PRINTED: 05/19/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING	00	COMPL	
		15G811	B. W			03/28/	12023
	PROVIDER OR SUPPLIER			1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CAF	RE INC			GREEN	NCASTLE, IN 46135		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG W 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCE		DATE
VV 0000							
Bldg. 00	This visit was for th #IN00402349.	e investigation of complaint	W	0000			
	Complaint #IN00402349: Substantiated, federal						
		es related to the allegations are					
	cited at: W104, W14	49, W153, W154 and W157.					
	Dates of Survey: 3/2	27/23 and 3/28/23.					
	Facility Number: 01	3405					
	Provider Number: 15G811 AIMS Number: 201267570  These deficiencies also reflect state findings in						
	accordance with 410	_					
	Quality Review of the on 4/21/23.	his report completed by #27547					
W 0104	483.410(a)(1) GOVERNING BOI	ΟΥ					
Bldg. 00		dy must exercise general					
		d operating direction over					
	the facility.						0.7/4.0/5.55
		iew and interview for 4 of 4	W (	104	To correct the deficient practic		05/19/2023
		#2, #3 and #4), plus 16 5, #6, #7, #8, #9, #10, #11, #12,			the van has been repaired and		
		#17, #18, #19 and #20), the			deemed safe. All staff have be re-trained any issues found with		
		ed to exercise general policy,			the van are to be reported	uı	
		g direction over the facility to			immediately. Additional		
		van utilized by clients #1, #2,			monitoring will be achieved by	the	
	-	8, #9, #10, #11, #12, #13, #14,			staff completing daily van		
		#19 and #20 was in good repair.			inspections. The RM will revie the inspections weekly. Ongoin		
	Findings include:				monitoring will be achieved by monthly environmental site rev	a	
	The facility's BDDS	(Bureau of Developmental			completed by ResCare		
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	SNATURI	3	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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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 03/28/2023
NAME OF P	ROVIDER 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
	were reviewed on 3 indicated the follow	-		administration staff.	
	at 7:03 PM, while o	1 2/21/23 indicated, "On 2/19/23 in a sensory awareness van n) safely pulled over so that			
	company vehicle du next to getting agita	lient #1] to another seat in the sea to the peer he was sitting steed. During the move, [client steed			
	being fixed) which	a broken seatbelt (currently caused a laceration on his right eration on his left calf.			
	#1's] right calf due they could get back	ce of clothing around [client to continuous bleeding until to residential (the facility) to			
	were back in resider #1] and noted a 2.5	essed by the nurse. Once they ntial, the nurse assessed [client cm (centimeter) laceration on em laceration on his left leg			
	(sic) and advised sta the [hospital emerge	aff to transport [client #1] to ency room] due to his left leg			
	doctor assessed [client #]	ent #1], administered 5  's] left calf, and made the :: Laceration to the right lower			
	leg and left lower le The discharge instru	eg. No foreign body present. uction states; "Protect ound area clean. Keep			
	wounds dry. Apply	bacitracin (antibiotic) twice d be removed in five days."			
	(Program Manager) 2:00 PM. QAM ind	urance Manager) and PM were interviewed on 3/27/23 at icated the investigation of			
	were broken and res	njury determined two seat belts sulted in client #1's injury.			
	PM indicated two se	eat belts were not functional.			

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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. BU	JILDING	00	COMPLETED	
		15G811	B. WI	NG	_	03/28/	/2023
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				BLOOMINGTON STREET		
RES-CAF	RE INC		_	GREEN	CASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		as not aware of how long the		TAG	DEFICIENC 11		DATE
		broken prior to the 2/19/23					
		ted staff should complete a					
	vehicle check prior to driving the van. PM						
	-	ld document any repair issues					
	on the same form us	sed to document mileage. PM					
	-	ou that the prior couple of					
	• ` '	weren't doing them (vehicle					
	· ·	the day (he) got hurt." PM					
		ot aware of the van seat belts					
		to the 2/19/23 incident. PM					
		eporting maintenance issues					
	to the PM or to someone in administration." PM indicated the RM (Residential Managers)						
	· ·	ing with staff as a component					
	-	(On the Job Training) packet.					
	01 4110 140011109 5 00 1	(on the tot 11mmig) pueden					
	RM #1 was intervie	ewed on 3/27/23 at 3:39 PM. RM					
	#1 indicated she wa	s 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					
	· ·	nd when they got back and					
		eg and (sic) went back and					
	checked."						
	RM #2 was intervie	ewed on 3/27/23 at 3:53 PM. RM					
		d helped train staff regarding					
		icated staff should complete a					
		the van was in good repair and					
		vorking order. RM #2 stated,					
		ve known for a while. Wasn't					
		naintenance was going to fall					
	on me. I finally did	call and got the green van					
		eated the van's seatbelts had					
	_	e other previous occasion but					
	_	ecifics or dates. RM #2					
		ot sure how the seat belts					
		. RM #2 stated, "We had staff					
		ne client (unspecified) had					
	bumped his leg and	got a scratch and the nurse					

