with an				
		ips should be snug for				
		person's elbow backward and				
	secure snugly over	your hip. Keep head tucked				
	or away to avoid bi					
		ase a lifting belt if possible, use				
		e two person standing/seated				
	-	le knee down and outside knee				
	angle.	lift together at a 45 degree				
	_	ing to Supine Restraint: One				
		ach side with one assuming				
		individual's wrist with your				
	outside arm, place	inside legs and hips behind the				
	-	eels behind the individual's				
		and to support under the				
		ers, take a step forward with				
	-	ver the individual to the floor				
		keeping hips close. Slide arms individual's shoulders once				
		or and place hand on their				
		ir wrist and should to the floor				
		close. Optional: a staff to				
	secure the legs by	wrapping their arms around the				
	,	just above the knees, a staff to				
	secure the individu	al's head."				
	2. Client #14's reco	ord was reviewed on 6/20/23 at				
	3:25 PM. Client #1	4's BSP dated 6/9/23 indicated				
	the following:					
	-"[Client #14] can	be very aggressive with peers				
		of his behaviors appear to take				
	_	ing. He spits on others when				
	_	may engage in this behavior				
		wing why he is upset. Due to				
		of physical aggression toward				
	demonstrating prec	signed staff when he is				
	acmonstrating prec	MIDOID.				l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF I	PROVIDER OR SUPPLIER		130)6 S E	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFI TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	friendly to threatent clear environmental observed to be yelli having "arguments' present, punching a to himself in differe beneficial for [clien campus such as the etc. in order to take hall and [client #14 programming outside continuous aggressis [client #14] include aggression, property non-compliance, see and neglect, sexuall boundary violations instigation." -"For Physical Agg Destruction/Self Injensure the health art immediate environment. To he stops the behavior location and problethim for doing this we continues' block all attempt to redirect, he is placing himself implement YOU'RI beginning with the or One person YSIS or Two person supin	durious Behaviors: Immediately ad safety of everybody in the ment. For others to a different area of cell him to stop the behavior. If cor, redirect him to a safe m solve with him and praise with us. If the behavior attempts of aggression and if the behavior continues and lift or others in danger, E SAFE I'M SAFE (YSIS) least restrictive measures.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		06/21	/2023
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			BLOOMINGTON STREET		
RES-CAI	DE INC						
NES-CAI	NE INC			GREENCASTLE, 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 CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	OF TECHNIQUES						
	Listed in order of le	east restrictive to most					
	restrictive.						
	Basic Moves	Basic Moves					
	_	epared Stance: maintain visual,					
	_	vay, feet shoulder width apart					
	and body at 45 degr	_					
		sition, non-threatening tone of					
	voice.						
		on or swinging objects: from					
		se both arms parallel to each					
	_	the direction of the blow with					
	your outside forearms, resume prepared stance.						
		on: from behind the individual,					
	_	ns between elbow and shoulder					
	-	, tuck head or lean back to					
		ock hips, move the person to a					
		old, resume prepared stance.					
		from the individual, keep only					
	_	on, assume "The Heisman"					
		on upraised foot and move					
	•	vidual, resume prepared stance.					
		ist Roll (one handed): close					
		out arm toward the individual's					
		pared stance. Two-Handed					
		e hand, quickly roll out arm					
		al's thumbs (use your other					
	_	d fist for leverage if					
	necessary), resume						
		Front Hair Pull: raise shoulders					
		x, press the individual's hands					
		sen grip, apply downward					
	_	ling and stepping back, block					
		sume prepared stance. Back					
		ulders to protect your neck,					
	-	's hands to your head to					
		pivot, step back and block with					
	other hand, resume						
		r Pull: raise shoulders to					
	protect your neck, s	secure hair and individual's					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		06/21	/2023
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			BLOOMINGTON STREET		
RES-CAI	DE INC				ICASTLE, IN 46135		
RES-CAI	KE INC			GREEN	ICASTLE, IN 40133		
(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		TAG	DEFICIENCY)		DATE
	1	ead, flatten hand against your					
	head, call for assista	ance, step away while bending					
	at the waist, assista	at the waist, assistant peels the individual's hand					
	beginning with pinky finger with their thumb,						
	resume prepared sta	ance.					
	_	Front or Side: trap the					
	individual's hand cl	ose to body with open hand,					
		ar the individual's hand, pull					
	_	ep back and pull clothing out					
		epared stance. Back: secure					
	clothing as tight as	possible in front, quickly spin,					
	resume prepared sta						
	_	vay, anchor the individual's					
	•	body part being bitten into the					
	-	ess down while rolling out					
		on, resume prepared stance.					
		ont or Back Choke: tuck chin,					
		straight up, quickly turn away					
	_	gain visual contact, resume					
		ll Choke (headlock): tuck chin					
		s elbow, step behind					
		dividual's wrist with one hand					
	_	lual's elbow with the other					
		n, pull out and away from					
	individual, resume						
		elease: with open palms, place					
		idual's forearms/wrists, have					
		ırn head to side, bend at knees					
		person's hands over your head,					
	step away and resur						
		Release: move one leg forward					
		grasp fatty part of the					
		and roll in an outward motion,					
		and face individual and resume					
	prepared stance.						
	Advanced Moves						
		ng Restraint/Escort: approach					
		arm across the back to grasp					
	the person's furthes	t forearm in an overhand grip,					

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF I	PROVIDER OR SUPPLIEF	R		1306 S I	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135			
(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	the person's forearm escort the person to reinforcing situation. Two Person Stand approach from each leading role, reach grasp the individual overhand grip, reach grasp the individual underhand grip. (Sindividual's forearm their own forearm with should be snug for elbow backward and can escort the person fall, go down on the arm position. Two Person Seated from each side with reach across the individual's outside grip, reach across yindividual's wrist clunderhand grip. His stability. Draw the secure snugly over or away to avoid bing. Two Person Lift: the same hold as the restraint, keep inside up, count to 3 and 1 angle. Two Person Stand staff approach on each grasp the industries arm, place in person with their height outside arm, place in person with their height of the same hold arm, place in person with their height of the same person with the s	ing Restraint/Escort: one staff in side with one taking the across the individual's back to I's outside forearm using an h across your own body to I's wrist closest to you with an taff may instead grab the in with outside hand and grab with their inside hand). Hips stability. Draw the person's d secure snugly over your hip; on to safety or away from a in. If the person attempts to the closer knee while maintaining d Restraint: one staff approach in one taking the leading role, lividual's back to grasp the forearm using an overhand our own body to grasp the losest to you with an tips should be snug for person's elbow backward and your hip. Keep head tucked						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023		
	OF PROVIDER OR SUPPLIES	R	STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	outside leg and low on inside leg while out from under the they are on the floor shoulder. Hold the while keeping hips secure the legs by vindividual's thighs secure the individual's thigh secure the legs by individual's thigh secure the individual's thigh secure the legs by	his peer, [client #19] do not get uld make an effort to program he another when possible." ord was reviewed on 6/20/23 at 9's BSP dated 6/8/23 indicated for [client #19] include verbal sion, property destruction, iance, self injury, allegations of false reports to 911, and iate behaviors. The target lation was also added as a lifferentiate this behavior from ression." demonstrated a pattern of int #14] and efforts should be ne two away from one another						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SI COMPLE 06/21/2	TED			
NAME OF F	PROVIDER OR SUPPLIEI	₹	STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135						
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRI (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE			
TAG	and problem solvedoing this with us. block all attempts of redirect, if the behat placing himself or a YOU'RE SAFE I'M the least restrictive of One person YSIS of Two person Supiror Transfer of the restrictive. Basic Moves -Personal Space/Problem 1½ arm's length avand body at 45 degenon-threatening positione. -Blocking aggressic prepared stance, raid other and sweep in your outside forear -Physical Redirectipin individual's arm with your forearms avoid head butts, losafe area, release hericks: move away one side to the persposition, step back away from the individually roll of thumb, resume prepared the summary of the sum	with him and praise him for If the behavior continues' of aggression and attempt to vior continues and he is others in danger, implement If SAFE (YSIS) beginning with measures. If M SAFE (YSIS) SUMMARY east restrictive to most repared Stance: maintain visual, way, feet shoulder width apart	TAG	DEFICIENCY		DATE			
		al's thumbs (use your other							

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/21/2023		
NAME OF P	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135			
(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)	λΤΕ	(X5) COMPLETION DATE
TAG	hand on your closed necessary), resume Hair Pull Release: It to protect your need to your head to loos pressure while bend with other hand, rest Hair Pull: raise shot press the individual loosen grip, bend, pother hand, resume Long/Wrapped Hair protect your neck, shand toward your head, call for assistat the waist, assistat beginning with pinh resume prepared statelothing Release: individual's hand clitighten clothing neat the clothing free, stoof grasp, resume preclothing as tight as resume prepared statelothing as tight as resume prepared stance. Further way from the person's mouth, prepared stance. Further way from the person's mouth, grasp in and turn back to regprepared stance. Further way from the person's individual, grasp in and push on individual's individual, resume pupper Bear Hug R	d fist for leverage if prepared stance. Front Hair Pull: raise shoulders to prepared stance. Back alders to protect your neck, shands to your head to sivot, step back and block with prepared stance. The Pull: raise shoulders to secure hair and individual's ead, flatten hand against your ance, step away while bending ant peels the individual's hand to sivot, step back and block with prepared stance. The Pull: raise shoulders to secure hair and individual's ead, flatten hand against your ance, step away while bending ant peels the individual's hand to finger with their thumb, ance. Front or Side: trap the sose to body with open hand, are the individual's hand, pull eep back and pull clothing out epared stance. Back: secure possible in front, quickly spin, ance. Way, anchor the individual's body part being bitten into the ses down while rolling out on, resume prepared stance. Ont or Back Choke: tuck chin, straight up, quickly turn away gain visual contact, resume all Choke (headlock): tuck chin is elbow, step behind dividual's wrist with one hand dual's elbow with the other n, pull out and away from prepared stance elease: with open palms, place		TAG		TE	DATE
I	inumbs under indiv	idual's forearms/wrists, have					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15G811 B. WING 06/21/2023	
15G811 B. WING 06/21/2023	
STREET ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER 1306 S BLOOMINGTON STREET	
RES-CARE INC GREENCASTLE, IN 46135	
PROVIDER'S PLAN OF CORRECTION	5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG: PEGLII ATORY OR LSC IDENTIFYING INFORMATION TAG DAY TAG: PEGLII ATORY OR LSC IDENTIFYING INFORMATION TAG TAG: PEGLII ATORY OR LSC IDENTIFYING INFORMATION TAG DAY TAG: PEGLII ATORY OR LSC IDENTIFYING INFORMATION TAG TAG: PE	
TAG REGULATOR OR ESC IDENTIFIED IN ORIGINATION TAG DA	Е
one foot forward, turn head to side, bend at knees	
while pushing the person's hands over your head, step away and resume prepared stance	
-Lower Bear Hug Release: move one leg forward	
and bend at waist, grasp fatty part of the	
individual's thumbs and roll in an outward motion,	
release, step away and face individual and resume	
prepared stance.	
prepared stance.	
Advanced Moves	
-One Person Standing Restraint/Escort: approach	
from rear, slide one arm across the back to grasp	
the person's furthest forearm in an overhand grip,	
lock hips, reach across your own body to grasp	
the person's forearm in an underhand grip; can	
escort the person to safety or away from a	
reinforcing situation.	
-Two Person Standing Restraint/Escort: one staff	
approach from each side with one taking the	
leading role, reach across the individual's back to	
grasp the individual's outside forearm using an	
overhand grip, reach across your own body to	
grasp the individual's wrist closest to you with an	
underhand grip. (Staff may instead grab the	
individual's forearm with outside hand and grab	
their own forearm with their inside hand). Hips	
should be snug for stability. Draw the person's	
elbow backward and secure snugly over your hip;	
can escort the person to safety or away from a	
reinforcing situation. If the person attempts to fall, go down on the closer knee while maintaining	
arm position.	
-Two Person Seated Restraint: one staff approach	
from each side with one taking the leading role,	
reach across the individual's back to grasp the	
individual's outside forearm using an overhand	
grip, reach across your own body to grasp the	
individual's wrist closest to you with an	
underhand grip. Hips should be snug for	
stability. Draw the person's elbow backward and	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF P	ROVIDER OR SUPPLIER		STREET A 1306 S GREEN		
(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 BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	secure snugly over yor away to avoid bit -Two Person Lift: u the same hold as the restraint, keep insid up, count to 3 and li angleTwo Person Standistaff approach on eather lead, grasp the it outside arm, place it person with their he heels, use inside hain individual's shoulder outside leg and low on inside leg while out from under the they are on the floor shoulder. Hold their while keeping hips secure the legs by windividual's thighs j secure the individual	se a lifting belt if possible, use two person standing/seated e knee down and outside knee fit together at a 45 degree Ing to Supine Restraint: One such side with one assuming individual's wrist with your inside legs and hips behind the els behind the individual's and to support under the ers, take a step forward with er the individual to the floor keeping hips close. Slide arms individual's shoulders once and place hand on their remist and should to the floor close. Optional: a staff to prapping their arms around the just above the knees, a staff to	TAG	DEFICIENCY	DATE
W 0207 Bldg. 00	483.440(c)(2) INDIVIDUAL PRO Appropriate facility interdisciplinary te	staff must participate in			
	Based on record rev additional client (#1 direct care staff wer client #14's interdist Findings include:	tiew and interview for 1 4), the facility failed to ensure the invited to and participated in ciplinary team (IDT) meetings. FPM, client #14's record was	W 0207	To correct the deficient practic QIDP has been trained to ens DSP's are given the opportun attend IDT meetings and voic opinions pertinent to the IDT held. An IDT procedure has becreated to include all appropriparties and reasonings for ID staff suggestion form has been created to gather staff comme	ure ity to e any peing peen ate Fs. A

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/21/2023		
NAME OF I	PROVIDER OR SUPPLIEI	₹		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135			
(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)	ΓE	(X5) COMPLETION DATE
IAG	Client #14 had IDT 6/4/23, 6/5/23, 6/7/6/14/23. The recor IDT meetings in M direct care staff wa attend the meetings Client #14's 4/28/2 indicated the Interdincluded client #14 Behavior Consultar Disabilities Profess Nursing Manager, Coordinator), BDD Disabilities Service A member of the dipart of the IDT. On 6/13/23 at 9:08 #2 was interviewed Manager (QAM) w RM #2 was asked i meetings. RM #2 s The QAM explaine RM #2 indicated she meeting for a client participated in any On 6/13/23 at 10:3: Technician (BT) windicated she hasn't meeting. On 6/13/23 at 11:2: Professional (DSP) indicated they discuss to manage #11 indicated the manager #11 indicated the manager #11 indicated they manager #11 indicated they manager #11 indicated they manager #11 indicated them manager #11 indicated the manager #11 indicated ind	meetings on 6/2/23, 6/3/23, 23, 6/8/23, 6/9/23, 6/10/23 and dindicated client #14 had 17 ay 2023. A member of the s not invited to and did not it. 3 Individual Support Plan (ISP) disciplinary Team Members it, client #14's guardian, at, QIDP/Qualified Intellectual itional, Executive Director, QAC (Quality Assurance S (Bureau of Developmental its) and the Program Manager. It is a sincert care staff was not listed as it is a present for the interview. If she participated in IDT it is a participated in an IDT it is a sample of the interview in the last year. 5 AM, the Behavioral is an interviewed. The BT is participated in an IDT is a sample of the interviewed. The BT is participated in an IDT is a sample of the interviewed. The BT is participated in an IDT is sample of the interviewed. The BT is participated in an IDT is sample of the interviewed. The BT is participated in an IDT is sample of the interviewed. The BT is participated in an IDT is sample of the interviewed. The BT is participated in an IDT is sample of the indicated she reports her indicated she reports h		IAG	when they are unavailable to attend the IDT. All staff have be made aware of the suggestion forms. The QIDP will be responsible for inviting the appropriate staff members and reviewing any recommendation stated by staff. Ongoing monitoring will be achieved by QIDP reviewing all IDTs month ensure all appropriate parties in had a chance to state their input.	the ally to nave	DATE
	to communication a	and they follow up on her					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	NG		06/21/	2023
NAME OF P	PROVIDER OR SUPPLIER		<u>. </u>	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 CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
W 0209 Bldg. 00	concerns. On 6/13/23 at 2:28 line Disabilities Profession interviewed. QIDP IDT meetings, but the attend. QIDP #1 incomplete given the opported 483.440(c)(2) INDIVIDUAL PRO Participation by the client is a minor guardian is required is unobtainable or Based on record revadditional client (#1 client #14 and/or his participated in client (IDT) meetings. Findings include: On 6/14/23 at 12:05 reviewed and indicated the had a ginterdisciplinary Temporary	PM, Qualified Intellectual onal (QIDP) #1 was #1 indicated he participates in he direct care staff do not dicated direct care staff should unity to participate. GRAM PLAN e client, his or her parent (if or), or the client's legal ed unless the participation inappropriate. riew and interview for 1 4), the facility failed to ensure a guardian were invited to and to #14's interdisciplinary team FPM, client #14's record was sted the following: Individual Support Plan (ISP) quardian and the am Members included client ardian, Behavior Consultant, ellectual Disabilities tive Director, Nursing ality Assurance Coordinator), Developmental Disabilities	W)209	To correct the deficient practice the QIDP has been trained to ensure Guardians can attend I meetings and voice any opinion pertinent to the IDT being held. An IDT procedure has been created to include all appropria parties and reasonings for IDT. The QIDP will be responsible finviting the guardians and obtaining any information gives from them if they choose not to attend the IDT. Ongoing monitoring will be achieved by QIDP reviewing all IDTs month ensure all appropriate parties I had a chance to provide their input.	e, DT ns . ate ss. for the nly to	DATE 08/12/2023
	on 6/2/23, 6/3/23, 6/6/9/23, 6/10/23 and	d client #14 had IDT meetings /4/23, 6/5/23, 6/7/23, 6/8/23, 6/14/23. The record indicated DT meetings in May 2023. The					

