AND PLAN OF CORRECTION IDE		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/18/2019	
	PROVIDER OR SUPPLIEI	LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143		
(X4) ID PREFIX TAG W 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE SICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
Bldg. 00	#IN00284619.  Complaint #IN0028 Federal/State deficition are cited at W122, Survey dates: Febrical Facility Number: Open Number: AIM Number: 200 These federal deficition accordance with 46	ruary 14, 15 and 18, 2019.  004615 15G723 1528230 iencies reflect state findings in	W 0000			
W 0122 Bldg. 00	protections requir Based on observation interview for 1 of 2 Condition of Partice not met. The facility policies and procedule clients to be free of protect client A frow ho encouraged him medications and what upon rules and failed	ensure that specific client	W 0122	1. The Program Manager will ensure the Area Supervisor and Residential Manager retrain direcare staff on the Abuse, Negled and Exploitation Policy. Failure follow policy will result in disciplinary action up to and including termination.  2. Upon return of Client A to the facility, a no trespassing/contact order between Client A and Relative to prevent contact was initiated and is being enforced.	ect ct e to e	

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

1. The facility failed to ensure the facility's

TITLE

Clark County Sheriff's Department.

(X6) DATE

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: RC1B11 Facility ID: 004615 If continuation sheet Page 1 of 23

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

PRINTED: 03/28/2019 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G723		A. BUILDING B. WING	00	COMPLETED 02/18/2019	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD HORIZON DR	
RES CAF	RE COMMUNITY AL	TERNATIVES SE IN		HIS, IN 47143	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	A from a repeat visi in which she did not medications and rett promised. Please see 2. The facility negle measures to keep cli his relative wherein for items purchased encouraged him to redications. Please	ing staff neglect to keep client t with his relative after a visit t ensure he took prescribed urned to the facility as e W149.  Acted to implement corrective tient A from a repeat visit with she failed to return receipts with client A's money and not take his prescribed		The facility administrator petitioned for an Emergency Protective Order that was sent to Relative and the order was granted on 3/14/2019. The fa administrator will contact the County Sheriff's Department i event of attempted contact by Relative with Client A.  3. ResCare received a request \$130 of personal spending more for which no receipts were received. Client A has been reimbursed \$130 for the unaccounted funds. The Prog Manager Area Supervisor and Residential manager will be re-trained on policy for request personal funds. Failure to foll the policy will result in disciplinaction up to and including termination.  4. Before any client leaves the Facility, the guardian/family/friends the clien will be departing with will be trained on the medical administration standard and wisign a Leave of Absence Form before the client is released to leave. Upon return, the Facility ensure medication was administered appropriately, if the client will be assessed by Nurse, and the incident will be reported to Quality Assurance submission of an incident reported to Sulphinister to the policy of an incident reported to Sulphinister to Sulphiniste	cility Clark n the  st for oney  ram d st of ow nary  e ent  y will not the e for

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Event ID:

RC1B11 Facility ID: 004615

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

PRINTED: 03/28/2019 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	` ′	JILDING	ONSTRUCTION 00	(X3) DATE COMPL 02/18/	ETED
	ROVIDER OR SUPPLIER	L LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR MEMPHIS, IN 47143				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
W 0149	483 420(4)(4)				Monitoring of Corrective Action The Program Manager, Area Supervisor, and Residential Manager will ensure all allega of abuse, neglect and exploits are reported to the Quality Assurance department. The Program Manager, Quality Assurance, QIDP, Nursing, Behavior Clinician, Area Supervisor and Residential Manager from the facility will a weekly for 90 days to review a reports and ensure accurate reporting of abuse, neglect or exploitation. The Residential Manager will review daily documentation to ensure accurate reporting has been completed 90 days. Administrative staff a complete a minimum of three unannounced visits weekly for days for monitoring. The Residential Manager will ensu incidents are reported to QA a QA will review all incident rep- and follow the abuse, neglect exploitation policy when applicable.  Persons Responsible: Progr Manager, Area Supervisor, QIDP, Residential Manager, and DSPs.	meet all urate I for vill ure all and orts and	
W 0149 Bldg. 00		ENT OF CLIENTS develop and implement					

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Event ID:

