STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00402349. Complaint #IN00402349: Substantiated, federal and state deficiencies related to the allegations are cited at: W104, W149, W153, W154 and W157. Dates of Survey: 3/27/23 and 3/28/23. 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 #27547 on 4/21/23.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 16 additional clients (#5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility's van utilized by clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20 was in good repair. Findings include: The facility's BDDS (Bureau of Developmental	W 0104	To correct the deficient practice the van has been repaired and deemed safe. All staff have been re-trained any issues found with the van are to be reported immediately. Additional monitoring will be achieved by the staff completing daily van inspections. The RM will review the inspections weekly. Ongoing monitoring will be achieved by a monthly environmental site review completed by ResCare	05/19/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick O'Heran	QAM	05/03/2023

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

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	Disabilities Services) reports and Investigations were reviewed on 3/27/23 at 1:32 PM. The review indicated the following: -BDDS report dated 2/21/23 indicated, "On 2/19/23 at 7:03 PM, while on a sensory awareness van ride, staff (unknown) safely pulled over so that they could move [client #1] to another seat in the company vehicle due to the peer he was sitting next to getting agitated. During the move, [client #1] moved against a broken seatbelt (currently being fixed) which caused a laceration on his right calf and another laceration on his left calf. Staff wrapped a piece of clothing around [client #1's] right calf due to continuous bleeding until they could get back to residential (the facility) to have [client #1] assessed by the nurse. Once they were back in residential, the nurse assessed [client #1] and noted a 2.5 cm (centimeter) laceration on his left leg and a 1 cm laceration on his left leg (sic) and advised staff to transport [client #1] to the [hospital emergency room] due to his left leg continuing to bleed. Once at the hospital, the doctor assessed [client #1], administered 5 stitches to [client #1's] left calf, and made the following diagnosis: Laceration to the right lower leg and left lower leg. No foreign body present. The discharge instruction states; "Protect wounds and keep wound area clean. Keep wounds dry. Apply bacitracin (antibiotic) twice daily. Sutures should be removed in five days." QAM (Quality Assurance Manager) and PM (Program Manager) were interviewed on 3/27/23 at 2:00 PM. QAM indicated the investigation of client #1's 2/19/23 injury determined two seat belts were broken and resulted in client #1's injury. PM indicated two seat belts were not functional.		administration staff.	

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PM indicated she was not aware of how long the seat belts had been broken prior to the 2/19/23 incident. PM indicated staff should complete a vehicle check prior to driving the van. PM indicated staff should document any repair issues on the same form used to document mileage. PM stated, "I can tell you that the prior couple of months they (staff) weren't doing them (vehicle checks). I was told the day (he) got hurt." PM indicated she was not aware of the van seat belts being broken prior to the 2/19/23 incident. PM stated, "Should be reporting maintenance issues to the PM or to someone in administration." PM indicated the RM (Residential Managers) completed van training with staff as a component of the facility's OJT (On the Job Training) packet.

RM #1 was interviewed on 3/27/23 at 3:39 PM. RM #1 indicated she was not aware of any issues with the van's seat belts. RM #1 stated, "I didn't know about that seat belt. It was completely off (plastic cover). I missed it and when they got back and heard he sliced his leg and (sic) went back and checked."

RM #2 was interviewed on 3/27/23 at 3:53 PM. RM #2 indicated she had helped train staff regarding the van. RM #2 indicated staff should complete a checklist to ensure the van was in good repair and everything was in working order. RM #2 stated, "The seat belts; we've known for a while. Wasn't aware of (sic) the maintenance was going to fall on me. I finally did call and got the green van fixed." RM #2 indicated the van's seatbelts had been repaired on one other previous occasion but did not recall the specifics or dates. RM #2 indicated she was not sure how the seat belts were being damage. RM #2 stated, "We had staff come in an tell us one client (unspecified) had bumped his leg and got a scratch and the nurse

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reviewed. Think the worst injury was [client #1]." RM #2 indicated other clients had scratched themselves on the seat belts prior to client #1's 2/19/23 incident. RM #2 indicated she did not recall a specific timeframe of when the other incidents occurred. RM #2 indicated client #9 had sustained scratches on his legs from the damaged seat belt in the van. RM #2 stated it was "probably closer to summertime (that she) was aware of damaged areas." RM #2 indicated she did not recall any specific retraining regarding completion of the van checklist or timely communication and repair of vehicle maintenance issues.