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF P	ROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(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 APPROPRIAT DEFICIENCY)	Œ	(X5) COMPLETION DATE
	IDT meeting notes of client #14 or his attending the meetin documentation indiffrom the meetings vand/or his guardian On 6/13/23 at 2:28 Disabilities Profess interviewed. The Q(QAM) was present indicated it would be and guardians) to part of the team and opportunity to voice indicated the clients participate in the m staff review the detay with the clients after occur, but recomment them. The QAM in	did not include documentation guardian being invited to or ngs. There was no cating the recommendations were reviewed with client #14. PM, Qualified Intellectual ional (QIDP) #1 was Quality Assurance Manager at for the interview. QIDP #1 we important for them (clients articipate because they are at they should be given the tentier opinions. QIDP #1 is and guardians do not eetings. The QAM indicated ails of incidents/behaviors or the incidents/behaviors are the incidents/behaviors are not implemented until the					
W 0227	483.440(c)(4) INDIVIDUAL PRO						·
Bldg. 00	specific objectives client's needs, as comprehensive as paragraph (c)(3) of Based on observation interview for 3 addit the facility failed to #20's identified con	ssessment required by	W 0	227	To correct the deficient practice the QIDP has been trained to ensure plans are in place to me the needs of the individuals. To QIDP will review the CFA for clients #8, #16 and #20's to determine at what level the communication needs are. The QIDP will develop a	eet ne	08/12/2023

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G811	B. W	ING		06/21/	2023
		l .		STDEET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
NES-CAI	VE IINO			GREEN			
(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Observations were	re conducted in the facility on			communication goal based on	the	
		om to 3:30 pm and from 5:00 pm			information gathered from the		
	to 6:00 pm and on 6/13/23 from 8:00 am to 10:00 am and from 11:30 am to 12:30 pm. Client #8 was present in the facility throughout the observation				CFA. To ensure no others are)	
					affected the QIDP will review a	all	
					client CFAs and ISPs to ensur	e	
	period.				individuals current needs are I	peing	
					met. Ongoing monitoring will b	е	
	Throughout the obs	ervation period, client #8			achieved by quarterly reviews	of	
	paced and jumped throughout the facility. Client				the ISPs with the IDT to determ	mine	
	#8 did not engage in meaningful interactions with				the client needs are being met	t.	
	his staff or peers. C	Client #8 responded to verbal					
	and physical redirection but did not attend to						
	activities. Throughout the observation periods,						
	client #8 went into	his peers' bedrooms to look for					
	food and drinks. On	n 6/13/23 at 9:30 am, client #8					
	walked into the day	room with a pink cup with a					
	peer's name on it. (Client #8 drank the contents of					
	the cup and left it or	n the dining table. On 6/13/23					
	at 12:29 pm, client	#8 walked into the day room,					
	and Residential Ma	nager (RM) #2 stated, "Where					
	did you get that shin	rt?" Activities Coordinator					
	(AC) stated, "That's	s [client #6's] shirt." RM #2					
	stated, "He's going	through [client #6's] clothes."					
	RM #2 assisted clie	nt #8 to his bedroom to					
	change his shirt.						
	Client #8's record w	vas reviewed on 6/14/23 at 10:40					
	am.						
	Client #8's Comprel						
	Assessment (CFA)	dated 6/17/22 indicated the					
	following communi	cation abilities:					
	"Language Develop	ement:					
	Expression:						
	Cannot write or prin	nt any words					
	Nods head/smiles to	o express happiness: No.					
	Indicates hunger: N	o.					
	Indicates wants by 1	pointing or vocal noises: No.					
	Indicates sounds of objects or animals: No.						
	Expresses pleasure/	anger by vocal noises: No.					
	Speech: Does not speak.						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. W	ING		06/21/	2023
				CTREET	DDDFGG CITY GTATE ZID COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CAF	DE INC				ICASTLE, IN 46135		
KES-CAI	RE INC			GREEN	ICASTLE, IN 40135		
(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Speaks in primitive	phrases only or is nonverbal.					
	Is nonverbal or near	rly nonverbal.					
	Verbal Comprehension: Recognizes fewer than ten (written) words.						
		and even very simple verbal					
	communication.						
	Social Language Development: Uses phrases such as 'please' and 'thank you': No. Is sociable and talks during meals: No.						
	Talks to others about sports, family, activities, etc:						
	No.						
	Can be reasoned wi						
	Responds when talk						
	Talks sensibly: No.						
		apers/magazines for					
	enjoyment: No.	- 1:41 1:66 N-					
		n little or no difficulty: No.					
	reasonably well: No	ms on an application form					
	leasonably well. No	o.					
	Client #8's ISP date	d 10/20/22 indicated the					
	following communi	cation goal:					
	"Priority Objectives	: Communication Skills."					
	"Area: Reporting						
		loitation/Mistreatment.					
	Goal: To improve a	bility to report					
		loitation/Mistreatment thus					
	increasing safety sk						
	I -	sign to staff when he needs to					
	report an issue inclu	•					
		loitation/Mistreatment, with 2					
		ess 70% of the opportunities					
	1 -	2 consecutive months by					
	10/20/23.						
	Methodology:						
	- During second shift, staff will ask [client #8]						
	what he should do i	-					
	Abuse/Neglect/Exp	Abuse/Neglect/Exploitation/Mistreatment.					

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	NT OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED 06/21/2023		
NAME OF I	PROVIDER OR SUPPLIEF		•	1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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
TAG	- [Client #8] will re - A successful trial #8] signs a response Abuse/Neglect/Exp verbal prompts or le - Verbal praise and each attempt." - Client #8's ISP die his basic communic Direct Support Prof interviewed on 6/12 "[Client #8] can use 'thank you,' 'mom,' and 'swing.' Somet park, he'll sign 'swi what his signs mean sign language. I do know." DSP #13 st communication car goes on his outings specific restaurant a with pictures." DSI knows the sign for He doesn't use it for the toileting commu when he needs to g like this." DSP #13 first and second fin "That means restroe	spond with an appropriate sign. will be recorded when [client e to report loitation/Mistreatment with 2 ess. recognition will be given for d not include a goal to address eation needs. fessional (DSP) #13 was 4/23 at 12:43 pm and stated, e sign language. He knows 'dad,' 'you're welcome,' 'love,' imes, when we take him to the ng.' DSP #13 stated, "I know n. I've been teaching myself on't know if the other staff		TAG	DEFICIENCY)		DATE
	6/14/23 at 11:50 an non-verbal. We att cards. He points to wants to eat." RM	er (RM) #3 was interviewed on an and stated, "[Client #8] is empt to use communication his mouth to communicate he #3 stated, "We keep the ds in the day room." RM #3					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		 UILDING	nstruction <u>00</u>	(X3) DATE : COMPL 06/21 /	ETED	
NAME OF I	PROVIDER OR SUPPLIEF		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, 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)	.TE	(X5) COMPLETION DATE
IAU	stated, "The cards a the same cards for a about wants, needs, stated, "I don't know learn to use the card does not understand thing he can sign fo #3 stated, "He does for drinks, bathroor the bathroom before to sign for that." Program Manager v 1:55 pm and stated, where you're going to what he wants." sign language. Staf recognize it. He ha language, I'm not av right now." PM sta understand abuse an Qualified Intellectu (QIDP) #1 was inte and stated, "[Client are a bit limited. I'n communication wit #1 indicated he has managers and the b client #8 but had no asked if client #8 us communicate, QIDI tell." QIDP #1 state needs to go to the b #1 stated, "We have communication pro Quality Assurance in interviewed on 6/14	ren't specific to him. We use all of the clients. They are and emotions." RM #3 vif [client #8] has a goal to las." RM #3 stated, "[Client #8] labuse and neglect. The only rat the moment is food." RM in thave a goal to learn to sign in, or needing help. He goes to exwe can attempt to teach him leaves interviewed on 6/14/23 at "[Client #8] likes to pull you to lif he has options, he'll point life has options, he'll point life have not been trained to so a goal to learn to use sign life ware of what he's working on ted, "[Client #8] could not life help has limited for how the learn to use sign life life life life life life life life	IAU			DATE

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811			JILDING	instruction 00	(X3) DATE COMPL 06/21 /	ETED	
NAME OF P	ROVIDER OR SUPPLIER			1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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 BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	(X5) COMPLETION
TAG		t he wants or to get what he		TAG	DEFICIENCY)		DATE
		d, "[Client #8] does not have					
	,	ation goal. If his assessments					
	deem he needs it, he	e should have a formal					
	communication goa						
		ere conducted at the facility on					
		PM to 3:25 PM, 6/12/23 from 4:54					
	PM to 6:09 PM, 6/13/23 from 8:51 AM to 9:54 AM, 6/13/23 from 11:38 AM to 12:35 PM, and 6/13/23						
	from 4:03 PM to 4:						
		#16 did not communicate					
	·	inguage, or use a Picture					
	Exchange Commun	ication System.					
		AM, a focused review of client nducted. Client #16's 7/1/22					
		port Plan (ISP) indicated, "He					
		iking a listener to what he					
		sign to communicate, but it is					
		on his chest to respond 'yes' to					
	an inquiry if he war	nts something. It is reported					
	_	nication has been used with					
		The Needs section of his ISP					
	indicated he needed						
		ls. Client #16's ISP indicated					
	to TRUTHFULLY	goal was, "To improve ability					
		loitation/Mistreatment thus					
		ills. OBJECTIVE: [Client #16]					
	will sign what to do						
	Abuse/Neglect/Exp	loitation/Mistreatment with 3					
		of the opportunities across 12					
	consecutive months						
		: 1. During second shift, staff					
	HONESTLY suspe	what he should do if he					
	•	loitation/Mistreatment. 2.					
		s with [client #16] the					
		fully discussing allegations of					
		loitation/Mistreatment. 3.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 06/21/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CA	RE INC				CASTLE, IN 46135		
(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 APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	Answers to be signed include Notify you	ed from [client #16] can r staff member"					
	Client #16's ISP did not include any additional goals to increase his communication skills.						
	indicated, "He is appropriately tell st He does know some	Behavior Support Plan (BSP) non-verbal and struggles to aff what he wants and needs. e sign language but he will communicate this way"					
	Disabilities Profess	PM, the Qualified Intellectual ional (QIDP) #1 indicated client nunication goal to address his icits.					
	6/12/23 from 1:37 I PM to 6:09 PM, 6/1 6/13/23 from 11:38 from 4:03 PM to 4: observations, client	#20 did not communicate anguage, or use a Picture					
	#20's record was co ISP indicated, "H use ASL (Americar communication dev gestures, make loud be vocal or get wha plop down on the fl unhappiness." The needed to improve a however a commun in his prioritized ob goal "To improve a	7 AM, a focused review of client inducted. Client #20's 4/11/23 is is non-verbal and does not in Sign Language) or rices. He will point or use it noises, or flap his hands to the wants. [Client #20] will oor to communicate his ISP indicated client #20 his communication skills ication goal was not included jectives. The ISP did include a billity to TRUTHFULLY report loitation/Mistreatment thus					

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	INT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTII A. BUILDII B. WING		NSTRUCTION 00	(X3) DATE COMPL 06/21 /	ETED
	PROVIDER OR SUPPLIEF		13	06 S E	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF TA		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	will sign what to do Abuse/Neglect/Exp verbal prompts 70% consecutive months METHODOLOGY will ask [client #20 HONESTLY suspe Abuse/Neglect/Exp Staff should discuss importance of truth Abuse/Neglect/Exp Answers to be sign include: Notify you Client #20's ISP did goals to increase hi Client #20's 6/8/23 non-verbal and doe communication. To have been purchase use them to communication thirsty' or 'I am hur these cards but they encouraged. When hang inside [client are available. [Client imake loud vocalizate yelling. He may do upset" On 6/14/23 at 12:43 Professional (DSP) believe client #20 u abuse, neglect and delayed.	loitation/Mistreatment with 3 % of the opportunities across 12 % by 6/30/2023. 1. During second shift, staff what he should do if he ets loitation/Mistreatment. 2. So with [client #20] the fully discussing allegations of loitation/Mistreatment. 3. ed from [client #20] can					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF F	PROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET 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)	(X5) COMPLETION DATE
	(RM) #3 indicated of in any way. RM #3 Completely non-ver #20's goal to report ineffective. RM #3 (abuse, neglect and he doesn't understar #20 needed to have On 6/14/23 at 9:57 Manager (QAM) in were a form of comindicated client #20 not a main priority have a communicat On 6/14/23 at 10:11 indicated client #20 communication goal	AM, the Program Manager needed to have a prioritized			
W 0249 Bldg. 00	formulated a clien each client must re treatment program	EMENTATION erdisciplinary team has t's individual program plan, eceive a continuous active n consisting of needed services in sufficient			
	number and frequ achievement of th individual program Based on observation interview for 2 of 5 plus 8 additional cli	ency to support the e objectives identified in the	W 0249	To correct the deficient practic site staff have been trained in individual ISP/BSP/HRP, facili activity schedule and to imple	each ity

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. WI	ING		06/21/	2023
				CTREET	ADDRESS OF A STATE SID COD		
NAME OF P	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
DEC OA	DE INO				BLOOMINGTON STREET		
RES-CAF	RE INC			GREEN	ICASTLE, 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	#3, #4, #8, #9, #12,	#13, #14, #15, #16 and #20's			plans as written. The QIDP ha	s	
		Plans (ISPs) and Behavior			been trained to ensure staff ar		
		s) were implemented at all			following plans as written. All		
	opportunities.	, 1			adaptive equipment and		
	11				programming tools have been		
	Findings include:				inventoried and distributed to		
	-8				facility for staff to appropriately		
	1. The facility's RD	DS (Bureau of Developmental			implement plans. The	,	
	1	s) and Investigations were			administrative team and activi	ties	
		3 at 2:35 PM. The review			director will review the current		
	indicated the follow				activities schedule to ensure it		
	marcated the follow	5.			appropriate. Additional monitor		
	a RDDS report date	ed 6/5/23 indicated, "On June 4,			will be achieved by the	Jillig	
		lient #16] was in the dayroom			administrative staff completing	ı fivo	
		ers began to shout at staff.			times a week facility observati		
	_	e over stimulated by the noise			for one month to ensure the	OH	
		(Self-Injurious Behavior) by			activity schedules and ISPs ar	.0	
		d using his left hand to slap			being implemented. Ongoing	C	
	_	ead. Then his peer [client #8]			monitoring will be achieved by	tho	
		[client #16] engaged in			QAC, PM, and QIDP completi		
	I -	towards his peer by using			routine observations of the fac	-	
		e [client #8] in his chest,			as well as monthly site review	-	
		st the wall with his back."			be completed by ResCare	5 10	
	knocking inin again	ist the wall with his back.			administration.		
	And,						
	² 1110,				Addendum:		
	"Staff will continue	to follow [client #16's]			Audendum.		
		(Human Rights Committee)			After the one menth period of		
	_	avior Support Plan) and ISP			After the one-month period of observations the		
		Plan) regarding verbal and			administrative team will asses		
						S	
		, threats, YSIS (You're Safe, restraint) intervention, PRN (as			the current needs of staff and	no.	
					clients to determine the freque	нсу	
		d coping skills. Staff will			of the observations. Ongoing	. 415 -	
	_	lient #16] with his coping			monitoring will be achieved by		
	skills when he becomes upset or agitated."				QAC, PM, and QIDP being in		
	1 DDDG				facility at least five times a we	ек	
		ed 5/30/23 indicated, "On May			to provide administrative	.,	
	29, 2023 at 8:15 pm, [client #16] was walking				oversight. In addition, monthly	site	
		when he became over			reviews will be completed by		
	stimulated due to th	e noise and engaged in self	1		ResCare administration.		