RC1B11

Facility ID: 004615

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i i i i i i i i i i i i i i i i i i i		(X2) MU	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLE	TED
		15G723	B. WI	NG		02/18/2	2019
		<u> </u>	•	STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		13009	HORIZON DR		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		MEMPI	HIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE .	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		nd procedures that prohibit					
		glect or abuse of the client.	117.0	1.40	1 7 5 4		02/20/2010
		view and interview for 1 of 2	W O	W 0149 1. The Program Manager v			03/20/2019
		o, for 3 of 5 investigations of			ensure the Area Supervisor at		
		pitation reviewed, the facility			Residential Manager retrain di		
	failed to ensure the facility's neglect/abuse/mistreatment policy was				care staff on the Abuse, Negle		
	implemented regarding staff neglect of client A.				and Exploitation Policy. Failur	re to	
	The facility failed to keep client A from a repeat				follow policy will result in		
					disciplinary action up to and		
	visit with his relative after a visit in which she did not ensure he took prescribed medications and				including termination.		
	returned to the facility as promised.				2. Upon return of Client A to the	20	
	returned to the facility as profilised.				facility, a no trespassing/conta		
Findings include:				order between Client A and	101		
	Findings include:					.	
	The facility's Rurea	u of Developmental Disabilities			Relative to prevent contact wa initiated and is being enforced		
		ports, incident reports and			Clark County Sheriff's Departr	-	
	_	reviewed on 2/14/19 at 11:45			The facility administrator	Helli.	
	_	at 10:00 AM and indicated the			petitioned for an Emergency		
	following:	at 10.00 Aw and indicated the			Protective Order that was serv	,od	
	ionowing.				to Relative and the order was	veu	
	1 A 1/16/19 RDDS	S report indicated an incident of			granted on 3/14/2019. The fa	cility	
	1/15/19 at 2:00 PM	-			administrator will contact the (	-	
	1/13/19 41 2:00 1111	•			County Sheriff's Department in		
	"Narrative:				event of attempted contact by		
		to the home after being on			Relative with Client A.		
		rith his [relative], [name] since			Total of the original origina		
		B. When [name] took [Client A]			3. ResCare received a reques	st for	
		2/15/18 she stated he would			\$130 of personal spending mo		
		services. All medications and			for which no receipts were	-,	
		ninistration were provided to			received. Client A has been		
		1/15/2019, [Name] contacted			reimbursed \$130 for the		
		anager and stated she could no			unaccounted funds. The Progr	ram	
	2.1	ent A] and was bringing him			Manager Area Supervisor and		
	back to the group home. When [Client A] returned				Residential manager will be		
	his [relative] stated she did not allow him to take				re-trained on policy for reques	st of	
	any medications for	r over 20 days and no			personal funds. Failure to follo		
	· ·	eturned to the home. The nurse			the policy will result in discipling		
	completed an assess	sment of [Client A] and noted			action up to and including	·	
	_	nent she believed to be tardive			termination		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
			· /			` ′	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		15G723	B. WI	NG		02/18/	/2019
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	e. It was also noted by the					
		d weight loss of 30-35lbs			4. Before any client leaves the	;	
		ember 2018 and [Client A] was			Facility, the		
	_	statements during the			guardian/family/friends the client		
		all the concerns, the nurse			will be departing with will be		
	instructed staff to take [Client A] to the ER				trained on the medical		
	(Emergency Room)	for an evaluation.			administration standard and w		
					sign a Leave of Absence Forn	า	
	Plan to Resolve:				before the client is released to	)	
	[Client A] has been admitted to the behavioral				leave. Upon return, the Facility	y will	
	unit at [name] hospital for further evaluation and				ensure medication was		
	ResCare remains in contact with the hospital for				administered appropriately, if	not	
	updates and discharge planning. The team is				the client will be assessed by	the	
	working with BDD	S and APS (Adult Protective			Nurse, and the incident will be	)	
	Services) to determ	ine what protective measures			reported to Quality Assurance	for	
	can be implemented	l to ensure [Client A]'s safety			submission of an incident repo	ort.	
	upon his discharge	from the hospital. In addition,					
	the program manag	er spoke with APS via phone			5. In the event an emancipate	d	
	explaining the situa	tion. APS is contacting [name]			individual's decision puts them	n at	
	to inform her she is	not to have any contact with			risk of abuse, neglect or		
	[Client A] until she	meets with APS."			exploitation an IDT will be held	d to	
					discuss and determine		
	The 1/22/19 investi	gation regarding the 1/16/19			recommendations. The decision	ion	
	BDDS report indica	nted:			of the IDT will be presented to	the	
					Facility Executive Director for	final	
	"Factual Findings:				approval.		
	[Client A], [name o	f relative], and [LPN #1] stated					
	[client A] did not ta	ke his medications while away			Monitoring of Corrective Action	n:	
	with his relative for	more than 20 days.			The Program Manager, Area		
	[Client A]'(s) [name	e of relative] did not want			Supervisor, and Residential		
	[client A] to take hi	s medications until he was			Manager will ensure all allega	tions	
	re-evaluated.		1		of abuse, neglect and exploita		
	[Client A] returned	to the home (facility) with			are reported to the Quality		
		oss and obvious side effects			Assurance department. The		
	from not taking his				Program Manager, Quality		
	Text messages from [name of relative] confirm				Assurance, QIDP, Nursing,		
		aking his medications.			Behavior Clinician, Area		
	[2.12.1.7.1] was not until g ins insurentions.				Supervisor and Residential		
	Conclusion:				Manager from the facility will r	neet	
		client A] did not take his			weekly for 90 days to review a		
		*	1		l , , , , , , , , , , , , , , , , , , ,		I