DSP (Direct Support Professional) #1 was interviewed on 3/27/23 at 4:03 PM. DSP #1 stated she had received training to check the van before trips to "make sure (the) seat belts and lights are working. We have a notebook with miles, (and) fuel. Even if we don't get gas (should be completed)." DSP #1 indicated she was aware of one of the seat belts on the green van being broken. DSP #1 stated, "One of the seat belts was broke. Single seat by the double (side) door. We sent it to be serviced. Was maybe a week before [client #1] cut his leg." DSP #1 indicated she had been working at the facility on 2/19/23 but was not on the van at the time of the incident. DSP #1 indicated she was the staff who assisted client #1 to the ER. DSP #1 was not aware of other clients being injured from the broken seat belt.

Client #9 was interviewed on 3/27/23 at 4:17 PM. Client #9 indicated the green van was utilized for outings with larger groups or the other smaller vans were utilized. Client #9 indicated he had scratched his legs on the seat belt in the van. Client #9 physically gestured to his left calf as the location of being scratched. Client #9 indicated he

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	was not certain of a date of his scratches but estimated it was within the past 2 months. Client #9 indicated the nurse had assessed his scratches and he was given a bandage but was not sent to the hospital. This federal deficiency relates to complaint #IN00402349. 5-1.2			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to prevent neglect of client #1 resulting in injury, report, investigate and develop and implement effective corrective measures to prevent recurrence regarding a damaged component of a vehicle's seat belt system. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations were reviewed on 3/27/23 at 1:32 PM. The review indicated the following: -BDDS report dated 2/21/23 indicated, "On 2/19/23 at 7:03 PM, while on a sensory awareness van ride, staff (unknown) safely pulled over so that they could move [client #1] to another seat in the company vehicle due to the peer he was sitting next to getting agitated. During the move, [client #1] moved against a broken seatbelt (currently being fixed) which caused a laceration on his right calf and another laceration on his left calf.	W 0149	To correct the deficient practice all staff have been re-trained Rescare ANEM policy procedures, reporting policy, and maintenance reporting policy. The van has been repaired and deemed safe. Additional monitoring will be achieved by the staff completing daily van inspections. The RM will review the inspections weekly. Ongoing monitoring will be achieved by the QIDP/PM/QAC/QAM/ED doing routine drop ins at the facility as well as vehicle inspections.	05/19/2023

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Staff wrapped a piece of clothing around [client #1's] right calf due to continuous bleeding until they could get back to residential (the facility) to have [client #1] assessed by the nurse. Once they were back in residential, the nurse assessed [client #1] and noted a 2.5 cm (centimeter) laceration on his left leg and a 1 cm laceration on his left leg (sic) and advised staff to transport [client #1] to the [hospital emergency room] due to his left leg continuing to bleed. Once at the hospital, the doctor assessed [client #1], administered 5 stitches to [client #1's] left calf, and made the following diagnosis: Laceration to the right lower leg and left lower leg. No foreign body present. The discharge instruction states; "Protect wounds and keep wound area clean. Keep wounds dry. Apply bacitracin (antibiotic) twice daily. Sutures should be removed in five days."

The review indicated the 2/19/23 incident was reported to BDDS on 2/21/23.

-Unknown Injury Investigation dated 2/22/23 indicated DSP (Direct Support Professionals) #2 and #3 and client #1 were interviewed in the investigation process. DSPs #2 and #3's witness statements did not address if they had completed a pre-trip checklist to ensure the van was in good repair. The Investigation did not include documentation of a review of the vehicle's maintenance logs, checklists or training records regarding how DSPs #2 and #3 were to ensure the van was safe and in good repair. The Unknown Injury Investigation dated 2/22/23 indicated, "Recommendations: A monthly site review will be conducted every month which will include an inspection of company vehicles. The company van will be sent off to replace the seatbelt buckle." The review did not indicate specifically who