	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF I	PROVIDER OR SUPPLIEI	3	1306 S	ADDRESS, CITY, STATE, ZIP CO BLOOMINGTON STREE NCASTLE, IN 46135		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION	
	himself in his head [client #16] in using as well as took him but [client #16] cor #16] then engaged hitting himself in the Nurse assessed [client #16] there is currently readministered a behanceded). [Client #1 skills and calmed head and appeared to further issues." And, "Staff will continue guardian and HRC regarding verbal and YSIS (You're Safe, protocol and coping assist [client #16] verbecomes upset or a c. BDDS report dat 27, 2023 at 5:35 pn dinner when one of staff and other peer and began to engage by biting both wrist [client #16] in using but [client #16] in using but [client #16] cor #16] then began to sides of his head and aggression towards and digging his nait trained staff initiate approved 3 person	by using both hands to hit Staff attempted to assist g his coping skills to calm down for a walk around the property attinued to be agitated. [Client in self injurious behavior by the nose causing it to bleed. The self injurious behavior by the nose causing it to bleed. The self injurious behavior by the nose causing it to bleed. The self injurious behavior by the nose causing it to bleed. The self injurious his coping the self was able to use his coping timself down. He laid down in the fall asleep. There were no The self injurious part of the self was the self will continue to the self injurious behaviors the self injurious behavior the self injurious behavior the self i				

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	r í	JILDING	nstruction 00	(X3) DATE : COMPL 06/21/	ETED
NAME OF F	PROVIDER OR SUPPLIER			1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
TAG	#16] continued to b Nurse assessed [clie behavioral IM (inje able to use his copin down. He was relea lasted 18 minutes. In noted no injuries. [G programming without And, "Staff will continue guardian and HRC regarding verbal an YSIS intervention, Staff will continue coping skills when d. BDDS report dat 17, 2023 at 6:30 pm #16] became agitate dayroom and engag injurious behaviors the right side of his [client #16] in using but [client #16] con engaged in physical using both hands to this time, trained sta HRC approved 2 pe they could assist in environment. He wa room. The hold last assist [client #16] in	e agitated while in the hold. ent #16] and administered a etion) PRN. [Client #16] was ng skills and calmed himself sed from the hold. The hold Nurse assessed [client #16] and Client #16] returned to normal out further issues." to follow [client #16's] approved BSP and ISP d physical aggression, threats, PRN protocol and coping skills. to assist [client #16] with his the becomes upset or agitated." ed 5/18/23 indicated, "On May in while in the dayroom [client ed due to the noise in the		TAG	DEFICIENCY		DATE
	kitchen, and urinate him back to the day Staff continued to n	d in the sink. Staff redirected room and cleaned up the urine. nonitor [client #16]. Nurse					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MUI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE (COMPL 06/21/	ETED
NAME OF P	ROVIDER OR SUPPLIEF			1306 S E	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	And,						
	guardian and HRC regarding verbal an YSIS intervention, Staff will continue coping skills when e. BDDS report dat 13, 2023 at 8:49 am take his morning m meds, he entered th dayroom [client #16 the noise and begar behavior by biting I hand to hit the left sattempted to assist he engaged in phys by using both hands [client #16] and adr behavioral PO PRN #16] was able to us himself down. Nurs noted a red mark or did not cause bruisi side of his head (sk bruising). [Client # programming without And, "Staff will continue guardian and HRC regarding verbal an YSIS intervention, Staff will continue staff will continue of the staff will continue of the staff will continue the staff will be staff will b	I. With staff assistance, [client e his coping skills to calm se assessed [client #16] and a his left wrist (skin still intact, ng) and a red mark on the left in still intact, did not cause [16] returned to normal					
		scuss recent behaviors					

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BUILDING 00 COMP. B. WING 06/21			COMPL 06/21/	ETED	
NAME OF I	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CA	RE INC			GREEN	CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	6/13/23 at 3:40 PM encouraged to be or group activities and ED (Executive Dire 6/14/23 at 1:25 PM encouraging clients go outside. Observations were 6/12/23 from 1:37 I PM to 6:09 PM, 6/13/23 from 11:38 from 4:03 PM to 4: observations on 6/1 as evidenced by eng behavior of biting hobservations, client provided a PECS (I Communication Sy wrist guards, sensor canceling headphor On 6/13/23 at 1:39 #16's record was concerned by the will often che way. A PECS comprovided for [client his wants and needs an extensive history has resulted in scarr behavior of 'sucking initially added to the however, it was obs more of a self sooth	ager) was interviewed on . PM indicated clients should be at of their bedrooms and doing active treatment. Ector) was interviewed on . ED indicated staff should be to participate in activities or conducted at the facility on PM to 3:25 PM, 6/12/23 from 4:54 3/23 from 8:51 AM to 9:54 AM, AM to 12:35 PM, and 6/13/23 33 PM. Throughout the 2/23, client #16 was agitated gaging in self injurious its hand and wrist. During the #16 did not use and was not Picture Exchange stem) communication book, ry chew items and noise					

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 15G811 B. WING			COMPL 06/21/	ETED		
NAME OF P	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CAF	RE INC			CASTLE, IN 46135		
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION
TAG	behavior and instea	d, an ISP (Individualized	TAG	DEFICIENC!)		DATE
	place to encourage	for skin integrity was put in the use of wrist guards.				
	items have been bot	rous sensory sensory chew aght for [client #16] to try to				
	He will sometimes	from sucking/biting himself. use these chews but mostly				
	Wrist/hand guards v	nd/wrist to suck on will be provided for [client				
	-	nsive history of chewing and s Noise canceling				
	_	een provided for [client #16] ff to remind him or retrieve				
		sensory sensory chews allable to [client #16] to deter				
	him from sucking o encouraged to use the	n his wrists, he should be hese chews A				
		k has been provided for [client ISP goal of utilizing the book in				
		ate with staff If [client #16] is ate with staff, ask him to show				
	-	his communication book or ds can be used for this"				
		PM, Direct Support				
	should have been in	#13 indicated client #16's BSP inplemented as written for the				
	headphones and sen	PECS, noise canceling asory chew items. DSP #13				
	indicated the staff s #16 with his adaptiv	hould have provided client ve equipment.				
		PM, Qualified Intellectual				
	#16's BSP should ha	ional (QIDP) #1 indicated client ave been implemented as				
	canceling headphon	of wrist guards, PECS, noise es and sensory chew items. I the staff should have				
		with his adaptive equipment.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811			JILDING	nstruction <u>00</u>	(X3) DATE COMPL 06/21/	ETED		
NAME OF P	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	(RM) #3 indicated of been implemented a guards, PECS, noise sensory chew items	2 AM, Residential Manager client #16's BSP should have as written for the use of wrist the canceling headphones and and RM #3 indicated the staff and client #16 with his adaptive						
	(ED) indicated clier implemented as wri PECS, noise cancel chew items. The E BSP and he "should staff should have pr	AM, the Executive Director nt #16's BSP should have been tten for the use of wrist guards, ing headphones and sensory D stated these were part of his I be using all the time." The rovided client #16 with his The ED stated, "even during n't use the adaptive						
	Manager (QAM) in should have been in use of wrist guards, headphones and ser	AM, the Quality Assurance dicated client #16's BSP inplemented as written for the PECS, noise canceling asory chew items. The QAM should have provided client we equipment.						
	indicated staff shou	AM, the Program Manager ld have implemented client n by providing him with his						
	6/12/23 from 4:54 I 8:51 AM to 9:54 Al client #12 walked p rolling walker in the to put his walker on 9:21 AM, client #12	PM to 6:09 PM and 6/13/23 from M. On 6/12/23 at 5:57 PM, ast the surveyor carrying his e air. Staff did not prompt him the ground. On 6/13/23 at 2 walked from a couch to a table rying his rolling walker in the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF F	PROVIDER OR SUPPLIEI	R		1306 S I	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAU		rompt him to put his walker on		IAG			DATE
	#12's record was co ISP indicated, "[Cl- his safety protocol The ISP indicated, shifts, staff will ren- safety plan for falls reminders and ask themSit safely and potential tripping he stabilitySit in a co- changing clothes, poor strength by parangle with and pick up feet who has been suppropriately with and pick up feet who has been recently begund to have helped less sometimes use in (sometimes use in (sometimes use in (sometimes use in sometimes use in suppropriate in the ground as he even if staff are wand that he needs to put into it" The BSF Prevention Restrict will have a walker it 12-18 inches in for the walker before por forward again"	PM, a focused review of client onducted. Client #12's 12/14/22 itent #12] will discuss with staff to prevent falls twice daily" "1. During first & second mind [client #12] that he has a second second for the stand up safely. Be alert to azardsUse handrails for chair, NOT your bed, when outting on shoesIncrease reticipating in daily life skill on on campusUtilize walker VC (verbal cues)Walk slowly men walking" Client #12's apport Plan indicated, "He has a using a walker and this seems en his falls even though he will sic) inappropriately [Client mpliant with using his walker sometimes carry it or will tap it to walks. This can be the case lking with him and explaining at the walker down and step of indicated in the Fall ions section, "[Client #12] to prevent falls, he should place front of him and should walk into nicking it up and moving it					
	(ED) indicated staf walker on the floor be doing it (implen	AM, the Executive Director If should prompt him to put his The ED stated, "Staff need to menting his plan). Staff should If time. (He) never uses it					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
OVIDER OR SUPPLIER			1306 S	BLOOMINGTON STREET		
(EACH DEFICIEN REGULATORY OR	CY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
On 6/14/23 at 10:11 (PM) stated client # "on-going issue. St plan." 3) Observations we 6/12/23 from 1:37 I	212 carrying his walker was an aff need to implement his ere conducted at the facility on PM to 3:25 PM, 6/12/23 from 4:54					
6/13/23 from 11:38 from 4:03 PM to 4:	AM to 12:35 PM, and 6/13/23 33 PM.					
staff (#11) poured c #11 looked up, clien	lient #5's drink. When staff nt #20 was in the kitchen. Staff					
the dining room. C the dining room. C toast from his plate. #20 and attempted t Staff #11 tried num	lient #18 was eating alone in lient #20 grabbed client #18's . Staff #11 ran over to client to get him to spit out the toast. erous times to remove the toast					
#20's record was co Behavior Support P take food or persons sees an opportunity to be cut up very sn and snacks must be he will over fill his he can get his hands requires honey-thich had a targeted behave food as defined as,	nducted. Client #20's 6/8/23 clan indicated, "He will also al items from his peers if he . [Client #20] requires his food hall (1/4 inch) and his meals closely supervised because mouth with any food items that s on. He is a choking risk and kened liquids" Client #20 vior of inappropriate access to "any time he takes items from					
	OVIDER OR SUPPLIEF E INC SUMMARY (EACH DEFICIEN REGULATORY OF appropriately." On 6/14/23 at 10:11 (PM) stated client # "on-going issue. St plan." 3) Observations we 6/12/23 from 1:37 I PM to 6:09 PM, 6/1 6/13/23 from 11:38 from 4:03 PM to 4: On 6/12/23 at 5:30 staff (#11) poured c #11 looked up, clier #11 ran into the kitch the kitchen. On 6/13/23 at 9:07 the dining room. C the dining room. C toast from his plate. #20 and attempted t Staff #11 tried num from his mouth with On 6/13/23 at 10:27 #20's record was co Behavior Support P take food or person. sees an opportunity to be cut up very sn and snacks must be he will over fill his he can get his hands requires honey-thic had a targeted beha food as defined as,	IDENTIFICATION NUMBER 15G811 OVIDER OR SUPPLIER E INC SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION appropriately." On 6/14/23 at 10:11 AM, the Program Manager (PM) stated client #12 carrying his walker was an "on-going issue. Staff need to implement his plan." 3) Observations were conducted at the facility on 6/12/23 from 1:37 PM to 3:25 PM, 6/12/23 from 4:54 PM to 6:09 PM, 6/13/23 from 8:51 AM to 9:54 AM, 6/13/23 from 11:38 AM to 12:35 PM, and 6/13/23 from 4:03 PM to 4:33 PM. On 6/12/23 at 5:30 PM, client #20's one on one staff (#11) poured client #5's drink. When staff #11 looked up, client #20 was in the kitchen. Staff #11 ran into the kitchen to escort client #20 from	OVIDER OR SUPPLIER E INC SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION appropriately." On 6/14/23 at 10:11 AM, the Program Manager (PM) stated client #12 carrying his walker was an "on-going issue. Staff need to implement his plan." 3) Observations were conducted at the facility on 6/12/23 from 1:37 PM to 3:25 PM, 6/12/23 from 4:54 PM to 6:09 PM, 6/13/23 from 8:51 AM to 9:54 AM, 6/13/23 from 11:38 AM to 12:35 PM, and 6/13/23 from 4:03 PM to 4:33 PM. On 6/12/23 at 5:30 PM, client #20's one on one staff (#11) poured client #5's drink. When staff #11 looked up, client #20 was in the kitchen. Staff #11 ran into the kitchen to escort client #20 from the kitchen. On 6/13/23 at 9:07 AM, client #20 was standing in the dining room. Client #18 was eating alone in the dining room. Client #18 ran over to client #20 and attempted to get him to spit out the toast. Staff #11 tried numerous times to remove the toast from his mouth with no success. On 6/13/23 at 10:27 AM, a focused review of client #20's record was conducted. Client #20's 6/8/23 Behavior Support Plan indicated, "He will also take food or personal items from his peers if he sees an opportunity. [Client #20] requires his food to be cut up very small (1/4 inch) and his meals and snacks must be closely supervised because he will over fill his mouth with any food items that he can get his hands on. He is a choking risk and requires honey-thickened liquids" Client #20 had a targeted behavior of inappropriate access to food as defined as, "any time he takes items from	OVIDER OR SUPPLIER E INC SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION appropriately." On 6/14/23 at 10:11 AM, the Program Manager (PM) stated client #12 carrying his walker was an "on-going issue. Staff need to implement his plan." 3) Observations were conducted at the facility on 6/12/23 from 1:37 PM to 3:25 PM, 6/12/23 from 4:54 PM to 6:09 PM, 6/13/23 from 8:51 AM to 9:54 AM, 6/13/23 from 11:38 AM to 12:35 PM, and 6/13/23 from 4:03 PM to 4:33 PM. On 6/12/23 at 5:30 PM, client #20's one on one staff (#11) poured client #3's drink. When staff #11 looked up, client #20 was in the kitchen. Staff #11 ran into the kitchen to escort client #20 from the kitchen. On 6/13/23 at 9:07 AM, client #20 was standing in the dining room. Client #20 was standing in the dining room. Client #18 was eating alone in the dining room. Client #20 grabbed client #18's toast from his plate. Staff #11 ran over to client #20 and attempted to get him to spit out the toast. Staff #11 tried numerous times to remove the toast from his mouth with no success. On 6/13/23 at 10:27 AM, a focused review of client #20's record was conducted. Client #20's 6/8/23 Behavior Support Plan indicated, " He will also take food or personal items from his peers if he sees an opportunity. [Client #20] requires his food to be cut up very small (1/4 inch) and his meals and snacks must be closely supervised because he will over fill his mouth with any food items that he can get his hands on. He is a choking risk and requires honey-thickened liquids" Client #20 had a targeted behavior of inappropriate access to food as defined as, "any time he takes items from	OVIDER OR SUPPLIER EINC SUMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRICEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION appropriately." On 6/14/23 at 10:11 AM, the Program Manager (PM) stated client #12 carrying his walker was an "on-going issue. Staff need to implement his plan." 3) Observations were conducted at the facility on 6/12/23 from 1:37 PM to 3:25 PM, 6/12/23 from 4:54 PM to 6:09 PM, 6/13/23 from 8:51 AM to 9:54 AM, 6/13/23 from 11:38 AM to 12:35 PM, and 6/13/23 from 4:03 PM to 4:33 PM. On 6/12/23 at 5:30 PM, client #20's one on one staff (#11) poured client #5's drink. When staff #11 looked up, client #20 was in the kitchen. Staff #11 rain into the kitchen to escort client #20 from the dining room. Client #18 was eating alone in the dining room. Client #18 was eating alone in the dining room. Client #20 grabbed client #18's toast from his plate. Staff #11 ran over to client #20 and attempted to get him to spit out the toast. Staff #11 tried numerous times to remove the toast from his mouth with no success. On 6/13/23 at 10:27 AM, a focused review of client #20's record was conducted. Client #20's 6/8/23 Behavior Support Plan indicated, "He will also take food or personal items from his peers if he sees an opportunity. [Client #20] requires his food to be cut up very small (1/4 inch) and his meals and snacks must be closely supervised because he will over fill his mouth with any food items that he can get his hands on. He is a choking risk and requires honey-thickened liquids" Client #20 had a targeted behavior of inappropriate access to food as defined as, "any time he takes items from	DOUDER OR SUPPLIER EINC SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION appropriately." On 6/14/23 at 10:11 AM, the Program Manager (PM) stated client #12 carrying his walker was an "on-going issue. Staff need to implement his plan." 3) Observations were conducted at the facility on 6/12/23 from 1:37 PM to 3:25 PM, 6/12/23 from 4:54 PM to 6:09 PM, 6/13/23 from 8:51 AM to 9:54 AM, 6/13/23 at 7:30 PM, client #20 so on one staff (#11) poured client #5's drink. When staff #11 looked up, client #20 was in the kitchen. Staff #111 ran into the kitchen to escort client #20 from the drining room. Client #18 was eating alone in the drining room. Client #20 was standing in the drining room. In the was eating alone in the drining room. Client #20 was standing in the drining room. Client #20 was standing in the drining room. In the mach was the was eating alone in the drining room. Client #20 was standing in the drining room. Client #20