	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		15G723	B. WI	NG		02/18/	2019
NAME OF P	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP COD		
					HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG			DATE
	[relative].	+ (plus) days while with his			reports and ensure accurate		
		client Al'(s) [relative] stonned			reporting of abuse, neglect or exploitation. The Residential		
	It is substantiated [client A]'(s) [relative] stopped his medications because she felt he was being				Manager will review daily		
	overmedicated."				documentation to ensure accu	ırate	
					reporting has been completed		
	The investigation's Peer Review dated 1/22/19				90 days. Administrative staff w		
	indicated the following recommendations:				complete a minimum of three		
	_				unannounced visits weekly for	90	
	"1. Continue to follow agency protocols for				days for monitoring. The		
	therapeutic leaves.				Residential Manager will ensu	re all	
		dsman assisting with oversight			incidents are reported to QA a		
	of this case."				QA will review all incident repo		
					and follow the abuse, neglect	and	
	_	S Report dated 1/29/19 to the			exploitation policy when		
	_	6/19 for incident on 1/15/19 at			applicable.		
	2:00 PM indicated:						
	"[Client A] was dis	charged on 1/21/19 with a			Persons Responsible:		
		of Bipolar disorder and			Executive Director, Program		
		ne (genetic disorder). His			Manager, Nurse, QA, Busine	ss	
	lithium was discont	inued. Zyprexa (olanzapine)			Manager, Area Supervisor,		
	was reduced from 4	0 mg QD (once daily) to 30 mg			QIDP, Residential Manager,		
		ote (divalproex sodium) was			and DSPs.		
		mg BID (twice daily) to 750 mg					
		vere also given for [client A] to					
		osychiatrist within 2 weeks.					
		ned on the changes and [client					
	-	vith his psychiatrist on 2/1/2019.					
		A's] [relative] stated she did dications but did so because					
		s over medicated. [Client A's]					
		[relative], BDDS and APS met					
		ne to the agreement [client A]					
		vices with ResCare and will					
		s as prescribed by his					
		P (primary care physician). If					
		[client A's] [relative], they will					
		ed to ensure there are no					
	recurring issues."						
	i e e e e e e e e e e e e e e e e e e e		1		İ		