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	would be responsible for the monthly site review. The Investigation did not address recommendations regarding pre-trip checklist or how staff would monitor and report issues with the vehicle to prevent recurrence. The review did not indicate documentation of a Peer Review (administrative review) of the 2/22/23 Investigation. QAM (Quality Assurance Manager) and PM (Program Manager) were interviewed on 3/27/23 at 2:00 PM. QAM indicated his role was to review the Unknown Injury Investigation (UII)dated 2/22/23 for thoroughness. QAM indicated a administrative Peer Review was not completed regarding the 2/22/23 UII. QAM indicated the UII determined two seat belts were broken and resulted in client #1's injury. PM indicated two seat belts were not functional. PM indicated she was not aware of how long the seat belts had been broken prior to the 2/19/23 incident. PM indicated staff should complete a vehicle check prior to driving the van. PM indicated staff should document any repair issues on the same form used to document mileage. PM stated, "I can tell you that the prior couple of months they (staff) weren't doing them (vehicle checks). I was told the day (he) got hurt." PM indicated she was not aware of the van seat belts being broken prior to the 2/19/23 incident. PM stated, "Should be reporting maintenance issues to the PM or to someone in administration." PM indicated the RM (Residential Managers) completed van training with staff as a component of the facility's OJT (On the Job Training) packet. QAM indicated the UII did not include documentation of a review of staff's training regarding van checklist completion. QAM			

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	indicated the UII did not include documentation of recommendations regarding re-training staff on completing a pre-vehicle inspection or reporting vehicle maintenance issues to the PM or administrative staff. RM #1 was interviewed on 3/27/23 at 3:39 PM. RM #1 indicated she was working at the facility on 2/19/23 when client #1 injured his leg. RM #1 indicated she was not on the van at the time of the incident. RM #1 indicated the RMs train staff to complete a van checklist before and after using the facility van. RM #1 indicated the checklist included a review of the van to ensure the van was in good repair, head lights and turn signals worked and tires were properly inflated. RM #1 indicated the RMs should ensure staff complete the vehicle checklists. RM #1 indicated she was not aware of any issues with the van's seat belts. RM #1 stated, "I didn't know about that seat belt. It was completely off (plastic cover). I missed it and when they got back and heard he sliced his leg and (sic) went back and checked." RM #1 indicated she had a meeting with her staff to retrain them on completing the checklist. RM #1 indicated there was not documentation of her meeting and was not able to recall if an in-service was completed by administrative staff. RM #1 indicated client #1 was sent to the ER (emergency room) and received stitches on 2/19/23. RM #1 indicated staff should report allegations to her and then she reports to PM. RM #1 indicated the timeframe for reporting an allegation was immediate. RM #1 indicated she did not assist in completing BDDS reports or investigations but did assist in training staff in the identification and internal reporting of abuse, neglect and mistreatment. RM #1 stated neglect included but was not limited to "not ensuring a client's needs or safety was taken care of."			

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	RM #2 was interviewed on 3/27/23 at 3:53 PM. RM #2 indicated she had helped train staff regarding the van. RM #2 indicated staff should complete a checklist to ensure the van was in good repair and everything was in working order. RM #2 stated, "The seat belts; we've known for a while. Wasn't aware of the maintenance was going to fall on me. I finally did call and got the green van fixed." RM #2 indicated the van's seatbelts had been repaired on one other previous occasion but did not recall the specifics or dates. RM #2 indicated she was not sure how the seat belts were being damage. RM #2 stated, "We had staff come in an tell us one client (unspecified) had bumped his leg and got a scratch and the nurse reviewed. Think the worst injury was [client #1]." RM #2 indicated other clients had scratched themselves on the seat belts prior to client #1's 2/19/23 incident. RM #2 indicated she did not recall a specific timeframe of when the other incidents occurred. RM #2 indicated client #9 had sustained scratches on his legs from the damaged seat belt in the van. RM #2 stated it was "probably closer to summertime (that she) was aware of damaged areas." RM #2 indicated she did not recall any specific retraining regarding completion of the van checklist or timely communication and repair of vehicle maintenance issues. DSP (Direct Support Professional) #1 was interviewed on 3/27/23 at 4:03 PM. DSP #1 stated she had received training to check the van before trips to "make sure (the) seat belts and lights are working. We have a notebook with miles, (and) fuel. Even if we don't get gas (should be completed)." DSP #1 indicated she was aware of one of the seat belts on the green van being broken. DSP #1 stated, "One of the seat belts was broke. Single seat by the double (side) door. We			

