PRINTED:	06/07/2023
FORM API	PROVED

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255 NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			154 CH	ALLLES, IN 47042	OMB NO. 0938-039 3) DATE SURVEY COMPLETED 05/10/2023
(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 APPROPRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
W 0000 Bldg. 00	#IN00407693. Complaint #IN004 related to the allega W104, W122, W14 Survey dates: April and 10, 2023 Facility Number: 0 Provider Number: 10 These deficiencies accordance with 46 Quality Review of	15G255 0248960 also reflect state findings in 0 IAC 9.	W 0000		
W 0102 Bldg. 00	accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/16/23. 483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview for 7 of 8 clients (A, C, D, E, F, G and H) the facility was designated as the representative payee, the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to ensure the clients' funds were not exploited by the Office Coordinator. The governing body failed to provide sufficient oversight of the clients' funds to prevent exploitation of their funds entrusted to the facility. The governing body failed to ensure there were sufficient checks and balances in place to prevent the clients' funds from being mismanaged and		W 0102	W102: The facility failed to exercise general policy, budget and operating direction over the facility to implement its written policies and procedures to ensur the group home was operated in clean and sanitary manner. The governing body failed to exercise general policy, budget and operating direction over the facili to ensure the facility met the Condition of Participation. The governing body failed to exercise	a e ity

 LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
 TITLE
 (X6) DATE

 Anna Brison
 Program Director
 05/24/2023

 Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin
 etcamp of program Director

 ather software of provide sufficient protocol in the protection to the protection to the protection of the protection of the findings stated above are disclosed to the protection.
 etcamp of protection of the protection of the

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.

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/ AND PLAN OF CORRECTION IDENTIFICATION 15G255	N NUMBER	X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/10/2023
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVE	S SE IN	154 C	t address, city, state, zip cod CHAD DR SAILLES, IN 47042	
(X4) IDSUMMARY STATEMENT OFPREFIX(EACH DEFICIENCY MUST BE PRTAGREGULATORY OR LSC IDENTIFYI	ECEDED BY FULL NG INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAGREGULATORY OR LSC IDENTIFYIstolen. The governing body failed did not neglect client A by leaving unsupervised.Findings include:1) Please refer to W104. For 7 of D, E, F, G and H) the facility was representative payee, the governin to exercise operating direction ove ensure the clients' funds were not of Office Coordinator. The governing provide sufficient oversight of the to prevent exploitation of their fund there were sufficient checks and by to prevent the clients' funds from the mismanaged and stolen. The facility body failed to account for the client the penny. The governing body fa staff did not neglect client A by leaving to meet the Condition of Participat Protections. The governing body fa the clients' funds were not exploite Coordinator. The governing body fa2) Please refer to W122. For 7 of D, E, F, G and H) the facility was representative payee, the governing to meet the Condition of Participat Protections. The governing body fa the clients' funds were not exploite Coordinator. The governing body fa the clients' funds were not exploite to prevent exploitation of their fund the facility. The governing body fa	NG INFORMATION to ensure staff him at home '8 clients (A, C, designated the g body failed to the facility to exploited by the g body failed to clients' funds ds entrusted to ailed to ensure alances in place being ty's governing nts' finances to iiled to ensure aving him at '8 clients (A, C, designated as the g body failed tion: Client failed to ensure ed by the Office failed to clients' funds ds entrusted to ailed to ensure aving him at		general policy, budget and operating direction over the fa- to ensure the facility met the condition of participation. Corrective Action: All staff trained on the At and Neglect Exploitation Police (Attachment A) All Management staff tra on updated Financial Preventa Measures that were put into p to prevent further misappropri of client funds and to ensure financial accuracy to the penn (Attachment B) Area Supervisors trained updated procedures to requess client funds from their RFMS accounts. (Attachment C) Office Coordinator termin from Rescare for the theft of c funds. (Attachment D) Rescare Management created a spreadsheet to track client reimbursements to ensu- all client meetings are conduc reimbursement is received an deposited into clients RFMS accounts. Rescare reimbursed client for missing money (\$18.00). (Attachment E) Rescare reimbursed client	acility buse bus
to prevent the clients' funds from b mismanaged and stolen. The gove failed to account for the clients' fir penny. The governing body failed did not neglect client A by leaving unsupervised.	erning body nances to the to ensure staff		for missing money (\$2604.00) (Attachment F) · Rescare reimbursed clien for missing money (\$134.00). (Attachment G) · Rescare reimbursed clien	nt D

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Event ID: LWFE11 Facility ID: 000775

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE COMPL 05/10/	LETED
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			154 CH	ADDRESS, CITY, STATE, ZIP COD HAD DR AILLES, IN 47042		
(X4) ID PREFIX TAG	(EACH DEFICIE	Ý STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLET DATE
		lates to complaint #IN00407693.		for missing money (\$104.00). (Attachment H) • Rescare reimbursed clief for missing money (\$82.00). (Attachment I) • Rescare reimbursed clief for missing money (\$7734.00) (Attachment O) • Rescare reimbursed clief for missing money (\$194.00). (Attachment T) • Financial Audits will be conducted by Rescare Management 3 times weekly no less than 60 days to audit financials in the facility. (Attachment J) • Daily calls are conducte with Rescare Management to discuss financial processes a procedures, financial policies implementation of those polic and are tracked by the Qualit Assurance Manager. • Area Supervisor weekly check updated to include listi the amount of money each cl has in the facility as well as th RFMS balance. (Attachment • Area Supervisor/QIDP completes a monthly summa that includes clients financial totals from RFMS and Cash of Hand in the facility. (Attachment L) • Rescare Management I been granted access to view clients RFMS statements as needed to ensure all client fu are accounted for. (Attachment • Rescare Management I been granted access to view	ent F ent G i). ent H for all d ound and cies. y / ng ient ne : K) ry on ent has all nds	DATE

TATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G255	A. BUILDING B. WING	00	completed 05/10/2023
AME OF F	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		AILLES, IN 47042	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
REFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				M)	
				Area Supervisor conducts	
				monthly house meetings to rev	lew
				items as needed, the Abuse	
				Neglect Exploitation Policy are	
				included in this meeting as wel the finance policy and procedu	
				process. (Attachment N)	
				• All client requests that are	<u>_</u>
				completed asking that funds be	
				sent to their funeral trust, ARC	
				Able trust accounts will be	
				processed through their RFMS	;
				accounts and the checks will b	
				made out directly to the vendor	rs
				and will be sent certified to	
				ensure we have supporting	
				documentation that it was	
				received.	
				Once client requests are	
				processed and checks are prin	
				an approved signer will go to the	
				bank and deposit the checks.	
				following day an approved sigr will go to the bank and withdra	
				the funds for the clients and re	
				to the office to deposit the fund	
				into the safe until clients are	
				brought to the office to pick up	and
				sign out their funds they had	
				requested.	
				· The Program Manager,	
				Program Director and Business	s
				Manager will rotate weekly and	l will
				audit any funds in the safe wee	ekly
				and sign the safe ledger	
				acknowledging the amounts ar	e
				accurate.	

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Event ID: LWFE11 Facility ID: 000775

If continuation sheet Page 4 of 75

	T OF DEFICIENCIES DF CORRECTION	x1) provider/supplier/clia identification number 15G255	A. BUILDING <u>00</u> COM			e survey pleted 0/2023
	ROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	1	REET ADDRESS, CITY, STATE, ZIF 54 CHAD DR ERSAILLES, IN 47042	P COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	II PRE T/	PROVIDER'S PLAN OF C	N SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
				Monitoring of Corre Action: Area Supervisor weekly check that indentify balance of the in hour to the Program Mana- and to ensure complet Daily calls are of during the condition of Rescare Management Weekly adversed calls with Senior Direc Quality Support and Operation Support S Rescare Management condition level finding progress on citations complaint survey. Observation for to the Program Mana- monitoring, follow up ensure completion. Financial Audit completed 3 times with Rescare Management the Program Management the Program Director for ensure completion. All financial requisite spending will be apple Executive Director, a exceed \$499 will req Director approval for QIDP will compi monthly summary and IDT team. The monthi includes RFMS balances for	r submits cludes the use finances ager for review etion. conducted period with nt. e actions ector of Rescare pecialist with nt to monitor gs and a noted during ms are sent ager for and to will be eekly by nt and sent to er and review and to uests for roved by the umounts that uire Regional processing. lete a ad send to the nly summary nces as well	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN OF CORRECTION				JILDING	00		LETED
		15G255	B. WI)/2023
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COI HAD DR)	
RES CAP	RE COMMUNITY A	ALTERNATIVES SE IN			AILLES, IN 47042		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					in the facility.		
					Completion Date: 5/27/	23	
N 0104	483.410(a)(1)						
	GOVERNING BC	DDY					
Bldg. 00	The governing bo	ody must exercise general					
		nd operating direction over					
	the facility.						
		view and interview for 7 of 8	W C	0104	W104: The governing bo		05/27/2023
		, F, G and H) the facility was			exercise general policy, l		
		resentative payee, the iled to exercise operating			and operating direction of	over the	
		facility to ensure the clients'			facility. Corrective Action:		
		bloited by the Office			• All staff trained on t	he Abuse	
	-	governing body failed to			and Neglect Exploitation		
		oversight of the clients' funds			(Attachment A)	,	
	to prevent exploita	tion of their funds entrusted to			· All Management sta	aff trained	
		overning body failed to ensure			on updated Financial Pre		
		nt checks and balances in place			Measures that were put i		
	-	nts' funds from being			to prevent further misapp	•	
	-	tolen. The facility's governing			of client funds and to ens		
		ount for the clients' finances to verning body failed to ensure			financial accuracy to the	penny.	
		t client A by leaving him at			(Attachment B) · Area Supervisors tr	ained on	
	home unsupervise				updated procedures to re		
					client funds from their RF	-	
	Findings include:				accounts. (Attachment C Office Coordinator t	C)	
	1) Please refer to	W140. For 7 of 8 clients (A, C,			from Rescare for the the		
		the governing body was			funds. (Attachment D)		
		epresentative payee, the			· Rescare Manageme	ent	
		g body failed to account for the			created a spreadsheet to		
	clients' finances to				client reimbursements to		
	2) Dianso rator ta	W140 for 7 of 8 clients (A.C.D.			all client meetings are co		
	21 r lease refer to	W149. for 7 of 8 clients (A, C, D,	1		reimbursement is receive	eu and is	1

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 05/10/2023	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	154 CI	ADDRESS, CITY, STATE, ZIP COD HAD DR AILLES, IN 47042		
RES CA (X4) ID PREFIX TAG	SUMMARY (EACH DEFICIE REGULATORY O E, F, G and H) the as the representati to implement its p prevent financial o conduct a thoroug names of the clien money stolen from did not neglect cli unsupervised.	ALTERNATIVES SE IN (STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION (governing body was designated (ve payee, the facility neglected olicies and procedures to exploitation of the clients, h investigation including the ts affected and the amount of n each client, and ensure staff ent A by leaving him at home lates to complaint #IN00407693.	VERS/ ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) deposited into clients RFMS accounts. • Rescare reimbursed clie for missing money (\$18.00). (Attachment E) • Rescare reimbursed clie for missing money (\$2604.00 (Attachment F) • Rescare reimbursed clie for missing money (\$134.00) (Attachment G) • Rescare reimbursed clie for missing money (\$134.00) (Attachment G) • Rescare reimbursed clie for missing money (\$104.00) (Attachment H) • Rescare reimbursed clie for missing money (\$104.00) (Attachment I) • Rescare reimbursed clie for missing money (\$7734.00 (Attachment O) • Rescare reimbursed clie for missing money (\$194.00) (Attachment T) • Financial Audits will be conducted by Rescare	ent A ent C)). ent D • ent E • ent F ent G)). ent H	(X5) COMPLETIG DATE
				Management 3 times weekly no less than 60 days to audit financials in the facility. (Attachment J) Daily calls are conducted with Rescare Management to discuss financial processes a procedures, financial policies implementation of those polic and are tracked by the Qualit Assurance Manager. Area Supervisor weekly check updated to include list the amount of money each co has in the facility as well as t	all and and cies. ty y ing lient	

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	· · · · · · · · · · · · · · · · · · ·	(3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER 15G255	A. BUILDING B. WING	<u>00</u>	COMPLETED 05/10/2023
NAME OF PI	ROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD	
RES CAR		ALTERNATIVES SE IN		IAD DR AILLES, IN 47042	
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETI
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				RFMS balance. (Attachment K	
				Area Supervisor/QIDP	
				completes a monthly summary	
				that includes clients financial totals from RFMS and Cash on	
				Hand in the facility.(Attachment	.
				L)	•
				Rescare Management has	
				been granted access to view all	
				clients RFMS statements as	
				needed to ensure all client fund	S
				are accounted for. (Attachment	:
				M)	
				Area Supervisor conducts	
				monthly house meetings to revie	
				items as needed, the Abuse and	t l
				Neglect Exploitation Policy is	
				included in this meeting as well	
				the finance policy and procedure	e
				process.(Attachment N) All client requests that are 	
				completed asking that funds be	
				sent to their funeral trust, ARC of	or
				Able trust accounts will be	
				processed through their RFMS	
				accounts and the checks will be	
				made out directly to the vendors	6
				and will be sent certified to	
				ensure we have supporting	
				documentation that it was	
				received.	
				Once client requests are	ad
				processed and checks are print an approved signer will go to the	
				bank and deposit the checks. The	
				following day an approved signed	
				will go to the bank and withdraw	
				the funds for the clients and retu	
				to the office to deposit the funds	
				into the safe until clients are	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	СОМ	(X3) DATE SURVEY COMPLETED 05/10/2023	
	ROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	154 CH	ADDRESS, CITY, STATE, ZIP C IAD DR AILLES, IN 47042	OD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETIC DATE	
TAG		R LSC IDENTIFYING INFORMATION		brought to the office to sign out their funds the requested. The Program Mar Program Director and E Manager will rotate were audit any funds in the sa and sign the safe ledge acknowledging the ame accurate. Monitoring of Correcti Action: Area Supervisor s weekly check that inclue balance of the in house to the Program Manage and to ensure completi Daily calls are cor during the condition pe Rescare Management. Weekly adverse a calls with Senior Direct Quality Support and Re Operation Support Spe Rescare Management condition level findings progress on citations n complaint survey. Observation forms to the Program Manage monitoring, follow up al ensure completion. Financial Audit wi completed 3 times wee Rescare Management the Program Manager a Program Director for re	pick up and y had ager, Business ekly and will safe weekly or ounts are ive submits ides the e finances er for review on. inducted riod with actions or of escare ecialist with to monitor and oted during s are sent er for nd to II be ekly by and sent to and	DATE	