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

PRINTED: 03/28/2019 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G723		A. BUILDING B. WING	00 00	COMI	PLETED 8/2019	
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	13009 H	ADDRESS, CITY, STATE, ZIP COI HORIZON DR HIS, IN 47143	)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	FERENCED TO THE APPROPRIATE	
	11:18 AM indicated after returning to the informed to dischare Client A's relative h without informing the unit at the local host went to the relative's back to the facility of had not allowed a host 2. A 2/12/19 BDDS 2/11/19 at 6:30 PM:  Narrative: "On 2/3/2019 [clien his [relative] [name] home on 2/11/19 it not take any of his rethe group home. He psychotropic medicagroup home."  Plan to Resolve: "[Client A] will be the evaluation and a val (Depakote/divalproof In addition, visits whimmediately suspens BDDS, APS and the discuss what protect implemented to ensure previous team meeting BDDS, and APS it we calculate the provious team meeting BDDS are the provi	t A] went on a home visit with   . Upon returning to the group was determined [client A] did nedications while away from has also refused to take any ations since his return to the  aken to the ER for an proic acid level ex sodium) will be requested.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 02/18/2019			
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE COMPLETION
	records indicated he funds on 2/5/19 to while visiting his redrawn on client A's and the check was of Client A did not go brother. He did not receipts when he revisit.  3. A 2/13/19 BDDS 2/12/19 at 5:00 PM  Narrative: "[Client A] was spegoing to the ERar [relative] he was exstated the ResCare and the ground his [relative associating with. Accounty] Sherriff's (sto the home and a reallegations."  Plan to Resolve: "A restraining/no tragainst [client A's] access code to the genaged. The team 2/13/19 and it was a allowed with the [reappointed guardian and the process imm. A] is currently refuse medications and refused.	29 PM) of client A's financial e had requested personal visit his brother out of state clative. A check for \$130.00 was personal account dated 2/6/19 cashed by him on 2/7/19. out of state to visit his bring back any money or turned on 2/11/19 from the description of the descript			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  02/18/2019			
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	13009 H	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	ResCare has contaction inpatient medication has agreed criteria in the contact of	requested. In addition, ted a psych hospital for n evaluation and the hospital s met and they will complete on as soon as a bed becomes			
	3:28 PM, client A v #1 indicated on 2/14 QIDP/Qualified Intu #1 and staff #1 were psychiatric hospital admittance. AD #1 surveyor if client A to the facility on 2/1 surveyor (2/14/19 7 had not been accept	ellectual Disability Professional e with client A at the			
	8:28 AM until 9:30 facility. He was eath Client A asked the something in them (unknown in his egg body leaned to the liperiodically. The m Client A indicated but the fruit seemed obtained more pears A. Residential Man of milk after he stat up." Client A indicated he had medications during local workshop and AM until 11:17 AM	s at the facility on 2/15/19 from AM, client A was at his living and scrambled eggs and pears. Surveyor if "they put (did facility staff put something is or pears)?" Client A's upper eft and his torso would jerk overnents were involuntary. He was having difficulty eating a to go down well. Client C is from the refrigerator for client ager #1 offered client A a glass ed his eggs might "come back ated he had visited a relative not been taking his the visits. Client A went to a was observed there from 9:56 If on 2/15/19. Client A was It to do a job of putting long			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  02/18/2019			IPLETED	
	PROVIDER OR SUPPLIER		13009 H	ADDRESS, CITY, STATE, ZIP CO	D	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	MEMP	HIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)		COMPLETION DATE
TAG		aggies. Client A did an	TAG			DATE
	1 ^	which he seemed to enjoy more.				
	Review of client A's indicated an ISP/Ind 11/14/18. The plan included, but were in Disorder (psychotic Disorder (when son appearing sick, by pself-injury), Mild Ir Anti-social and Bor Klinefelter's Syndrochromosome), Hy thyroid gland), Ast Incontinence, Anem blood pressure)."  The review indicate MARs/Medication listed the medication his visit with his rel 12/15/18 - 1/15/19) Advair Diskus 1 pu (asthma), Amitiza 24 mcg./m (constipation), Amoxicillin 500 mg (anti-biotic), Benztropine 2 mg. t side effects of medicetirizine 10 mg. da	s record on 2/15/19 at 2:57 PM dividual Support Plan dated indicated client A's diagnoses not limited to, "Bi-Polar 1 disorder),Factitious neone deceives others by purposely getting sick, or notellectual Difficulties, derline Personality Disorder, ome (genetic disorder/extra X repothyroidism (underactive nma, Constipation, Urinary nia, and Hypertension (high ad client A's 12/18 Administration Records which nis he was taking at the time of ative (leave of absence fibre of the polymer of the				
	incontinence), Divalproex Sod (So mg. twice daily (Bi	dium) DR/delayed release 500 polar),				
	Ferrous Sulf (Sulfat	(e) 325 mg. daily (mineral				
	supplement),	doily (gumplement)				
	_	daily (supplement), tion) 30 ml/milliliters twice				
	daily (constipation)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G723	B. W	NG		02/18/	/2019
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8			HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			HS, IN 47143		
				<u> </u>	,		ı
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY		DATE
	_	cg. daily (hormone),					
	lithium carb (carbonate) ER (extended release) 450 mg. twice daily (Bipolar),						
		•					
	loratadine 10 mg. d	ree times daily (for drop in					
	_	n standing/orthostatic					
	~	ii standing/orthostatic					
	hypotension), olanzapine 10 mg. twice daily plus 20 mg. once						
	daily (anti-psychoti						
		daily (stomach acid),					
		mg. with 200 units Vitamin D					
	(supplement),	g. \\ 200 \( \text{units} \) \\ \\					
		tion aerosol) 2 puffs four times					
	daily (breathing),						
	Strattera 18 mg. one	ce daily (behavior).					
	_	ram) twice daily (stomach					
	ulcers), and						
	Vesicare 10 mg. da	ily (urinary incontinence).					
		gram Manager/PM #1 on					
		indicated client A had no					
		quired physical behavior					
	•	ques and had exhibited verbal					
		re verbally redirectable prior to					
		his psychotropic medications. 2/14/19 at 1:51 PM, client A					
		semi-independent living					
		nome) until his being					
		elative to stop taking his					
	medications.	tiative to stop taking ins					
	medications.						
	Confidential intervi	ew (CI) #1 stated "we dropped					
		A by allowing him to go home					
		ain after the first visit. The					
	_	the client did well when he					
	took his required m	edication. The interview					
		ake time, but if he took his					
		uld be doing as well as he had					
		terview indicated client A was					
	on track to be earni	ng a placement in a less					