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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 03/28/2023		
NAME OF I	PROVIDER 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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	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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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	ULTIPLE CO	ONSTRUCTION 00	l ′	(X3) DATE SURVEY COMPLETED	
		15G811	B. WI	NG		03/28	/2023	
NAME OF I	PROVIDER OR SUPPLIEF			1306 S	ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET 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 APPROPRI	ATE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	estimated it was wi #9 indicated the nur and he was given a the hospital.	date of his scratches but thin the past 2 months. Client rese had assessed his scratches bandage but was not sent to ncy relates to complaint						
W 0149	483.420(d)(1)							
Bldg. 00	STAFF TREATMENT OF CLIENTS		W	149	To correct the deficient practistaff have been re-trained Re ANEM policy procedures, reporting policy, and mainten reporting policy. The van has repaired and deemed safe. Additional monitoring will be achieved by the staff complet daily van inspections. The Riveriew the inspections weekly Ongoing monitoring will be achieved by the QIDP/PM/QAC/QAM/ED doir routine drop ins at the facility well as vehicle inspections.	ance been ting M will y.	05/19/2023	
	they could move [c company vehicle do next to getting agita #1] moved against a being fixed) which	lient #1] to another seat in the sea to the peer he was sitting sted. During the move, [client a broken seatbelt (currently caused a laceration on his right eration on his left calf.						

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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	COMPLETED	
		15G811	B. W	'ING		03/28	/2023
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
					BLOOMINGTON STREET		
RES-CAF	RE INC			GREEN	CASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Staff wranned a nie	ce of clothing around [client					
		to continuous bleeding until					
	they could get back to residential (the facility) to						
		essed by the nurse. Once they					
		ntial, the nurse assessed [client					
	_	cm (centimeter) laceration on					
	-	em laceration on his left leg					
		aff to transport [client #1] to					
		ency room] due to his left leg					
	•	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						
		eg. No foreign body present.					
	-	uction states; "Protect					
	-	round area clean. Keep					
	-	bacitracin (antibiotic) twice					
		d be removed in five days."					
	The review indicate	ed the 2/19/23 incident was					
	reported to BDDS of						
	TT 1 T						
		nvestigation dated 2/22/23					
	· ·	ect Support Professionals) #2  I were interviewed in the					
		ss. DSPs #2 and #3's witness					
		address if they had completed					
		to ensure the van was in good					
		ation did not include					
	-	review of the vehicle's					
	maintenance logs, c	hecklists or training records					
	regarding how DSP	s #2 and #3 were to ensure the					
		good repair. The Unknown					
		dated 2/22/23 indicated,					
	"Recommendations: A monthly site review will be						
		onth which will include an					
		any vehicles. The company					
		to replace the seatbelt buckle."					
	The review did not	indicate specifically who					

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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	LETED
		15G811	B. W	ING		03/28	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			BLOOMINGTON STREET		
RES-CAI	RE INC				ICASTLE, IN 46135		
INLO-CAI	\L IIVO			GIVEEN	10/10/10/10/10/10/10/10/10/10/10/10/10/1		
(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
	_	le for the monthly site review.					
	The Investigation d						
		egarding pre-trip checklist or					
		onitor and report issues with					
	the vehicle to prevent recurrence. The review did						
	not indicate documentation of a Peer Review						
	(administrative revi	new) of the 2/22/23					
	Investigation.						
	OAM (Ovality Assurance Manager) and DM						
	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						
		Review was not completed					
		23 UII. QAM indicated the UII					
		t belts were broken and					
	resulted in client #1						
	resurted in elicite wit	. S injury.					
	PM indicated two s	eat belts were not functional.					
	PM indicated she w	vas not aware of how long the					
		broken prior to the 2/19/23					
	incident. PM indica	ated staff should complete a					
	vehicle check prior	to driving the van. PM					
	indicated staff shou	lld document any repair issues					
	on the same form us	sed to document mileage. PM					
	stated, "I can tell yo	ou 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 n	ot aware of the van seat belts					
		to the 2/19/23 incident. PM					
	stated, "Should be r	reporting maintenance issues					
		neone in administration." PM					
	,	Residential Managers)					
		ning with staff as a component					
	of the facility's OJT	(On the Job Training) packet.					
	1	UII did not include					
		review of staff's training					
	regarding van checl	klist completion. QAM					