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	sent it to be serviced. Was maybe a week before [client #1] cut his leg." DSP #1 indicated she had been working at the facility on 2/19/23 but was not on the van at the time of the incident. DSP #1 indicated she was the staff who assisted client #1 to the ER. DSP #1 was not aware of other clients being injured from the broken seat belt. Client #9 was interviewed on 3/27/23 at 4:17 PM. Client #9 indicated the green van was utilized for outings with larger groups or the other smaller vans were utilized. Client #9 indicated he had scratched his legs on the seat belt in the van. Client #9 physically gestured to his left calf as the location of being scratched. Client #9 indicated he was not certain of a date of his scratches but estimated it was within the past 2 months. Client #9 indicated the nurse had assessed his scratches and he was given a bandage but was not sent to the hospital. QAC (Quality Assurance Coordinator) and PM were interviewed on 3/27/23 at 4:25 PM. QAC indicated she had completed the 2/22/23 UII. QAC indicated the facility should complete an administrative Peer Review of the investigation. QAC indicated the investigation should be thorough and include interviews with witnesses and potential witnesses. QAC indicated the investigation should include documentation of records and documentation reviewed during the investigation process. QAC indicated she interviewed DSP #2, DSP #3 and client #9. QAC indicated she did not review vehicle logs or maintenance requests or policies. QAC indicated the investigation did not determine how the seat belt was broken or how long it had been broken before client #1's 2/19/23 injury. QAC indicated the recommendations to prevent reoccurrence were to complete a weekly site review of the			

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vehicle. QAC indicated the investigation did not identify or document other recommendations. QAC stated neglect was "not taking care of a client. Not meeting their needs." PM indicated client #1 was on a community outing and not available for interview. PM indicated DSP #2 and DSP #3 were not working at the time of the interview.

The facility's green van vehicle mileage logs dated from 1/1/23 through 3/27/23 were reviewed on 3/27/23 at 5:30 PM. The vehicle mileage log had a section entitled "Inspection/Issues." There was no identified/documented inspection issues during the 1/1/23 to 3/27/23 review period.

DSP #2's OJT (On the Job Training) dated 11/30/22 was reviewed on 3/27/23 at 5:50 PM. The OJT training packet dated 11/30/22 indicated DSP #2 was trained by RM #2 regarding routine maintenance and reporting issues with the vehicle and completion of the monthly vehicle checklist on 11/30/22.

DSP #3's OJT training dated 8/23/22 was reviewed on 3/27/23 at 5:45 PM. The OJT training packet dated 8/23/22 indicated DSP #3 was trained by RM #2 regarding routine maintenance and reporting issues with the vehicle and completion of the monthly vehicle checklist on 8/23/22.

ED (Executive Director) was interviewed on 3/27/23 at 12:17 PM. ED indicated the abuse policy should be implemented, allegations of abuse, neglect and mistreatment should be immediately reported to the administrator and to BDDS within 24 hours, thoroughly investigated within 5 business days and corrective measures to prevent recurrence should be developed and implemented.

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The facility's Policy and Procedures were reviewed on 3/28/23 at 10:30 AM. The facility's Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights policy dated 1/10/18 indicated the following:

-"ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare, local, state and federal guidelines."

-"ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights."

-"Procedures:
1. Any ResCare staff person who suspects an individual is the victim of abuse, neglect, exploitation or mistreatment of an individual should immediately notify the Program Manager, and then complete an Incident Report. The Program Manager will then notify the Executive Director. This step should be done within 24 hours.

2. The Program Manager, or designee, will report the suspected abuse, neglect, exploitation, mistreatment or violations of Individual's rights within 24 hours of the initial report to the appropriate contacts, which may include... f. Bureau of Developmental Disabilities Service Coordinator...."

-"4. The Program Manager will assign an investigative team. A full investigation will be

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	conducted by investigators who have received training from Labor Relations Association and ResCare's internal procedures on investigations." -"One of the investigators will complete a detailed investigative case summary based on witness statements and other evidence collected." -"5. An investigative peer review committee chosen by the Executive Director will meet to discuss the outcome of the investigation and to ensure that a thorough investigation has been completed. Members of the committee must include at least one of the investigators, the Executive Director or designee, Program Manager for Supported Living, and a Human Resources representative." This federal deficiency relates to complaint #IN00402349. 5-1.2			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.			
	Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to report an injury regarding client #1 requiring emergency medical evaluation and treatment to BDDS (Bureau of Developmental Disabilities Services) within 24 hours of the incident. Findings include:	W 0153	To correct the deficient practice all staff have been re-trained to ensure incident reports are sent to QA in a timely manner. QA has been re-trained on ensuring all BDDS reports are submitted 24hrs. The QAM will monitor all incident reports submitted and	05/19/2023