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	ľ	JILDING	nstruction 00	(X3) DATE : COMPL 06/21/	ETED
NAME OF F	PROVIDER OR SUPPLIER		•	1306 S	NDDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL A LSC IDENTIFYING INFORMATION TO BE ADMITTANCE TO BE A STATEMENT OF THE		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	within arm's reach. of peer's plates duri seems to prefer 'stea opposed to eating heven though they are plan indicated, "[a approximately arm' hours. When sleep checks. Staff shoul frequently as necess 1:1 staff include: A daily living tasks in (including assisting and providing activ Supervising all meas food is cut up approstealing food from pwith his 1:1 staff at from his peers durin staff will block [clic from peers Monithat he may potentismaking sure that he Monitoring [client staff at items from others On 6/14/23 at 12:43 Professional (DSP) implement client #2 On 6/14/23 at 2:29 should implement costealing as written.	als/snacks and making sure all opriately (see below). Due to opeer's plates, [client #20] will sit a table or couch/chair awaying meals and snacks The 1:1 ent #20] from taking food items toring [client #20] for any items ally try to eat/drink, including a does not drink from the toilet. #20] so that he does not take B PM, Direct Support #13 indicated staff should					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15G811	B. WI	NG		06/21/	2023
			_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	2			BLOOMINGTON STREET		
RES-CAF	RE INC				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	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		4:03 PM to 4:33 PM. Qualified					
		ities Professional (QIDP) #1					
		ents #10, #14 and #19 in the					
	yard. QIDP #1 was the only staff present outside.						
		ng at the picnic table while					
	1	s #10 and #14 walked around					
	the yard interacting	with each other.					
	On 6/14/23 at 12:05	5 PM, client #14's record was					
		14's 6/1/23 BSP indicated,					
		is peer, [client #19] do not get					
		ald make an effort to program					
	_	e another when possible."					
	·	•					
	On 6/14/23 at 2:28	PM, QIDP #1 was interviewed.					
	QIDP #1 indicated	clients #14 and #19 do not get					
	along very well. Q	IDP #1 was asked about client					
	#14's BSP addressing	ng client #14 and client #19 not					
		ing together. QIDP #1 stated,					
		buble check. There have been					
) incidents. Based on past					
		t impression. When I first got					
		thing I was concerned about. I					
	_	#19] targeting [client #14]. I					
	_	#14] target [client #19] any					
		guys". QIDP #1 indicated					
		plemented as written.					
		re conducted in the facility on					
		om to 3:30 pm and from 5:00 pm 6/13/23 from 8:00 am to 10:00 am					
		to 12:30 pm. Clients #3, #4, #8,					
		ere in the facility throughout					
	the observation per						
	and descrivation per						
	On 6/12/23 at 1:45	pm, Residential Manager (RM)					
	l '	#9 and #20 had dedicated 1:1					
	staff.						
	_	#1, #12, #20, #2, #15, #8, and					
	#19 were in the day	room. RM #2 was the only					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	î ´	JILDING	nstruction 00	(X3) DATE : COMPL 06/21/	ETED
NAME OF I	PROVIDER OR SUPPLIER			1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	#15, #8, and #19 we activities and were Client #1 sat at the set up. Client #1 as with him, and RM # #20]." Client #19 a asked to use the pluc call my dad once a the nurses station." client #19 to ask his #19 asked RM #2 if RM #2 stated, "I ca 2:35 pm, Quality A following client #8 prompting him to k went into the kitche fruit on the counter. Professional (DSP) and down the hallw At 2:45 pm, RM #2 pureed snack at a di wandering through of the kitchen. Clie the day room. Client estaff chair then chair. RM #2 promound chair. Client #19 st then jumped off. C day room, reached in adult brief. DSI bedroom to put on a #3 went into his bed his adult brief. DSI bedroom, so he coupm, client #2 wander facility repeating hi him. Staff did not put.	ere not engaged in meaningful not encouraged to do so. dining table with a board game ked RM #2 to play the game #2 stated, "I can't leave [client pproached the surveyor and one. Client #19 stated, "I can day. Staff get the phone from The surveyor encouraged staff for assistance. Client The could use the phone, and n't leave my one on one." At a ssurance Coordinator was down the hallway and was eep his clothing on. Client #8 on and knocked over a rack of the At 2:45 pm, Direct Support #11 was following client #8 up ays. assisted client #3 with his ming table. Client #15 was the day room and in and out not #2 was sitting on a sofa in the #19 jumped up and down on perched on the arm of the ood on the arm of the ood on the arm of the chair lient #8 walked through the into his pants, and ripped off the ood on the arm of the chair droom and laid down in his M #2 called client #19 to the ald make a phone call. At 2:55 ered in and out of the kitchen. It the surveyor around the second meaningful activities. In Manager was in the Qualified					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL		
		15G811	B. W	TNG	_	06/21/	/2023	
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				BLOOMINGTON STREET			
RES-CAF	RE INC		GREENCASTLE, IN 46135					
(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	ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ties Professionals (QIDPS)						
		6. The gym, consumer room,						
		ere empty. Client #14 was in a						
		tivities Coordinator (AC). ing to himself and others not						
		e room. AC stated, "[Client						
		ately programmed, so he can't						
	, o ,	being aggressive today."						
		were in the art room playing						
		r Technician (BT). Client #18						
	_	om with Quality Assurance						
	Coordinator (QAC)	· •						
	,							
	On 6/12/23 at 5:00	pm, client #14 and AC were in						
	· ·	ing kitchen. From 5:00 pm to						
		paced through the day room.						
	Client #4 indicated	he was going on an outing and						
	would eat in the cor	nmunity. Client #4 indicated						
	he was waiting for a	a staff member to be available						
	to take him on his o	outing. Client #4 was not						
	provided with an ac	tivity while he was waiting.						
		r clients participating in						
		eation building. At 4:57 pm,						
		16, #8, #20, and #4 were in the						
	-	t #20's one to one staff. Clients						
		2 were in the kitchen. At 5:07						
	-	ed DSP #13 was assigned as						
		ne staff and DSP #10 was						
	-	20's one to one staff. At 5:13						
	-	l, "I think [client #5] is in his						
		ked DSP #13 to prompt client						
		#13 left client #9 in the day						
	-	rompt client #5 for dinner. At and client #5 returned to the day						
	-	ved client #5 his meal. Client						
	#16 was walking through the day room with a pudding cup. Client #16 did not have a spoon							
		ne pudding into his mouth						
		t 5:18 pm, client #16 was						
	-	e day room with a bowl of						
	,, aiking anough the	an, room wim a bowl or						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF P	ROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET NCASTLE, IN 46135	
(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 BE CROSS-REFERENCED TO THE APPROPRIA	
	green beans. Client and poured the gree the bowl. At 5:23 p hands and was pacin Client #16 went into client #16 to leave thand, and RM #2 gree Client #16 bit down stated, "He bit me!" #16 to the end of the to the facility. RM bedroom and sat in RM #2 sat on the client #20 went into take something from physically blocked sit on the sofa in the his bedroom and lai lights off. Client #8 hallways with his hallways with his bedroom the sofa in the his bedroom and lai lights off. Client #8 hallways with his hallways with his bedroom the sofa in the his bedroom and lai lights off. Client #8 hallways with his bedroom the sofa in the his bedroom and lai lights off. Client #8 hallways with his bedroom the sofa in the his bedroom and lai lights off. Client #8 hallways with his bedroom the sofa in the his bedroom and lai lights off. Client #8 hallways with his bedroom the sofa in the his bedroom and lai lights off. Client #8 hallways with his bedroom the sofa in the his bedroom and lai lights off. Client #8 hallways with his bedroom and lai lights off. Client #8 hallways with his bedroom and lai lights off. Client #8 hallways with his bedroom and lai lights off. Client #8 hallways with his bedroom and lai lights off. Client #8 hallways with his bedroom and lai lights off. Client #8 hallways with his bedroom and lai lights off. Client #8 hallways with his hallways with his bedroom and lai lights off. Client #8 hallways with his hallways with			(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
	At 8:30 am, clients	tivities planned for the day. #2, #3, #4, and #5 were in their am, client #8 was walking			

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

PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BUIL	A. BUILDING 00 B. WING			COMPLETED 06/21/2023	
NAME OF I	PROVIDER OR SUPPLIER	₹			DDRESS, CITY, STATE, ZIP COD		
RES-CA	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	*	ICY MUST BE PRECEDED BY FULL		REFIX	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG	 	R LSC IDENTIFYING INFORMATION vearing one white sock and one		TAG	DEI CHERCI)		DATE
		eet. Client #8 had a black sock					
		up to his elbow. Client #10					
		nd pulled it off of client #8's					
	-	AC. AC stated, "It's ok." DSP					
		t #10 to assist with putting the					
	dining chairs away.	Client #10 complied. At 8:45					
	am, client #2 was s	eated in a chair in the day room.					
	Clients #3, #4, and	#5 were in their bedrooms.					
	Client #8 was pacir	ng up and down the halls, and					
		ng him. RM #2 stated, "We					
		ensory toys for him." At 9:00					
		#4 were in their bedrooms.					
		ling in the hallway, and client					
		the day room. At 9:06 am,					
	_	a piece of toast from client					
	_	c a bite. DSP #11 grabbed the					
		0's hand and threw it into the 0 ran to the sofa and put the					
		d into his mouth. DSP #11					
		20, leaning over his shoulder,					
		ke the toast from his hand and					
	_	rated, "Spit it out. Spit it out."					
		#3 went into the day room.					
	· ·	in his bed with the lights off.					
		#8 went into the day room with a					
	pink cup in his han	d. Client #8 drank the contents					
		l, then put the cup on the					
	table. Client #7 we	ent into the day room, took the					
	_	nat's mine! Stay out of my					
		and #5 were in their bedrooms.					
		g in a chair in the day room.					
		ging in verbal aggression with					
	_	am, client #3 was sitting in his					
		ay room and was yelling for					
		ked through the dayroom and					
	· ·	l" Client #4 was engaging in					
		with his peers. Clients #11, #9, #4 were in the day room and					
		n meaningful activity. At 9:48					
	were not engaged in	i incamingful activity. At 9.40					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	 UILDING	instruction 00	(X3) DATE COMPL 06/21 /	ETED
NAME OF F	PROVIDER OR SUPPLIER		1306 S	NDDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, 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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	am, client #4 was posaying, "F***," repolients #12 and #16 into the kitchen and banana. Client #12 stated, "Hold on. Gasked AC to play a stated, "Hold on. [Or can't leave the day on a special diet." (hallway to the dayrestaff. Client #8 were AC directed him out kitchen without his the surveyor asked AC stated, "Me." Aday room. Clients #4 were in the day room other staff in the but knowledge." At 10 the gym, recreation room, consumer room. Clients #14, movie room with B training. On 6/13/23 at 11:30 gym, recreation buit movie room, consumer room. Clients #13, #18 were in the art room to assist QAC and #14 were in the staff in the day room preparing lunch. Quassigned one to one were in their bedroom was saying a saying a saying was saying a sa	acing through the day room eatedly. Client #8 went into its bedroom. Client #8 went got a banana. Client #7 got a asked for a banana, and AC ive me a minute." Client #4 card game with him. AC Client #12] wants a banana. I room to get it for him, and he's Client #9 walked down the form without his one to one int into client #15's bedroom. It. Client #9 went into the one to one staff. At 9:56 am, who was assigned to client #9. It was the only staff in the interpretation who was assigned to client #9. It was the only staff in the interpretation who was assigned to client #9. It was the only staff in the interpretation who was assigned to client #9. It was the only staff in the interpretation who was assigned to client #9. It was the only interpretation who was assigned to client in the interpretation who was assigned to client #9. It was the interpretation who was assigned to clients in the interpretation. It was client #10, #12, and room with QAC. PM was as smoking. When PM saw the reterior who was as the only interpretation. AC was the only interpretation. AC was the only interpretation with their doors closed. On the restroom.				

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF I	PROVIDER OR SUPPLIER	3		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135			
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		were in the day room with no						
		nt into the day room and sat on						
		am, client #9 went into the day ne to one staff. Client #9						
		get this stuff off the table for						
		e here." Client #9 removed a						
		from the table and put them on						
		lient #8 walked down the						
	•	2 followed him. RM #2 directed						
	client #8 back to th	e day room. Client #8						
	_	ed a chair over. RM #2 stated,						
	•	doing this." RM #2 did not						
		an activity. Client #9 was						
	_	room. When asked who is						
	-	client #9 stated, "I have no						
		, client #8 was biting his hands,						
		and yelling. RM #2 stated, vay. You need to find another						
		" RM #2 did not direct client						
		ty. At 12:00 pm, clients #2, #4,						
		r bedrooms with their doors						
		m, client #2 went to the day						
	-	n, client #4 went to the day room						
	and laid down on th	ne sofa. RM #2 stated, "[Client						
	#4], I would really	appreciate it if you would sit						
	-	not move. At 12:17 pm, lunch						
	was served. Client	#5 was in his bedroom and						
		for lunch. Clients #3 and #20						
	-	ame table. AC indicated she						
	_	h of them. At 12:21 pm, AC						
		h client #3, and she did. Client						
	-	d onto the table with his spoon and ate it with his hands. AC						
		ent #20 to use his spoon or						
		napkin or assistance to clean						
	_	or his hands. DSP #13 was						
		nallway while eating a burrito						
		At 12:29 pm, client #3 finished						
	eating, went to this	bedroom, and got into bed.						
	At 12:30 pm, RM #	2 stated, "[Client #8], where did						

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/21/2023
NAME OF I	PROVIDER OR SUPPLIEI		1306 S	ADDRESS, CITY, STATE, ZIP CO B BLOOMINGTON STREE NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION
	#6's] shirt." RM #2 [client #6's] clothes "Everyone is done with the stated, "We tried to other building for his stated, "We tried to other building for his went to client #5's relike to eat in the da guess," and followed 12:36 pm, client #4 outside, so he could now. I'm watching into his bedroom and PM was interviewed stated, "Staff should every 15 minutes." Quality Assurance interviewed on 6/14 "Plans and schedule written. Staff should activities." 5a. On 6/13/23 at 9 on a community va #13 indicated he and only staff going on Client #3's record was pm. Client #3's Incidated 8/17/22 indicated 8/17/22 indicated states, using when dining, using when dining, using	d on 6/14/23 at 1:55 pm and d be prompting for activity Manager (QAM) was 4/23 at 4:10 pm and stated, es should be followed as ld be providing choices and :48 am, DSP #13 took client #3 n ride with 4 other clients. DSP d a staff in training were the			