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

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	A. B	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/28/2023	
NAME OF I	PROVIDER OR SUPPLIEI	3	•	1306 S	DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET CASTLE, IN 46135		
(X4) ID PREFIX	(EACH DEFICIEN	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)		DATE
		id not include documentation as regarding re-training staff on					
		ehicle 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 w	ere properly inflated. RM #1					
		should ensure staff complete					
		sts. RM #1 indicated she was					
	-	sues with the van's seat belts.					
		dn't know about that seat belt.					
		off (plastic cover). I missed it					
		back and heard he sliced his					
		pack and checked." RM #1 meeting with her staff to					
		npleting the checklist. RM #1					
		not documentation of her					
		ot able to recall if an in-service					
	_	administrative staff. RM #1					
		was sent to the ER (emergency					
	room) and received	l stitches on 2/19/23. RM #1					
	indicated staff show	ald report allegations to her					
	_	s to PM. RM #1 indicated the					
	_	rting an allegation was					
		indicated she did not assist in					
		reports or investigations but					
		g staff in the identification and					
		f abuse, neglect and					
		#1 stated neglect included but					
	or safety was taken	'not ensuring a client's needs					
	or sarcty was taken	care O1.					İ

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

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	ENT OF DEFICIENCIES N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  03/28/2023	
NAME OF	PROVIDER OR SUPPLIER	<del></del>		ADDRESS, CITY, STATE, ZIP COD		
	ARE INC			S BLOOMINGTON STREET NCASTLE, IN 46135	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPL	LD BE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	RM #2 was intervie #2 indicated she ha the van. RM #2 indicated she ha the van. RM #2 indichecklist to ensure everything was in v "The seat belts; we' aware of the mainted on one other previorable the specifics or date not sure how the set RM #2 stated, "We one client (unspecific got a scratch and the worst injury was [c other clients had see seat belts prior to client she did of when the other in indicated client #9 legs from the dama stated it was "probashe) was aware of condicated she did not regarding completed timely communicated maintenance issues  DSP (Direct Supposite interviewed on 3/2) she had received tratips to "make sure working. We have fuel. Even if we do completed)." DSP #0 one of the seat belts broken. DSP #1 states.	ewed on 3/27/23 at 3:53 PM. RM d helped train staff regarding icated staff should complete a the van was in good repair and working order. RM #2 stated, we known for a while. Wasn't enance was going to fall on me. d got the green van fixed." RM n's seatbelts had been repaired the soccasion but did not recall these. RM #2 indicated she was at belts were being damage. That had staff come in an tell us fied) had bumped his leg and the enurse reviewed. Think the lient #1]." RM #2 indicated themselves on the lient #1's 2/19/23 incident. RM defined a soccurred. RM #2 that sustained scratches on his god seat belt in the van. RM #2 that sustained scratches on his god seat belt in the van. RM #2 that damaged areas." RM #2 to trecall any specific retraining from of the van checklist or ion and repair of vehicle the seat belts and lights are anotebook with miles, (and) in't get gas (should be #1 indicated she was aware of son the green van being ted, "One of the seat belts was				
ı	I proke Single seaf h	ov the double (side) door. We	1	1		i

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		15G811	B. W	'ING		03/28	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			BLOOMINGTON STREET		
RES-CAF	RE INC				CASTLE, IN 46135		
	Т	CT A TEMENT OF DEFICIENCIE	1	1	•		(V5)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		d. Was maybe a week before	1	IAG			DATE
		eg." DSP #1 indicated she had					
	1	e facility on 2/19/23 but was not					
	on the van at the time of the incident. DSP #1						
		ne staff who assisted client #1					
		was not aware of other clients					
		the broken seat belt.					
	Client #9 was interv	viewed on 3/27/23 at 4:17 PM.					
	Client #9 indicated	the green van was utilized for					
		groups or the other smaller					
		Client #9 indicated he had					
	_	n the seat belt in the van.					
		gestured to his left calf as the					
	_	ratched. Client #9 indicated he					
		date of his scratches but					
		thin the past 2 months. Client					
		rse had assessed his scratches					
	_	bandage but was not sent to					
	the hospital.						
	OAC (Quality Assu	rance Coordinator) and PM					
		n 3/27/23 at 4:25 PM. QAC					
		ompleted the 2/22/23 UII. QAC					
		y should complete an					
		Review of the investigation.					
		investigation should be					
		le interviews with witnesses					
	and potential witnes	sses. QAC indicated the					
	investigation should	d include documentation of					
		entation reviewed during the					
		ss. QAC indicated she					
		2, DSP #3 and client #9. QAC					
		ot review vehicle logs or					
	_	ets or policies. QAC indicated					
		d not determine how the seat					
		how long it had been broken					
		19/23 injury. QAC indicated					
		ns to prevent reoccurrence					
	were to complete a	weekly site review of the					