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		15G723	B. W	ING		02/18/	2019
NAME OF F	PROVIDER OR SUPPLIER	}			ADDRESS, CITY, STATE, ZIP COD		
					HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		MEMP	HIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION
TAG	regulatory or LSC IDENTIFYING INFORMATION restrictive environment prior to his visits in 12/18			TAG	DEFICIENCE		DATE
	and 1/19 with his re	-					
	and 1/17 with his relative.						
	Confidential interview #2 indicated client A had been doing well working and doing his						
		to the 12/15/18 to 1/15/19 visit					
		he client was exhibiting					
	aggressive behaviors which had not been						
	apparent prior to his psychotropic medic	s visits and refusal to take his					
	psychotropic medic	ations.					
	The agency's "Oper	ration Standard Reporting and					
	Investigating Abuse, Neglect, Exploitation,						
		olation of an Individual's					
	Rights" dated 3/08/	2018 was reviewed on 2/18/19					
		icated the agency prohibited,					
		ed and implemented corrective					
	measures in regards						
		oitation/mistreatment of the ne review of the agency's					
	policy indicated, in						
	poney marcacca, m	part, the following.					
	"ResCare strictly	prohibits abuse, neglect,					
	exploitation, mistre	atment or violation of an					
	Individual's rights	_					
		ervention: Failure to provide					
		es necessary for the					
		physical harm and /or o implement a support plan,					
		cation of intervention, etc.					
		jeopardy without qualified					
	1	review Any situation					
	1 ^	regardless if abuse, neglect,					
		lation of an Individual's rights					
	is suspected, will be	e immediately investigated.					
	A 111	ing Americain and an Indian					
		ive training upon hire ns/causes of different types of,					
	~ ~	event, document, remedial					
		timely debriefing following the					
	action to be taken, t	Tollowing the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	TE SURVEY MPLETED 18/2019	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP ( HORIZON DR HIS, IN 47143	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	exploitation, mistre Individual's rights, an investigation. A	atment or violation of an as well as what to expect from all employees receive this nd annually, thereafter.				
	individual is the vice exploitation or mist should immediately and then complete a	off person who suspects an etim of abuse, neglect, reatment of an individual renotify the Program Manager, an Incident Report. The will then notify the Executive ly.				
	the suspected abuse mistreatment or vio	anager, or designee, will report s, neglect, exploitation, lations of Individual's rights e initial report to the s				
	neglect, exploitation an Individual's righ	is suspected of abuse, n, mistreatment or violation of ts toward an individual will be ided until the allegation can be				
	investigative team. conducted by investraining from Labor ResCare's internal processes and conducting, directing managerial activity allegation of abuse, mistreatment, by prof an alleged perpermanagerial activities	nager will assign an A full investigation will be tigators who have received Relations Association and procedures on investigations. How for nepotism during the ag, reviewing or other of an investigation into an neglect, exploitation or ohibiting friends and relatives grator from engaging in these as. One of the investigators will investigative case summary				

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

PRINTED: 03/28/2019 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15G723		A. BUILDING B. WING	00	COMPLETED 02/18/2019	
NAME OF PROVIDER OR SUPPLIER			13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR	
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN	MEMPI	HIS, IN 47143	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG		atements and other evidence	IAG		DATE
		rt will be maintained in a			
	_	d file at the office. The			
		ill include the following			
	components: a clear	statement indicating why the			
	investigation/reviev	v is being conducted along			
	with the nature of th	ne allegations/event (e.g.,			
	allegation of neglec	t, etc.), a clear statement of the			
	event or alleged eve	ent in a time-line format			
	including what, who	ere, and when the event			
		ged to have happened,			
	1	me and title of all involved			
		volved parties including any			
		victim(s), all staff assigned to			
		ged victim(s) at the time of the			
	_	perpetrators, when indicated;			
		tential witnesses to the event			
		gned and dated statements			
		arties, including all actual and			
	1 ^	to the event or alleged event,			
		ing all record and other			
		ssociated with the event or			
		es of all records and other			
		d that provide evidence			
		ng of the investigation or			
		any discrepancies/conflicts ce gathered, the discrepancy			
		xplained, a determination if blated, if services and/or care			
	_	or were not appropriately			
	_	policies and/or procedures			
		and/or if any federal or state			
		t followed, a clear statement of			
		n-substantiation of any			
		ides a description/summary of			
	_	sult in the finding, a definitive			
		orrective actions developed			
	_	nd/or to be implemented as a			
	_	gation or review, including			
		r each corrective action, the			
			1	1	