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	r í	ILDING	nstruction <u>00</u>	(X3) DATE : COMPL 06/21/	ETED
NAME OF F	PROVIDER OR SUPPLIEF		•	1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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)	ATE	(X5) COMPLETION DATE
	_	oservation periods, client #3 I to participate in his formal s.					
	6/1/23 indicated clic staff when in the co - Client #3 was not	r Support Plan (BSP) dated ent #3 required a one to one mmunity. provided a one to one staff d in a community outing.					
	and stated, "Due to wheelchair now, he goes on outings." I						
	clients on a common DSP #13 indicate	was only the staff with 5 munity outing on 6/13/23. ed he was not aware of					
	community.RM 6/14/23 at 11:50	wision level when in the #2 was interviewed on am and stated, "[Client #3]					
	community."PM at 1:55 pm and s	ned to him when he's in the was interviewed on 6/14/23 tated, "[Client #3] has a					
	one to one staff s	when he's on outings. The should be implemented."5b. d was reviewed on 6/13/23					
	indicated the foll	ent #4's ISP dated 8/1/22 lowing goals: Medication oral hygiene, cleaning his					
	room, bathing, en	motional regulation, social ney management, preparing					
	allegations Thr periods, client #4	refraining from false oughout the observation 4 was not encouraged to					
	participate in his	formal goals and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15G811	B. WI	NG		06/21/	2023
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					BLOOMINGTON STREET		
RES-CAF	KE INC			GKEEN	CASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		ient #8's record was		IAG			DATE
		4/23 at 10:40 am. Client					
		0/20/22 indicated the					
	following goals:						
		on, oral hygiene, use of					
		personal hygiene, emotional					
		l interaction, communication,					
	_	neglect, exploitation, and					
	1	andry room access					
	· · · · · · · · · · · · · · · · · · ·	observation periods, client					
		uraged to participate in his					
		objectives.Client #8's BSP					
	_	icated the following:"[Client					
	#8] will have an	assigned staff across all					
	checks. He will	have 10 minute checks					
	while he is in his	s bedroom. The assigned					
	staff is responsib	ole for the following:					
	Assisting [client	#8] with his hourly toileting					
	and hygiene. Ma	aking sure he is not entering					
	peer bedrooms/k	itchen. Assisting with					
	possible commu	nication barriers.					
	Meal/snack supe	rvision. Providing/offering					
	walks around car	mpus (twice on first and					
	2nd shift). At the	e end of the assigned time,					
	staff will check [[client #8's] room for fall					
	hazards and will	assist with cleaning up any					
	messes that were	e made.""Wrist guards can					
	be used (as tolera	ated) if [client #8] is					
	chewing/sucking	g on his wrists/hands.""[Client					
	#8] recently (7/2	2) began chewing/sucking					
	on his wrists afte	er observing a new peer					
	engage in this be	ehavior. Wrist guards and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF	PROVIDER OR SUPPLIEI	R			ADDRESS, CITY, STATE, ZIP COD		
RES-CA	RE INC				BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID	SUMMARY	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 APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		ews are available for use					
		vior continue to occur."-					
	1	observation periods, client					
		an assigned staff to prevent					
	1	into his peers' rooms and the					
		client #8 bit his wrists and					
		ot offered wrist guards or					
	1	OSP #13 was interviewed on					
		pm and stated, "[Client #8]					
		upervision at all times. Once					
	we notice him going down a specific hall, we verbally prompt him to go back toward the						
	1 -	remind him he can't go into					
	_	. If he does not listen to the					
		taff hastily get next to [client					
	1 -	eter him away from					
		ne is trying to enter." DSP					
	· ·	doesn't participate in oes have a puzzle book that					
		Ie will do that from time to					
		s if we turn the T. V. on in					
	1	He will watch certain shows.					
	1 -	ne recreation building, he					
		the gym. He doesn't do					
		group."RM #2 was					
		6/14/23 at 11:50 am and					
		#8] is line of sight supervision					
	_	of his room. He doesn't have					
		to him, he's always in the					
	1 -	ommon areas, and there are					
	1 *	re to redirect him." RM #2					
	I -	to go to [client #5's] room.					
	'	C]					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15G811	B. W	ING		06/21/	2023
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DES CAE	DE INC				BLOOMINGTON STREET ICASTLE, IN 46135		
	RES-CARE INC			L	10A31EE, IN 40133		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		room and eats crumbs off					
		ve to direct him out."PM					
	was interviewed	on 6/14/23 at 1:55 pm and					
		8] is 15 minute checks in					
		assigned staff when out of					
		t of his room, we have to					
	assign someone	to keep an eye on him and					
	watch him. He's	constantly being (sic) in					
	and out of people	e's rooms, attempting to get					
	into things. He l	nas a history of eating					
	non-edibles." PN	M stated, "[Client #8] likes					
	his tablet, but he	's constantly breaking them.					
	He likes his walk	ss. He loves water." PM					
	stated, "He has h	ad wrist guards available.					
	He's not a fan of	them, and he's thrown them					
	away. He should	l have one available."QAM					
	was interviewed	on 6/14/23 at 4:10 pm and					
	stated, "[Client #	[8] is to have an assigned					
	staff with 10 min	nute checks. An assigned					
	staff is a staff de	dicated to monitoring him.					
	We need to discu	ss what assigned staff					
	means. The RM	should say, 'You are					
	responsible for [o	client #8] at this time.'"					
	QAM stated, "If	a person is one to one with					
	someone else, th	ey cannot be an assigned					
	staff for [client #	8]."6. Client #9's record					
	was reviewed on	6/14/23 at 11:00 am.					
	Client #9's BSP	dated 6/6/23 indicated the					
	following, "[Clie	ent #9] has a history of					
	sexually inappro	priate behaviors and he has					
	been charged wit	th rape on more than one					
	occasion in the p	ast. Sexual aggression has					
	1		1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023		
NAME OF F	PROVIDER OR SUPPLIEF	3		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION
TAG		both male and female		TAG	DEFICIENCE		DATE
	_	as placements and [client #9]					
	1	eful and thorough planning					
	_	ally assault another person.					
	He engages in 'g	rooming' behaviors where					
	he will try to win	n over the trust of others.					
	These grooming	behaviors serve the specific					
	purpose of settin	g up circumstances so that					
	[client #9] can se	exually act out or victimize					
	others. He may b	be overly nice to others, flirt					
	with them, or give them items in an effort to						
	have the peer fee	el that they 'owe' [client #9]					
	sexual favors. O	ther specific grooming					
	examples can be	found in the target behavior					
	definition for gro	ooming. [Client #9] has					
	historically enga	ged in sexual activity with					
	peers in his bedr	oom without the knowledge					
	of staff. It is im	perative that [client #9] never					
	be left unsupervi	ised with any client or while					
	in the communit	y as there is a risk for others					
	to be victimized.	[Client #9] must have 1:1					
	staff supervision	due to his opportunist					
	nature and due to	o the risk of reoffence.					
	[Client #9] has a	dmitted to previous					
	providers that th	e only reason that he has not					
	sexually acted or	ut with other clients is					
	because he is det	terred by his 1:1 staff and					
	_ ·	hat were in place."- At					
		observation periods, client					
	#9 did not have a	a one to one staff assigned					
		one to one staff left him to					
	assist other clien	ts.DSP #13 was					

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF F	PROVIDER OR SUPPLIER			1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, 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)	NTE.	(X5) COMPLETION DATE	
1710		/14/23 at 12:43 pm and		mg			DATE	
		[‡] 9 required a one to one						
		PM was interviewed on						
	6/14/23 at 1:55 p	m and indicated client #9						
	-	one staff at all times.QAM						
	-	on 6/14/23 at 4:10 pm and						
	indicated client #	49 required a one to one						
	staff at all times.	7. Throughout the						
	observation perio	ods, client #13 was not						
	wearing his pres	cribed eye glasses. Staff did						
	not prompt clien	t #13 to wear his glasses.						
	Throughout the o	observation periods, client						
	#13 was not wea	ring socks, and the tongues						
	of his shoes were	e pushed into the toes of his						
	shoes. Staff did	not prompt client #13 to						
	put on socks or t	o fix his shoes. Throughout						
	the observation p	periods on 6/12/23, client						
	#13 was not wea	ring a singlet under his						
	clothing.Client#	13's record was reviewed						
	on 6/14/23 at 9:3	0 am. Client #13's ISP						
	dated 10/10/22 in	ndicated goals for client						
	#13 to wear his s	inglet daily, to clean and						
		daily, to wear socks daily,						
		hoes correctly daily.DSP						
	#13 was intervie	wed on 6/14/23 at 12:43						
	pm and indicated	l staff should prompt client						
	_	glasses, singlet, and socks						
		hoes correctly.RM #2 was						
		/14/23 at 11:50 am and						
		hould prompt client #13 to						
		singlet, and socks, and to						
	wear his shoes co	orrectly.PM was						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 B. WING			COMPLETED	
		15G811	B. W.			06/21/2023		
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD			
RES-CAI	RE INC				BLOOMINGTON STREET CASTLE, IN 46135			
	T	OT LITELY OF DEFINITION	<u> </u>	<u> </u>		ı	ave.	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE	
	interviewed on 6	5/14/23 at 1:55 pm and						
	indicated staff should prompt client #13 to							
	wear his glasses,	singlet, and socks and to						
	wear his shoes co	orrectly.8. On 6/13/23 at						
	8:36 am, client #	15 was in the bathtub in the						
	community show	ver room. The bathroom						
	door was open, a	and there were no staff in						
	the area. Clients	s #10, #13, and #17 stood						
	in the bathroom	doorway and pointed at						
	client #15. At 8:	:43 pm, QIDP #1 looked						
	into the bathroon	n and stated, "I was just						
	checking on you	." QIDP #1 did not close						
	the door or addre	ess client #15's lack of						
	privacy. At 8:45	am, AC was standing						
	outside the bathr	room door, and the door						
	was closed.Clien	nt #15's record was						
	reviewed on 6/14	4/23 at 10:36 am. Client						
	#15's BSP dated	6/1/23 indicated client #15						
	should have stan	d by assistance while						
	showering and b	athing due to a history of						
	seizures and over	rflowing the bathtub.DSP						
	#13 was intervie	wed on 6/14/23 at 12:43						
	pm and stated, "l	I don't think [client #15]						
	requires any sup-	ervision while he's in the						
	bathtub."RM #2	was interviewed on						
	6/14/23 at 11:50	am and stated, "There						
	should be a staff	outside the bathroom while						
	[client #15] is in	the bath or shower. The						
	door is closed, b	ut we check on him. He						
	likes to flood the	e bathtub. We have to be						
	right there to ma	ke sure he doesn't overflow						
	it. He also has a	history of seizures."PM						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023		
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, 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)	TE	(X5) COMPLETION DATE
W 0250 Bldg. 00	stated, "[Client # in the bath due to should close the him."QIDP #1 w at 2:28 pm and st be monitored wh to seizures."QAM 6/14/23 at 4:10 p implement the pl 483.440(d)(2) PROGRAM IMPLE The facility must d schedule that outli treatment program available for review Based on observation interview for 3 addithe facility failed to #20's active treatment individualized to the Findings include: 1) On 6/14/23 at 12 Professional (DSP) not need and did no staffing at any time On 6/14/23 at 11:52 (RM) #3 initially in and did not receive specifically asked all hour before and one indicated client #16 indicated client #16 active treatment sch	evelop an active treatment nes the current active n and that is readily w by relevant staff. on, record review, and tional clients (#8, #16 and #20), ensure clients #8, #16 and nt schedules were eir personal needs. 2:43 PM, Direct Support #13 indicated client #16 did t receive one on one (1:1) during his day. 2: AM, Residential Manager dicated client #16 did not need	Wo	0250	To correct the deficient practice the QIDP has been trained to ensure appropriate activity schedules are in place to meen needs of the individuals. The Cwill review the CFA for clients #16 and #20 to determine what skills and activities they are about to complete or need improvem The QIDP will develop an individualized activity schedule based on the information gather from the CFA. To ensure no or are affected the QIDP will review all client activity schedules to ensure the individuals current needs are being met. Ongoing monitoring will be achieved by quarterly reviews of the ISP/activity schedules with the to determine the client's needs being met.	t the QIDP #8, at ble nent. e ered thers ew	08/12/2023

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BUILDING B. WING	00	COMPLETED 06/21/2023	
NAME OF I	PROVIDER OR SUPPLIEF		1306 S	ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET NCASTLE, IN 46135	
(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)	(X5) COMPLETION DATE
	Disabilities Profess #16 did not receive the day. When info on one staffing one the QIDP indicated should reflect the in should be involved On 6/14/23 at 2:29 Manager indicated at mealtimes. On 6/13/23 at 10:19 #16's record was concluded at mealtimes. On 6/13/23 at 10:19 #16's record was concluded at mealtimes. On 6/13/23 at 10:19 #16's record was concluded at mealtimes. On 6/13/23 at 10:19 #16's record was concluded at mealtimes. On 6/13/23 at 10:19 #16's record was concluded at mealtimes. On 6/13/23 at 10:19 #16's record was concluded at mealtimes. On 6/13/23 in midicated at mealtimes. It is approximately a fine and should be same active peers. Client #16's (BSP) indicated, " 1:1 approximately a fine all meals and snack when he struggles this 1:1 will be with hour after the mealtimes. 12:00pm so [client 11:00pm. responsible for taking around campus in a [client #16] doesn't plates or eat food fine the fine fine fine fine fine fine fine fin	PM, the Quality Assurance client #16 received 1:1 staffing D AM, a focused review of client inducted. Client #16 did not zed active treatment schedule red one on one staffing one is hour after meals. Client #16 is treatment schedule as 9 of his 6/8/23 Behavior Support Plan. At this time, [client #16] has arms-reach supervision during is since these are the times he most. During mealtimes, him for the hour before and the For example, lunch is at #16] would have a 1:1 staff from During the 1:1 time, the 1:1 is ing [client #16] on walks ddition to making sure that steal food from his peer's from the floor" PM to 3:25 PM, 6/12/23 from 4:54 and 6/13/23 from 8:51 AM to 9:54 AM, AM to 12:35 PM, and 6/13/23			