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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	ETED
		15G811	B. W	'ING		03/28/	/2023
		<u> </u>		STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER 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	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ated the investigation did not					
	1	nt other recommendations.					
	QAC stated neglect was "not taking care of a client. Not meeting their needs." PM indicated						
	_						
		community outing and not					
		ew. PM indicated DSP #2 and					
		orking at the time of the					
	interview.						
	The facility's green	van vehicle mileage logs dated					
		a 3/27/23 were reviewed on					
	_	. The vehicle mileage log had a					
		spection/Issues." There was					
	no identified/documented inspection issues						
	during the 1/1/23 to	3/27/23 review period.					
		the Job Training) dated					
		wed on 3/27/23 at 5:50 PM. The					
		t dated 11/30/22 indicated DSP					
		LM #2 regarding routine					
		porting issues with the vehicle					
	1 -	he monthly vehicle checklist					
	on 11/30/22.						
	DSP #3's OJT traini	ing dated 8/23/22 was reviewed					
		PM. The OJT training packet					
		ated DSP #3 was trained by					
		outine maintenance and					
	1	h the vehicle and completion					
		cle checklist on 8/23/22.					
	_						
		ector) was interviewed on					
		M. ED indicated the abuse policy					
	_	nted, allegations of abuse,					
	1 -	tment should be immediately					
		inistrator and to BDDS within					
		y investigated within 5					
	1	orrective measures to prevent					
	recurrence should b	e developed and implemented.					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	, ,	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 03/28/	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 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)	ATE	(X5) COMPLETION DATE
	reviewed on 3/28/2 Reporting and Inve Exploitation, Mistre Individual's Rights the following:  -"ResCare staff acti and safety of all ind occurrences of abus mistreatment or vio shall be reported to through the appropri will be thoroughly of ResCare, local, s  -"ResCare strictly p exploitation, mistre Individual's rights."  -"Procedures:  1. Any ResCare sta individual is the vio exploitation or mist should immediately and then complete a Program Manager v Director. This step hours.  2. The Program Ma the suspected abuse mistreatment or vio within 24 hours of ta appropriate contact	and Procedures were 3 at 10:30 AM. The facility's stigating Abuse, Neglect, eatment or a Violation of policy dated 1/10/18 indicated  vely advocate for the rights lividuals. All allegations or se, neglect, exploitation, elation of an Individual's rights the appropriate authorities riate supervisory channels and investigated under the policies tate and federal guidelines."  prohibits abuse, neglect, atment, or violation of an individual violation of an individual violation of an individual violation of an individual violation of the Executive should be done within 24  mager, or designee, will report expected, exploitation, elations of Individual's rights the initial report to the se, which may include f. mental Disabilities Service					
	_	Manager will assign an A full investigation will be					

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039		
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY  COMPLETED  03/28/2023	
NAME OF I	PROVIDER OR SUPPLIEF	<b>?</b>	1306 \$	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	conducted by invest training from Labor ResCare's internal pure and investigative cases on witness statement collected."  -"5. An investigative chosen by the Exect discuss the outcome ensure that a thorous completed. Membe include at least one Executive Director for Supported Living representative."	tigators who have received r Relations Association and procedures on investigations."				
W 0153 Bldg. 00	The facility must e mistreatment, neg injuries of unknow immediately to the officials in accorda established proce Based on record rev sampled clients (#1 injury regarding cli medical evaluation	view and interview for 1 of 4 ), the facility failed to report an ent #1 requiring emergency and treatment to BDDS omental Disabilities Services)	W 0153	To correct the deficient practistaff have been re-trained to ensure incident reports are set QA in a timely manner. QA heen re-trained on ensuring a BDDS reports are submitted 24hrs. The QAM will monitor	ent to nas all	

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Findings include:

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incident reports submitted and