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER A		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/18/2019	
	ROVIDER OR SUPPLIER	LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
W 0157 Bldg. 00	signature, name and the investigation and was completed.  5. An investigative by the Executive Di outcome of the investigation and the investigation one of the investigati	title of the person completing d the date the investigation  peer review committee chosen rector will meet to discuss the estigation and to ensure that a ion has been completed. In mittee must include at least tors, the Executive Director or Manager, QA representative arces representative."  Ites to Complaint #IN00284619.	W 0157	1. The Program Manager will ensure the Area Supervisor ar Residential Manager retrain dicare staff on the Abuse, Negle and Exploitation Policy. Failur follow policy will result in disciplinary action up to and including termination.  2. Upon return of Client A to the facility, a no trespassing/contar order between Client A and Relative to prevent contact was initiated and is being enforced Clark County Sheriff's Departrements.	o3/20/2019 irrect ect re to  ne act as l by	
	1. A 1/16/19 BDDS 1/15/19 at 2:00 PM:	report indicated an incident of		petitioned for an Emergency Protective Order that was sent to Relative and the order was		

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/18/2019
	PROVIDER OR SUPPLIE	LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION
TAG	"Narrative: [Client A] returned therapeutic leave w December 15, 2018 home with her on 1 not be returning to instructions for adm her at that time. On [name], program m longer care for [Cli back to the group h his relative stated s any medications were recompleted an asses involuntary movem dyskinesia in natural nurse [Client A] ha November 2018 an nonsensical statemed Due to all the concetto take [Client A] to an evaluation.  Plan to Resolve: [Client A] has been unit at [name] hosp ResCare remains in updates and discharworking with BDD Services) to determ can be implemented upon his discharge the program manage explaining the situation.	to the home after being on ith his relative, [name] since 3. When [name] took [Client A] 2/15/18 she stated he would services. All medications and ministration were provided to 1/15/2019, [Name] contacted anager and stated she could no ent A] and was bringing him ome. When [Client A] returned the did not allow him to take over 20 days and no eturned to the home. The nurse sment of [Client A] and noted tent she believed to be tardive at twas also noted by the diverse with a was making ents during the assessment. The state of the ER (Emergency Room) for admitted to the behavioral ital for further evaluation and a contact with the hospital for the ER (Emergency Room) for the ER (Emergency Room) for the ER (Elient A]'s safety from the hospital. In addition, the spoke with APS via phone tion. APS is contacting [name] not to have any contact with meets with APS."	TAG	granted on 3/14/2019. The far administrator will contact the County Sheriff's Department in event of attempted contact by Relative with Client A.  3. ResCare received a request \$130 of personal spending more for which no receipts were received. Client A has been reimbursed \$130 for the unaccounted funds. The Prog Manager Area Supervisor and Residential manager will be re-trained on policy for request personal funds. Failure to foll the policy will result in disciplinaction up to and including termination.  4. Before any client leaves the Facility, the guardian/family/friends the clien will be departing with will be trained on the medical administration standard and wing a Leave of Absence Form before the client is released to leave. Upon return, the Facility ensure medication was administered appropriately, if the client will be assessed by Nurse, and the incident will be reported to Quality Assurance submission of an incident reports. In the event an emancipate individual's decision puts them risk of abuse, neglect or	Clark In the  St for coney  ram It is t of cow mary  element  y will  not the element  of for cort.  d