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NAME OF P	ROVIDER OR SUPPLIEF	2		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	(X5) COMPLETION DATE
	one staffing (1:1) the There were no disco	es. Client #20 received one on aroughout the observations. ernible structured activities to client #20 throughout the					
	#20's record was co Behavior Support P #20] will have a 1:1 during all waking h have 5 minute chec	7 AM, a focused review of client and acted. Client #20's 6/8/23 Plan (BSP) indicated, "[Client approximately arm's reach staff ours. When sleeping, he will ks. Staff should be switched					
	of the 1:1 staff incluant daily living task bathing (including a clean) and providin Supervising all mea	necessary. Responsibilities ude: Assisting [client #20] with s including toileting and assisting with keeping his feet g active treatment options. uls/snacks and making sure all					
	stealing food from with his 1:1 staff at from his peers during be provided with a utensils can be used	periately (see below). Due to peer's plates, [client #2-] will sit a table or couch/chair away ng meals and snacks. He will TV tray for his meal. Alternate I to help [client #20] eat					
	from taking food ite [client #20] for any try to eat/drink, incl does not drink from	et:1 staff will block [client #20] ems from peers. Monitoring items that he may potentially luding making sure that he at the toilet. Monitoring [client is not take items from others"					
	was not individuali:	d Active Treatment schedule zed. Client #20's Group B nedule was the same as 9 of his					
	Professional (DSP) received one on one	B PM, Direct Support #13 indicated client #20 e staffing (one staff working SP #13 indicated client #20 did					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/21/2023			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	not have an individuone staffing to impl	ualized schedule for his one on ement. DSP #13 indicated reatment schedule was the					
	(RM) #3 indicated of staffing. RM #3 indicated all a specific schedule RM #3 indicated all Active Treatment (A individualized for half client #20's AT scheduler and the staff of the client #20's AT scheduler and the staff of t	2 AM, Residential Manager client #20 received one on one dicated client #20 did not have for his one on one staffing. though client #20 had an AT) schedule, it was not is needs. RM #3 indicated edule was the same as edule. RM #3 stated "it would ing client #20 having an dule for staff to implement					
	#20 received one or indicated client #20 active treatment schactivities and prograengaging him in thr 3. Observations were 6/12/23 from 1:40 pt to 6:00 pm and on 6 and from 11:30 am	PM, QIDP #1 indicated client in one staffing. The QIDP did not have an individualized nedule indicating the types of arms the staff should be roughout the day. The conducted in the facility on the most of 3:30 pm and from 5:00 pm to 3:30 pm and from 5:00 pm to 12:30 pm. Client #8 was the throughout the observation					
	paced and jumped t #8 did not engage in his staff or peers. C and physical redirect activities. Through client #8 went into I food and drinks. On	ervation period, client #8 hroughout the facility. Client in meaningful interactions with Client #8 responded to verbal ection but did not attend to out the observation periods, his peers' bedrooms to look for in 6/13/23 at 9:30 am, client #8 room with a pink cup with a					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF F	PROVIDER OR SUPPLIER			1306 S	NDDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	the cup and left it of at 12:29 pm, client and Residential Madid you get that shin (AC) stated, "That's stated, "He's going RM #2 assisted clie change his shirt. Client #8's record wam. Client #8's undated indicated he was assindicated the follow "Daily: 7:00 am - Ward Breakfast Prep (prep. Res. 100 am - Cle Sunday: 9:30 am - Cle Sunday: 9:30 am - Cle Sunday: 9:30 am - Foom. Tuesday: 10:30 am - Sprep/meds (medicated pm - lunch, 1:00 pm rest/sensory/relaxin Sunday: 2:30 pm - Foom. Tuesday:	Vake up/Hygiene, 7:30 am - paration), 8:00 am - Breakfast an/rooms, 9:00 am - Laundry. nusic, 10:00 am - music. movie room, 10:00 am - movie a0 am - Bingo!, 10:00 am - y: 9:30 am - corn hole, 10:00 am ay: 9:30 am - chalk art, 10:00 ay: 9:30 am - Friday, 10:00 am - 9:30 am - basketball, 10:00 am - nack, 11:00 am - Choice/lunch ions), 12:00 pm - lunch, 12:30 n - clean, 1:30 pm -					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/21/2023			
NAME OF P	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE		
TAG	pm - clean, 6:00 pm zumba class. Frida; Daily: 7:00 pm - bo snack, 8:30 pm - ressleep." Direct Support Profinterviewed on 6/14 "[Client #8] is line asked what activitie #13 stated, "None. with activities. He'lenjoys if we turn the There are things he his tablet." DSP #1 rec. (recreation) bui gym. He doesn't ever group." Residential Manage 6/14/23 at 11:50 ambe line of sight whereach when he's out [client #5's] room, and He eats crumbs off kitchen and takes from #8] is non-verbal. Communication care take [client #8] on vyou can keep up wire live taken him to the have much interest. Sometimes he'll go the big yellow ball.	ds with him." RM #3 stated, "I walks outside. He runs, but if th him, he likes to go outside. e sensory room, but he doesn't He just likes to run. to the gym, and he'll play with He sits on the yellow ball in nd him of his coping skills, but	TAG		DATE		
	6/14/23 at 1:55 pm	PM) was interviewed on and stated, "[Client #8] has 15 s bedroom and an assigned					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BU	A. BUILDING <u>00</u> C			survey .eted /2023	
NAME OF F	PROVIDER OR SUPPLIEF	3	STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		TE	(X5) COMPLETION DATE
W 0268 Bldg. 00	being in and out of get into things. He non-edible items." but he's constantly He loves water." 5-7.1(a) 483.450(a)(1)(i) CONDUCT TOWAThese policies and	d procedures must promote					
	the growth, development and independence of the client. Based on observation and interview for 4 of 5 sample clients (#1, #2, #3 and #5) and 6 additional clients (#7, #8, #15, #17, #19, and #20), the facility failed to promote clients #1, #2, #3, #5, #7, #8, #15, #17, #19, and #20's dignity in regards to their appearance. Findings include: 1. Observations were conducted at the facility on 6/12/23 from 1:37 PM to 3:25 PM, 6/12/23 from 4:54 PM to 6:09 PM, 6/13/23 from 8:51 AM to 9:54 AM, 6/13/23 from 11:38 AM to 12:35 PM, and 6/13/23 from 4:03 PM to 4:33 PM. During the observations, client #17 had food stuck in between his teeth. Client #17 had food stuck on his teeth. On 6/13/23 after eating birthday cake, client #17 had blue icing on and in between his teeth from 4:03 PM to 4:33 PM. Staff did not prompt client #17 to brush his teeth or clean his teeth. Staff did not assist client #17 to clean his teeth. Staff did not assist client #17 to clean his teeth. Observations were conducted in the facility on 6/12/23 from 1:40 pm to 3:30 pm and from 5:00 pm to 6:00 pm and on 6/13/23 from 8:00 am to 10:00 am and from 11:30 am to 12:30 pm. Clients #3, #5,		W	0268	To correct the deficient practice, all site staff have been re-trained in ensuring client appearance is dignified and clothing is always in good repair. The PM's and RMs will inspect all individuals' current supply of clothing. Any ripped or stained items will be removed from the facility and inventory list. Additional monitoring will be achieved by the administrative staff completing five times a week facility observation for one month. Ongoing monitoring will be achieved by the QAC, PM, and QIDP completing routine observations of the facility as well as monthly site reviews to be completed by ResCare administration.		08/12/2023

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811 A. BUILDING 00 B. WING	COMPLETED 06/21/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZI 1306 S BLOOMINGTON STR	
RES-CARE INC GREENCASTLE, IN 46135	11221
(X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDERS PLAN OF PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO T DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE COMPLETION COMPLETION
throughout the observation periods. 2. On 6/12/23 at 1:40 pm, client #2 greeted the surveyor in the hallway outside his bedroom. Client #2's sweatshirt had a white substance smeared across the front of it. Client #2 continued to wear the sweatshirt for the remainder of the observation period and from 5:00 pm to 6:00 pm. Staff working in the facility did not encourage client #2 to change his shirt. 3. On 6/12/23 at 1:40 pm, client #5 was in his bedroom mopping his floor. Client #5's clothing was stained and had food remnants on the front of his shirt and pants. Client #5 continued to wear his soiled clothing for the remainder of the observation period and from 5:00 to 6:00 pm. Staff working in the facility did not encourage client #5 to change his shirt. 4. On 6/12/23 from 5:00 pm to 6:00 pm, clients #1, #7, and #19's shirts were soiled with food remnants and the front of their shirts were wet with drool. Staff working in the facility did not encourage clients #1, #7, and #19 to change their shirts. 5. On 6/12/23 at 5:10 pm, client #3 at his purced meal with 1:1 staff supervision. Client #3 was not provided a shirt protector or a napkin while he ate. Client #3 spilled food onto his shirt and pants while he ate. Direct Support Professional (DSP) #11 prompted client #3 to his bedroom to change his clothing. Client #3 returned to the dayroom, and his clothing was soiled with a white substance on the shirt and pants. 6. On 6/12/23 at 5:23 pm, client #8 was pacing through the facility. Client #8 had eaten ravioli for dinner and had a wet, red substance on the back	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF P	PROVIDER OR SUPPLIER			1306 S I	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, 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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	of his shirt. Staff we encourage client #8 pm, client #8 was with his right hand brief. Client #8's ha Staff working in the #8 or encourage him. 7. On 6/12/23 at 5:5 backwards. Staff we encourage client #1. 8. On 6/13/23 at 8:1	orking in the facility did not to change his shirt. At 6:00 ralking through the dayroom inside the front of his adult and was moving up and down. It facility did not redirect client in to go to his bedroom. 12 pm, client #15's shirt was orking in the facility did not 5 to turn his shirt around. 18 am, clients #8 and #15's pants unknown substance. Clients					
	throughout the obse	ed to wear the same pants rvation period and were not to change their clothing.					
	the dining table with box and a milkshak and sat with his mo- out of his mouth an- a drink from his mil- open. The milkshal and onto his shirt.	20 am, client #5 was seated at h a large breakfast pizza in a le. Client #5 took a bite of pizza buth open. Client #5's food fell d onto his shirt. Client #5 took likshake and sat with his mouth we ran out of client #5's mouth Client #5's 1:1 staff did not napkin and did not encourage buth or shirt.					
	the back of his sweathigh. Staff workin client #20 to change	at pants in the upper right g in the facility did not prompt this pants, and he continued whout the observation period.					
	interviewed on 6/14 "We try to not keep so when we take the	ressional (DSP) #13 was ./23 at 12:43 pm and stated, clothes with holes or stains, em out into public, they're not ppears to be not pleasing to					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	l í	ILDING	nstruction <u>00</u>	(X3) DATE : COMPL 06/21/	ETED
NAME OF F	PROVIDER OR SUPPLIEF	2		1306 S I	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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 APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	regulatory of the eye." DSP #13 dirty, we try to char "For the ones who a towel around their around their wrist of prompt them to wip Residential Manage 6/14/23 at 11:50 and we prompt them to Clothing with holes #2 stated, "If they a we have bibs and re "Staff should recogn dirty and should prefaces." Program Manager (6/14/23 at 1:55 pm holes or stains should prompt them hands." PM stated, "Qualified Intellectur (QIDP) #1 was interested assisting the clients should get them new QIDP #1 stated, "Staff slassisting the sassist themselves to assist themselves."	stated, "When their clothes are nge them." DSP #13 stated, drool, we try to keep them with r shoulders or a handkerchief r in their pockets. Staff should			CROSS-REFERENCED TO THE APPROPR	ATE	
	interviewed on 6/14 "Staff should promy clothing." QAM st has holes, it should	Manager (QAM) was 4/23 at 4:10 pm and stated, of the clients to change their ated, "If clothing is stained or be removed from the ng is soiled, staff should					

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STATEMENT OF DEFICIENCIES X13		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G811	B. WI	NG		06/21/	2023
				CTD FFT A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
DEC CAE	DE INC				BLOOMINGTON STREET		
RES-CAF	KE INC			GREEN	ICASTLE, IN 46135		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLA		PROVIDER'S PLAN OF CORRECTION	OF CORRECTION (X:	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	prompt the clients to	o change their clothes. Staff					
	should prompt the c	lients to wipe their faces as					
	needed."	-					
	5-1.2(d)						
W 0288	483.450(b)(3)						
D		ROPRIATE CLIENT					
Bldg. 00	BEHAVIOR						
		nage inappropriate client					
		ver be used as a substitute					
	for an active treatr	. •					
		on, interview and record	W 0	288	To correct the deficient practic		08/12/2023
		nal clients (#10 and #19), the			site staff have been re-trained on		
	-	sure staff did not restrict the			not restricting client rights for		
		e phone in order to prevent			anything without guardian and		
	maladaptive behavio	ors.			HRC approval. The phone has		
					been removed from the nurse		
	Findings include:				station for individuals to have f access. The BC will review all	ull	
	On 6/12/23 from 1:3	37 PM to 3:25 PM, an			individuals plans to indicate wh	nat	
		inducted at the facility. At 2:30			individuals have disruptive beh		
		d staff if he could use the			regarding the community phon		
		ndicated the phone was locked			The QIDP will then develop an		
	-	tion and he did not have			appropriate ISP goal for individ		
	•	#10 stated his access to the			with disruptive behavior regard		
		ed" and the phone used to be			the phone. Additional monitori	-	
	•	nts to use. Client #10 stated,			will be achieved by the	·9	
	-	when I want." At 2:39 PM,			administrative staff completing	five	
		the phone. Client #10 stated,			times a week facility observation		
		The staff present told client			for one month. Ongoing monitor		
		and could not get the phone			will be achieved by the QAC, F	•	
	•	M, the Program Manager told			and QIDP completing routine	IVI,	
		I not get the phone for him. At			observations of the facility as v	vell	
		al Manager (RM) #2 told client			as monthly site reviews to be	• OII	
		et the phone for him due to			completed by ResCare		
		staff on the unit due to the			administration.		
		e on one staffing. At 2:54 PM,			administration.		
	•	give client #10 the phone					
	-	side. RM #2 gave the phone					
	1.5 c . c. ne was out	size. Tell "2 gave the phone					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		15G811	B. W	ING		06/21/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L			BLOOMINGTON STREET		
RES-CAF	DE INC				ICASTLE, IN 46135		
INLO-OAI	NE INO			OILLIN			
(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
	to client #19. At 2:	58 PM, client #10 used the					
	phone.						
		3 AM, a focused review of client					
		nducted. Client #10's 4/11/23					
		lan (BSP) indicated, "[Client					
		radic phone contact with family					
	_	his father and mother but he					
		ioral difficulties following					
		[Client #10] tends to get his					
		family calling or visiting him					
		behaviors when he feels let					
		rill sometimes promise to obtain					
		client #10] and will sometimes					
	-	the is coming to get him. This					
		sed [client #10] to have behaviors as he gets his					
		d will follow through. The					
		that [client #10] have no					
	-	ner, but this has been difficult					
		#10] will call him or contact					
	_	er/tablet. [Client #10's] family					
	_	ecially common around					
	-	ays as [client #10] has high					
		visits and gifts around this					
	-	has numerous acts of					
		ated to phone use as he					
	•	s family members. A					
		in place due to the problems					
	• •	ling has caused for his mother					
	• •	Staff will dial the phone for					
	_	to call his guardian/advocate					
		vicinity to make sure that he is					
		ills. This is due to obsessive					
	-	arents which have affected					
	their employment						
	Client #10's BSP di	d not indicate the intervention					
	of the phone being	restricted/locked up.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET	
RES-CAF	RE INC			NCASTLE, IN 46135	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE
		3 PM, Direct Support			
		#13 stated the facility's phone			
		ed in the nurse's station. ne phone. More control with it			
	-	's) out, everybody wants to			
		ated, "Used to keep it on the			
	-	x (in the day room)." DSP #13			
		had a plan to restrict his access			
	to the phone.				
	On 6/14/23 at 11:52	2 AM, Residential Manager			
		arding the facility's phone,			
	"Usually out on top	of the fire box. Should be			
	available at all time	s. Shouldn't be restricted."			
	Disabilities Profess was not sure why th nurse's station. QII couple of clients wh	PM, Qualified Intellectual ional (QIDP) #1 indicated he he phone was locked in the DP #1 indicated there were a no needed to be monitored however no one required the			
	phone to be locked.	-			
	(PM) indicated she was locked. The Pl not be restricted with	AM, the Program Manager was not sure why the phone M indicated the phone should thout being a part of the written informed and Human consent.			
W 0331	483.460(c)				
Dida oo	NURSING SERVI				
Bldg. 00		provide clients with nursing lance with their needs.			
		view and interview for 1 of 5	W 0331	To correct the deficient practic	e 08/12/2023
		ent #5), the facility's nursing		the nurses have been trained	
		e documentation was		documenting the injection site	
	injections for client	ministering intramuscular #5		after each injection. The Quick Mar was updated to ensure nu	
	injections for effent			document the injection site bef	l l

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLET	
		15G811	B. W	ING	_	06/21/2	023
NAME OF T	ADOLUDED OF CURRY TO			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	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	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE '	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	Findings include:				documenting for the medication	on.	
	Client #5's record w	vas reviewed on 6/13/23 at 4:00			Additional monitoring will be achieved by the nurse manage	or	
		ent #5's Physician's Orders			reviewing the Quick Mar daily		
	-	had an order for "olanzapine			ensure the injection site has b		
		ction 10mg (milligrams)			documented for one month.	CCII	
		ery 6 hours as needed for			Ongoing monitoring will be		
	_	n," dated 1/26/2021.			achieved by the nurse manage	er	
	moreasea aggressio.	.,			reviewing Quick Mar weekly.	~·	
	A review of client #	#5's Medication Administration			1.5 1.5 Willing Scalott Mail Wookly.		
		March 2023 indicated he had a					
	` ′	r "olanzapine (antipsychotic)					
		x vial with 2.1 ML (milliliters)					
		ject 1 ML intramuscularly every					
	6 hours as needed for	or increased aggression." The					
	review indicated cli	ent #5 received this medication					
	on 3/2/23, 3/3/23, 3	/5/23, 3/15/23, 3/19/23, 3/23/23					
	and 3/25/23.						
	A raviany of client to	#5's MAR for April 2023					
		a physician's order for					
		on 10mg, mix vial with 2.1 ML					
		ject 1 ML intramuscularly every					
		for increased aggression." The					
		ent #5 received this medication					
	on 4/6/23 and 4/21/						
	A review of client #	#5's MAR for May 2023					
		a physician's order for					
		on 10mg, mix vial with 2.1 ML					
		ject 1 ML intramuscularly every					
		or increased aggression." The					
		ent #5 received this medication					
	on 5/21/23, 5/22/23	, 5/25/23 and 5/28/23.					
	The review indicate	ed the facility's nursing staff					
		ne site where client #5 received					
	the intramuscular injection.						
	Licensed Practical 1	Nurse (LPN) #3 was					
i	Licensea i factical i	10100 (111) 110 1140	- 1			1	