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15G811	B. W	ING		03/28	/2023
NAME OF D	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·			ADDRESS, CITY, STATE, ZIP COD	_	
					BLOOMINGTON STREET		
RES-CAF	RE INC			GREEN	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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The facility's DDD	S (Bureau of Developmental			ensure the QA department .  Ongoing monitoring will be		
		s) reports and Investigations			achieved by the Quality and s	afety	
		/27/23 at 1:32 PM. The review			committee review all incident	aicty	
	indicated the follow				reports to ensure they are .		
					,		
	•	d 2/21/23 indicated, "On 2/19/23					
		on a sensory awareness van					
		lled over so that they could					
		another seat in the company					
	-	eer he was sitting next to					
		ring the move, [client #1] bken seatbelt (currently being					
	_	d a laceration on his right calf					
	and another lacerati	<del>-</del>					
	<b></b>	(CAT CAT AND 1010 CM1)					
	Staff wrapped a pie	ce of clothing around [client					
	#1's] right calf due	to continuous bleeding until					
	they could get back	to residential (the facility) to					
		essed by the nurse. Once they					
		ntial, the nurse assessed [client					
	_	cm (centimeter) laceration on					
	-	em laceration on his left leg					
		aff to transport [client #1] to ency room] due to his left leg					
		. Once at the hospital, the					
	-	ent #1], administered 5					
		l's] left calf, and made the					
	-	: Laceration to the right lower					
	leg and left lower le	eg (sic). No foreign body					
	present. The discha	rge instruction states;					
	"Protect wounds an	d keep wound area clean.					
		Apply bacitracin (antibiotic)					
	1	s should be removed in five					
	days."						
	The review indicate	ed the 2/19/23 incident was					
	reported to BDDS						
	reported to DDDs (	ni					
	RM #1 was intervie	owed on 3/27/23 at 3:30 PM_RM					

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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 03/28/2023	
NAME OF P	ROVIDER 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 LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
W 0154 Bldg. 00	(emergency room) a 2/19/23. RM #1 ind allegations to her ar #1 indicated the tim allegation was immediated was immediately reported BDDS within 24 horomorphisms. The facility must halleged violations. Based on record revisampled clients (#1) thoroughly investigation #1 requiring earny treatment.  Findings include:  The facility's BDDS Disabilities Services were reviewed on 3 indicated the follow. BDDS report dated at 7:03 PM, while or ride, staff (unknown they could move [cl. 2015] client #1 requiring earny treatment.	ctor) was interviewed on  M. ED indicated allegations of mistreatment should be ed to the administrator and to nurs.  ENT OF CLIENTS have evidence that all hare thoroughly investigated. Friew and interview for 1 of 4 h, the facility failed to hate an incident of injury to hemergency medical evaluation  G (Bureau of Developmental hs) reports and Investigations  /27/23 at 1:32 PM. The review	W 0154	To correct the deficient pract members of the QA departm well as any trained investiga have been re-trained by the on the components of a thoroustigation. Additional monitoring will be achieved to QAM reviewing all investigat prior to being submitted to the for final approval. Ongoing monitoring will be achieved to routine record reviews by administrative staff to ensure investigations completed are thorough.	ent as tors  QAM ough  by the ions ie ED  by

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	· ′		NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	
		15G811	B. W	TNG	_	03/28/	2023
NAME OF F	DROLUBER OF GUIDNIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	C.		1306 S	BLOOMINGTON STREET		
RES-CAI	RE INC			GREEN	CASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
		ated. During the move, [client					
		a broken seatbelt (currently					
	- '	caused a laceration on his right eration on his left calf.					
	can and another fac	eration on his left carr.					
	Staff wrapped a pie	ce of clothing around [client					
	#1's] right calf due to continuous bleeding until						
		to residential (the facility) to					
	have [client #1] asse	essed by the nurse. Once they					
	were back in reside	ntial, the nurse assessed [client					
	#1] and noted a 2.5	cm (centimeter) laceration on					
	his left leg and a 1 o	em laceration on his left leg					
		aff to transport [client #1] to					
		ency room] due to his left leg					
	_	Once at the hospital, the					
	_	ent #1], administered 5					
	_	l's] left calf, and made the					
		: Laceration to the right lower					
	-	eg. No foreign body present.					
	_	uction states; "Protect					
	_	round area clean. Keep					
		bacitracin (antibiotic) twice					
	daily. Sutures shoul	d be removed in five days."					
	-Unknown Injury Ir	rvestigation dated 2/22/23					
		ect Support Professionals) #2					
		I were interviewed in the					
		ss. DSPs #2 and #3's witness					
		address if they had completed					
		to ensure the van was in good					
		ation did not include					
	documentation of a	review of the vehicle's					
	maintenance logs, c	hecklists or training records					
	regarding how DSP	s #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 mo	onth which will include an					
	inspection of compa	any vehicles. The company					
	van will be sent off	to replaced the seatbelt					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		15G811	B. W	ING		03/28	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF F	PROVIDER OR SUPPLIEF	3			BLOOMINGTON STREET		
RES-CAF	RE INC				ICASTLE, IN 46135		
	Г	OT A TEMENT OF DEPLOYENCE	1		· I		(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		w did not indicate specifically		IAU			DATE
		onsible for the monthly site					
	_	gation did not address					
		egarding pre-trip checklist or					
	how staff would monitor and report issues with						
		ent recurrence. The review did					
		entation of a Peer Review of					
	the 2/22/23 Investigation.						
	QAM (Quality Ass	urance Manager) and PM					
	(Program Manager)	) were interviewed on 3/27/23 at					
	1	licated his role was to review					
		y Investigation (UII) dated					
	_	hness. QAM indicated a					
		Review was not completed					
		23 UII. QAM indicated the UII					
		t belts were broken and					
	resulted in client #1	's injury.					
	QAM indicate the U	III did not include					
	1	review of staff's training					
		klist completion. QAM					
		d not include documentation					
		s regarding re-training staff on					
		ehicle inspection or reporting					
		e issues to the PM or					
	administrative staff	·					
		ewed on 3/27/23 at 3:39 PM. RM					
		as working at the facility on					
		t #1 injured his leg. RM #1					
		ot on the van at the time of the					
		dicated the RMs train staff to					
	_	cklist before and after using					
		I #1 indicated the checklist					
		of the van to ensure the van					
		head lights and turn signals					
		ere properly inflated. RM #1					
		should ensure staff complete sts. RM #1 indicated she was					
I	i me vemete checkiis	sis. Kivi #1 muicaicu siic was	1		l		1