	F OF DEFICIENCIES	V1) DDOVIDED/CUDDI IED/CUIA				
	F CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIPLE (A. BUILDING B. WING	00	(X3) DATE COMPI 05/10	
	ROVIDER OR SUPPLIE	LTERNATIVES SE IN	154 C	f address, city, state, zip cod HAD DR AILLES, IN 47042	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
				 All financial requests for spending will be approved by Executive Director, amounts for exceed \$499 will require Reg Director approval for processition QIDP will complete a monthly summary and send to IDT team. The monthly summary includes RFMS balances as we as cash balances for each clining in the facility. Completion Date: 5/27/23 	the chat ional ing. o the nary vell	
W 0122 Bldg. 00	clients. Therefore Based on record re clients (A, C, D, E, designated as the re facility failed to me Participation: Clier failed to ensure the exploited by the Of failed to provide su funds to prevent ex entrusted to the face ensure there were so in place to prevent mismanaged and st account for the clief facility failed to en	ensure the rights of all	W 0122	 W122: The facility must ensure that specific client protections met. Corrective Action: All staff trained on the A and Neglect Exploitation Police (Attachment A) All Management staff trained on updated Financial Prevent Measures that were put into p to prevent further misappropriof client funds and to ensure financial accuracy to the pening (Attachment B) Area Supervisors trained updated procedures to requesic client funds from their RFMS 	buse cy. hined ative blace iation hy.	05/27/202

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION (2) 00	x3) date survey completed 05/10/2023
RES CA	1		STREET A	ILLES, IN 47042	(X5)
PREFIX TAG	REGULATORY O	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
	 D, E, F, G and H) representative paye for the clients' fina 2) Please refer to T D, E, F, G and H) representative paye implement its policifinancial exploitation thorough investigan clients affected and from each client, and client A by leaving 3) Please refer to T D, E, F, G and H) representative paye a thorough investigant the clients affected and representative paye 	the facility was designated as the ee, the facility failed to account inces to the penny. W149. For 7 of 8 clients (A, C, the facility was designated as the ee, the facility neglected to cies and procedures to prevent ion of the clients, conduct a tion including the names of the d the amount of money stolen nd ensure staff did not neglect g him at home unsupervised. W154. For 7 of 8 clients (A, C, the facility was designated as the ee, the facility failed to conduct gation including the names of l and the amount of money		 Office Coordinator terminal from Rescare for the theft of clia funds. (Attachment D) Rescare Management created a spreadsheet to track a client reimbursements to ensure all client meetings are conducter reimbursement is received and deposited into clients RFMS accounts. Rescare reimbursed client for missing money (\$18.00). (Attachment E) Rescare reimbursed client for missing money (\$2604.00). (Attachment F) Rescare reimbursed client for missing money (\$2604.00). (Attachment F) Rescare reimbursed client for missing money (\$134.00). (Attachment G) Rescare reimbursed client for missing money (\$104.00). (Attachment H) Rescare reimbursed client for missing money (\$104.00). (Attachment H) Rescare reimbursed client for missing money (\$104.00). (Attachment H) Rescare reimbursed client for missing money (\$120.00). (Attachment I) Rescare reimbursed client for missing money (\$194.00). (Attachment I) Rescare reimbursed client for missing money (\$194.00). (Attachment O) Rescare reimbursed client for missing money (\$194.00). (Attachment T) Diancial Audits will be conducted by Rescare Management 3 times weekly for no less than 60 days to audit all financials in the facility. (Attachment J) Daily calls are conducted with Rescare Management to discuss financial processes and 	rted ent all e ed, is A C C C F C F C G C H

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Event ID: LWFE11 Facility ID: 000775

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PRINTED: 06/07/2023 FORM APPROVED

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	·	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G255	A. BUILDING B. WING	<u>00</u>	COMPLETED 05/10/2023	
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY A	ALTERNATIVES SE IN		HAD DR AILLES, IN 47042		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET DATE	
				procedures, financial policies ar implementation of those policies and are tracked by the Quality Assurance Manager. • Weekly adverse actions calls with Senior Director of Quality Support and Rescare Operation Support Specialist wi Rescare Management to monito condition level findings and progress on citations noted duri complaint survey. • Area Supervisor weekly check updated to include listing the amount of money each clier has in the facility as well as the RFMS balance. (Attachment K • Area Supervisor/QIDP completes a monthly summary that includes clients financial totals from RFMS and Cash on Hand in the facility. (Attachment L) • Rescare Management has been given access to view all clients RFMS statements as needed to ensure all client fund are accounted for. (Attachment M) • Area Supervisor conducts monthly house meetings to revisi items as needed, the Abuse and Neglect Exploitation Policy is included in this meeting as well the finance policy and procedure process.(Attachment N) • All client requests that are completed asking that funds be sent to their funeral trust, ARC of Able trust accounts will be	th or ng tt s s t ew d as e	

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	onstruction ((X3) DATE SURVEY COMPLETED	
AND I LAN C	JI CORRECTION	15G255	B. WING	<u></u>	05/10/2023	
NAME OF PI	ROVIDER OR SUPPLII	ER		ADDRESS, CITY, STATE, ZIP COD		
RES CAR	E COMMUNITY	ALTERNATIVES SE IN		HAD DR AILLES, IN 47042		
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETI DATE	
1710	REGULATORI		ind	processed through their RFMS		
				accounts and the checks will be	e	
				made out directly to the vendor	S	
				and will be sent certified to		
				ensure we have supporting		
				documentation that it was received.		
				· Once client requests are		
				processed and checks are prin	ted	
				an approved signer will go to the		
				bank and deposit the checks. T		
				following day an approved sign	er	
				will go to the bank and withdraw	N	
				the funds for the clients and ref		
				to the office to deposit the fund	s	
				into the safe until clients are	and	
				brought to the office to pick up sign out their funds they had	anu	
				requested.		
				• The Program Manager,		
				Program Director and Business	3	
				Manager will rotate weekly and		
				audit any funds in the safe wee	•kly	
				and sign the safe ledger		
				acknowledging the amounts ar	e	
				accurate.		
				Monitoring of Corrective		
				Action:		
				Area Supervisor submits		
				weekly check that includes the		
				balance of the in house finance		
				to the Program Manager for rev	liew	
				and to ensure completion. • Daily calls are conducted		
				during the condition period with	,	
				Rescare Management.	·	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMP	LETED	
		15G255	B. WING	ì		05/10	05/10/2023	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
		ALTERNATIVES SE IN			IAD DR NLLES, IN 47042			
	1							
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETIO	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
					 Weekly adverse actions 			
					calls with Senior Director of			
					Quality Support and Rescare			
					Operation Support Specialist			
					Rescare Management to more	nitor		
					condition level findings and			
					progress on citations noted d	uring		
					complaint survey.			
					 Observation forms are s 	ent		
					to the Program Manager for			
					monitoring, follow up and to			
					ensure completion.			
					Financial Audit will be			
					completed 3 times weekly by			
					Rescare Management and se	ent to		
					the Program Manager and			
					Program Director for review a	and to		
					ensure completion.			
					· All financial requests for			
					spending will be approved by	the		
					Executive Director, amounts	that		
					exceed \$499 will require Reg	ional		
					Director approval for process			
					· QIDP will complete a	U		
					monthly summary and send t	o the		
					IDT team. The monthly summ			
					includes RFMS balances as			
					as cash balances for each cli	ent		
					in the facility.			
					Completion Date: 5/26/23			
10140								
/ 0140	483.420(b)(1)(i)							
	CLIENT FINANC							
Bldg. 00		establish and maintain a						
		res a full and complete ents' personal funds						
							1	

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	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G255	î î	JILDING	<u>00</u>	(3) DATE SURVEY COMPLETED 05/10/2023	
	PROVIDER OR SUPPLI	^{ER} ALTERNATIVES SE IN		154 CH	address, city, state, zip cod HAD DR AILLES, IN 47042		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH		(X5) COMPLETIO	
TAG	REGULATORY O	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	Based on record record record record record record records (A, C, D, Federation and the records record			0140	W140: The facility must establis and maintain a system that assures a full and complete accounting of client's personal funds and entrusted to the facility on behalf of the clients.		
	i manigs metade.				Corrective Action:		
	On 4/25/23 at 4:00	6 PM, a review of the facility's			· All staff trained on the Abu	se	
		as conducted and indicated the			and Neglect Exploitation Policy.	у.	
	following:		(Attachment A)				
					· All Management staff train	ed	
		of Developmental Disabilities			on updated Financial Preventati	ve	
		incident report indicated, "There			Measures that were put into pla	ce	
	-	ation of misappropriation of			to prevent further misappropriat	ion	
		it of the account is being			of client funds and to ensure		
		nount of funds is undetermined			financial accuracy to the penny.		
		alleged to be responsible for			(Attachment B)		
		of funds has been suspended			Area Supervisors trained o	n	
		tion. In addition, the police have			updated procedures to request		
		the initial case number is [case			client funds from their RFMS		
		nds proven to be missing will be			accounts. (Attachment C)		
	reimbursed by Re	sCare"			Office Coordinator termina		
	0 5/4/02 + 2.40				from Rescare for the theft of clie	ent	
		PM, a review of the clients'			funds. (Attachment D)		
		anagement Service (RFMS) d the clients had the following			Rescare Management		
		dulent" from their accounts:			created a spreadsheet to track a client reimbursements to ensure all client meetings are conducte	;	
	1) Client A: \$18.0	00			reimbursement is received and		
	2) Client C: \$260				deposited into clients RFMS		
	3) Client D: \$134				accounts.		
	4) Client E: \$104				· Rescare reimbursed client	A	
	5) Client F: \$82.0				for missing money (\$18.00).		
	6) Client G: \$773				(Attachment E)		
	7) Client H: \$194				Rescare reimbursed client	с	
	Total: \$10870.00				for missing money (\$2604.00). (Attachment F)		
	The facility's 4/26	/23 Investigative Summary			Rescare reimbursed client	D	

	T OF HEALTH AND HU R MEDICARE & MEDIO						RM APPROV IB NO. 0938-	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPI	LETED	
		15G255	B. W	ING		05/10	05/10/2023	
NAME OF	PROVIDER OR SUPPLIE	۲. ۲.		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF	I KO VIDEK OK SOTTELE			154 CH	IAD DR			
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN		VERSA	AILLES, IN 47042			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLET	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	indicated in the Co	onclusion, "It is substantiated			for missing money (\$134.00).			
	[Office Coordinate	or/OC] embezzled client and			(Attachment G)			
	ResCare funds from	m [name of bank] 'pass through'			· Rescare reimbursed clie	nt E		
	account. It is subs	tantiated [OC] exploited clients			for missing money (\$104.00).			
	through theft of cli	ient funds." The investigation's			(Attachment H)			
	statement from the	Business Office Manager			Rescare reimbursed clie	nt F		
	(BOM) indicated,	"[BOM] was asked what			for missing money (\$82.00).			
	issue(s) he noticed	with the pass-through			(Attachment I)			
	expenditures accou	unt and if he had spoken with			Rescare reimbursed clie	nt G		
	any other business	office staff about the issue.			for missing money (\$7734.00)			
	He replied with the	e following email: 'When			(Attachment O)			
	reviewing the "pas	s through" account statements			Rescare reimbursed clie	nt H		
	on 4/11/2023, I no	ticed previous ending balances			for missing money (\$194.00).			
	were below the arr	nount of funds ResCare funded			(Attachment T)			
	the account with.	I knew there had to be an issue			Financial Audits will be			
	because the initial	balance on the account should			conducted by Rescare			
	remain the same, g	given no bank fees occurred, as			Management 3 times weekly f	or		
		d and withdrawn in the same			no less than 60 days to audit a			
		reviewing the statements and			financials in the facility.			
		deposits and withdrawals, I			(Attachment J)			
		to [OC]. I made comments			· Daily calls are conducted	ł		
		something is off with the			with Rescare Management to			
	-	tting at her desk as I was			discuss financial processes ar			
		vas occupied, signing client			procedures, financial policies			
		Her direct involvement in the			implementation of those polici			
		at time was minimal. I did not			and are tracked by the Quality			
		larch 2023) statement, so I			Assurance Manager.			
		and went to the bank to get a			· Area Supervisor weekly			
		he statement, I noticed the			check updated to include listin			
		0.86. After getting the most			the amount of money each cli	-		
		went back to the office and had			has in the facility as well as th			
		h [Quality Assurance			RFMS balance. (Attachment			
		I asked [QAM] if she had time			· Area Supervisor/QIDP	,		
		professional opinion and brief			completes a monthly summar	v		
		ons I had. She did have time			that includes clients financial	,		

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experiencing.

and we spoke in private in the ResCare

lunchroom. I explained to her what the "pass

through" account was and how we utilized it. In

addition, I showed her the discrepancies we were

Event ID:

LWFE11

Facility ID: 000775

L)

If continuation sheet

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totals from RFMS and Cash on