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	
		15G811	B. WI	NG		06/21/	2023
NAME OF P	ROVIDER 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 CROSS-REFERENCED TO THE APPROPRIATION OF THE ACTION OF THE APPROPRIATION OF THE APPROPRIATION OF THE ACTION OF THE	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
W 0436	"the nurses give pat indicated the site on documented when c LPN stated "it should The Nursing Manag 6/14/23 at 11:00 am injection site was no MAR. The NM state always be documen 5-4(e) 483.470(g)(2) SPACE AND EQU	ger (NM) was interviewed on a. The NM indicated the of documented on client #5's ed "injection sites should ted."					
Bldg. 00	repair, and teach of informed choices a eyeglasses, hearing communications and devices identified team as needed by Based on observation interview for 1 of 5 additional clients (# ensure clients #1 and good repair and were client #16's PECS (It Communication Systems guards, sensor canceling headphon provided to him to the Findings include: 1) Observations were 6/12/23 from 1:37 FPM to 6:09 PM, 6/1	ids, braces, and other by the interdisciplinary y the client. on, record review and clients in the sample (#1) and 2 8 and #16), the facility failed to d #8's glasses remained in re available for him to wear and Picture Exchange stem) communication book, y chew items and noise es were available and	Wo	436	To correct the deficient practice all site staff have been trained ensuring adaptive equipment it good repair and utilized and reporting to the administration team when supplies are not available or in good repair. Clic #1s glasses have been repaire and provided to him. Additional monitoring will be achieved by administrative staff completing times a week facility observation for one month. Ongoing monitor will be achieved by the QAC, Fand QIDP completing routine observations of the facility as was monthly site reviews to be	in s in ent ed al the i five on oring PM,	08/12/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CONSTRUCTION (X3) DATE: A. BUILDING 00 COMPL B. WING 06/21/					
NAME OF F	PROVIDER OR SUPPLIER	.		1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
	REGULATORY OF REGULATORY OF from 4:03 PM to 4: observations on 6/1 as evidenced by engine behavior of biting head phore observations, client provided a PECS (I Communication Sy wrist guards, sensor canceling head phore of 6/13/23 at 1:39 #16's record was concerned behavior Support of following, "He do but he will often che way. A PECS comprovided for [client his wants and needs an extensive history has resulted in scarn behavior of 'sucking initially added to the however, it was observed in the support Plan) goal place to encourage Additionally, numeritems have been be prevent [client #16] He will sometimes prefers to use his has wrist/hand guards with the will sometimes prefers to use his has wrist/hand guards with the sucking on his hand with the sucking of his hand with the sucking on his hand with the sucking on his hand with the sucking of his hand with the sucking on his hand with the sucking on his hand with the sucking on his hand with the sucking of his hand with the sucking h	2/23, client #16 was agitated gaging in self injurious hand and wrist. During the #16 did not use and was not Picture Exchange stem) communication book, ry chew items and noise			(EACH CORRECTIVE ACTION SHOULD BE	TE	
	them for him to use	aff to remind him or retrieve sensory sensory chews ailable to [client #16] to deter					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BUILDING <u>00</u> CO			(X3) DATE COMPL 06/21/	ETED	
NAME OF F	PROVIDER OR SUPPLIEI	₹		1306 S I	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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)	TE	(X5) COMPLETION DATE
TAG	him from sucking of encouraged to use to communication bood #16] along with an order to communicatrying to communicatrying to communicatrying to communication care. On 6/14/23 at 12:42. Professional (DSP) should have been in use of wrist guards, headphones and serindicated the staff's #16 with his adaption on 6/14/23 at 2:29. Disabilities Profess #16's BSP should have been in the staff's with his adaption of 6/14/23 at 2:29.	on his wrists, he should be these chews A ok has been provided for [client ISP goal of utilizing the book in ate with staff If [client #16] is eate with staff, ask him to show his communication book or ds can be used for this" 3 PM, Direct Support #13 indicated client #16's BSP mplemented as written for the PECS, noise canceling asory chew items. DSP #13 should have provided client we equipment. PM, Qualified Intellectual ional (QIDP) #1 indicated client ave been implemented as of wrist guards, PECS, noise		TAG	DEFICIENCY		DATE
	canceling headphones and sensory chew items. QIDP #1 indicated the staff should have provided client #16 with his adaptive equipment. On 6/14/23 at 11:52 AM, Residential Manager (RM) #3 indicated client #16's BSP should have						
	guards, PECS, nois sensory chew items	as written for the use of wrist e canceling headphones and s. RM #3 indicated the staff ed client #16 with his adaptive					
	(ED) indicated clie implemented as wr PECS, noise cancel chew items. The E BSP and he "should	AM, the Executive Director nt #16's BSP should have been itten for the use of wrist guards, ling headphones and sensory D stated these were part of his d be using all the time." the rovided client #16 with his					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		· /	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 06/21/	ETED	
NAME OF F	PROVIDER OR SUPPLIER	3		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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)	ΓE	(X5) COMPLETION DATE
TAG	adaptive equipment a behavior they did equipment." On 6/14/23 at 8:56 Manager (QAM) in should have been it use of wrist guards, headphones and set indicated the staff's #16 with his adaption on 6/14/23 at 10:1 indicated staff should have been it with the staff's adaptive equipment adaptive equipment.	AM, the Quality Assurance dicated client #16's BSP implemented as written for the pecces, noise canceling insory chew items. The QAM should have provided client we equipment. I AM, the Program Manager and have implemented client in by providing him with his		TAG			DATE
	6/12/23 from 1:37 I PM to 6:09 PM, 6/1 6/13/23 from 11:38 from 4:03 PM to 4: observations, client	PM to 3:25 PM, 6/12/23 from 4:54 13/23 from 8:51 AM to 9:54 AM, AM to 12:35 PM, and 6/13/23					
	record was conduct Individualized Supp #1] will wear his gl opportunities across 10/20/2023. 1. Dupass staff and the n wearing his glasses verbally prompt [cl Staff may explain thim to see better, ir 4. A successful tria [client #1] wears hi	PM, a review of client #1's ed. Client #1's 10/20/22 port Plan indicated, "[Client ass independently 100% of s 12 consecutive months by ring 8AM and 8PM medication urse will note if [client #1] is . 2. If not, then staff will ient #1] to wear his glasses. 3. hat wearing his glasses allows in a superior with the staff will ient #1 will be documented when s glass independently. 5. Give recognition for all efforts"					

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		l ′	LDING NG	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF RES-CA	PROVIDER OR SUPPLIE	R	[1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET ICASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		(X5) COMPLETION DATE
	(RM) #3 indicated however his glasses RM stated his glass couple of weeks." #1's glasses weren them. The RM indiry to get him to w 3. Observations we 6/12/23 from 1:40 to 6:00 pm and on and from 11:30 ampresent throughout did not have acces guards. On 6/13/2 Manager (RM) #2 the facility and state sensory toys for his Client #8's record am. Client #8's Behavit 6/6/23 indicated the "For Hand/Wrist Common of his sensory putting on his wrist Activities Coordin 6/14/23 at 11:45 and not have bite guards. Direct Support Profinterviewed on 6/1 not aware of a bite I only noticed him	ere conducted in the facility on pm to 3:30 pm and from 5:00 pm 6/13/23 from 8:00 am to 10:00 am a to 12:30 pm. Client #8 was at the observation periods and as to sensory chews or wrist 3 at 8:50 am, Residential was following client #8 through ted, "We need to get some m." was reviewed on 6/14/23 at 10:40 or Support Plan (BSP) dated the following: Chewing: Chewing: Chewisuck, prompt him to sue chews and assist him with the guards (if tolerated)." ator (AC) was interviewed on m and stated, "[Client #8] does does or chews." offessional (DSP) #13 was 4/23 at 12:43 pm and stated, "I'm guard or chews for [client #8]. bitting in the last couple of agh and bite himself. I don't					

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		X1) PROVIDER/SUPPLIER/CLIA					3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL		
		15G811	B. Wl	NG		06/21/	2023	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135					
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROWING IN AN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
W 0440 Bldg. 00	Program Manager (PM) was interviewed on 6/14/23 at 1:55 pm and stated, "[Client #8] has had bite guards and chews available. He's not a fan of them, and he throws them away. He should have them available." Qualified Intellectual Disabilities Professional (QIDP) #1 was interviewed on 6/14/23 at 2:28 pm and indicated client #8's adaptive equipment should be available to him in his home. 483.470(i)(1) EVACUATION DRILLS		W			e all	08/12/2023	
	clients living in the #7, #8, #9, #10, #11 #18, #19, and #20), quarterly evacuation personnel. Findings include: On 6/13/23 at 10:52 evacuation drills was following affecting #7, #8, #9, #10, #11 #18, #19, and #20: -During the day shift were no evacuation to 6/13/23. -During the evening there were no evacuation to 6/18/22 to 12/16/22 On 6/13/23 at 11:05 Manager indicated to	facility (#1, #2, #3, #4, #5, #6, #12, #13, #14, #15, #16, #17, the facility failed to conduct a drills for each shift of AM, a review of the facility's as conducted and indicated the clients #1, #2, #3, #4, #5, #6, #12, #13, #14, #15, #16, #17, ft (8:00 AM to 4:00 PM), there drills conducted from 1/17/23			To correct the deficient practice all site staff have been re-trained in completing one drill per shift per quarter and the drill calendar. All scheduled drills have been updated into TMP, the electronic documentation system. Staff will be aware of each scheduled drill by reviewing the daily documentation on TMP. Additional monitoring will be achieved by the PM reviewing the documentation of a drill after each scheduled occurrence. Ongoing monitoring will be achieved by the quality and safety committee reviewing drills each quarter.		08/12/2023	

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		X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G811	B. W.	JILDING ING	00	06/21/	
		133011	Б. 11		-	00/21/	2023
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CAF	RE INC			GREENCASTLE, IN 46135			
(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
	stated the facility sh drills "one per shift On 6/14/23 at 10:11	AM, the Program Manager y should conduct quarterly					
W 9999							
Bldg. 00							
Blag. OU	State Findings: 1. The following Community Residential Care Facilities for Persons with Developmental Disabilities rules were not met. 410 IAC 16.2-5-11.1 Mental health screening for individuals who are recipients of Medicaid or federal Supplemental Security Income Authority: IC 16-28-1-7; IC 16-28-1-12 Affected: IC 12-10-6; IC 16-28-5-1 Sec. 11.1. (a) As used in this section, "mental health service provider" means the community mental health center local to the residential care facility. (b) If the individual is a recipient of Medicaid or federal Supplemental Security Income (SSI), the individual needs evaluation provided in section 2(a) of this rule shall include, but not be limited to, the following: (1) Screening of the individual for major mental illness, such as a diagnosed major mental illness, is limited to the following disorders: (A) Schizophrenia.		WS	9999	To correct the inadequate practice, all staff responsible for admissions have been trained ensure that a person admitted from a mental health hospital receives a comprehensive carplan within 30 days of admissi. The nursing manager will obta appointment to receive mental health screening. The facility with develop an appropriate food services program that meets at the requirements. The program be supervised by the nurse manager and include trained dining aids. Ongoing monitorin will be achieved by the ED reviewing all CRMNF referral packets and ensuring mental health needs are met if coming from a mental health institution. The nurse manager will supervand monitor the food services program by completing routine observations at meal prep and mealtimes.	e on. in an vill ill of n will ig	08/12/2023

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023				
NAME OF I	PROVIDER OR SUPPLIE	R	•		DDRESS, CITY, STATE, ZIP COD		
RES-CAI	RE INC			GREEN	CASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	disorder.	R LSC IDENTIFYING INFORMATION		TAG	DE IELENET.		DATE
	(D) Paranoid or del	usional disorder					
	` /	severe anxiety disorder.					
	(F) Somatoform or						
	 (G) Personality disorder. (H) Atypical psychosis or other psychotic disorder (not otherwise specified). (2) Obtaining a history of treatment received by the individual for a major mental illness within the last two (2) years. (3) Obtaining a history of individual behavior within the last two (2) years that would be considered dangerous to facility residents, the 						
	staff, or the individual.						
		recipient of Medicaid or federal					
	-	r mental illness as defined by					
		s assessment, the person will					
		nental health service provider					
		on needed treatment services.					
	_	participate in Medicaid or SSI					
		1 1, 1997, shall have a nal needs assessment in their					
		persons admitted after April 1,					
		e assessment completed prior					
		nd, if a mental health center					
	·	ded, the consultation shall be					
		the admission and a copy					
	maintained	ino udimission und a vopy					
	in the clinical recor	·d.					
	(d) When a state ho	ospital refers a person with a					
	, ,	s, the residential care facility					
	shall request that a	copy of the psychosocial and					
	treatment recommendations collaboratively developed between the state hospital and the mental health center be forwarded to the residential care facility so that the residential care facility can determine the degree to which it can						
	1 -	for the provision of such					
	service.						
	(e) The residential	care facility shall not admit					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. BUILDING 00 B. WING			COMPLETED 06/21/2023		
NAME OF I	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CAI	RE INC				CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	residents with a maj			IAU			DATE
		h service provider determines					
	` '	eeds cannot be met; and					
	(2) the residential ca	are facility does not have a					
	means to access needed services to carry out the						
	comprehensive care	plan.					
	* *	th a major mental illness must					
	_	ve care plan that is developed					
		ays after admission to the					
	residential care faci	•					
		care facility, in cooperation					
		lth service providers, shall					
		hensive care plan for the					
	resident that include						
		nabilitation services that are to					
	be provided within	-					
		re range of activities to meet					
	_	eed, including the following:					
	(A) Recreational an (B) Social skills.	d socialization activities.					
		ational, and work programs.					
		or progression into less					
	restrictive and more	independent living					
	arrangements.						
	` '	care facility shall provide or					
	-	to carry out the resident's					
	comprehensive care	-					
		are facility shall seek					
		e placement in accordance 2-3 if the resident's needs or					
	by the residential ca	e plan, or both, cannot be met					
	by the residential ca	ire racility.					
	This state rule was a	not met as evidenced by the					
	following:	not mot as ovidenced by the					
	10110 Willig.						
	Based on record rev	view and interview for 1					
		9), the facility failed to ensure					
	·	prehensive care plan within 30					
		on to the facility from a state					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING			(X3) DATE COMPL 06/21 /	ETED		
NAME OF F	PROVIDER OR SUPPLIER		1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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)	TE	(X5) COMPLETION DATE
1110	hospital.					5.112
	Findings include:					
		vas reviewed on 6/20/23 at 4:23 P (Behavior Support Plan) ted the following:				
		ace and gender] who is state hospital] to ResCare in				
	with rape on more t	history of sexually viors and he has been charged han one occasion in the past. has taken place with both male				
	[client #9] is capab planning in order to	at previous placements and le of careful and thorough o sexually assault another				
	where he will try to These grooming be	s in 'grooming' behaviors win over the trust of others. haviors serve the specific up circumstances so that				
	He may be overly n give them items in	ally act out or victimize others. ice to others, flirt with them, or an effort to have the peer feel nt #9] sexual favors. Other				
	specific grooming of target behavior defination has historically eng	examples can be found in the nition for grooming. [Client #9] aged in sexual activity with				
	staff. It is imperation unsupervised with a	n without the knowledge of we that [client #9] never be left any client or while in the e is a risk for others to be				
	victimized. [Client supervision due to to the risk of re-offe	#9] must have 1:1 staff nis opportunist nature and due ence. [Client #9] has admitted rs that the only reason that he				
	-	ted out with other clients is ted by his 1:1 staff and by the				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF F	PROVIDER OR SUPPLIER		1306 S	ADDRESS, CITY, STATE, ZIP COD B BLOOMINGTON STREET NCASTLE, IN 46135	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	functioning individual incapable or lower in pretend that he does state that he was un into peer's bedroom realize that he was un behaviors for [clien aggression, property inappropriate behave and non-compliance -"DIAGNOSIS & M. 450B: Mild Intellect Compulsive Disord (and) Intermittent E. Client #9's ISP (Ind. 3/16/23 indicated the -"Date of admission Client #9's record dof a comprehensive from a mental health psychosocial and tree to (Executive Direct 6/14/23 at 1:25 PM. transferred to the faindicated client #9 care plan or psychorecommendations. PM (Program Mana 6/13/23 at 3:40 PM. community mental the town the agency client #9 did not atterpretations and the second point with the community mental the town the agency client #9 did not atterpretations.	MEDICATION: tual Disability, OCD (Obsessive er), Impulse Control Disorder, explosive Disorder." ividual Support Plan) dated he following: h: 2/2/23." id not include documentation care plan or recommendations h center regarding client #9's			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		ľ	JILDING	nstruction 00	(X3) DATE : COMPL 06/21/	ETED	
NAME OF PRO	OVIDER OR SUPPLIER			1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
RES-CARE	INC			GREEN	CASTLE, IN 40133		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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
PREFIX TAG tu nu p p p p p p p p p p p p p p p p p p	ransferred to the factorial assessment and plant approved by the depth of the factorial approved by Adming assistance is based of the factorial approved by the depth of the f	LSC IDENTIFYING INFORMATION cility in February 2023, had and did not have ment or comprehensive care r) was interviewed on 6/14/23 icated client #9 transferred to ate hospital. NM indicated is psychiatrist since his of received a psychosocial rehensive care plan regarding nesses. mmunity Residential Care is with Developmental are not met. Dining assistants -1-7; IC 16-28-1-12 5-1; IC 16-28-13-3; IC 25-23-1-1 ning assistant shall te a sixteen (16) hour training assistants that has been artment. at training program must at the department prior to a to individuals. do the following: ent selection for dining and the charge nurse's resident's most recent			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	
(i	B) Feeding techniq ndividual resident.	et, likes, and dislikes. ues appropriate to the e of a dining assistant on the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 15G811			(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/21/2023
NAME OF I	PROVIDER OR SUPPLIE	3	1306 \$	ADDRESS, CITY, STATE, ZIP CO B BLOOMINGTON STREE NCASTLE, IN 46135	
1120 071					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE	
PREFIX	`	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API	PROPRIATE COMPLETION
TAG	 	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	-	and review at each care plan			
	conference.				
	` '	e aide registry prior to training			
	an individual as a d	_			
		duals as dining assistants who			
	have successfully c				
		ed training program for dining			
	assistants.				
		actice for dining assistants is			
	as follows:				
	` '	ant shall work under the			
	supervision of a licensed nurse who is on the unit				
	or floor where the dining assistance is furnished and is immediately available to provide assistance				
	as needed.				
		y, a dining assistant shall call			
		se using the resident call			
	system or any other	ant shall assist only residents			
		omplicated eating problems,			
	which include, but				
	limited to, the follo				
	(A) Difficulty swal	_			
	(B) Recurrent lung	_			
	(C) Tube or parenta	•			
		stant training program shall			
	` '	ot limited to, the following:			
		of classroom instruction prior			
		et with a resident that includes			
	the following:				
	(A) Feeding technic	aues.			
	(B) Regular and sp	-			
	(C) Reporting food				
		n feeding and hydration.			
		and interpersonal skills.			
	(F) Infection contro				
		ncy procedures including the			
	Heimlich maneuve	• •			
		dents' independence.			
		and misappropriation of			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF F	PROVIDER OR SUPPLIEF	· :		T ADDRESS, CITY, STATE, ZIP COD	
RES-CAF	RE INC			S BLOOMINGTON STREET ENCASTLE, IN 46135	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECT	
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
	property.	rdunction			
	(J) Nutrition and hy	anges in residents that are			
		eir normal behavior and the			
	importance of report				
	these changes to the	~			
		nd social service needs			
		spond to a resident's behavior.			
	_	ts including the following:			
	(i) Privacy.	5 6			
	(ii) Confidentiality. (iii) Promoting residents' right to make personal choices to accommodate their needs. (iv) Maintaining care and security of residents'				
	personal possession	as.			
	(v) Dignity.				
		of clinical instruction that			
		ot limited to, the following:			
	(A) Feeding technic	-			
	1 '	eating and hydration.			
		tant training program and			
		applicable, must ensure that			
	clinical instruction	-			
		vision of the dining assistant			
	by a licensed nurse.				
		ogram shall have a qualified			
	-	ole for program oversight who			
	at a minimum:	d Indiana registered nurse			
	license under IC 25	-			
		2) years of licensed nursing			
		· ·			
	experience, of which at least one (1) year of experience is in the provision of long term care services; and (3) completed a department-approved training program.				
		ogram director of a department			
		program constitutes a qualified			
	instructor under	· ·			
	subsection (g) and i	nay conduct dining assistant			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		r í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 06/21 /	ETED	
NAME OF	PROVIDER OR SUPPLIEF		•	1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	by: (1) a registered nur. (2) a licensed pract (3) a qualified dieti (4) an occupational (5) a speech-langua Certified nurse aide personnel shall not dining assistant trai (j) In order to issue completion to the d assistant training pr dining assistant der areas of instruction the department. (k) Each approved student file that: (1) is retained for a and (2) contains: (A) individualized (i) classroom trainin attendance and area (ii) clinical instruct attendance and area procedures and acti clinical experience; (B) a copy of the co successful completi training program, w by the instructor an of the training prog This state rule was following: Based on record rev	training may only be provided se; ical nurse; cian; therapist; or ge pathologist. and qualified medication aide participate in or provide any ning. a certificate or letter of ining assistant, the dining togram shall ensure that the monstrates competency in all using a checklist approved by program shall maintain a minimum of three (3) years; documentation of the: ng that includes dates of as of instruction; and ion that includes dates of as of instruction including vities completed during the and entificate or letter confirming on of the dining assistant which shall be signed and dated d bear the name and address					