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COM	E SURVEY PLETED 28/2023
NAME OF I	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CO BLOOMINGTON STREE		
RES-CAI	RE INC			NCASTLE, IN 46135	= 1	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AL DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION sues with the van's seat belts.	TAG	DEFICIENCE		DATE
	1	dn't know about that seat belt.				
		off (plastic cover). I missed it				
		back and heard he sliced his				
		back and checked." RM #1				
		meeting with her staff to				
		npleting the checklist. RM #1				
		not documentation of her				
		ot able to recall if an in-service				
		administrative staff. RM #1 was sent to the ER (emergency				
		stitches on 2/19/23.				
	Toom) and received	statemes on 2, 19, 23.				
	RM #2 was intervie	ewed on 3/27/23 at 3:53 PM. RM				
	#2 indicated she ha	d helped train staff regarding				
	the van. RM #2 ind	icated staff should complete a				
	checklist to ensure	the van was in good repair and				
	everything was in v	vorking order. RM #2 stated,				
	"The seat belts; we'	ve known for a while. Wasn't				
		enance was going to fall on me.				
	1	d got the green van fixed." RM				
		n's seatbelts had been repaired				
	_	ous occasion but did not recall				
	1 -	es. RM #2 indicated she was				
		at belts were being damage.				
		had staff come in an tell us fied) had bumped his leg and				
	` *	e nurse reviewed. Think the				
	1 -	lient #1]." RM #2 indicated				
		ratched themselves on the				
		lient #1's 2/19/23 incident. RM				
		d not recall a specific timeframe				
		ncidents occurred. RM #2				
	indicated client #9	had sustained scratches on his				
		ged seat belt in the van. RM #2				
		ably closer to summertime (that				
		lamaged areas." RM #2				
		ot recall any specific retraining				
		on of the van checklist or				
	timely communicat	ion and repair of vehicle				

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

PRINTED: 05/19/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G811		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SUR'         A. BUILDING       00       COMPLETED         B. WING       03/28/202			LETED		
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET		
RES-CAF	RE INC				CASTLE, IN 46135		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	ì ·	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	+	DEFICIENCY		DATE
	maintenance issues.	•					
	DSP (Direct Suppor	rt Professional) #1 was					
		7/23 at 4:03 PM. DSP #1 stated					
		nining to check the van before					
		(the) seat belts and lights are					
	_	a notebook with miles, (and)					
	_	n't get gas (should be					
	completed)." DSP #	‡1 indicated she was aware of					
	one of the seat belts	s on the green van being					
	broken. DSP #1 sta	ted, "One of the seat belts was					
	broke. Single seat b	y the double (side) door. We					
	sent it to be service	d. Was maybe a week before					
		eg." DSP #1 indicated she had					
	1	facility on 2/19/23 but was not					
		ne of the incident. DSP #1					
		ne staff who assisted client #1					
		was not aware of other clients					
	being injured from	the broken seat belt.					
	Client #9 was interv	viewed on 3/27/23 at 4:17 PM.					
	Client #9 indicated	the green van was utilized for					
		groups or the other smaller					
		Client #9 indicated he had					
	_	n the seat belt in the van.					
		gestured to his left calf as the					
		ratched. Client #9 indicated he					
		date of his scratches but					
		thin the past 2 months. Client					
		rse had assessed his scratches					
		bandage but was not sent to					
	the hospital.						
		rance Coordinator) and PM					
		n 3/27/23 at 4:25 PM. QAC					
		ompleted the 2/22/23 UII. QAC					
		y should complete an					
		Review of the investigation.					
		investigation should be					
	thorough and include	le interviews with witnesses					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BU	ILDING	ONSTRUCTION 00	(X3) DATE COMPI	LETED	
		15G811	B. WI	NG		03/28	/2023	
NAME OF P	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD BLOOMINGTON STREET			
RES-CAF	RE INC				NCASTLE, IN 46135			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE	
	-	sses. QAC indicated the dinclude documentation of						
	-	entation reviewed during the						
		ss. QAC indicated she						
		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 recommendation	ns to prevent recurrence were						
	to complete a week	ly site review of the vehicle.						
	QAC indicated the investigation did not identify							
	or document other	recommendations.						
		ector) was interviewed on						
		M. ED indicated allegations of mistreatment should be						
	thoroughly investig							
	thoroughly hivestig	arca.						
	This federal deficie #IN00402349.	ency relates to complaint						
	5-1.2							
W 0157	483.420(d)(4)							
		ENT OF CLIENTS						
Bldg. 00	-	ation is verified, appropriate						
	corrective action r							
		view and interview for 1 of 4	W 0	157	To correct the deficient practi		05/19/2023	
		), the facility failed to develop			members of the QA departme			
	•	rective measures to prevent			well as any trained investigate			
	_	g an injury to client #1  by medical care and treatment.			have been re-trained by the C	Ų.ΑIVI		
	requiring emergenc	y medical care and treatment.			on the appropriate corrective actions to investigations.			
	Findings include:				Additional monitoring will be achieved by the QAM reviewi	ng all		
	-	S (Bureau of Developmental			investigations and			
		es) reports and Investigations			recommendations prior to bei	ng		
	were reviewed on 3	3/27/23 at 1:32 PM. The review			submitted to the ED for final			

