PRINTED: 07/14/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CI AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G255			(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/22/2023			
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 154 CHAD DR VERSAILLES, IN 47042				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION	
TAG W 0000	REGULATORY OR	LISC IDENTIFYING INFORMATION	TAG	DEFEREN		DATE	
Bldg. 00			W 0000				
	accordance with 46 Quality Review of t on 6/28/23.	00775 5G255 0248960 o reflects state findings in					
W 0149 Bldg. 00	written policies an mistreatment, neg Based on record rev incident/investigativ client A, the facility and procedures to p	ent of clients develop and implement d procedures that prohibit lect or abuse of the client. riew and interview for 1 of 10 we reports reviewed affecting failed to implement its policies revent neglect of client A.	W 0149	W149: The facility must develor and implement written policies procedures that prohibit mistreatment, neglect or abust the client.	and	07/10/2023	
	incident/investigative indicated the follow On 5/29/23 at 11:53 program staff asked return to the group between the control of the group between the group b	PM, a review of the facility's we reports was conducted and ring:  6 AM, a facility-operated day when client A was going to mome from a home visit. The Developmental Disabilities		Corrective Action:  All staff trained on the Aband Neglect Exploitation Police (Attachment A)  Staff terminated from employment from Rescare for Neglect of client (A). (Attachment)	y.		

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

TITLE (X6) DATE

Anna Brison Program Director 07/07/2023

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

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STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	a. Building <u>00</u>		00	COMPLETED	
15G255		15G255	B. WING 06/22/2		2023		
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				154 CH			
RES CARE COMMUNITY ALTERNATIVES SE IN					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		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		port indicated, "The group			<ul> <li>QIDP put a roll call sheet</li> </ul>		
		en the clients to the day			place to be used in the van da	•	
		gram staff asked where [client			to ensure all clients are loaded	d in	
	_	w he wasn't with the group.			the van prior to departure.		
	-	nmediately went to the home			(Attachment C)		
		been left at the group home.			· All staff trained on the ne	·W	
		well and received no injuries			roll call sheet process.		
	from this incident	·"			(Attachment D)		
	Th - (/2/22 I	-4i C			Monitoring of Corrective		
		ative Summary indicated in the "The allegation that [staff #6]			Action:	•	
		group home the morning of			All staff are trained on the  Abuse Neglect policy upon hir		
		ated. [Staff #6] stated they left			Abuse Neglect policy upon him		
		ween 8:30am-8:40am and he			and reviewed monthly with the Area Supervisor during house		
	~ .	ad left [client A] until [Program			meetings.		
		led to suspend him. Day			IDT team meets quarterly	,	
		-			and as needed to discuss nee	•	
	program staff realize (sic) [client A] was at the group home that morning when [client B] states at				the clients and behavior	u ioi	
	lunch that [client A] was at the group home. [Day				interventions.		
	_	called [PM]. [PM] called			· All abuse neglect allegati	ions	
	-	[name of city]. [Nurse] text			will be investigated by Quality		
	(sic) [PM] at 12:13 pm saying she had [client A]				Assurance.		
	and he is fine. [Client A] was at the group home						
	alone appropriately (sic) 3 hours and 45 minutes				Completion Date: 7/10/23		
	alone."				•		
	G. 66 H.C. 61-100 -						
		orrective Action Form indicated,					
	"As you know, ResCare believes in helping						
	people live their best life. For all teams, the						
		standards (LEGACY) set the					
	_	we are to manage the we are to interact with others.					
		player, you are not only					
	_	the LEGACY Quality					
		are required to conduct					
		sional manner when					
	conducting company business and when on						
	company property.						
	As you are aware, I	ResCare maintains that certain					

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		X1) PROVIDER/SUPPLIER/CLIA	l í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING 00 COMPLE  B. WING 06/22/2					
15G255		B. W	ING		06/22	/2023	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
				154 CH	AD DR ILLES, IN 47042		
RES CARE COMMUNITY ALTERNATIVES SE IN				VERSA	ILLES, IN 47042		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE.	COMPLETION DATE
TAG		as regarding employee	+	TAG			DATE
	-	ary for the efficient operation					
		d for the benefit and safety of					
		he persons we serve. Conduct					
	that interferes with	operations is not acceptable					
		rated. ResCare Standards of					
	· ·	ns A1 states, 'Any acts of					
		tion, abuse, and/or neglect					
		als we serve will result in					
		to and including a release.' It n 5/29/23, you left a client at					
	home alone that was to receive 24/7 (24 hours a day/7 days a week) care. This is a direct violation						
	of the above referenced policy. As a result, your						
	employment with ResCare has been terminated."						
	On 6/21/22 at 2,29	DM a marriagy of the facility's					
		PM, a review of the facility's Violations of Policies and					
		iducted. The policy indicated,					
		rohibits abuse, neglect,					
		atment, or violation of an					
	-	A review of an undated					
	Abuse, Neglect and	Exploitation policy indicated,					
	-	ersons served are free from					
	abuse, neglect, or exploitation ResCare does not						
		ect, or exploitation of any					
	persons served. All employees are required to						
		r suspected incidents of exploitation. All alleged or					
	-	-					
	suspected abuse, neglect, and/or exploitation will be immediately investigated. Appropriate						
		ill be taken to ensure					
		arther occurrence"					
		s cited on 5/10/23. The facility					
	-	a systemic plan of correction					
	to prevent recurrence	ce.					
	This federal tag rela	ates to complaint #IN00407693					
	This federal tag relates to complaint #IN00407693.						

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Event ID: LWFE12 Facility ID: 000775

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/14/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		15G255	B. WING			06/22/2023	
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	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL			TE	COMPLETION	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	9-3-2(a)						
'			•		•		•

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