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	The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations were reviewed on 3/27/23 at 1:32 PM. The review indicated the following: -BDDS report dated 2/21/23 indicated, "On 2/19/23 at 7:03 PM, while on a sensory awareness van ride, staff safely pulled over so that they could move [client #1] to another seat in the company vehicle due to the peer he was sitting next to getting agitated. During the move, [client #1] moved against a broken seatbelt (currently being fixed) which caused a laceration on his right calf and another laceration on his left calf. Staff wrapped a piece of clothing around [client #1's] right calf due to continuous bleeding until they could get back to residential (the facility) to have [client #1] assessed by the nurse. Once they were back in residential, the nurse assessed [client #1] and noted a 2.5 cm (centimeter) laceration on his left leg and a 1 cm laceration on his left leg (sic) and advised staff to transport [client #1] to the [hospital emergency room] due to his left leg continuing to bleed. Once at the hospital, the doctor assessed [client #1], administered 5 stitches to [client #1's] left calf, and made the following diagnosis: Laceration to the right lower leg and left lower leg (sic). No foreign body present. The discharge instruction states; "Protect wounds and keep wound area clean. Keep wounds dry. Apply bacitracin (antibiotic) twice daily. Sutures should be removed in five days." The review indicated the 2/19/23 incident was reported to BDDS on 2/21/23. RM #1 was interviewed on 3/27/23 at 3:39 PM. RM		ensure the QA department . Ongoing monitoring will be achieved by the Quality and safety committee review all incident reports to ensure they are .	

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	#1 indicated client #1 was sent to the ER (emergency room) and received stitches on 2/19/23. RM #1 indicated staff should report allegations to her and then she reports to PM. RM #1 indicated the timeframe for reporting an allegation was immediate. ED (Executive Director) was interviewed on 3/27/23 at 12:17 PM. ED indicated allegations of abuse, neglect and mistreatment should be immediately reported to the administrator and to BDDS within 24 hours. This federal deficiency relates to complaint #IN00402349. 5-1.2			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to thoroughly investigate an incident of injury to client #1 requiring emergency medical evaluation and treatment. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations were reviewed on 3/27/23 at 1:32 PM. The review indicated the following: -BDDS report dated 2/21/23 indicated, "On 2/19/23 at 7:03 PM, while on a sensory awareness van ride, staff (unknown) safely pulled over so that they could move [client #1] to another seat in the company vehicle due to the peer he was sitting	W 0154	To correct the deficient practice all members of the QA department as well as any trained investigators have been re-trained by the QAM on the components of a thorough investigation. Additional monitoring will be achieved by the QAM reviewing all investigations prior to being submitted to the ED for final approval. Ongoing monitoring will be achieved by routine record reviews by administrative staff to ensure all investigations completed are thorough.	05/19/2023

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	next to getting agitated. During the move, [client #1] moved against a broken seatbelt (currently being fixed) which caused a laceration on his right calf and another laceration on his left calf. Staff wrapped a piece of clothing around [client #1's] right calf due to continuous bleeding until they could get back to residential (the facility) to have [client #1] assessed by the nurse. Once they were back in residential, the nurse assessed [client #1] and noted a 2.5 cm (centimeter) laceration on his left leg and a 1 cm laceration on his left leg (sic) and advised staff to transport [client #1] to the [hospital emergency room] due to his left leg continuing to bleed. Once at the hospital, the doctor assessed [client #1], administered 5 stitches to [client #1's] left calf, and made the following diagnosis: Laceration to the right lower leg and left lower leg. No foreign body present. The discharge instruction states; "Protect wounds and keep wound area clean. Keep wounds dry. Apply bacitracin (antibiotic) twice daily. Sutures should be removed in five days." -Unknown Injury Investigation dated 2/22/23 indicated DSP (Direct Support Professionals) #2 and #3 and client #1 were interviewed in the investigation process. DSPs #2 and #3's witness statements did not address if they had completed a pre-trip checklist to ensure the van was in good repair. The Investigation did not include documentation of a review of the vehicle's maintenance logs, checklists or training records regarding how DSPs #2 and #3 were to ensure the van was safe and in good repair. The Unknown Injury Investigation dated 2/22/23 indicated, "Recommendations: A monthly site review will be conducted every month which will include an inspection of company vehicles. The company van will be sent off to replaced the seatbelt			