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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 _		03/28/	/2023
		ı		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			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	1	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
	indicated the follow	ving:			approval. Ongoing monitoring		
					be achieved by the peer review		
	_	d 2/21/23 indicated, "On 2/19/23			reviewing all investigations for		
		on a sensory awareness van			appropriate recommendations		
	· ·	n) safely pulled over so that					
		lient #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						
		· · · · · · · · · · · · · · · · · · ·					
		caused a laceration on his right					
	call and another lac	eration on his left calf.					
	Stoff wronned a nie	ce of clothing around [client					
		to continuous bleeding until					
	1 2	to residential (the facility) to					
		essed by the nurse. Once they					
		ntial, the nurse assessed [client					
		cm (centimeter) laceration on					
	_	cm laceration on his left leg					
	_	aff to transport [client #1] to					
	1 1	ency room] due to his left leg					
		Once at the hospital, the					
	_	ent #1], administered 5					
		l's] left calf, and made the					
		s: Laceration to the right lower					
		eg (sic). No foreign body					
	_	rge instruction states;					
	1 ~	d keep wound area clean.					
		Apply bacitracin (antibiotic)					
	twice daily. Sutures	s should be removed in five					
	days."						
	1	nvestigation dated 2/22/23					
		ect Support Professionals) #2					
		l were interviewed in the					
		ss. DSPs #2 and #3's witness					
		address if they had completed					
		to ensure the van was in good					
		ation did not include					
	documentation of a	review of the vehicle's					

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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  03/28/2023
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	PROVIDERS PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION (X5)  DULD BE PROPRIATE COMPLETION  DATE
	regarding how DSF van was safe and in Injury Investigation "Recommendations conducted every mainspection of comp van will be sent off buckle." The review who would be respereview. The Investigation of the Investigation of the 2/22/23 Investigation of the 2/22/23 Investigation of the 2/22/23 Investigation of the Investig	urance Manager) and PM ) were interviewed on 3/27/23 at licated his role was to review y Investigation (UII)dated thness. QAM indicated a Review was not completed			

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	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	COMP	E SURVEY PLETED 3/2023
NAME OF F	PROVIDER OR SUPPLIEF	3	1306 S	ADDRESS, CITY, STATE, ZIP CO 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 CORRI (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE AP DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETION DATE
	of the facility's OJT	ning with staff as a component (On the Job Training) packet.				
	regarding van check indicated the UII di of recommendation completing a pre-ve- vehicle maintenance administrative staff RM #1 was intervie #1 indicated she was	review of staff's training klist completion. QAM d not include documentation s regarding re-training staff on chicle inspection or reporting e issues to the PM or				
	incident. RM #1 incomplete a van che the facility van. RM included a review of was in good repair, worked and tires windicated the RMs the vehicle checklis not aware of any issue.	ot on the van at the time of the dicated the RMs train staff to exhist before and after using 1/4 indicated the checklist of the van to ensure the van head lights and turn signals are properly inflated. RM #1 should ensure staff complete sts. RM #1 indicated she was sues with the van's seat belts.				
	It was completely of and when they got leg and (sic) went be indicated she had a retrain them on con- indicated there was meeting and was no was completed by a indicated client #1	dn't know about that seat belt.  off (plastic cover). I missed it back and heard he sliced his back and checked." RM #1 meeting with her staff to apleting the checklist. RM #1 not documentation of her bat able to recall if an in-service administrative staff. RM #1 was sent to the ER (emergency estitches on 2/19/23.				
	#2 indicated she ha	ewed on 3/27/23 at 3:53 PM. RM d helped train staff regarding icated staff should complete a				