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PREFIX TAG REGULATORY OR LEGIDENTIFYING INFORMATION ### REGULATORY OR LEGIDENTIFY OR LEGIDENTIFYING INFORMATION ### REGULATORY OR LEGIDENTICS ### REGULATORY OR LEGIDENT OR	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 15G811		(X2) MULTI A. BUILD! B. WING		NSTRUCTION 00	(X3) DATE COMPL 06/21 /	ETED		
PREFIX TAG REGULATORY OR LEGIDENTIFYING INFORMATION ### REGULATORY OR LEGIDENTIFY OR LEGIDENTIFYING INFORMATION ### REGULATORY OR LEGIDENTICS ### REGULATORY OR LEGIDENT OR			8	1306 S BLOOMINGTON STREET					
facility failed to ensure certified dining assistants were utilized regarding clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #9 and #20's meals. Findings include: RM (Residential Manager) #2 and QAM (Quality Assurance Manager) were interviewed on 6/13/23 at 9-08 AM. RM #2 indicated her daily duties included but were not limited to observing staff and clients during mealtimes and completing meal preparation. RM #2 indicated the Kitchen Supervisor (KS) went over meal preparation, sanitation and food handling on an annual basis. RM #2 indicated she was not a certified dining assistant and had not received dining assistant training. RM #2 indicated the agency did not have dining assistants. RM #2 indicated the agency did not have dining assistants. RM #2 indicated direct support staff complete meal preparation on a daily basis. DSP (Direct Support Professional) #11 and QAM were interviewed on 6/13/23 at 11:25 AM. DSP #11 indicated she had been trained at previous jobs regarding dictary assistant duties. DSP #11 indicated she had not been training in her current role as a dictary assistant. DSP #11 indicated she was not aware of any dictary assistants being utilized at the agency. DSP #11 indicated the agency had a KS. DSP #11 indicated the agency had a KS. DSP #11 indicated the score preparation. DSP #11 indicated the KS completed training during initial hire orientation on food preparation. DSP #11 indicated the KS training was not dining assistant certification. DSP #11 indicated meal preparation.	PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PRE	FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION DATE	
was about 2 hours of her shift. QIDP (Qualified Intellectual Disabilities		#12, #13, #14, #15 facility failed to en were utilized regar #6, #7, #8, #9, #10 #17, #18, #19 and # Findings include: RM (Residential M. Assurance Manage at 9:08 AM. RM #2 included but were and clients during a preparation. RM #2 Supervisor (KS) we sanitation and food RM #2 indicated sl assistant and had ne training. RM #2 indining assistants. R staff complete mea DSP (Direct Suppowere interviewed of DSP #11 indicated previous jobs regar DSP #11 indicated her current role as a indicated her daily limited to assisting indicated she was r assistants being utilindicated the agency the KS completed to orientation on food indicated KS's train certification. DSP # was about 2 hours of	#16, #17, #18, #19 and #20), the sure certified dining assistants ding clients #1, #2, #3, #4, #5, #11, #12, #13, #14, #15, #16, #20's meals. Idanager) #2 and QAM (Quality r) were interviewed on 6/13/23 22 indicated her daily duties not limited to observing staff mealtimes and completing meal 22 indicated the Kitchen ent over meal preparation, handling on an annual basis. The was not a certified dining for received dining assistant dicated the agency did not have M #2 indicated direct support all preparation on a daily basis. For the Professional of #11 and QAM in 6/13/23 at 11:25 AM. The shad been trained at ding dietary assistant duties. The shad been training in a dietary assistant. DSP #11 and the agency DSP #11 and the agency DSP #11 and a KS. DSP #11 indicated raining during initial hire preparation. DSP #11 indicated raining during initial hire preparation. DSP #11 indicated raining during initial hire preparation. DSP #11 indicated meal preparation of ther shift.						

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		A. Bl	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF I	PROVIDER OR SUPPLIEI	₹		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135			
(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
	2:28 PM. QIDP #1 at the facility since indicated he had pa training but no spec QIDP #1 indicated preparation at the facility since indicated preparation at the facility says indicated preparation at the facility as a since of the facility says interview QAM was interview QAM indicated the not aware of the KS professional credenindicated the KS copreparation and asstraining on meal pr KS job description did not utilize an aptraining program. Can be serve Safe food proparation training the KS who was not dining assistant propreparation training of classroom or clir Safe food preparation program.	tials or certifications. QAM ompleted shopping, food isted with aspects of staff eparation. QAM provided the QAM indicated the agency oproved dining assistant QAM indicated the agency used					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF F	PROVIDER OR SUPPLIEF	₹	1306 9	FADDRESS, CITY, STATE, ZIP COD S BLOOMINGTON STREET ENCASTLE, IN 46135	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	LD BE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		dicated the agency did not have rogram and did not use dining			
	assistants.				
		d on 6/14/23 at 1:20 PM. KS			
		y did not have a formal dining			
		nd did not utilize dining			
	assistants.				
		ommunity Residential Care			
		ns with Developmental			
	Disabilities rules were not met.				
	410 IAC 16.2-5-5.1 Food and nutritional services				
	Authority: IC 16-28	3-1-7; IC 16-28-1-12			
	Affected: IC 16-28-	-5-1			
	Sec. 5.1.				
	(g) There shall be a	n organized food service			
	department directed	l by a supervisor competent in			
	_	ement and knowledgeable in			
		s, food handling, food			
	preparation, and me				
		must be one (1) of the			
	following:				
	(A) A dietitian.				
		tudent enrolled in and within			
	1	ompleting a division approved,			
	1	0) hour classroom instruction			
	_	s classroom instruction in			
	_	rision who has a minimum of			
		erience in some aspect of			
	institutional food se				
		dietetic technician program			
		merican Dietetic Association.			
		an accredited college or			
		one (1) year of graduating			
	degree in foods and	college or university with a			
	_	a minimum of one (1) year of			
		a minimum of one (1) year of aspect of food service			
	experience in some	aspect of food service		1	

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811			JILDING	nstruction <u>00</u>	(X3) DATE COMPL 06/21 /	ETED	
NAME OF P	PROVIDER OR SUPPLIEF	3		1306 S I	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(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)	TE	(X5) COMPLETION DATE
		vith training and experience in ision and management.					
	(3) Food service staff shall be on duty to ensure proper food preparation, serving, and sanitation. This state rule was not met as evidenced by the following:						
	clients (#1, #2, #3, #12, #13, #14, #15, facility failed to ensidepartment was directly regarding the manaclients #1, #2, #3, #	view and interview for 20 of 20 #4, #5, #6, #7, #8, #9, #10, #11, #16, #17, #18, #19 and #20), the sure the food service ected by a qualified supervisor gement of meal services for 44, #5, #6, #7, #8, #9, #10, #11, #16, #17, #18, #19 and #20.					
	Findings include:						
	Assurance Manager at 9:08 AM. RM #2 included but were n and clients during n preparation. RM #2 Supervisor (KS) we sanitation and food RM #2 indicated sh assistant and had no training. RM #2 indicates. R	anager) #2 and QAM (Quality r) were interviewed on 6/13/23 2 indicated her daily duties not limited to observing staff mealtimes and completing meal indicated the Kitchen ent over meal preparation, handling on an annual basis. He was not a certified dining of received dining assistant dicated the agency did not have M #2 indicated direct support a preparation on a daily basis.					
	were interviewed or DSP #11 indicated previous jobs regard	rt Professional) #11 and QAM n 6/13/23 at 11:25 AM. she had been trained at ding dietary assistant duties. she had not been training in					

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AND PLAN OF CORRECTION IDENTIFY		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/21/2023	
NAME OF PROVIDER OR SUPPLIER RES-CARE INC		STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
RES-CAR (X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION her current role as a dietary assistant. DSP #11 indicated her daily role included but was not limited to assisting with meal preparation. DSP #11 indicated she was not aware of any dietary assistants being utilized at the agency. DSP #11 indicated the agency had a KS. DSP #11 indicated the KS completed training during initial hire orientation on food preparation. DSP #11 indicated KS's training was not dining assistant certification. DSP #11 indicated meal preparation was about 2 hours of her shift. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 6/14/23 at 2:28 PM. QIDP #1 indicated he had been assisting at the facility since March of 2023. QIDP #1 indicated he had participated in client specific training but no specific meal preparation training. QIDP #1 indicated he had assisted with meal				BE COMPLETION	
	direct support staff clients assisting. ED (Executive Dire 6/14/23 at 1:25 PM not have dietary ass program. QAM was interview QAM indicated the not aware of the KS professional creden indicated the KS co preparation and assistraining on meal processions. So we will be considered to the tenton of the tenton	actility. QIDP #1 indicated prepared the meals with actor) was interviewed on ED indicated the agency did istants or a dietary assistant actor of the agency did istants or a dietary assistant actor of the agency did istants or a dietary assistant actor of the agency did istants or a dietary assistant actor of the agency did istants or certifications. QAM actor of the agency proved dining assistant actor of the agency proved dining assistant actor of the agency				

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 15G811		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/21/2023			
NAME OF PROVIDER OR SUPPLIER RES-CARE INC			STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		P	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		λΤΕ	(X5) COMPLETION DATE
	6/12/23 at 5:17 PM Supervisor job desc receipt on 6/12/23 a indicated the follow -"General Summary Supervises workers serving food. Respo management of the -"Essential Job Res	The undated Dietary ription was reviewed upon at 5:17 PM. The job description ring: y engaged in preparing and onsible for overall day-to-day food services department."					
	-Established quality preparing and food -Creates and submi nutritional adequace modified diets and -Recommends and/ supplies used by the ensures adequate quality -Obtains in-service -Provides training the -Holds in-service training the accommends and supplies used by the ensures adequate quality -Obtains in-service -Provides training the -Holds in-service training the accommendation of the supplies and the supplies are supplied to the supplies are supplied to the supplies and supplies are supplied to the suppli	n dietary consultants. y standards for planning, yield. ts menus that assure y and variety, including special diets. or orders food and other e dietary department and nantities are on hand. training at least annually. o all new staff. aining on specific dietary I but not less than annually.					
	dietary procedures a standardsAssists in training good nutrition and a -Confers with the a development of pol written documentat -Develops written p defining the use of Serves as the team accordance wit the -Functions as a con	dministrator in the icies, procedures and other					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
15G811		15G811	B. WING			06/21/2023		
NAME OF PROVIDER OR SUPPLIER RES-CARE INC				STREET ADDRESS, CITY, STATE, ZIP COD 1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDENCE NAVOE CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTF	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	other assigned com	mittees.						
	-Attends administra	_						
	communicates with	staff to enhance the flow of						
	information.							
		mmittees as required.						
	_	are filled in a timely manner.						
	1	chedule to the timekeeper.						
	-Ensures staff cover	_						
	-Develops departmental work schedules.							
		ions and disciplinary actions in						
	a timely manner.							
	-Other duties as assigned."							
	"Ovalifications/Education							
	-"Qualifications/Education Qualifications: One years (sic) of supervisory							
	1	d; One year experience working						
	in a cafeteria/institutional kitchen preferred. Education: High school diploma or GED. Some							
	college coursework or vocational school							
	preferred."							
	F							
	KS was interviewed on 6/14/23 at 1:20 PM. KS							
	indicated she had 16 years of food management							
	experience. KS indicated she did not have formal							
	_	or certifications in food						
	1	management. KS indicated a						
	_	was routinely at the agency						
		d review of client needs.						
		AM, the Quality Assurance						
		dicated the Dietary Manager						
	, ,	ated in dietary services and						
		quired credentials per the						
	•	AM indicated the DM trained						
	1	requirements however there						
		nining (ServSafe Manager						
	Certification verifie	_						
	person-in-charge has sufficient food safety							
	knowledge to protect the public from foodborne							
	illness) for the DM or the staff.							

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