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	buckle." The review did not indicate specifically who would be responsible for the monthly site review. The Investigation did not address recommendations regarding pre-trip checklist or how staff would monitor and report issues with the vehicle to prevent recurrence. The review did not indicate documentation of a Peer Review of the 2/22/23 Investigation. QAM (Quality Assurance Manager) and PM (Program Manager) were interviewed on 3/27/23 at 2:00 PM. QAM indicated his role was to review the Unknown Injury Investigation (UII) dated 2/22/23 for thoroughness. QAM indicated a administrative Peer Review was not completed regarding the 2/22/23 UII. QAM indicated the UII determined two seat belts were broken and resulted in client #1's injury. QAM indicate the UII did not include documentation of a review of staff's training regarding van checklist completion. QAM indicated the UII did not include documentation of recommendations regarding re-training staff on completing a pre-vehicle inspection or reporting vehicle maintenance issues to the PM or administrative staff. RM #1 was interviewed on 3/27/23 at 3:39 PM. RM #1 indicated she was working at the facility on 2/19/23 when client #1 injured his leg. RM #1 indicated she was not on the van at the time of the incident. RM #1 indicated the RMs train staff to complete a van checklist before and after using the facility van. RM #1 indicated the checklist included a review of the van to ensure the van was in good repair, head lights and turn signals worked and tires were properly inflated. RM #1 indicated the RMs should ensure staff complete the vehicle checklists. RM #1 indicated she was			

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	not aware of any issues with the van's seat belts. RM #1 stated, "I didn't know about that seat belt. It was completely off (plastic cover). I missed it and when they got back and heard he sliced his leg and (sic) went back and checked." RM #1 indicated she had a meeting with her staff to retrain them on completing the checklist. RM #1 indicated there was not documentation of her meeting and was not able to recall if an in-service was completed by administrative staff. RM #1 indicated client #1 was sent to the ER (emergency room) and received stitches on 2/19/23. RM #2 was interviewed on 3/27/23 at 3:53 PM. RM #2 indicated she had helped train staff regarding the van. RM #2 indicated staff should complete a checklist to ensure the van was in good repair and everything was in working order. RM #2 stated, "The seat belts; we've known for a while. Wasn't aware of the maintenance was going to fall on me. I finally did call and got the green van fixed." RM #2 indicated the van's seatbelts had been repaired on one other previous occasion but did not recall the specifics or dates. RM #2 indicated she was not sure how the seat belts were being damage. RM #2 stated, "We had staff come in an tell us one client (unspecified) had bumped his leg and got a scratch and the nurse reviewed. Think the worst injury was [client #1]." RM #2 indicated other clients had scratched themselves on the seat belts prior to client #1's 2/19/23 incident. RM #2 indicated she did not recall a specific timeframe of when the other incidents occurred. RM #2 indicated client #9 had sustained scratches on his legs from the damaged seat belt in the van. RM #2 stated it was "probably closer to summertime (that she) was aware of damaged areas." RM #2 indicated she did not recall any specific retraining regarding completion of the van checklist or timely communication and repair of vehicle			

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maintenance issues.

DSP (Direct Support Professional) #1 was interviewed on 3/27/23 at 4:03 PM. DSP #1 stated she had received training to check the van before trips to "make sure (the) seat belts and lights are working. We have a notebook with miles, (and) fuel. Even if we don't get gas (should be completed)." DSP #1 indicated she was aware of one of the seat belts on the green van being broken. DSP #1 stated, "One of the seat belts was broke. Single seat by the double (side) door. We sent it to be serviced. Was maybe a week before [client #1] cut his leg." DSP #1 indicated she had been working at the facility on 2/19/23 but was not on the van at the time of the incident. DSP #1 indicated she was the staff who assisted client #1 to the ER. DSP #1 was not aware of other clients being injured from the broken seat belt.

Client #9 was interviewed on 3/27/23 at 4:17 PM. Client #9 indicated the green van was utilized for outings with larger groups or the other smaller vans were utilized. Client #9 indicated he had scratched his legs on the seat belt in the van. Client #9 physically gestured to his left calf as the location of being scratched. Client #9 indicated he was not certain of a date of his scratches but estimated it was within the past 2 months. Client #9 indicated the nurse had assessed his scratches and he was given a bandage but was not sent to the hospital.

QAC (Quality Assurance Coordinator) and PM were interviewed on 3/27/23 at 4:25 PM. QAC indicated she had completed the 2/22/23 UII. QAC indicated the facility should complete an administrative Peer Review of the investigation. QAC indicated the investigation should be thorough and include interviews with witnesses