Hand in the facility.(Attachment

been granted access to view all

Rescare Management has

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/10/2023	
NAME OF	PROVIDER OR SUPPLIE	ER		STREET A	ADDRESS, CITY, STATE, ZIP COD		
RES CA	RE COMMUNITY /	ALTERNATIVES SE IN			AILLES, IN 47042		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	OMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					clients RFMS statements as		
	After the conversa	tion, I explained I was not sure			needed to ensure all client fund	ls	
	what the next step	s were going to be and had to			are accounted for. (Attachmen	t	
	bring [ED], up to o	date. This concluded our			M)		
	conversation. Sho	ortly after having the			Area Supervisor conducts	;	
	conversation with	[QAM], I asked [OC] to join me			monthly house meetings to rev		
		e could review it together. As			items as needed, the Abuse ar		
	we sat down at the	table, I pointed out the			Neglect Exploitation Policy is		
	September 2022 st	tatement. This was the first			included in this meeting as wel	as	
	-	balance dropped below the			the finance policy and procedu		
		unded it with (\$7000.00). I then			process.(Attachment N)		
		month showing the influx in			· All client requests that are		
	-	was about to continue my			completed asking that funds be		
		hat we were looking for, [OC]			sent to their funeral trust, ARC		
	stopped me and said, "I did it. I took the money. I'm so sorry." I did not say anything right away				Able trust accounts will be		
				processed through their RFMS			
		She continued to cry and			accounts and the checks will b		
		ize stating she would pay it all			made out directly to the vendor		
		e need to go talk to [Human			and will be sent certified to ens		
		er/HRM]. She explained she			we have supporting documenta		
		rith [ED] and she didn't want			that it was received.		
	_	her in the state she was in.			• Once client requests are		
		ait in [ED's] office. I said that			processed and checks are prin	tod	
		got to HR, I shut the door and			an approved signer will go to the		
		ing that [OC] and I had just			bank and deposit the checks. T		
		IRM]. We then called [ED] and					
	-	itted to stealing the funds. We			following day an approved sign		
		e next steps would be and went			will go to the bank and withdraw		
		-			the funds for the clients and ref		
		ith [ED] on speaker. [OC] and			to the office to deposit the fund	s	
		was apologetic and promised to			into the safe until clients are		
		ck. The conversation ended			brought to the office to pick up	and	
] and me signing her suspension			sign out their funds they had		
		ent is the best recollection of			requested.		
		versation that transpired on			• The Program Manager,		
	4/11/2023.'				Program Director and Business		
					Managerwill rotate weekly and		
		questioning, [BOM] states that			audit any funds in the safe wee	ekly	
		stablished in April 2021 and that			and sign the safe ledger		
		l with opening the account at			acknowledging the amounts ar	e	
	[[manua of hamle] II	e states that the initial opening	1		accurate.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES. IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE balance was \$500 and then there was a second deposit of \$6500, meaning that ResCare funded the account with a total of \$7000. He states that authorized signers on the account are himself, [OC], [Program Manager], [former Program **Monitoring of Corrective** Manager], [name of current Program Director], Action: [Program Manager], [name of former Program Area Supervisor submits Director], and [former Office Coordinator for weekly check that includes the payroll]. He states that all signers have had balance of the in house finances access to the account since its opening, however, to the Program Manager for review of those listed, only [OC] and he had ever gone to and to ensure completion. the bank to make transactions using the account. Daily calls are conducted He states that the account was used as a during the condition period with 'pass-through' account, meaning it was Rescare Management. established as a means for providing clients with Weekly adverse actions access to their funds in the form of cash. He calls with Senior Director of states that anytime a client needs cash, a check Quality Support and Rescare was cut to Normal Life of Indiana (ResCare). The Operation Support Specialist with check can then be deposited into the Rescare Management to monitor 'pass-through' account and the exact deposited condition level findings and amount can be withdrawn. The balance of the progress on citations noted during account should always remain the same complaint survey. (\$7000.00), as funds deposited are then Observation forms are sent immediately withdrawn (in the same amount). He to the Program Manager for states that the account was monitored daily by monitoring, follow up and to the [OC] as deposits and withdrawals were made. ensure completion. The [BOM] was responsible for overseeing the Financial Audit will be account by doing reconciliations. He states that completed 3 times weekly by the majority of the clients for whom ResCare Rescare Management and sent to serves as rep-payee have had funds pass through the Program Manager and the account. On average, the account is used Program Director for review and to weekly. It was used regularly for group home ensure completion. clients monthly allowances and waiver client All financial requests for cash-on-hand monthly allowances. Any other spending will be approved by the times the account was used it would have been Executive Director, amounts that for special requests where cash is necessary. exceed \$499 will require Regional Director approval for processing. [BOM] describes the process of the QIDP will complete a 'pass-through' account as follows: monthly summary and send to the IDT team. The monthly summary 1. Receive request for funds for client (if Event ID: LWFE11 Facility ID: 000775 Page 18 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G255	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/10/2023	
	PROVIDER OR SUPPLI	ER ALTERNATIVES SE IN	154 CH	ADDRESS, CITY, STATE, ZIP COI HAD DR AILLES, IN 47042)	
RES CA		ALTERNATIVES SE IN	VERSA	AILLES, IN 47042		
(X4) ID		Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX		ENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	PROPRIATE	COMPLETIO
TAG		OR LSC IDENTIFYING INFORMATION	TAG			DATE
	necessary).	27		includes RFMS balance		
	-	k request spreadsheet (including		as cash balances for each client	ch client	
		S ID, amount, description, and		in the facility.		
	vendor (Normal L					
	-	et to RFMS processing				
	team-they queue of			Completion Date: 5/26/	23	
		ator [OC] prints check.				
	-	spreadsheet used to label money				
		ent) with the appropriate amount				
	of money enclose					
	•	ated per client in the batch.				
	_	thdrawal slips completed.				
	8. Drive to bank.	-1(-)				
	-	t slip(s) and/or check(s)				
	provided to bank					
		ip provided with exact amount.				
		eaks up cash into money nt in the exact amount.				
		nator or Business Manager				
		vith cash. Ledgers are completed				
		g funds have been deposited				
	into the office safe					
		notified that funds are ready to				
	be picked up.	notified that failes are feady to				
		pick up funds and sign them out				
	on the ledger.					
		n either spent or signed into a				
		e for tracking cash-on-hand.				
	[BOM] states he c	cannot recall if any policies or				
		maging the new account had				
	-	him over the phone in				
	_	arding the establishing of the				
		s he does not have a physical				
		les or procedures for managing				
		account. He states [Treasurer				
		ectives for the account to be				
		y. He states he noticed				
	discrepancies in e	arly January 2023, however,				
	-	been fully reconciling the		1		

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE account monthly. After his discovery, he spoke to [Program Director] and [Program Manager] in private, noting his concern for the account seemingly not balancing correctly. He asked them to keep the conversation private and to not let [OC] know that he was reviewing. [PM] offered her assistance with reviewing. He states that at this point, he was working on getting the remaining statements and check copies in order to complete a thorough review. He states he mentioned to [ED] that he thought 'something was up' and that he would follow-up with her once he had completed his review. He states he informed [QAM], [OC], [HRM], and [ED] on 4/11/23 that he had verified discrepancies " The OC's statement in the facility's investigation indicated, "[OC] was contacted via phone and was asked if there were any other accounts affected after her admission to taking money that did not belong to her. She stated that it was only the 'pass-through' account. She was asked if any client funds had been taken during the process and stated that all clients received their money and none were affected. An appointment was made for further interview following collection of evidence and [OC] initially agreed to meet, but later stated she had changed her mind and declined." The ED's statement in the facility's investigation indicated, "...On Tuesday approximately 2:31pm, I received a text from [BOM] to let me know he needed me to call him because he has a problem and doesn't know what to do. He called me shortly thereafter with [HRM] on speaker phone and relayed that he wanted to reconcile the 'pass-through' account at [name of bank] before the new Business Manager starts but noticed a problem. He suspected some fraudulent activity Event ID: LWFE11 Facility ID: 000775 Page 20 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G255 05/10/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE and said he asked [OC] for the bank statements. He told me that she had put him off and then finally relayed that she had taken money. They had [OC] go into my office and took the phone in there. I relayed to her that she was suspended and she kept apologizing and said she had a gambling problem. She said she started online gambling on her phone. I asked if there was any client money involved and she said no, only ResCare money from the 'pass-through' account at [name of bank]. She states, '[OC] was suspended immediately and an investigation started.' She states, 'On Thursday morning on my way into work, I called [OC] and said, 'It wasn't just the 'passthrough (sic) account was it? It was client funds too ... you made checks for cash that was (sic) supposed to go to the ARC (Association of Remarkable Citizens) and took them, you took spending money? '[OC] replied with, 'Yes.' I then asked,'How much are we talking about, [OC]? She replied with, 'I don't know, maybe \$20,000.' The rest of the conversation consisted of her apologizing and saying she would take it all back (if she could)." The PD's statement in the facility's investigation indicated, "[PD] was asked to describe the conversation between she, [BOM], and [PM] when he came to them to speak about a potential issue he had noticed with the balance of the 'pass-through' account. She states, 'I can't recall if it was August or September (2022) but [BOM] had stopped in our office and said he had a feeling something was 'off' in the cash account at [name of bank]. [BOM] stated that he was thinking the account may be off and if the checks weren't ran (sic) through right it could cause the balance to be off. I never heard any more about the 'pass-through' account until 4/11/23 when the current investigation was initiated." Event ID: LWFE11 Facility ID: 000775 Page 21 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		15G255	B. WING		05/10/2023
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	154 CH	ADDRESS, CITY, STATE, ZI IAD DR NILLES, IN 47042	P COD
(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 ACTIO CROSS-REFERENCED TO T	N SHOULD BE COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
	investigation indica process, all client R (date of pass throug April of 2023 were transactions were lif with supporting doc was obtained to ver transactions were fir on behalf of the clie generated to track a review and their ver client RFMS statem issued to Normal Li behalf of clients for ARC, Funeral, and (tax-advantaged say for individuals with spending needs. Re statements confirms Life of Indiana (Res Stimulus funds for mentioned above. I account (pass-throu issued to Normal Li deposited in the 'pas of the [name of ban [OC] was the only p the accounts for t in their RFMS state Resource Ledger SI receive all funds iss for weekly/monthly ABLE trust funds, a needs. Client lists/s will be added to the	gs section of the facility's ted, "During the investigative FMS statements from 4/1/21 th account opening) through audited. Suspicious sted and flagged for review cumentation. Documentation ify which of the flagged audulent or executed correctly ents. A spreadsheet was Il transactions flagged for rification status. Review if (sic) nents confirms checks were ife of Indiana (ResCare) on weekly/monthly spending, ABLE trust funds vings and investment accounts a disabilities), and other client eview if (sic) client RFMS is checks were issued to Normal scare) on behalf of clients for various needs including those Review of the [name of bank] gh) confirms client checks ife of Indiana (ResCare) were ss through' account. Review k] withdrawal slips confirms berson withdrawing funds from w of client Funeral, ARC, and affirms deposits were not made the designated amounts noted ments. Review of client neets confirms clients did not sued from their RFMS accounts a spending, ARC, Funeral, and and other client spending spreadsheets of audit results i investigation file when final completed. Review of the			