The 1/22/19 investigation regarding the 1/16/19

exploitation an IDT will be held to

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		l í		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING <u>00</u>		COMPLETED	
15G723		B. WING 02/18/2019			)		
MANTEORY	NOTABLE OF CAMPACA		_	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	t .		13009 H	HORIZON DR		
	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CON	MPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG			DATE
	BDDS report indica	ned:			discuss and determine		
	"Factual Findings:				recommendations. The decis		
	_	f relative], and [LPN #1] stated			of the IDT will be presented to	<b>I</b>	
		ke his medications while away			Facility Executive Director for approval.	IIIIai	
		or more than 20 days.			арргочат.		
		e of relative] did not want			Monitoring of Corrective Actio	<sub>n</sub> .	
	2	s medications until he was			The Program Manager, Area		
	re-evaluated.	2 11 212			Supervisor, and Residential		
		to the home (facility) with			Manager will ensure all allega	tions	
		oss and obvious side effects			of abuse, neglect and exploita	<b>I</b>	
	from not taking his	medications.			are reported to the Quality		
	Text messages from	n [name of relative] confirm			Assurance department. The		
	[client A] was not to	aking his medications.			Program Manager, Quality		
					Assurance, QIDP, Nursing,		
	Conclusion:				Behavior Clinician, Area		
	_	client A] did not take his			Supervisor and Residential		
		+ (plus) days while with his			Manager from the facility will r	<b>I</b>	
	[relative].				weekly for 90 days to review a	ıll	
		client A]'(s) [relative] stopped			reports and ensure accurate		
		ause she felt he was being			reporting of abuse, neglect or		
	overmedicated."				exploitation. The Residential		
	The investigation's	Peer Review dated 1/22/19			Manager will review daily	rato	
	-	ving recommendations:			documentation to ensure accu		
	mulcated the follow	ing recommendations.			reporting has been completed 90 days. Administrative staff v		
	"1 Continue to fol	low agency protocols for			complete a minimum of three	/'''	
	therapeutic leaves.				unannounced visits weekly for	. 90	
	-	Isman assisting with oversight			days for monitoring. The		
	of this case."	5 <del></del> <del></del>			Residential Manager will ensu	re all	
					incidents are reported to QA a	<b>I</b>	
	A Follow-up BDDS	S Report dated 1/29/19 to the			QA will review all incident repo		
	_	6/19 for incident on 1/15/19 at			and follow the abuse, neglect		
	2:00 PM indicated:				exploitation policy when		
					applicable.		
		charged on 1/21/19 with a					
		of Bipolar disorder and			Persons Responsible:		
	-	ne (genetic disorder). His			Executive Director, Program		
		inued. Zyprexa (olanzapine)			Manager, Nurse, QA, Busine	ss	
	was reduced from 4	was reduced from 40 mg QD (once daily) to 30 mg			Manager, Area Supervisor,		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  02/18/2019	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD HORIZON DR	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		HIS, IN 47143	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	DATE
		ote (divalproex sodium) was mg BID (twice daily) to 750 mg		QIDP, Residential Manager and DSPs.	,
		rere also given for [client A] to		and DOFS.	
		osychiatrist within 2 weeks.			
		ned on the changes and [client rith his psychiatrist on 2/1/2019.			
	In addition, [client A	A's] [relative] stated she did			
		dications but did so because sover medicated. [Client A's]			
		[relative], BDDS and APS met			
		e to the agreement [client A]			
		vices with ResCare and will s as prescribed by his			
		P (primary care physician). If			
	there are visits with	[client A's] [relative], they will			
	be closely monitore recurring issues."	d to ensure there are no			
	recurring issues.				
		gram Manager #1 on 2/14/19 at			
		I the hospital where client went e facility on 1/15/19 was			
	-	ge client A only to the facility.			
	Client A's relative h	and picked him up (1/20/19)			
		he facility from the behavioral			
		pital. Program Manager/PM #1 s house and brought client A			
		on 1/21/19. PM #1 indicated he			
	had not allowed a h	ome visit on 1/24/19.			
	2. A 2/12/19 BDDS 2/11/19 at 6:30 PM	report indicated an incident of:			
	Narrative:				
		at A] went on a home visit with			
	his [relative] [name	]. Upon returning to the group			
		was determined [client A] did			
		medications while away from has also refused to take any			
		ations since his return to the			
	group home."				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/18/2019
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	13009 H	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	Plan to Resolve: "[Client A] will be taken to the ER for an evaluation and a valproic acid level (Depakote/divalproex sodium) will be requested. In addition, visits with his [relative] are immediately suspended until the team, including BDDS, APS and the Ombudsman can meet to discuss what protective measures can be implemented to ensure [client A's] safety. In a previous team meeting on 1/29/19 with the [relative], BDDS, and APS it was agreed upon by all that [client A] would continue in services with ResCare and would take all medications as prescribed by his psychiatrist and PCR. That agreement was not honored during the home visit."  Review (2/14/19 2:29 PM) of client A's financial records indicated he had requested personal funds on 2/5/19 to visit his brother out of state while visiting his relative. A check for \$130.00 was drawn on client A's personal account dated 2/6/19 and the check was cashed by him on 2/7/19. Client A did not go out of state to visit his brother. He did not bring back any money or receipts when he returned on 2/11/19 from the visit.  3. A 2/13/19 BDDS report indicated an incident on 2/12/19 at 5:00 PM:  Narrative: "[Client A] was speaking with the nurse prior to going to the ERand alleged while with his [relative] he was exposed to people using drugs, stated the ResCare nurse and her family were in danger and the group home was at risk of being broken into. [Client A] stated he was fearful to be around his [relative] and the people she was			