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	ENT OF DEFICIENCIES  N OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	ľ	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 03/28/	ETED
	F PROVIDER OR SUPPLIE ARE INC	8		1306 S	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 APPROPRI. DEFICIENCY)	ATE	(X5) COMPLETION DATE
	everything was in v "The seat belts; we aware of the mainte I finally did call an #2 indicated the va on one other previot the specifics or date not sure how the se RM #2 stated, "We one client (unspeci got a scratch and the worst injury was [c other clients had so seat belts prior to c #2 indicated she did of when the other i indicated client #9 legs from the dama stated it was "proba she) was aware of c indicated she did in regarding completi timely communicat maintenance issues  DSP (Direct Suppo- interviewed on 3/2 she had received tr trips to "make sure working. We have fuel. Even if we do completed)." DSP i one of the seat belt broken. DSP #1 sta broke. Single seat to sent it to be service [client #1] cut his 1	art Professional) #1 was 7/23 at 4:03 PM. DSP #1 stated aining to check the van before (the) seat belts and lights are a notebook with miles, (and) n't get gas (should be #1 indicated she was aware of s on the green van being ted, "One of the seat belts was by the double (side) door. We dd. Was maybe a week before					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	ľ	JILDING	nstruction 00	(X3) DATE COMPL 03/28/	ETED		
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			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	outings with larger vans were utilized. scratched his legs of Client #9 physically location of being so was not certain of a estimated it was wi #9 indicated the nur and he was given a the hospital.  QAC (Quality Assawere interviewed or indicated she had confidered the facility administrative Peer QAC indicated the recurrence were to of the vehicle. QAC did not identify or or recommendations.  The facility's green from 1/1/23 through 3/27/23 at 5:30 PM section entitled "Instead of the indicated the indicated the recurrence were to of the vehicle. QAC did not identify or or recommendations.  The facility's green from 1/1/23 through 3/27/23 at 5:30 PM section entitled "Instead of the indicated the indicated the indicated the recurrence were to of the vehicle. QAC did not identify at the indicated the recurrence were to of the vehicle. QAC did not identify at the indicated the recurrence were to of the vehicle. QAC did not identify at the indicated the recurrence were to of the vehicle. QAC did not identify at the indicated the recurrence were to of the vehicle. QAC did not identify at the recurrence were to of the vehicle. QAC did not identify at the recurrence were to of the vehicle. QAC did not identify at the recurrence were to of the vehicle. QAC did not identify at the recurrence were to of the vehicle. QAC did not identify at the recurrence were to of the vehicle. QAC did not identify at the recurrence were to of the vehicle. QAC did not identify at the recurrence were to of the vehicle. QAC did not identify at the recurrence were to of the vehicle. QAC did not identify at the recurrence were to of the vehicle. QAC did not identify at the recurrence were to of the vehicle. QAC did not identify at the recurrence were to of the vehicle. QAC did not identified the recurrence were to of the vehicle. QAC did not identified the recurrence were to of the vehicle. QAC did not identified the recurrence were to of the vehicle. QAC did not identified the recurrence were to of the vehicle. QAC did not identified the re	the green van was utilized for groups or the other smaller Client #9 indicated he had in the seat belt in the van. It gestured to his left calf as the ratched. Client #9 indicated he date of his scratches but thin the past 2 months. Client rese had assessed his scratches bandage but was not sent to the arrance Coordinator) and PM in 3/27/23 at 4:25 PM. QAC completed the 2/22/23 UII. QAC by should complete an Review of the investigation. It indicated the investigation document other was vehicle mileage logs dated in 3/27/23 were reviewed on a recommendations to prevent complete a weekly site review and the investigation document other. The vehicle mileage log had a spection/Issues." There was mented inspection issues in 3/27/23 review period.  The bob Training dated wed on 3/27/23 at 5:50 PM. The indicated 11/30/22 indicated DSP in the dated 11/30/22 indicated DSP in the dated 11/30/22 indicated DSP in the dated 11/30/22 was reviewed in gearing issues with the vehicle the monthly vehicle checklist in gate dated 8/23/22 was reviewed in gate dated 8/23/							

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G811	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/28/2023			
NAME OF P	ROVIDER OR SUPPLIER	<b>1</b>	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 CROSS-REFERENCED TO THE APPRODE 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.							

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