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OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE [name of bank] pass through account confirms ResCare funds totaling \$7,000.00 were deposited to open the account and service fees of \$134.63 should result in a remaining balance of \$6,865.37. As of April 2023, the balance of the account is \$95.86 confirming a deficit of \$6,769.51. [BOM] stated he was not reconciling the 'pass-through' account thoroughly each month. [OC] admitted she took ResCare funds and client funds (ARC account funds and client spending funds) from the [name of bank] 'pass-through' account. [OC] initially denied taking client funds then recanted " The Conclusion indicated, "It is substantiated [OC] embezzled client and ResCare funds from the [name of bank] 'pass through' account. It is substantiated [OC] exploited clients through theft of client funds." The facility's investigation was not thorough as evidenced by: -Not identifying the clients involved in the exploitation. -Not identifying the amount of money stolen from each client. -Not identifying the amount of money each client was going to be reimbursed. On 4/27/23 at 9:34 AM, the Program Director (PD) stated the investigation was "very, very large. What you are seeing is the ResCare money portion and it mentions client funds were taken. It is not the final for every bit of it. The other portion is the clients' tally. Took a small piece to get her (OC) terminated. This is not the final investigation." The facility did not include additional information in the investigation as of 5/4/23 at 12:13 PM. On 5/4/23 at 12:58 PM, the PD indicated it was not Event ID: LWFE11 Facility ID: 000775 Page 23 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G255 05/10/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE a thorough investigation. The PD indicated the Operations Support Specialist (OSS) told her it was a small piece and additional information was going to be included in the final investigation. The PD indicated no additional information was included in the investigation. The PD indicated the investigation needed to include the total number of clients affected and how much money was stolen from each client. The PD indicated the total amount of money stolen from all the clients involved was over \$260,000.00. On 5/4/23 at 1:02 PM, the OSS stated "we need to add client information. Need to add an addendum statement. Need to break it out by client. It is not thorough without the information." On 5/4/23 at 3:48 PM, the Program Director (PD) sent an email with a Financial Investigation Summary attached. The Factual Findings section indicated, "During the investigative process, all client RFMS statements from 4/1/21 (date of pass through account opening) through April of 2023 were audited. Suspicious transactions were listed and flagged for review with supporting documentation. Documentation was obtained to verify which of the flagged transactions were fraudulent or executed correctly on behalf of the clients. A spreadsheet was generated to track all transactions flagged for review and their verification status. Review of client RFMS statements confirms checks were issued to Normal Life of Indiana (ResCare) on behalf of clients for weekly/monthly spending, ARC, Funeral, and ABLE trust funds, and other client spending needs. Review of client RFMS statements confirms checks were issued to Normal Life of Indiana (ResCare) on behalf of clients for Stimulus funds for various needs including those mentioned above. Review of the [name of bank] LWFE11 Facility ID: 000775 Page 24 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G255 05/10/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE account (pass through) confirms client checks issued to Normal Life of Indiana (ResCare) were deposited in the 'pass through' account. Review of the [name of bank] withdrawal slips confirms [OC] was the only person withdrawing funds from the account. Review of client Funeral, ARC, and ABLE accounts confirms deposits were not made to the accounts for the designated amounts noted in their RFMS statements. Review of client Resource Ledger Sheets confirms clients did not receive all funds issued from their RFMS accounts for weekly/monthly spending, ARC, Funeral, and ABLE trust funds, and other client spending needs. Client lists/spreadsheets of audit results will be added to the investigation file when final auditing has been completed. Review of the [name of bank] pass through account confirms ResCare funds totaling \$7,000.00 were deposited to open the account and service fees of \$134.63 should result in a remaining balance of \$6,865.37. As of April 2023, the balance of the account is \$95.86 confirming a deficit of \$6,769.51. [BOM] stated he was not reconciling the 'pass-through' account thoroughly each month. [OC] admitted she took ResCare funds and client funds (ARC account funds and client spending funds) from the [name of bank] 'pass-through' account. [OC] initially denied taking client funds then recanted. Conclusion: It is substantiated [OC] embezzled client and ResCare funds from the [name of bank] 'pass through' account. It is substantiated [OC] exploited clients through theft of client funds." The summary indicated, "ADDENDUM: Upon final audit the following funds were embezzled from the [name of group home] clients: [Client E] - \$104.00 [Client D] - \$134.00 [Client H] - \$194.00 [Client G] - \$7734.00 LWFE11 Facility ID: 000775 Page 25 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE [Client F] - \$82.00 [Client A] - \$18.00 [Client C] - \$2604.00 (Total: \$10870.00) Additionally, it was determined that collectively, \$253,305.59 was embezzled from 106 clients. All financial documentation reviewed for this investigation is being released to the [name of city] PD (police department)/Prosecutor, and the Attorney General for prosecution of [OC] for the embezzlement. ResCare will comply with all requests/directives from the above entities as received." On 5/9/23 at 12:08 PM, the OSS emailed a copy of the investigation with the following Addendum, "...[BOM] and [OC] are no longer with the company. Recommendations Being Implemented: Implement Pass Through Account Procedure, Retrain all management staff ... on Client Trust Funds Policy, Implement review process for ABLE, ARC, and Funeral Trust Accounts, Retrain all management staff ... on RFMS statement review process, and Report all discrepancies immediately to Quality Assurance Dept for investigation." On 5/5/23 at 9:19 AM, the OSS indicated the BOM was going to be terminated due to knowing there was an issue with the ResCare pass through account in February 2023 but not taking action to resolve the issue at the time. The BOM showed the OSS a text he (BOM) sent to the Executive Director (ED) on 2/1/23 indicating the pass through account balance was \$93.00 when it should have been around \$6,800.00. The BOM did not report his concerns to the Quality Assurance department for them to investigate the issue. The BOM did report his concerns to the ED. Neither of them took action at the time. The Event ID: LWFE11 Facility ID: 000775 Page 26 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE ED indicated to the OSS during her interview she was not aware of the pass through account issues until April 2023. On 4/27/23 at 9:17 AM, a review of an email from the QAM was conducted. The email included a 4/26/23 Investigation Peer Review (administrative review). The review indicated, "The allegations of exploitation and theft of client funds and theft of ResCare funds has been substantiated. Recommendations include termination of employment for [OC] and ineligible for rehire due to substantiated exploitation and theft. Additional recommendations will be added upon final audit." On 5/4/23 at 1:17 PM, a review of 5/3/23 Investigation Peer review indicated, "The allegations of exploitation and theft of client funds and theft of ResCare funds has been substantiated. [OC] has been terminated of her employment and is deemed ineligible for rehire due to substantiated exploitation and theft. Her access has been removed from all ResCare financial applications/accounts. She has been removed as a representative on all ARC and ABLE accounts associated with our clients. All clients will be fully reimbursed by ResCare. ResCare has added internal protective measures until corporate establishes new policies and/or procedures associated with client finances." On 4/25/23 at 12:43 PM, the Program Director (PD) stated "funds were misappropriated by the former Office Coordinator. The police are involved. Working on the investigation. Many thousands of dollars were stolen from the RFMS accounts. Stimulus checks were also taken. Discovered on 4/11/23." The PD indicated the OC was an employee for 17 years. When the Business Manager asked her to reconcile the account, she Event ID: LWFE11 Facility ID: 000775 Page 27 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G255 05/10/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE admitted to taking the clients' money. The PD indicated approximately 131 clients were affected totaling over \$200,000. The PD indicated Rescare funds were also stolen from a pass through account created in April 2021. The PD stated the OC took the money by using "fake requests" of the clients' money going to ARC, funeral trusts and ABLE accounts. The PD indicated the OC indicated she had a gambling problem. The PD stated, "ResCare will be reimbursing the clients their money... Substantiated exploitation without a doubt." On 4/25/23 at 2:46 PM, the PD indicated the OC admitted to the ED, BOM and her (PD) she took the money. The PD indicated the OC started taking money 2 years ago when the pass through account was created. The PD stated the BOM told her and the Program Manager "something wasn't right in August/September 2022. Wasn't like he was reporting exploitation, just said money wasn't adding up. He wasn't reporting missing money at the time." The PD indicated she was not aware of the clients missing out on making purchases due to the theft of the clients' money. On 4/25/23 at 1:26 PM, the Operations Support Specialist (OSS) indicated some of the clients living in the group home were affected by the OC. The OSS indicated approximately 100 clients were affected with a total of \$250,000 to \$300,000. The OSS indicated the situation started in June 2021 when the facility started using a pass through account for the clients' money. Money came to the account from the clients' RFMS accounts. He stated, "[OC] stole it at this point." The OSS stated it was "substantiated exploitation by [OC]." The OSS indicated he was recommending the OC be terminated. The OSS indicated the BOM turned in his resignation prior to this situation being uncovered. The BOM was conducting an audit when he discovered the issues. The OC LWFE11 Facility ID: 000775 Page 28 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE admitted to the BOM she stole the money from ResCare but denied taking any of the clients' finances. The OSS indicated the OC took money from ResCare and the clients by using the pass through account. The OSS indicated the BOM was not reconciling the pass through account as he should have. The OSS stated the BOM "will most likely be terminated." The OSS indicated the OC was stealing money going to funeral trusts, ARC trusts and ABLE trusts. On 4/26/23 at 1:55 PM, Qualified Intellectual Disabilities Professional (QIDP) #1 stated the clients "were exploited." QIDP #1 indicated the clients were not affected in a negative way and did not miss out on purchasing anything. On 4/26/23 at 1:55 PM, Qualified Intellectual Disabilities Professional (QIDP) #2 stated the clients "were exploited." QIDP #2 indicated the clients were not affected in a negative way and did not miss out on purchasing anything. On 4/25/23 at 1:47 PM, the BOM stated, "My [OC] has been stealing from ResCare and the clients." He indicated the OC was stealing funds through the pass through account. He indicated in January 2023, he noticed discrepancies in the pass through account. The balance should be close to \$7000.00. The money goes into the account and immediately gets withdrawn and distributed to the clients. In January 2023, the balance was around \$4000-5000. He indicated at the time he spoke to the PM and PD. He stated he "got busy" and did not look into the low balance until last week. He indicated he went to speak to the OC and she admitted to stealing funds from ResCare. He indicated she did not say anything about client funds. She denied touching the clients' funds. She was able to take the money with fake check LWFE11 Facility ID: 000775 Page 29 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G255 05/10/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE requests and forgery of staff and client signatures. He indicated the OC took check requests for ARC trust funds or funeral trusts and had the checks made out to Normal Life of Indiana instead of the trusts. She could take the checks made out to Normal Life to the bank and cash the checks. The BOM stated the OC needed to ensure Executive Director approval was obtained for anything over \$100.00. He stated the OC created "false ledgers." He indicated the RFMS ledger did not show the vendor (where the checks were payable). He indicated she started taking the funds in April 2021 when the pass through account was started. He indicated he started working at the facility in January 2021. He stated "I reconcile the accounts." He indicated he asked the OC to get statements for the accounts and she did not get them. She indicated she forgot and then never provided them to him. He indicated in September 2022, he noticed the balance dropped below \$6,600.00. He stated, "I told them I would do a full reconciliation. I got caught up in other things and didn't do it until this month when I reconciled the accounts for the new BOM." He stated, "I feel some responsibility. It was my responsibility to reconcile the account. I failed to do so for 3-5 months." He stated the OC was "deceiving" and she "committed a crime." The BC indicated there was no investigation conducted in September 2022 when he first noticed there was an issue. He stated, "I told [ED] I would review it and tell her what I found." The BOM stated, "She admitted to taking it. I would have never thought she would have taken it. The total funds missing is approximately \$282,000." He indicated he was not sure what percentage was from ResCare and what was from the client funds. The BOM stated there was "room for improvement. Clients will be Event ID: LWFE11 Facility ID: 000775 Page 30 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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ind	reimbursed. Ther	e is enough evidence to itation of the clients' funds."		<u> </u>			DAIL
	indicated there we than \$250,000 sto going to substanti terminated." The from the BOM on (BOM). He said I through account a ED stated the OC money of approxi "She (OC) admitte the money. She s She said it was just was going to pay indicated the facil The ED stated, "sl and ResCare's mo was taking money making the check and stated on 4/13/23, taking the clients' \$20,000.00 and pt The ED indicated discovered missin indicated the RFM certain ways did r others could not s out to. The ED in facility for 18 yea pass through account n didn't do it for a lo	9 PM, the Executive Director (ED) re 112 clients involved and more len. The ED stated, "Definitely ate exploitation. She will be ED indicated she received a text 4/11/23 asking her to call him ne went to reconcile the pass nd "something was off." The admitted to stealing ResCare mately \$6,600.00. The ED stated, ed it to me and HR that she stole aid she had a gambling problem. st ResCare money. She said she it back." On 4/12/23, she ity checked the clients' finances. he (OC) was taking the clients' ney." The ED indicated the OC ' intended for the ARC trust but out to Normal Life so she could d keep the money. The ED the OC "admitted she was funds. She said it was around comised to pay the money back." the amount of money g grew from there. The ED IS statements when printed to the whet vendor therefore ee who the checks were made dicated the OC worked at the rs. The ED indicated prior to the unt being instituted, the clients k accounts. The ED indicated posed to reconcile the pass nonthly. She stated the "[BOM] ong while. Over a year. When pass through account was low					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G255 05/10/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the BOM's job responsibility. She indicated the BOM reconciled the account for awhile with no issues noted. She indicated she was first aware of the issue on 4/11/23. She stated "just [OC] and [BOM] had access to the RFMS accounts." The ED stated, "she (OC) was printing and providing the (RFMS) statements in a format that did not provide all the information. Didn't know all the other information was available. Easily detected now that I know." She indicated she was not aware of any clients who couldn't buy something due to the missing funds. On 5/9/23 at 2:11 PM, the Chief Security Officer (CSO) indicated the pass through account was initially opened with \$500.00 and 5 signers. The CSO indicated the account should not have had 5 signers on the account. Due to the amount of funds going into and out of the account, the total amount in the account was increased to \$7000.00. The CSO indicated the amount in the account should not have been increased to \$7000.00 without corporate approval, which did not happen. The CSO stated the BOM "did not reconcile the account like he was supposed to" on a monthly basis. The CSO indicated the BOM forgot his password on the account and did not check it. The BOM asked the OC to get statements however she never provided them to the BOM. The BOM indicated he got busy and did not follow up to get the statements until the BOM went to the bank to request statements in January 2023. When the BOM got the statements, he realized the account dropped below \$7000.00 several times. The BOM informed the ED. The ED indicated she thought the BOM was taking care of the issue. The CSO stated the BOM "got busy" and after a few months, started to go through the statements. While going through the statements with the OC, the OC admitted to taking Event ID: LWFE11 Facility ID: 000775 Page 32 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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		The CSO indicated the total esCare's money and client 0.00.			
	directed to do" reg through account m ED should have for taking care of the BOM initially repo- indicated although suspicions about th reported it to the Q The CSO stated th requests."	e BOM, "didn't do what he was arding reconciling the pass onthly. The CSO indicated the llowed up to ensure he was ssue in January 2023 when the orted his concerns. The CSO there were staff who had he clients' funds, no one Quality Assurance department. e OC "falsified documents and			
	9-3-2(a)	lates to complaint #IN00407693.			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATM The facility must written policies a mistreatment, ne Based on record re clients (A, C, D, E designated as the r facility neglected t procedures to prev clients, conduct a t including the name amount of money	ENT OF CLIENTS develop and implement nd procedures that prohibit glect or abuse of the client. wiew and interview for 7 of 8 , F, G and H) the facility was epresentative payee, the o implement its policies and ent financial exploitation of the horough investigation es of the clients affected and the stolen from each client, and t neglect client A by leaving pervised.	W 0149	W149: The facility must develop and implement written policies an procedures that prohibit mistreatment, neglect or abuse of the client. Corrective Action: • All staff trained on the Abus and Neglect Exploitation Policy. (Attachment A)	f
		:06 PM, a review of the facility's as conducted and indicated the		All Management staff traine on updated Financial Preventativ Measures that were put into plac to prevent further misappropriation	e

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		· · ·	PLETED
		15G255	B. WING		05/10/2023	
			STRE	EET ADDRESS, CITY, STATE, ZIP CO	DD	
	PROVIDER OR SUPPLIE			CHAD DR		
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN	VEF	RSAILLES, IN 47042		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORF	ECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE A	OULD BE PPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG			DATE
	following:			of client funds and to er		
				financial accuracy to the	e penny.	
		of Developmental Disabilities		(Attachment B)		
		incident report indicated, "There		 Area Supervisors 	trained on	
	has been an allega	tion of misappropriation of		updated procedures to	request	
		t of the account is being		client funds from their F	RFMS	1
	completed and am	ount of funds is undetermined		accounts. (Attachment	C)	1
	at this time. Staff a	alleged to be responsible for		 Office Coordinator 	terminated	
	misappropriation of	of funds has been suspended		from Rescare for the th	eft of client	
	pending investigat	ion. In addition, the police have		funds. (Attachment D)		
	been notified and	the initial case number is [case		· Rescare Manager	nent	
		ds proven to be missing will be		created a spreadsheet		
	reimbursed by Res			client reimbursements t		
				all client meetings are o		
	On 5/4/23 at 3:48	PM, a review of the clients'		reimbursement is receiv		
		nagement Service (RFMS)		deposited into clients R		
		the clients had the following		accounts.		
		dulent" from their accounts:		· Rescare reimburs	ed client A	
	Transaction Traa			for missing money (\$18		
	1) Client A: \$18.0	00		(Attachment E)		
	2) Client C: \$2604			· Rescare reimburs	od client C	
	3) Client D: \$134				-	
	4) Client E: \$104.			for missing money (\$26	04.00).	
	5) Client F: \$82.0			(Attachment F)	ad alignt D	
	6) Client G: \$773			• Rescare reimburs		
	,			for missing money (\$13	4.00).	
	7) Client H: \$194	.00		(Attachment G)	! -!! -	
	Total: \$10870.00			• Rescare reimburs		
	TI C 114 1 4/06			for missing money (\$10	4.00).	
	-	23 Investigative Summary		(Attachment H)		1
		onclusion, "It is substantiated		Rescare reimburs		
	-	or/OC] embezzled client and		for missing money (\$82		
		m [name of bank] 'pass through'		(Attachment I)		1
		tantiated [OC] exploited clients		· Rescare reimburs		
	-	ient funds." The investigation's		for missing money (\$77	34.00).	
		Business Office Manager		(Attachment O)		1
		"[BOM] was asked what		Rescare reimburs		
		with the pass-through		for missing money (\$19	4.00).	1
	-	unt and if he had spoken with		(Attachment T)		
	-	office staff about the issue.		 Financial Audits w 	ill be	1
	He replied with the	e following email: 'When		conducted by Rescare		1

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 05/10/2023
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	154 CH	ADDRESS, CITY, STATE, ZIP COD AD DR ILLES, IN 47042	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (ROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETIO DATE
	reviewing the "pass on 4/11/2023, I no were below the am the account with. I because the initial remain the same, g funds get deposited amount. As I was photocopies of the was briefly talking along the line of, " account." I was sin reviewing. [OC] v funds out to staff. conversation at tha have Mar-2023 (M stopped reviewing copy. After I got t balance was at \$21 recent statement, I a conversation with Manager/QAM]. I so I could get her p her on the suspicio and we spoke in pr lunchroom. I expli- through" account v addition, I showed experiencing. After the conversa- what the next steps bring [ED], up to c conversation with in the lounge so we we sat down at the September 2022 st month the account	s through" account statements ticed previous ending balances yount of funds ResCare funded I knew there had to be an issue balance on the account should given no bank fees occurred, as d and withdrawn in the same reviewing the statements and deposits and withdrawals, I to [OC]. I made comments something is off with the tting at her desk as I was vas occupied, signing client Her direct involvement in the t time was minimal. I did not larch 2023) statement, so I and went to the bank to get a he statement, I noticed the 0.86. After getting the most went back to the office and had h [Quality Assurance asked [QAM] if she had time professional opinion and brief ns I had. She did have time tivate in the ResCare ained to her what the "pass vas and how we utilized it. In her the discrepancies we were tion, I explained I was not sure s were going to be and had to late. This concluded our rtly after having the [QAM], I asked [OC] to join me e could review it together. As table, I pointed out the atement. This was the first balance dropped below the unded it with (\$7000.00). I then		Management 3 times weekly no less than 60 days to audit financials in the facility. (Attachment J) Daily calls are conducted with Rescare Management to discuss financial processes a procedures, financial policies implementation of those polic and are tracked by the Qualit Assurance Manager. Area Supervisor weekly check updated to include listing the amount of money each cl has in the facility as well as the RFMS balance. (Attachment Area Supervisor/QIDP completes a monthly summar that includes clients financial totals from RFMS and Cash of Hand in the facility. (Attachment L) Rescare Management f been granted access to view clients RFMS statements as needed to ensure all client fun are accounted for. (Attachment M) Area Supervisor conduct monthly house meetings to re- items as needed, the Abuse a Neglect Exploitation Policy is included in this meeting as we the finance policy and proceed process. (Attachment N) All client requests that a completed asking that funds I sent to their funeral trust, ARC Able trust accounts will be processed through their RFM	for all d nd and ies. y ng ient ne K) y y on ent nas all nds ent ts eview and ell as ure ce C or