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	and potential witnesses. QAC indicated the investigation should include documentation of records and documentation reviewed during the investigation process. QAC indicated she interviewed DSP #2, DSP #3 and client #9. QAC indicated she did not review vehicle logs or maintenance requests or policies. QAC indicated the investigation did not determine how the seat belt was broken or how long it had been broken before client #1's 2/19/23 injury. QAC indicated the recommendations to prevent recurrence were to complete a weekly site review of the vehicle. QAC indicated the investigation did not identify or document other recommendations. ED (Executive Director) was interviewed on 3/27/23 at 12:17 PM. ED indicated allegations of abuse, neglect and mistreatment should be thoroughly investigated. This federal deficiency relates to complaint #IN00402349. 5-1.2			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 4 sampled clients (#1), the facility failed to develop and implement corrective measures to prevent recurrence regarding an injury to client #1 requiring emergency medical care and treatment. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations were reviewed on 3/27/23 at 1:32 PM. The review	W 0157	To correct the deficient practice all members of the QA department as well as any trained investigators have been re-trained by the QAM on the appropriate corrective actions to investigations. Additional monitoring will be achieved by the QAM reviewing all investigations and recommendations prior to being submitted to the ED for final	05/19/2023

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	indicated the following: -BDDS report dated 2/21/23 indicated, "On 2/19/23 at 7:03 PM, while on a sensory awareness van ride, staff (unknown) safely pulled over so that they could move [client #1] to another seat in the company vehicle due to the peer he was sitting next to getting agitated. During the move, [client #1] moved against a broken seatbelt (currently being fixed) which caused a laceration on his right calf and another laceration on his left calf. Staff wrapped a piece of clothing around [client #1's] right calf due to continuous bleeding until they could get back to residential (the facility) to have [client #1] assessed by the nurse. Once they were back in residential, the nurse assessed [client #1] and noted a 2.5 cm (centimeter) laceration on his left leg and a 1 cm laceration on his left leg (sic) and advised staff to transport [client #1] to the [hospital emergency room] due to his left leg continuing to bleed. Once at the hospital, the doctor assessed [client #1], administered 5 stitches to [client #1's] left calf, and made the following diagnosis: Laceration to the right lower leg and left lower leg (sic). No foreign body present. The discharge instruction states; "Protect wounds and keep wound area clean. Keep wounds dry. Apply bacitracin (antibiotic) twice daily. Sutures should be removed in five days." -Unknown Injury Investigation dated 2/22/23 indicated DSP (Direct Support Professionals) #2 and #3 and client #1 were interviewed in the investigation process. DSPs #2 and #3's witness statements did not address if they had completed a pre-trip checklist to ensure the van was in good repair. The Investigation did not include documentation of a review of the vehicle's		approval. Ongoing monitoring will be achieved by the peer review reviewing all investigations for appropriate recommendations.	

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maintenance logs, checklists or training records regarding how DSPs #2 and #3 were to ensure the van was safe and in good repair. The Unknown Injury Investigation dated 2/22/23 indicated, "Recommendations: A monthly site review will be conducted every month which will include an inspection of company vehicles. The company van will be sent off to replaced the seatbelt buckle." The review did not indicate specifically who would be responsible for the monthly site review. The Investigation did not address recommendations regarding pre-trip checklist or how staff would monitor and report issues with the vehicle to prevent re-occurrence. The review did not indicate documentation of a Peer Review of the 2/22/23 Investigation.

QAM (Quality Assurance Manager) and PM (Program Manager) were interviewed on 3/27/23 at 2:00 PM. QAM indicated his role was to review the Unknown Injury Investigation (UII)dated 2/22/23 for thoroughness. QAM indicated a administrative Peer Review was not completed regarding the 2/22/23 UII.

PM indicated two seat belts were not functional. PM indicated she was not aware of how long the seat belts had been broken prior to the 2/19/23 incident. PM indicated staff should complete a vehicle check prior to driving the van. PM indicated staff should document any repair issues on the same form used to document mileage. PM stated, "I can tell you that the prior couple of months they (staff) weren't doing them (vehicle checks). I was told the day (he) got hurt." PM indicated she was not aware of the van seat belts being broken prior to the 2/19/23 incident. PM stated, "Should be reporting maintenance issues to the PM or to someone in administration." PM indicated the RM (Residential Managers)

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completed van training with staff as a component of the facility's OJT (On the Job Training) packet.

QAM indicate the UII did not include documentation of a review of staff's training regarding van checklist completion. QAM indicated the UII did not include documentation of recommendations regarding re-training staff on completing a pre-vehicle inspection or reporting vehicle maintenance issues to the PM or administrative staff.