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

PRINTED: 03/28/2019 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  15G723	A. BUILDING B. WING	00	COMPLETED 02/18/2019
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD HORIZON DR	
RES CAF	RE COMMUNITY AI	TERNATIVES SE IN		HIS, IN 47143	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	county] Sherriff's (s	n officer with the [local ic) department was dispatched eport was filedregarding the			
	against [client A's]   access code to the g changed. The team 2/13/19 and it was a allowed with the [re appointed guardian and the process imm A] is currently refus medications and ref follow up with his F assessment will be r ResCare has contact inpatient medication has agreed criteria is	relative] [name] and the roup home has been met with BDDS and APS on agreed there would be no visits elative]. In addition, a court was recommended by APS nediately initiated. As [client sing his psych (psychiatric) that the property of t			
	3:28 PM, client A w #1 indicated on 2/14 QIDP/Qualified Into #1 and staff #1 were psychiatric hospital admittance. AD #1 surveyor if client A to the facility on 2/1 surveyor (2/14/19 7 had not been accept	ellectual Disability Professional e with client A at the			
		s at the facility on 2/15/19 from AM, client A was at his living			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/18/2019	
NAME OF PROVIDER OR SUPPLIER  RES CARE COMMUNITY ALTERNATIVES SE IN		13009 I	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	RIATE COMPLETION
TAG	facility. He was eat Client A asked the	ing scrambled eggs and pears. surveyor if "they put	TAG	DEFICIENCY)	DATE
	unknown in his egg	(did facility staff put something s or pears)?" Client A's upper eft and his torso would jerk			
	Client A indicated l	ovements were involuntary.  ne was having difficulty eating I to go down well. Client C			
	obtained more pears A. Residential Man	s from the refrigerator for client ager #1 offered client A a glass ed his eggs might "come back			
	up." Client A indic recently and he had	ated he had visited a relative not been taking his			
	local workshop and AM until 11:17 AM	the visits. Client A went to a was observed there from 9:56 I on 2/15/19. Client A was			
	plastic tubes into ba	I to do a job of putting long aggies. Client A did an which he seemed to enjoy more.			
		s record on 2/15/19 at 2:57 PM dividual Support Plan dated			
	11/14/18. The plan included, but were	indicated client A's diagnoses not limited to, "Bi-Polar 1 disorder),Factitious			
	Disorder (when son appearing sick, by p	neone deceives others by ourposely getting sick, or			
	Anti-social and Bor Klinefelter's Syndro	ntellectual Difficulties, derline Personality Disorder, ome (genetic disorder/extra X			
	thyroid gland), Asth Incontinence, Anen	pothyroidism (underactive nma, Constipation, Urinary nia, and Hypertension (high			
	blood pressure)." The review indicate MARs/Medication	ed client A's 12/18 Administration Records which			
		ns he was taking at the time of ative (leave of absence			
	· ·	ff by mouth twice daily			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CO A. BUILDING B. WING			
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		13009 H	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
TAG	(asthma), Amitiza 24 mcg./m. (constipation), Amoxicillin 500 mg. (anti-biotic), Benztropine 2 mg. to side effects of medicetirizine 10 mg. da desmopressin 1.1 m incontinence), Divalproex Sod (So mg. twice daily (Bip Ferrous Sulf (Sulfat supplement), Fish Oil 1000 mg. 3 Lactulose Sol (Solu daily (constipation) levothyroxine 88 m lithium carb (carbon mg. twice daily (Bip loratadine 10 mg. da Midodrine 5 mg. th blood pressure whe hypotension), olanzapine 10 mg. to daily (anti-psychoti omeprazole 20 mg. oyster calcium 500 (supplement), Proair HFA (inhalat daily (breathing), Strattera 18 mg. one sulcrafate 1 gm. (gr ulcers), and Vesicare 10 mg. dai  Interview with Prog	g./milligrams three times daily g./milligrams three times daily twice daily EPS/extrapyramidal cations, aily (allergies), ag. twice daily (urinary dium) DR/delayed release 500 polar), ae) 325 mg. daily (mineral daily (supplement), ation) 30 ml/milliliters twice aily (hormone), ate) ER (extended release) 450 polar), aily (allergies), are times daily (for drop in a standing/orthostatic daily (stomach acid), mg. with 200 units Vitamin D tion aerosol) 2 puffs four times are daily (behavior), am) twice daily (stomach aily (urinary incontinence). gram Manager/PM #1 on			DATE
		indicated client A had no			
		quired physical behavior			

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

Event ID:

RC1B11 Facility ID: 004615

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

PRINTED: 03/28/2019 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
	15G723 B. WING		02/18/2019				
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR MEMPHIS, IN 47143				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	outbursts which were his refusals to take he PM #1 indicated on was on the path to so (leaving the group he influenced by his respectively medications.  Confidential interview the ball" with client with his relative againterview indicated took his required medication he would been before. The into on track to be earning restrictive environment and 1/19 with his respectively with his respectively work of the programming prior with his relative. The aggressive behavior apparent prior to his psychotropic medication indicated the client sto continue visiting	re verbally redirectable prior to his psychotropic medications. 2/14/19 at 1:51 PM, client A emi-independent living tome) until his being lative to stop taking his  ew (CI) #1 stated "we dropped A by allowing him to go home tin after the first visit. The the client did well when he hedication. The interview ake time but if he took his d be doing as well as he had terview indicated client A was ng a placement in a less tent prior to his visits in 12/18 lative.		TAG	DEFICIENCY)		DATE
	9-3-2(a)						

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