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STATEMEN	R MEDICARE & MEDION NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIPLE CONSTRU A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/10/2023
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	STREET ADDRE 154 CHAD DI VERSAILLES		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD BE SSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	the balance. As I we explanation and we stopped me and sa I'm so sorry." I dia as I was in shock. previously apologi back. I told her we Resources Manage wanted to speak we anyone else to see She asked to go we was fine. Once I ge explained everythis spoken about to [F told her [OC] adm discussed what the to [ED's] office, we [ED] spoke. [OC] pay everything back with [OC], [HRM] form. This statem	month showing the influx in was about to continue my hat we were looking for, [OC] id, "I did it. I took the money. d not say anything right away She continued to cry and ze stating she would pay it all e need to go talk to [Human er/HRM]. She explained she ith [ED] and she didn't want her in the state she was in. ait in [ED's] office. I said that got to HR, I shut the door and ng that [OC] and I had just IRM]. We then called [ED] and itted to stealing the funds. We e next steps would be and went ith [ED] on speaker. [OC] and was apologetic and promised to ck. The conversation ended and me signing her suspension ent is the best recollection of versation that transpired on	mad and we h that · proc an a bank follo will g the f to th into brou sign requ · Prog Man audi and	bunts and the checks will le out directly to the vence will be sent certified to e have supporting document it was received. Once client requests are pessed and checks are pro- topproved signer will go to k and deposit the checks wing day an approved si go to the bank and withdue funds for the clients and withdue funds for the clients are ught to the office to pick u out their funds they had uested. The Program Manager, gram Director and Busine lager will rotate weekly a t any funds in the safe w sign the safe ledger nowledging the amounts urate.	dors nsure ntation e rinted, o the c. The gner raw return nds up and ess nd will reekly
	the account was es [Treasury] assisted [name of bank]. H balance was \$500 deposit of \$6500, j the account with a authorized signers [OC], [Program M Manager], [name of [Program Manager] Director], and [for payroll]. He states access to the account	questioning, [BOM] states that tablished in April 2021 and that I with opening the account at e states that the initial opening and then there was a second meaning that ResCare funded total of \$7000. He states that on the account are himself, anager], [former Program of current Program Director], r], [name of former Program mer Office Coordinator for s that all signers have had unt since its opening, however, y [OC] and he had ever gone to	Acti · wee bala to th and · durir Reso ·	hitoring of Corrective on: Area Supervisor submit kly check that includes the nce of the in house finance to ensure completion. Daily calls are conducted ing the condition period we care Management. Weekly adverse actions with Senior Director of	ne ices review ed vith

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	A. BUILDING <u>00</u> COI B. WING <u>05</u> /		COME	DATE SURVEY OMPLETED 5/10/2023	
NAME OF	PROVIDER OR SUPPLIE	ER			ADDRESS, CITY, STATE, ZIP COD HAD DR		
RES CA	RE COMMUNITY /	ALTERNATIVES SE IN			AILLES, IN 47042		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR	RIATE	COMPLETIC
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	the bank to make	transactions using the account.			Quality Support and Rescare	9	
	He states that the	account was used as a			Operation Support Specialis	t with	
	'pass-through' acco	ount, meaning it was			Rescare Management to mo	nitor	
		eans for providing clients with			condition level findings and		
		ds in the form of cash. He			progress on citations noted	during	
	-	e a client needs cash, a check			complaint survey.		
	was cut to Normal	Life of Indiana (ResCare). The			Observation forms are	sent	
	check can then be	deposited into the			to the Program Manager for		
	'pass-through' acco	ount and the exact deposited			monitoring, follow up and to		
	amount can be wit	hdrawn. The balance of the			ensure completion.		
	account should alw	ways remain the same			· Financial Audit will be		
	(\$7000.00), as fun	ds deposited are then			completed 3 times weekly by	/	
	immediately with	drawn (in the same amount). He			Rescare Management and s	ent to	
	states that the acco	ount was monitored daily by			the Program Manager and		
	the [OC] as depos	its and withdrawals were made.			Program Director for review	and to	
	The [BOM] was re	esponsible for overseeing the			ensure completion.		
	account by doing	reconciliations. He states that			All financial requests for	r	
	the majority of the	e clients for whom ResCare			spending will be approved b	y the	
	serves as rep-paye	e have had funds pass through			Executive Director, amounts	that	
	the account. On a	verage, the account is used			exceed \$499 will require Re	gional	
	weekly. It was us	ed regularly for group home			Director approval for process	sing.	
	clients monthly al	lowances and waiver client			· QIDP will complete a		
	cash-on-hand mor	thly allowances. Any other			monthly summary and send	to the	
	times the account	was used it would have been			IDT team. The monthly sum	mary	
	for special request	s where cash is necessary.			includes RFMS balances as	well	
					as cash balances for each c	ient	
	[BOM] describes	the process of the			in the facility.		
	'pass-through' acco	ount as follows:					
	1. Receive request	for funds for client (if			Completion Date: 5/27/23		
	necessary).						
	2. Complete check	request spreadsheet (including					
	client name, RFM	S ID, amount, description, and					
	vendor (Normal L	ife of Indiana).					
	3. Send spreadshe	et to RFMS processing					
	team-they queue c						
	4. Office Coordina	ator [OC] prints check.					
		preadsheet used to label money					
	-	ent) with the appropriate amount					
	of money enclosed						
	-	ated per client in the batch.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G255	A. BUILDING B. WING		Cor 05/	te survey Mpleted 10/2023
	PROVIDER OR SUPPLI	ER ALTERNATIVES SE IN	154 0	et address, city, state, zif CHAD DR SAILLES, IN 47042	, COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
	 8. Drive to bank. 9. Provide deposit provided to bank in 10. Withdrawal sliph. 11. Bank teller brue envelopes per client in the office way per client showing into the office safe 13. Staff are then be picked up. 14. Staff come to on the ledger. 15. Funds are then ledger in the homogeneous into the office procedures for marking in the homogeneous in the state is a state of the pass-through a Director] gave dir reconciled monthly. to [Program Director] private, noting his seemingly not ball to keep the conversion in the state is a state of the pass in the state is a state of the private in the homogeneous in the state is a state in the homogeneous in the state is a state in the homogeneous in the state is a state in the homogeneous in the state is a state in the homogeneous in the state is a state in the homogeneous in the state is a state in the homogeneous in the homogeneous in the state is a state in the homogeneous in the homogeneo	ip provided with exact amount. eaks up cash into money ent in the exact amount. nator or Business Manager <i>v</i> ith cash. Ledgers are completed g funds have been deposited				

OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE up' and that he would follow-up with her once he had completed his review. He states he informed [QAM], [OC], [HRM], and [ED] on 4/11/23 that he had verified discrepancies " The OC's statement in the facility's investigation indicated, "[OC] was contacted via phone and was asked if there were any other accounts affected after her admission to taking money that did not belong to her. She stated that it was only the 'pass-through' account. She was asked if any client funds had been taken during the process and stated that all clients received their money and none were affected. An appointment was made for further interview following collection of evidence and [OC] initially agreed to meet, but later stated she had changed her mind and declined." The ED's statement in the facility's investigation indicated, "...On Tuesday approximately 2:31pm, I received a text from [BOM] to let me know he needed me to call him because he has a problem and doesn't know what to do. He called me shortly thereafter with [HRM] on speaker phone and relayed that he wanted to reconcile the 'pass-through' account at [name of bank] before the new Business Manager starts but noticed a problem. He suspected some fraudulent activity and said he asked [OC] for the bank statements. He told me that she had put him off and then finally relayed that she had taken money. They had [OC] go into my office and took the phone in there. I relayed to her that she was suspended and she kept apologizing and said she had a gambling problem. She said she started online gambling on her phone. I asked if there was any client money involved and she said no, only ResCare money from the 'pass-through' account at [name of bank]. She states, '[OC] was suspended Facility ID: 000775

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE immediately and an investigation started.' She states, 'On Thursday morning on my way into work, I called [OC] and said, 'It wasn't just the 'passthrough (sic) account was it? It was client funds too ... you made checks for cash that was (sic) supposed to go to the ARC (Association of Remarkable Citizens) and took them, you took spending money? '[OC] replied with, 'Yes.' I then asked,'How much are we talking about, [OC]? She replied with, 'I don't know, maybe \$20,000.' The rest of the conversation consisted of her apologizing and saying she would take it all back (if she could)." The PD's statement in the facility's investigation indicated, "[PD] was asked to describe the conversation between she, [BOM], and [PM] when he came to them to speak about a potential issue he had noticed with the balance of the 'pass-through' account. She states, 'I can't recall if it was August or September (2022) but [BOM] had stopped in our office and said he had a feeling something was 'off' in the cash account at [name of bank]. [BOM] stated that he was thinking the account may be off and if the checks weren't ran (sic) through right it could cause the balance to be off. I never heard any more about the 'pass-through' account until 4/11/23 when the current investigation was initiated." The Factual Findings section of the facility's investigation indicated, "During the investigative process, all client RFMS statements from 4/1/21 (date of pass through account opening) through April of 2023 were audited. Suspicious transactions were listed and flagged for review with supporting documentation. Documentation was obtained to verify which of the flagged transactions were fraudulent or executed correctly on behalf of the clients. A spreadsheet was Event ID: LWFE11 Facility ID: 000775 Page 40 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G255 05/10/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE generated to track all transactions flagged for review and their verification status. Review if (sic) client RFMS statements confirms checks were issued to Normal Life of Indiana (ResCare) on behalf of clients for weekly/monthly spending, ARC, Funeral, and ABLE trust funds (tax-advantaged savings and investment accounts for individuals with disabilities), and other client spending needs. Review if (sic) client RFMS statements confirms checks were issued to Normal Life of Indiana (ResCare) on behalf of clients for Stimulus funds for various needs including those mentioned above. Review of the [name of bank] account (pass-through) confirms client checks issued to Normal Life of Indiana (ResCare) were deposited in the 'pass through' account. Review of the [name of bank] withdrawal slips confirms [OC] was the only person withdrawing funds from the account. Review of client Funeral, ARC, and ABLE accounts confirms deposits were not made to the accounts for the designated amounts noted in their RFMS statements. Review of client Resource Ledger Sheets confirms clients did not receive all funds issued from their RFMS accounts for weekly/monthly spending, ARC, Funeral, and ABLE trust funds, and other client spending needs. Client lists/spreadsheets of audit results will be added to the investigation file when final auditing has been completed. Review of the [name of bank] pass through account confirms ResCare funds totaling \$7,000.00 were deposited to open the account and service fees of \$134.63 should result in a remaining balance of \$6,865.37. As of April 2023, the balance of the account is \$95.86 confirming a deficit of \$6,769.51. [BOM] stated he was not reconciling the 'pass-through' account thoroughly each month. [OC] admitted she took ResCare funds and client funds (ARC account funds and client spending funds) from the [name of bank] 'pass-through' account. [OC] LWFE11 Facility ID: 000775 Page 41 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	A. B	UILDING	DNSTRUCTION 00	co 05	ate survey mpleted /10/2023
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		154 CH	ADDRESS, CITY, STATE, ZIP IAD DR NILLES, IN 47042	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	initially denied tak recanted" The G substantiated [OC] funds from the [na account. It is subs through theft of cl The facility's inver- evidenced by: -Not identifying th exploitation. -Not identifying th each client. -Not identifying th was going to be re On 4/27/23 at 9:34 stated the investig What you are seein portion and it men is not the final for portion is the clier get her (OC) termin investigation." The facility did not in the investig	cing client funds then Conclusion indicated, "It is] embezzled client and ResCare ime of bank] 'pass through' itantiated [OC] exploited clients ient funds." stigation was not thorough as the clients involved in the the amount of money stolen from the amount of money each client imbursed. A AM, the Program Director (PD) ation was "very, very large. Ing is the ResCare money tions client funds were taken. It every bit of it. The other tts' tally. Took a small piece to inated. This is not the final tt include additional information in as of 5/4/23 at 12:13 PM. B PM, the PD indicated it was not gation. The PD indicated the rt Specialist (OSS) told her it					
	going to be includ The PD indicated included in the inv the investigation n number of clients was stolen from ea	and additional information was ed in the final investigation. no additional information was vestigation. The PD indicated ueeded to include the total affected and how much money ach client. The PD indicated the oney stolen from all the clients \$260,000.00.					

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OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE On 5/4/23 at 1:02 PM, the OSS stated "we need to add client information. Need to add an addendum statement. Need to break it out by client. It is not thorough without the information." On 5/4/23 at 3:48 PM, the Program Director (PD) sent an email with a Financial Investigation Summary attached. The Factual Findings section indicated, "During the investigative process, all client RFMS statements from 4/1/21 (date of pass through account opening) through April of 2023 were audited. Suspicious transactions were listed and flagged for review with supporting documentation. Documentation was obtained to verify which of the flagged transactions were fraudulent or executed correctly on behalf of the clients. A spreadsheet was generated to track all transactions flagged for review and their verification status. Review of client RFMS statements confirms checks were issued to Normal Life of Indiana (ResCare) on behalf of clients for weekly/monthly spending, ARC, Funeral, and ABLE trust funds, and other client spending needs. Review of client RFMS statements confirms checks were issued to Normal Life of Indiana (ResCare) on behalf of clients for Stimulus funds for various needs including those mentioned above. Review of the [name of bank] account (pass through) confirms client checks issued to Normal Life of Indiana (ResCare) were deposited in the 'pass through' account. Review of the [name of bank] withdrawal slips confirms [OC] was the only person withdrawing funds from the account. Review of client Funeral, ARC, and ABLE accounts confirms deposits were not made to the accounts for the designated amounts noted in their RFMS statements. Review of client Resource Ledger Sheets confirms clients did not receive all funds issued from their RFMS accounts

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE for weekly/monthly spending, ARC, Funeral, and ABLE trust funds, and other client spending needs. Client lists/spreadsheets of audit results will be added to the investigation file when final auditing has been completed. Review of the [name of bank] pass through account confirms ResCare funds totaling \$7,000.00 were deposited to open the account and service fees of \$134.63 should result in a remaining balance of \$6,865.37. As of April 2023, the balance of the account is \$95.86 confirming a deficit of \$6,769.51. [BOM] stated he was not reconciling the 'pass-through' account thoroughly each month. [OC] admitted she took ResCare funds and client funds (ARC account funds and client spending funds) from the [name of bank] 'pass-through' account. [OC] initially denied taking client funds then recanted. Conclusion: It is substantiated [OC] embezzled client and ResCare funds from the [name of bank] 'pass through' account. It is substantiated [OC] exploited clients through theft of client funds." The summary indicated, "ADDENDUM: Upon final audit the following funds were embezzled from the [name of group home] clients: [Client E] - \$104.00 [Client D] - \$134.00 [Client H] - \$194.00 [Client G] - \$7734.00 [Client F] - \$82.00 [Client A] - \$18.00 [Client C] - \$2604.00 (Total: \$10870.00) Additionally, it was determined that collectively, \$253,305.59 was embezzled from 106 clients. All financial documentation reviewed for this investigation is being released to the [name of city] PD (police department)/Prosecutor, and the Attorney General for prosecution of [OC] for the Facility ID: 000775 LWFE11 Page 44 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	A. BUILDING B. WING	construction 00	COM 05/	te survey Mpleted 10/2023
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(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	embezzlement. R	esCare will comply with all s from the above entities as				
	the investigation w "[BOM] and [O company. Recom Implement Pass T Retrain all manag Funds Policy, Imp ABLE, ARC, and all management st process, and Repo to Quality Assurat On 5/5/23 at 9:19 was going to be te was an issue with account in Februa resolve the issue a the OSS a text he Director (ED) on through account b should have been did not report his Assurance departi	8 PM, the OSS emailed a copy of vith the following Addendum, C] are no longer with the mendations Being Implemented: hrough Account Procedure, ement staff on Client Trust dement review process for Funeral Trust Accounts, Retrain aff on RFMS statement review rt all discrepancies immediately nee Dept for investigation." AM, the OSS indicated the BOM rminated due to knowing there the ResCare pass through ry 2023 but not taking action to t the time. The BOM showed (BOM) sent to the Executive 2/1/23 indicating the pass alance was \$93.00 when it around \$6,800.00. The BOM concerns to the Quality nent for them to investigate the did report his concerns to the				
	ED. Neither of th ED indicated to th	and report his concerns to the em took action at the time. The e OSS during her interview she he pass through account issues				
	the QAM was cor 4/26/23 Investigat review). The revi exploitation and the ResCare funds has	7 AM, a review of an email from ducted. The email included a ion Peer Review (administrative ew indicated, "The allegations of heft of client funds and theft of s been substantiated. s include termination of				

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access has been removed from all ResCare financial applications/accounts. She has been removed as a representative on all ARC and ABLE accounts associated with our clients. All clients will be fully reimbursed by ResCare. ResCare has added internal protective measures until corporate establishes new policies and/or procedures

On 4/25/23 at 12:43 PM, the Program Director (PD) stated "funds were misappropriated by the former Office Coordinator. The police are involved. Working on the investigation. Many thousands of dollars were stolen from the RFMS accounts. Stimulus checks were also taken. Discovered on 4/11/23." The PD indicated the OC was an employee for 17 years. When the Business Manager asked her to reconcile the account, she admitted to taking the clients' money. The PD indicated approximately 131 clients were affected totaling over \$200,000. The PD indicated Rescare funds were also stolen from a pass through account created in April 2021. The PD stated the OC took the money by using "fake requests" of the clients' money going to ARC, funeral trusts and ABLE accounts. The PD indicated the OC indicated she had a gambling problem. The PD stated, "ResCare will be reimbursing the clients their money... Substantiated exploitation without

associated with client finances."