RM #1 was interviewed on 3/27/23 at 3:39 PM. RM #1 indicated she was working at the facility on 2/19/23 when client #1 injured his leg. RM #1 indicated she was not on the van at the time of the incident. RM #1 indicated the RMs train staff to complete a van checklist before and after using the facility van. RM #1 indicated the checklist included a review of the van to ensure the van was in good repair, head lights and turn signals worked and tires were properly inflated. RM #1 indicated the RMs should ensure staff complete the vehicle checklists. RM #1 indicated she was not aware of any issues with the van's seat belts. RM #1 stated, "I didn't know about that seat belt. It was completely off (plastic cover). I missed it and when they got back and heard he sliced his leg and (sic) went back and checked." RM #1 indicated she had a meeting with her staff to retrain them on completing the checklist. RM #1 indicated there was not documentation of her meeting and was not able to recall if an in-service was completed by administrative staff. RM #1 indicated client #1 was sent to the ER (emergency room) and received stitches on 2/19/23.

RM #2 was interviewed on 3/27/23 at 3:53 PM. RM #2 indicated she had helped train staff regarding the van. RM #2 indicated staff should complete a

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	checklist to ensure the van was in good repair and everything was in working order. RM #2 stated, "The seat belts; we've known for a while. Wasn't aware of the maintenance was going to fall on me. I finally did call and got the green van fixed." RM #2 indicated the van's seatbelts had been repaired on one other previous occasion but did not recall the specifics or dates. RM #2 indicated she was not sure how the seat belts were being damage. RM #2 stated, "We had staff come in an tell us one client (unspecified) had bumped his leg and got a scratch and the nurse reviewed. Think the worst injury was [client #1]." RM #2 indicated other clients had scratched themselves on the seat belts prior to client #1's 2/19/23 incident. RM #2 indicated she did not recall a specific timeframe of when the other incidents occurred. RM #2 indicated client #9 had sustained scratches on his legs from the damaged seat belt in the van. RM #2 stated it was "probably closer to summertime (that she) was aware of damaged areas." RM #2 indicated she did not recall any specific retraining regarding completion of the van checklist or timely communication and repair of vehicle maintenance issues. DSP (Direct Support Professional) #1 was interviewed on 3/27/23 at 4:03 PM. DSP #1 stated she had received training to check the van before trips to "make sure (the) seat belts and lights are working. We have a notebook with miles, (and) fuel. Even if we don't get gas (should be completed)." DSP #1 indicated she was aware of one of the seat belts on the green van being broken. DSP #1 stated, "One of the seat belts was broke. Single seat by the double (side) door. We sent it to be serviced. Was maybe a week before [client #1] cut his leg." Client #9 was interviewed on 3/27/23 at 4:17 PM.			

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Client #9 indicated the green van was utilized for outings with larger groups or the other smaller vans were utilized. Client #9 indicated he had scratched his legs on the seat belt in the van. Client #9 physically gestured to his left calf as the location of being scratched. Client #9 indicated he was not certain of a date of his scratches but estimated it was within the past 2 months. Client #9 indicated the nurse had assessed his scratches and he was given a bandage but was not sent to the hospital.

QAC (Quality Assurance Coordinator) and PM were interviewed on 3/27/23 at 4:25 PM. QAC indicated she had completed the 2/22/23 UII. QAC indicated the facility should complete an administrative Peer Review of the investigation. QAC indicated the recommendations to prevent recurrence were to complete a weekly site review of the vehicle. QAC indicated the investigation did not identify or document other recommendations.

The facility's green van vehicle mileage logs dated from 1/1/23 through 3/27/23 were reviewed on 3/27/23 at 5:30 PM. The vehicle mileage log had a section entitled "Inspection/Issues." There was no identified/documented inspection issues during the 1/1/23 to 3/27/23 review period.

DSP #2's OJT (On the Job Training) dated 11/30/22 was reviewed on 3/27/23 at 5:50 PM. The OJT training packet dated 11/30/22 indicated DSP #2 was trained by RM #2 regarding routine maintenance and reporting issues with the vehicle and completion of the monthly vehicle checklist on 11/30/22.

DSP #3's OJT training dated 8/23/22 was reviewed on 3/27/23 at 5:45 PM. The OJT training packet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	03/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dated 8/23/22 indicated DSP #3 was trained by RM #2 regarding routine maintenance and reporting issues with the vehicle and completion of the monthly vehicle checklist on 8/23/22. The review did not indicate documentation of re-training regarding the routine maintenance or reporting of issues with the vehicle. ED (Executive Director) was interviewed on 3/27/23 at 12:17 PM. ED indicated corrective measures to prevent recurrence should be developed and implemented. This federal deficiency relates to complaint #IN00402349. 5-1.2			