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		15G255	B. W	ING		05/10	/2023
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			•	154 CH	.DDRESS, CITY, STATE, ZIP COD AD DR ILLES, IN 47042	•	
RES CARE COMMUNITY ALTERNATIVES SE IN					ILLES, IN 47042		
(X4) ID		RY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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		C] and ineligible for rehire due					
	to substantiated exp	loitation and theft. Additional					
	recommendations v	vill be added upon final audit."					
	On 5/4/23 at 1:17 P	M, a review of 5/3/23					
	Investigation Peer r	eview indicated, "The					
	allegations of explo	itation and theft of client funds					
	and theft of ResCar	e funds has been					
	substantiated. [OC]	has been terminated of her					
		deemed ineligible for rehire					
		exploitation and theft. Her					
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE On 4/26/23 at 1:55 PM, Qualified Intellectual Disabilities Professional (QIDP) #1 stated clients "were exploited." QIDP #1 indicated the clients were not affected in a negative way and did not miss out on purchasing anything. On 4/26/23 at 1:55 PM, Qualified Intellectual Disabilities Professional (QIDP) #2 stated clients "were exploited." QIDP #2 indicated the clients were not affected in a negative way and did not miss out on purchasing anything. On 4/25/23 at 1:47 PM, the BOM stated, "My [OC] has been stealing from ResCare and the clients." He indicated the OC was stealing funds through the pass through account. He indicated in January 2023, he noticed discrepancies in the pass through account. The balance should be close to \$7000.00. The money goes into the account and immediately gets withdrawn and distributed to the clients. In January 2023, the balance was around \$4000-5000. He indicated at the time he spoke to the PM and PD. He stated he "got busy" and did not look into the low balance until last week. He indicated he went to speak to the OC and she admitted to stealing funds from ResCare. He indicated she did not say anything about client funds. She denied touching the clients' funds. She was able to take the money with fake check requests and forgery of staff and client signatures. He indicated the OC took check requests for ARC trust funds or funeral trusts and had the checks made out to Normal Life of Indiana instead of the trusts. She could take the checks made out to Normal Life to the bank and cash the checks. The BOM stated the OC needed to ensure Executive Director approval was obtained for anything over \$100.00. He stated the OC

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created "false ledgers." He indicated the RFMS ledger did not show the vendor (where the checks

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G255 05/10/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE were payable). He indicated she started taking the funds in April 2021 when the pass through account was started. He indicated he started working at the facility in January 2021. He stated "I reconcile the accounts." He indicated he asked the OC to get statements for the accounts and she did not get them. She indicated she forgot and then never provided them to him. He indicated in September 2022, he noticed the balance dropped below \$6,600.00. He stated, "I told them I would do a full reconciliation. I got caught up in other things and didn't do it until this month when I reconciled the accounts for the new BOM." He stated, "I feel some responsibility. It was my responsibility to reconcile the account. I failed to do so for 3-5 months." He stated the OC was "deceiving" and she "committed a crime." The BC indicated there was no investigation conducted in September 2022 when he first noticed there was an issue. He stated, "I told [ED] I would review it and tell her what I found." The BOM stated, "She admitted to taking it. I would have never thought she would have taken it. The total funds missing is approximately \$282,000." He indicated he was not sure what percentage was from ResCare and what was from the client funds. The BOM stated there was "room for improvement. Clients will be reimbursed. There is enough evidence to substantiate exploitation of the clients' funds." On 4/25/23 at 2:59 PM, the Executive Director (ED) indicated there were 112 clients involved and more than \$250,000 stolen. The ED stated, "Definitely going to substantiate exploitation. She will be terminated." The ED indicated she received a text from the BOM on 4/11/23 asking her to call him (BOM). He said he went to reconcile the pass through account and "something was off." The LWFE11 Facility ID: 000775 Page 49 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G255 05/10/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE ED stated the OC admitted to stealing ResCare money of approximately \$6,600.00. The ED stated, "She (OC) admitted it to me and HR that she stole the money. She said she had a gambling problem. She said it was just ResCare money. She said she was going to pay it back." On 4/12/23, she indicated the facility checked the clients' finances. The ED stated, "she (OC) was taking the clients' and ResCare's money." The ED indicated the OC was taking money intended for the ARC trust but making the check out to Normal Life so she could cash the check and keep the money. The ED stated on 4/13/23, the OC "admitted she was taking the clients' funds. She said it was around \$20,000.00 and promised to pay the money back." The ED indicated the amount of money discovered missing grew from there. The ED indicated the RFMS statements when printed certain ways did not show the vendor therefore others could not see who the checks were made out to. The ED indicated the OC worked at the facility for 18 years. The ED indicated prior to the pass through account being instituted, the clients had their own bank accounts. The ED indicated the BOM was supposed to reconcile the pass through account monthly. She stated the "[BOM] didn't do it for a long while. Over a year. When he figured out the pass through account was low he reconciled it." She indicated it was not part of the BOM's job responsibility. She indicated the BOM reconciled the account for awhile with no issues noted. She indicated she was first aware of the issue on 4/11/23. She stated "just [OC] and [BOM] had access to the RFMS accounts." The ED stated, "she (OC) was printing and providing the (RFMS) statements in a format that did not provide all the information. Didn't know all the other information was available. Easily detected now that I know." She indicated she was not aware of any clients who couldn't buy something LWFE11 Facility ID: 000775 Page 50 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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BOM initially reported his concerns. The CSO indicated although there were staff who had

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	suspicions about the reported it to the Q	the clients' funds, no one puality Assurance department. e OC "falsified documents and		me			
	On 4/28/23 at 5:05 BOM's Job Desc	PM, a review of the undated					
	ription Form wa	as conducted. The form					
	indicated, "Th	e Business Manager					
	monitors client	fund disbursements and					
	account balance	s. The Business Manager is					
	responsible for	the oversight of Purchase					
	Card receipt allo	ocation and collections					
	Manages and pa	-					
		nd business support functions					
	e e	ue Cycle accounts receivable					
	_	client financial and benefits					
		ince, accounts payable,					
		rogram, client funds					
	-	nd payroll. Acts as liaison to					
	-	e departments. Works under					
	e	n. Supervises Office					
		Ensures client funds are					
	e 1	ResCare policy"On					
		PM, a review of the					
		Coordinator's (OC) Job					
	-	m was conducted. The form					
		sist with processing of client					
	-	is required"On $4/27/23$ at					
		ew of the facility's 2/16/22					
		Policy and Procedures was					
		policy indicated, "It is the					
	poncy of this op	peration to responsibly					

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CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	ì í	UILDING ING	NSTRUCTION <u>00</u>	CO 05.	ATE SURVEY MPLETED /10/2023
	PROVIDER OR SUPPLIEF	R LTERNATIVES SE IN		154 CH	address, city, state, zip (AD DR ILLES, IN 47042	COD	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	•	nitor consumer finances at all					
		The General Practice					
		l, "1. No client shall have an					
	-	account other than their					
		gement trust fund account.					
		at is not limited to checking,					
	-	es of credit. 2. Checks,					
	-	paychecks, Social Security					
		necks, etc., are to be					
	-	client's personal RFMS					
	-	eck received will be					
	-	e account within 24 hours					
	of the receipt of	-					
	discrepancies wi	thin the individuals account					
	will be reported	to the Business Office					
	Manager and the	e Program Manager					
	immediately. Th	ese discrepancies include but					
	are not limited to	o: missing deposits, missing					
	funds, and cash	withdrawals from the					
	individual's acco	ount that are not recorded					
	nor are there any	receipts for the					
	withdrawal. 4.	In the event of missing					
	funds, discrepan	cies, or suspected policy					
	violations within	an individual's account, an					
	audit or review v	will be conducted. All					
	discrepancies wi	th regards to individuals					
		eviewed. 5. Please be					
	advised in regard	d to policy 7.1A.5 that					
	-	Personnel can be subject to					
		for purchasing items while					
		n individual and the individua	1				
		ems even if the Direct					

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CENTERS FO	R MEDICARE &	MEDICAID SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	ILDING	INSTRUCTION 00	CO	ate survey Mpleted /10/2023
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	154 CH	address, city, state, zip c AD DR ILLES, IN 47042	OD	
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A	IOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		nel pays the individual back				
		The agency will not tolerate				
		or carelessness by staff				
		nances of individuals. 6. As				
	-	Iuman Resources Manual				
	-	neft, unauthorized removal,				
	U	ssion, or deliberate				
	destruction of p	roperty, merchandise,				
	equipment, or p	ossessions belonging to the				
	individuals we	serve; applies to financial				
	management as	well. Violating this policy is				
	subject to corre	ctive action up to and				
	including termin	nation. 7. An employee that				
	uses an individu	al's money/identity for any				
	other purpose th	nan what was approved or				
	intended for that	t individual can/will be				
	prosecuted and	may serve time either in jail				
	-	he Funds Overview section				
	-	esCare has established policy				
		that govern how we will				
	-	iciary responsibilities for a				
		authorized us to manage their				
		s how to safeguard assets,				
		e deposits/withdrawals,				
		3/23 at 2:05 PM, a review				
	,	DDS report was conducted.				
		cated, "On 4/28/23 when				
	-	lients to go to the day				
		t A] was left alone at the				
		e QIDP arrived at the home,				
		e office, filing client books, d sound coming from [client				

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Event ID: LWFE11 Facility ID: 000775

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 OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICE	S

AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255		A. BUILDING <u>00</u> B. WING			_	COMPLETED 05/10/2023	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP COL 154 CHAD DR VERSAILLES, IN 47042) •	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SF CROSS-REFERENCED TO THE A DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
ind		She went to his bedroom		mo			DAIL	
	-	ed, then opened the door to						
		itting on his bed putting on his						
		DP remained with [client A]						
		turned and [client A] was						
	then taken to the day program. [Client A] is							
	doing well, he did not receive any injuries							
	from this incident."On 5/4/23 at 5:05 PM, a							
	review of a BDDS follow up report was							
		e 5/4/23 Incident Follow-Up						
		d, "Neglect investigation						
	-	allegation that staff left						
	-	at the home when the group						
		e clients to the day program						
		[Client A] is doing well and						
		ice any negative effects from						
	-	e investigation has been sent						
		Resources) for final						
		recommendation for term of						
	-	clients to the day program						
		ompleted. Neglect						
	•	eer review completed,						
		nt to HR for final disposition						
	-	dation for termination of staff						
	taking the client	ts to the day program. As						
	e e	easures staff training to ensure						
	-	s all clients in van by calling						
		ounting clients."On 5/3/23 at						
		ew of the undated						
	Investigative Su	mmary was conducted. The						
	-	he investigation indicated,						
		statements, allegations of						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		CO	(X3) DATE SURVEY COMPLETED 05/10/2023		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042				
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	I SHOULD BE	(X5) COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		Supervisor] against [client						
	-	ated. Allegations of neglect						
		inst [client A] are						
		" The 5/3/23 Investigation						
		icated, "Allegations of						
		client A] by [Area						
		e been substantiated due to						
		nts. Allegations of neglect						
] are unsubstantiated.						
		ns included termination of						
		l deemed ineligible for rehire						
		visor] due to substantiated						
	neglect against [client A]. It is						
	recommended th	nat [staff #2] be permitted to						
	return to work d	ue to unsubstantiated						
	allegations."On	5/3/23 at 4:42 PM, the						
	Program Directo	or (PD) indicated client A						
	was left at home	alone. The Area						
	Supervisor was t	the staff who transported the						
	clients to the day	y program and left client A at						
	the group home	unsupervised. The PD						
	stated client A h	ad "no alone time" and						
	"would not be sa	afe alone." The PD						
	indicated the QI	DP arrived to the home to						
	find client A alo	ne and unsupervised. The						
	PD stated the fac	cility "substantiated						
	neglect."On 4/27	7/23 at 4:28 PM, a review						
	-	7/18/11 Reporting Violations						
		Procedures was conducted.						
	The policy indic	ated, "ResCare strictly						
		neglect, exploitation,						
	-	violation of an Individual's						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & M	MEDICAID SERVICES
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RES CARE C (X4) ID PREFIX TAG rig Ne " fro Re exp em or exp im con pre im con pre im con pre con pre	SUMMARY (EACH DEFICIEN REGULATORY OF ghts." A review eglect and Exp Ensure that allow abuse, neglect scare does not ploitation of a ploiyees are re- suspected inci- ploitation. All glect, and/or e- umediately inv rrective action evention of an exploitation" m	LTERNATIVES SE IN STATEMENT OF DEFICIENCIE ACY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION w of an undated Abuse, bloitation policy indicated, all persons served are free lect, or exploitation of tolerate abuse, neglect, or ny persons served. All equired to report allegations idents of abuse, neglect, and alleged or suspected abuse, exploitation will be estigated. Appropriate a will be taken to ensure y further occurrence neans the fraudulent or		154 CH	ADDRESS, CITY, STATE, ZIP COD HAD DR AILLES, IN 47042 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
PREFIX TAG rig Ne " fro Re exj em or exj em or exj mor exj mor exj mor exj em or exj em or exj or exj em or exj em or exj exj em or ezj em or ezj em or ezj en or ezj ezj en or ezj ezj ezj ezj ezj ezj ezj ezj ezj ezj	(EACH DEFICIEN <u>REGULATORY OF</u> ths." A review eglect and Exp Ensure that all om abuse, negle csCare does no ploitation of a ployees are re- suspected inci- ploitation. All glect, and/or e umediately inv rrective action evention of an fxploitation" m	ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION w of an undated Abuse, bloitation policy indicated, ll persons served are free lect, or exploitation ot tolerate abuse, neglect, or ny persons served. All equired to report allegations idents of abuse, neglect, and alleged or suspected abuse, exploitation will be estigated. Appropriate a will be taken to ensure y further occurrence		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	COMPLETION
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Ne " fro Re exp em or exp nep im con pre "E. oth act can	eglect and Exp Ensure that al om abuse, negles Care does no ploitation of a ployees are re- suspected inci- ploitation. All glect, and/or e- umediately inv rrective action evention of an exploitation" m	bloitation policy indicated, Il persons served are free lect, or exploitation of tolerate abuse, neglect, or ny persons served. All equired to report allegations idents of abuse, neglect, and alleged or suspected abuse, exploitation will be estigated. Appropriate a will be taken to ensure y further occurrence					
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exp em or exp neg im con pre "E oth act can	ploitation of a pployees are re- suspected inci- ploitation. All glect, and/or e mediately inv rrective action evention of an exploitation" m	ny persons served. All equired to report allegations idents of abuse, neglect, and alleged or suspected abuse, exploitation will be estigated. Appropriate a will be taken to ensure y further occurrence					
em or exp neg im con pre "E oth act can	aployees are re- suspected inci- ploitation. All glect, and/or e mediately inv rrective action evention of an exploitation" m	equired to report allegations idents of abuse, neglect, and alleged or suspected abuse, exploitation will be estigated. Appropriate a will be taken to ensure y further occurrence					
or exp nep im con pre- "E: oth act can	suspected inci ploitation. All glect, and/or e mediately inv rrective action evention of an exploitation" m	idents of abuse, neglect, and alleged or suspected abuse, exploitation will be estigated. Appropriate a will be taken to ensure y further occurrence					
exp neg im con pre "E: oth act can	ploitation. All glect, and/or e mediately inv rrective action evention of an exploitation" m	alleged or suspected abuse, exploitation will be estigated. Appropriate a will be taken to ensure y further occurrence					
neg im con pre "E. oth act can	glect, and/or e mediately inv rrective action evention of an exploitation" m	exploitation will be estigated. Appropriate will be taken to ensure y further occurrence					
neg im con pre "E. oth act can	glect, and/or e mediately inv rrective action evention of an exploitation" m	exploitation will be estigated. Appropriate will be taken to ensure y further occurrence					
im con pre "E oth act can	mediately inv rrective action evention of an xploitation" m	estigated. Appropriate will be taken to ensure y further occurrence					
con pre "E: oth act can	rrective action evention of an xploitation" m	will be taken to ensure y further occurrence					
pre "E: oth act can	evention of an xploitation" n	y further occurrence					
"E oth act can	xploitation" n	-					
oth act car	-						
act car	harwise illegal	, unauthorized, or improper					
car		an individual, including a					
		iciary, that uses the					
	•						
	-	erson we support for					
		sonal benefit, profit, or gain,					
		depriving a person we					
-		ul access to, or use of,					
		es, belongings, or					
		deral tag relates to					
	•)407693.9-3-2(a)					
	3.420(d)(3)						
		ENT OF CLIENTS nave evidence that all					
	•	are thoroughly investigated.					
		view and interview for 7 of 8	W	0154	W154: Staff Treatment of	Clients	05/27/202
		F, G and H) the facility was					
	-	presentative payee, the			Corrective Action:	4	
		nduct a thorough investigation s of the clients affected and the			The Operation Support Specialist was trained on		
		tolen from each client.			a thorough investigation is		

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION 2	(X3) DATE SURVEY		
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
15G255		B. WING		05/10/2023			
			STREET	ADDRESS, CITY, STATE, ZIP COD			
	PROVIDER OR SUPPLIE			HAD DR			
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN	VERSA	AILLES, IN 47042			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	PROVIDER'S PLAN OF CO				
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	Findings include:			completed on all investigations			
	r manigs menude.			that involve multiple	ile		
	0 1/25/22 -+ 1.00			clients/locations, to ensure deta	lis		
		PM, a review of the facility's		are provided for the individual			
	-	as conducted and indicated the		client/locations in separate			
	following:			investigations for each location.			
	A 4/20/22 D			(Attachment O)			
		of Developmental Disabilities		• The Operation Support			
		ncident report indicated, "There		Specialist trained the Quality			
	Ū.	tion of misappropriation of		Assurance Manager and the			
		t of the account is being		Quality Assurance Coordinator			
	-	ount of funds is undetermined		Ensuring a thorough investigation			
		illeged to be responsible for		is completed on all investigation	IS		
		of funds has been suspended		that involve multiple			
		ion. In addition, the police have		clients/locations, to ensure deta	lls		
		he initial case number is [case		are provided for the individual			
		ds proven to be missing will be		client/locations in separate			
	reimbursed by Res	Care"		investigations for each location.			
				(Attachment P)			
		'PM, a review of the clients'		Quality Assurance Manage	er		
		nagement Service (RFMS)		and Quality Assurance			
		the clients had the following		Coordinator will conduct			
	"Transaction Frauc	dulent" from their accounts:		investigations for all allegations			
				Abuse Neglect and Exploitation			
	1) Client A: \$18.0			(Attachment Q)			
	2) Client C: \$2604			Rescare Management will			
	3) Client D: \$134.			peer review all investigations to			
	4) Client E: \$104.			ensure they are thorough.			
	5) Client F: \$82.0			(Attachment R)			
	6) Client G: \$7734			• Observations are being			
	7) Client H: \$194.	00		conducted by Rescare			
	Total: \$10870.00			Management 3 times weekly for			
				no less than 60 days to audit all			
	-	23 Investigative Summary		financials. (Attachment S)			
		onclusion, "It is substantiated		• Daily calls are conducted			
	-	or/OC] embezzled client and		with Rescare Management to			
		m [name of bank] 'pass through'		discuss financial processes and			
		tantiated [OC] exploited clients		procedures, financial policies ar			
	-	ent funds." The investigation's		implementation of those policies	3.		
	statement from the	Business Office Manager		and are tracked by the Quality			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES. IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE (BOM) indicated, "[BOM] was asked what Assurance Manager. issue(s) he noticed with the pass-through expenditures account and if he had spoken with any other business office staff about the issue. He replied with the following email: 'When reviewing the "pass through" account statements Monitoring of Corrective on 4/11/2023, I noticed previous ending balances Action: were below the amount of funds ResCare funded All investigations of ANE will the account with. I knew there had to be an issue be peer reviewed by the Program because the initial balance on the account should Manager, Human Resource remain the same, given no bank fees occurred, as Manager, Quality Assurance funds get deposited and withdrawn in the same Manager, Program Director and amount. As I was reviewing the statements and Executive Director. photocopies of the deposits and withdrawals, I After the investigation is was briefly talking to [OC]. I made comments reviewed by the internal peer along the line of, "something is off with the review the investigation will then account." I was sitting at her desk as I was be sent to the Regional Director reviewing. [OC] was occupied, signing client and Corporate Human Resources funds out to staff. Her direct involvement in the for further review to ensure the conversation at that time was minimal. I did not investigation is thorough and have Mar-2023 (March 2023) statement, so I complete. stopped reviewing and went to the bank to get a Daily Calls are tracked by copy. After I got the statement, I noticed the the Quality Assurance Manager balance was at \$210.86. After getting the most and include discussion of any recent statement, I went back to the office and had allegations of ANE and the a conversation with [Quality Assurance investigation into those Manager/QAM]. I asked [QAM] if she had time allegations. so I could get her professional opinion and brief her on the suspicions I had. She did have time Completion Date: 5/27/23 and we spoke in private in the ResCare lunchroom. I explained to her what the "pass through" account was and how we utilized it. In addition, I showed her the discrepancies we were experiencing. After the conversation, I explained I was not sure what the next steps were going to be and had to bring [ED], up to date. This concluded our conversation. Shortly after having the

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conversation with [QAM], I asked [OC] to join me

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OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G255 05/10/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE in the lounge so we could review it together. As we sat down at the table, I pointed out the September 2022 statement. This was the first month the account balance dropped below the amount ResCare funded it with (\$7000.00). I then went through each month showing the influx in the balance. As I was about to continue my explanation and what we were looking for, [OC] stopped me and said, "I did it. I took the money. I'm so sorry." I did not say anything right away as I was in shock. She continued to cry and previously apologize stating she would pay it all back. I told her we need to go talk to [Human Resources Manager/HRM]. She explained she wanted to speak with [ED] and she didn't want anyone else to see her in the state she was in. She asked to go wait in [ED's] office. I said that was fine. Once I got to HR, I shut the door and explained everything that [OC] and I had just spoken about to [HRM]. We then called [ED] and told her [OC] admitted to stealing the funds. We discussed what the next steps would be and went to [ED's] office, with [ED] on speaker. [OC] and [ED] spoke. [OC] was apologetic and promised to pay everything back. The conversation ended with [OC], [HRM] and me signing her suspension form. This statement is the best recollection of the events and conversation that transpired on 4/11/2023." During follow-up questioning, [BOM] states that the account was established in April 2021 and that [Treasury] assisted with opening the account at [name of bank]. He states that the initial opening balance was \$500 and then there was a second deposit of \$6500, meaning that ResCare funded the account with a total of \$7000. He states that authorized signers on the account are himself, [OC], [Program Manager], [former Program Manager], [name of current Program Director], LWFE11 Facility ID: 000775 Page 60 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE [Program Manager], [name of former Program Director], and [former Office Coordinator for payroll]. He states that all signers have had access to the account since its opening, however, of those listed, only [OC] and he had ever gone to the bank to make transactions using the account. He states that the account was used as a 'pass-through' account, meaning it was established as a means for providing clients with access to their funds in the form of cash. He states that anytime a client needs cash, a check was cut to Normal Life of Indiana (ResCare). The check can then be deposited into the 'pass-through' account and the exact deposited amount can be withdrawn. The balance of the account should always remain the same (\$7000.00), as funds deposited are then immediately withdrawn (in the same amount). He states that the account was monitored daily by the [OC] as deposits and withdrawals were made. The [BOM] was responsible for overseeing the account by doing reconciliations. He states that the majority of the clients for whom ResCare serves as rep-payee have had funds pass through the account. On average, the account is used weekly. It was used regularly for group home clients monthly allowances and waiver client cash-on-hand monthly allowances. Any other times the account was used it would have been for special requests where cash is necessary. [BOM] describes the process of the 'pass-through' account as follows: 1. Receive request for funds for client (if necessary). 2. Complete check request spreadsheet (including client name, RFMS ID, amount, description, and vendor (Normal Life of Indiana). 3. Send spreadsheet to RFMS processing team-they queue check. Event ID: LWFE11 Facility ID: 000775 Page 61 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G255	A. BUILDING B. WING	DNSTRUCTION 00	COM 05/	te survey Mpleted 10/2023
	PROVIDER OR SUPPLI RE COMMUNITY	ER ALTERNATIVES SE IN	154 CH	ADDRESS, CITY, STATE, ZIP IAD DR AILLES, IN 47042	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
	 5. Check request a envelopes (per cli of money enclose 6. Ledgers are cre 7. Deposit and wi 8. Drive to bank. 9. Provide deposi provided to bank 10. Withdrawal sli 11. Bank teller br envelopes per clie 12. Office Coordi returns to office v per client showing into the office safi 13. Staff are then be picked up. 14. Staff come to on the ledger. 15. Funds are ther ledger in the hom [BOM] states he of procedures for may been provided to a conversations reg account. He state copy of any polic the pass-through a Director] gave din reconciled month discrepancies in e admits he had not account monthly. to [Program Direct private, noting his seemingly not ball to keep the conversion 	ated per client in the batch. thdrawal slips completed. t slip(s) and/or check(s) teller. ip provided with exact amount. eaks up cash into money ent in the exact amount. nator or Business Manager vith cash. Ledgers are completed g funds have been deposited				

OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE her assistance with reviewing. He states that at this point, he was working on getting the remaining statements and check copies in order to complete a thorough review. He states he mentioned to [ED] that he thought 'something was up' and that he would follow-up with her once he had completed his review. He states he informed [QAM], [OC], [HRM], and [ED] on 4/11/23 that he had verified discrepancies " The OC's statement in the facility's investigation indicated, "[OC] was contacted via phone and was asked if there were any other accounts affected after her admission to taking money that did not belong to her. She stated that it was only the 'pass-through' account. She was asked if any client funds had been taken during the process and stated that all clients received their money and none were affected. An appointment was made for further interview following collection of evidence and [OC] initially agreed to meet, but later stated she had changed her mind and declined." The ED's statement in the facility's investigation indicated, "...On Tuesday approximately 2:31pm, I received a text from [BOM] to let me know he needed me to call him because he has a problem and doesn't know what to do. He called me shortly thereafter with [HRM] on speaker phone and relayed that he wanted to reconcile the 'pass-through' account at [name of bank] before the new Business Manager starts but noticed a problem. He suspected some fraudulent activity and said he asked [OC] for the bank statements. He told me that she had put him off and then finally relayed that she had taken money. They had [OC] go into my office and took the phone in there. I relayed to her that she was suspended and she kept apologizing and said she had a LWFE11 Facility ID: 000775 Page 63 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

06/07/2023

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE gambling problem. She said she started online gambling on her phone. I asked if there was any client money involved and she said no, only ResCare money from the 'pass-through' account at [name of bank]. She states, '[OC] was suspended immediately and an investigation started.' She states, 'On Thursday morning on my way into work, I called [OC] and said, 'It wasn't just the 'passthrough (sic) account was it? It was client funds too ... you made checks for cash that was (sic) supposed to go to the ARC (Association of Remarkable Citizens) and took them, you took spending money? '[OC] replied with, 'Yes.' I then asked,'How much are we talking about, [OC]? She replied with, 'I don't know, maybe \$20,000.' The rest of the conversation consisted of her apologizing and saying she would take it all back (if she could)." The PD's statement in the facility's investigation indicated, "[PD] was asked to describe the conversation between she, [BOM], and [PM] when he came to them to speak about a potential issue he had noticed with the balance of the 'pass-through' account. She states, 'I can't recall if it was August or September (2022) but [BOM] had stopped in our office and said he had a feeling something was 'off' in the cash account at [name of bank]. [BOM] stated that he was thinking the account may be off and if the checks weren't ran (sic) through right it could cause the balance to be off. I never heard any more about the 'pass-through' account until 4/11/23 when the current investigation was initiated." The Factual Findings section of the facility's investigation indicated, "During the investigative process, all client RFMS statements from 4/1/21 (date of pass through account opening) through April of 2023 were audited. Suspicious Event ID: LWFE11 Facility ID: 000775 Page 64 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G255 05/10/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE transactions were listed and flagged for review with supporting documentation. Documentation was obtained to verify which of the flagged transactions were fraudulent or executed correctly on behalf of the clients. A spreadsheet was generated to track all transactions flagged for review and their verification status. Review if (sic) client RFMS statements confirms checks were issued to Normal Life of Indiana (ResCare) on behalf of clients for weekly/monthly spending, ARC, Funeral, and ABLE trust funds (tax-advantaged savings and investment accounts for individuals with disabilities), and other client spending needs. Review if (sic) client RFMS statements confirms checks were issued to Normal Life of Indiana (ResCare) on behalf of clients for Stimulus funds for various needs including those mentioned above. Review of the [name of bank] account (pass-through) confirms client checks issued to Normal Life of Indiana (ResCare) were deposited in the 'pass through' account. Review of the [name of bank] withdrawal slips confirms [OC] was the only person withdrawing funds from the account. Review of client Funeral, ARC, and ABLE accounts confirms deposits were not made to the accounts for the designated amounts noted in their RFMS statements. Review of client Resource Ledger Sheets confirms clients did not receive all funds issued from their RFMS accounts for weekly/monthly spending, ARC, Funeral, and ABLE trust funds, and other client spending needs. Client lists/spreadsheets of audit results will be added to the investigation file when final auditing has been completed. Review of the [name of bank] pass through account confirms ResCare funds totaling \$7,000.00 were deposited to open the account and service fees of \$134.63 should result in a remaining balance of \$6,865.37. As of April 2023, the balance of the account is \$95.86 confirming a deficit of \$6,769.51. [BOM] LWFE11 Facility ID: 000775 Page 65 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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STATEMENT OF		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	(X2) MULTIP A. BUILDIN B. WING	√G 	00		DATE SURVEY COMPLETED D5/10/2023
NAME OF PROV		ER ALTERNATIVES SE IN	15	4 CHAE	DRESS, CITY, STATE, 2 DDR .ES, IN 47042	ZIP COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREF TA		PROVIDER'S PLAN O (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) Completic Date
acc sha acc the inii rec sul fur acc thr Th evi -N eac -N eac -N wa Or sta WI po is 1 po get inv Th in con the or sul fur acc thr thr thr evi -N eac -N -N eac -N -N eac -N eac -N -N eac -N -N eac -N - N eac -N - N eac -N - N eac -N - -N eac -N - -N - - -N - - - 	count thoroughle took ResCare count funds and fame of bank tially denied tal canted" The ostantiated [OC ads from the [na count. It is sub- ough theft of cl e facility's inve- idenced by: ot identifying the ploitation. ot identifying the ch client. ot identifying the client. ot identifying th	stigation was not thorough as he clients involved in the he amount of money stolen from he amount of money each client					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ENTERS FOR	MEDICARE & MEDIC	AID SERVICES				ОМ	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	INSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G255	B. WI	NG		05/10/	/2023
	ROVIDER OR SUPPLIER	TERNATIVES SE IN		154 CH	ADDRESS, CITY, STATE, ZIP COD AD DR ILLES, IN 47042	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	number of clients at	eded to include the total fected and how much money h client. The PD indicated the					

total amount of money stolen from all the clients involved was over \$260,000.00. On 5/4/23 at 1:02 PM, the OSS stated "we need to add client information. Need to add an addendum statement. Need to break it out by client. It is not thorough without the information."

> mentioned above. Review of the [name of bank] account (pass through) confirms client checks issued to Normal Life of Indiana (ResCare) were deposited in the 'pass through' account. Review of the [name of bank] withdrawal slips confirms [OC] was the only person withdrawing funds from the account. Review of client Funeral, ARC, and

On 5/4/23 at 3:48 PM, the Program Director (PD)	
sent an email with a Financial Investigation	
Summary attached. The Factual Findings section	
indicated, "During the investigative process, all	
client RFMS statements from 4/1/21 (date of pass	
through account opening) through April of 2023	
were audited. Suspicious transactions were listed	
and flagged for review with supporting	
documentation. Documentation was obtained to	
verify which of the flagged transactions were	
fraudulent or executed correctly on behalf of the	
clients. A spreadsheet was generated to track all	
transactions flagged for review and their	
verification status. Review of client RFMS	
statements confirms checks were issued to Normal	
Life of Indiana (ResCare) on behalf of clients for	
weekly/monthly spending, ARC, Funeral, and	
ABLE trust funds, and other client spending	
needs. Review of client RFMS statements	
confirms checks were issued to Normal Life of	
Indiana (ResCare) on behalf of clients for Stimulus	
funds for various needs including those	

Event ID:

LWFE11 Facility ID: 000775

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE ABLE accounts confirms deposits were not made to the accounts for the designated amounts noted in their RFMS statements. Review of client Resource Ledger Sheets confirms clients did not receive all funds issued from their RFMS accounts for weekly/monthly spending, ARC, Funeral, and ABLE trust funds, and other client spending needs. Client lists/spreadsheets of audit results will be added to the investigation file when final auditing has been completed. Review of the [name of bank] pass through account confirms ResCare funds totaling \$7,000.00 were deposited to open the account and service fees of \$134.63 should result in a remaining balance of \$6,865.37. As of April 2023, the balance of the account is \$95.86 confirming a deficit of \$6,769.51. [BOM] stated he was not reconciling the 'pass-through' account thoroughly each month. [OC] admitted she took ResCare funds and client funds (ARC account funds and client spending funds) from the [name of bank] 'pass-through' account. [OC] initially denied taking client funds then recanted. Conclusion: It is substantiated [OC] embezzled client and ResCare funds from the [name of bank] 'pass through' account. It is substantiated [OC] exploited clients through theft of client funds." The summary indicated, "ADDENDUM: Upon final audit the following funds were embezzled from the [name of group home] clients: [Client E] - \$104.00 [Client D] - \$134.00 [Client H] - \$194.00 [Client G] - \$7734.00 [Client F] - \$82.00 [Client A] - \$18.00 [Client C] - \$2604.00 (Total: \$10870.00) Additionally, it was determined that collectively, LWFE11 Facility ID: 000775 Page 68 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE \$253,305.59 was embezzled from 106 clients. All financial documentation reviewed for this investigation is being released to the [name of city] PD (police department)/Prosecutor, and the Attorney General for prosecution of [OC] for the embezzlement. ResCare will comply with all requests/directives from the above entities as received." On 5/9/23 at 12:08 PM, the OSS emailed a copy of the investigation with the following Addendum, "...[BOM] and [OC] are no longer with the company. Recommendations Being Implemented: Implement Pass Through Account Procedure, Retrain all management staff ... on Client Trust Funds Policy, Implement review process for ABLE, ARC, and Funeral Trust Accounts, Retrain all management staff ... on RFMS statement review process, and Report all discrepancies immediately to Quality Assurance Dept for investigation." On 5/5/23 at 9:19 AM, the OSS indicated the BOM was going to be terminated due to knowing there was an issue with the ResCare pass through account in February 2023 but not taking action to resolve the issue at the time. The BOM showed the OSS a text he (BOM) sent to the Executive Director (ED) on 2/1/23 indicating the pass through account balance was \$93.00 when it should have been around \$6,800.00. The BOM did not report his concerns to the Quality Assurance department for them to investigate the issue. The BOM did report his concerns to the ED. Neither of them took action at the time. The ED indicated to the OSS during her interview she was not aware of the pass through account issues until April 2023. On 4/27/23 at 9:17 AM, a review of an email from the QAM was conducted. The email included a Event ID: LWFE11 Facility ID: 000775 Page 69 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/10/2023 15G255 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 4/26/23 Investigation Peer Review (administrative review). The review indicated, "The allegations of exploitation and theft of client funds and theft of ResCare funds has been substantiated. Recommendations include termination of employment for [OC] and ineligible for rehire due to substantiated exploitation and theft. Additional recommendations will be added upon final audit." On 5/4/23 at 1:17 PM, a review of 5/3/23 Investigation Peer review indicated, "The allegations of exploitation and theft of client funds and theft of ResCare funds has been substantiated. [OC] has been terminated of her employment and is deemed ineligible for rehire due to substantiated exploitation and theft. Her access has been removed from all ResCare financial applications/accounts. She has been removed as a representative on all ARC and ABLE accounts associated with our clients. All clients will be fully reimbursed by ResCare. ResCare has added internal protective measures until corporate establishes new policies and/or procedures associated with client finances." On 4/25/23 at 12:43 PM, the Program Director (PD) stated "funds were misappropriated by the former Office Coordinator. The police are involved. Working on the investigation. Many thousands of dollars were stolen from the RFMS accounts. Stimulus checks were also taken. Discovered on 4/11/23." The PD indicated the OC was an employee for 17 years. When the Business Manager asked her to reconcile the account, she admitted to taking the clients' money. The PD indicated approximately 131 clients were affected totaling over \$200,000. The PD indicated Rescare funds were also stolen from a pass through account created in April 2021. The PD stated the OC took the money by using "fake requests" of Event ID: LWFE11 Facility ID: 000775 Page 70 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G255 05/10/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the clients' money going to ARC, funeral trusts and ABLE accounts. The PD indicated the OC indicated she had a gambling problem. The PD stated, "ResCare will be reimbursing the clients their money... Substantiated exploitation without a doubt." On 4/25/23 at 2:46 PM, the PD indicated the OC admitted to the ED, BOM and her (PD) she took the money. The PD indicated the OC started taking money 2 years ago when the pass through account was created. The PD stated the BOM told her and the Program Manager "something wasn't right in August/September 2022. Wasn't like he was reporting exploitation, just said money wasn't adding up. He wasn't reporting missing money at the time." The PD indicated she was not aware of the clients missing out on making purchases due to the theft of the clients' money. On 4/25/23 at 1:26 PM, the Operations Support Specialist (OSS) indicated some of the clients living in the group home were affected by the OC. The OSS indicated approximately 100 clients were affected with a total of \$250,000 to \$300,000. The OSS indicated the situation started in June 2021 when the facility started using a pass through account for the clients' money. Money came to the account from the clients' RFMS accounts. He stated, "[OC] stole it at this point." The OSS stated it was "substantiated exploitation by [OC]." The OSS indicated he was recommending the OC be terminated. The OSS indicated the BOM turned in his resignation prior to this situation being uncovered. The BOM was conducting an audit when he discovered the issues. The OC admitted to the BOM she stole the money from ResCare but denied taking any of the clients' finances. The OSS indicated the OC took money from ResCare and the clients by using the pass through account. The OSS indicated the BOM was not reconciling the pass through account as LWFE11 Facility ID: 000775 Page 71 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G255	A. B	BUILDING	DNSTRUCTION 00	_ co _ 05	ate survey Mpleted /10/2023
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(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
	he should have. T most likely be term OC was stealing m ARC trusts and AI On 4/25/23 at 1:47 has been stealing f He indicated the O the pass through ac January 2023, he m through account. T \$7000.00. The mo immediately gets w clients. In January \$4000-5000. He in the PM and PD. He not look into the lo indicated he went admitted to stealin indicated he went admitted to stealin indicated she did m funds. She denied She was able to tal requests and forge signatures. He ind requests for ARC to had the checks ma instead of the trust made out to Norm checks. The BOM ensure Executive I for anything over S created "false ledg ledger did not show were payable). He	he OSS stated the BOM "will ninated." The OSS indicated the oney going to funeral trusts,					
	account was starte working at the faci "I reconcile the act the OC to get state	d. He indicated he started lity in January 2021. He stated counts." He indicated he asked ments for the accounts and she She indicated she forgot and					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G255 05/10/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE then never provided them to him. He indicated in September 2022, he noticed the balance dropped below \$6,600.00. He stated, "I told them I would do a full reconciliation. I got caught up in other things and didn't do it until this month when I reconciled the accounts for the new BOM." He stated, "I feel some responsibility. It was my responsibility to reconcile the account. I failed to do so for 3-5 months." He stated the OC was "deceiving" and she "committed a crime." The BC indicated there was no investigation conducted in September 2022 when he first noticed there was an issue. He stated, "I told [ED] I would review it and tell her what I found." The BOM stated, "She admitted to taking it. I would have never thought she would have taken it. The total funds missing is approximately \$282,000." He indicated he was not sure what percentage was from ResCare and what was from the client funds. The BOM stated there was "room for improvement. Clients will be reimbursed. There is enough evidence to substantiate exploitation of the clients' funds." On 4/25/23 at 2:59 PM, the Executive Director (ED) indicated there were 112 clients involved and more than \$250,000 stolen. The ED stated, "Definitely going to substantiate exploitation. She will be terminated." The ED indicated she received a text from the BOM on 4/11/23 asking her to call him (BOM). He said he went to reconcile the pass through account and "something was off." The ED stated the OC admitted to stealing ResCare money of approximately \$6,600.00. The ED stated, "She (OC) admitted it to me and HR that she stole the money. She said she had a gambling problem. She said it was just ResCare money. She said she was going to pay it back." On 4/12/23, she indicated the facility checked the clients' finances. The ED stated, "she (OC) was taking the clients' and ResCare's money." The ED indicated the OC Event ID: LWFE11 Facility ID: 000775 Page 73 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G255 05/10/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 154 CHAD DR **RES CARE COMMUNITY ALTERNATIVES SE IN** VERSAILLES, IN 47042 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE was taking money intended for the ARC trust but making the check out to Normal Life so she could cash the check and keep the money. The ED stated on 4/13/23, the OC "admitted she was taking the clients' funds. She said it was around \$20,000.00 and promised to pay the money back." The ED indicated the amount of money discovered missing grew from there. The ED indicated the RFMS statements when printed certain ways did not show the vendor therefore others could not see who the checks were made out to. The ED indicated the OC worked at the facility for 18 years. The ED indicated prior to the pass through account being instituted, the clients had their own bank accounts. The ED indicated the BOM was supposed to reconcile the pass through account monthly. She stated the "[BOM] didn't do it for a long while. Over a year. When he figured out the pass through account was low he reconciled it." She indicated it was not part of the BOM's job responsibility. She indicated the BOM reconciled the account for awhile with no issues noted. She indicated she was first aware of the issue on 4/11/23. She stated "just [OC] and [BOM] had access to the RFMS accounts." The ED stated, "she (OC) was printing and providing the (RFMS) statements in a format that did not provide all the information. Didn't know all the other information was available. Easily detected now that I know." She indicated she was not aware of any clients who couldn't buy something due to the missing funds. On 5/9/23 at 2:11 PM, the Chief Security Officer (CSO) indicated the pass through account was initially opened with \$500.00 and 5 signers. The CSO indicated the account should not have had 5 signers on the account. Due to the amount of funds going into and out of the account, the total amount in the account was increased to \$7000.00. Event ID: LWFE11 Facility ID: 000775 Page 74 of 75 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

06/07/2023

TERS FO	R MEDICARE & MEDIC	AID SERVICES				(OMB NO. 0938-0	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE				ULTIPLE CO	CONSTRUCTION		(3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED		
		15G255	B. WING			05/10/2023		
NAME OF 1	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP C	OD		
RES CARE COMMUNITY ALTERNATIVES SE IN			154 CHAD DR VERSAILLES, IN 47042					
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH		COMPLET	
TAG		REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	The CSO indicated the amount in the account							
	should not have been increased to \$7000.00							
	without corporate approval, which did not							
		stated the BOM "did not						
	reconcile the account like he was supposed to" on							
	a monthly basis. The CSO indicated the BOM							
	forgot his password on the account and did not							
	check it. The BOM asked the OC to get							
	statements however she never provided them to							
	the BOM. The BOM indicated he got busy and							
	did not follow up to get the statements until the							
	BOM went to the bank to request statements in							
	January 2023. When the BOM got the statements,							
	he realized the account dropped below \$7000.00							
	several times. The BOM informed the ED. The							
	ED indicated she thought the BOM was taking							
	care of the issue. T	he CSO stated the BOM "got						
	busy" and after a few months, started to go							
	through the statements. While going through the							
	statements with the	OC, the OC admitted to taking						
	ResCare's money.	The CSO indicated the total						
	amount between Re	esCare's money and client						
	funds was \$280,000).00.						
	The CSO stated the	BOM, "didn't do what he was						
		arding reconciling the pass						
	•	onthly. The CSO indicated the						
	-	lowed up to ensure he was						
		sue in January 2023 when the						
		rted his concerns. The CSO						
		there were staff who had						
		e clients' funds, no one						
	-	uality Assurance department.						
		OC "falsified documents and						
	requests."							
	This federal tag rela	ates to complaint #IN00407693.						
	9-3-2(a)							
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