CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 093		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		15G194	B. WI	NG		09/03	/2021
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹	115 STONEGATE				
RES CARE COMMUNITY ALTERNATIVES SE IN				ORD, IN 47421			
(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 CROSS-REFERENCED TO THE APP			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
W 0000							
Bldg. 00	recertification and	pre-determined full state licensure survey. This vid-19 focused infection	W 0	000			
	Survey Dates: Aug 3, 2021	ust 30, 31, September 1, 2 and					
	Facility Number: 0 Provider Number: 1002	15G194					
	accordance with 46	also reflect state findings in 0 IAC 9. this report completed by #15068					
W 0102	483.410	DV AND MANAGEMENT					
Bldg. 00	The facility must e governing body a requirements are	met.					
	review for 8 of 8 cl (#1, #2, #3, #4, #5, to meet the Conditi Body. The governi operating direction ensure the clients w continuous active to implementing the c the Qualified Intelli (QIDP) functions w employee who was	on, interview and record ients living in the group home #6, #7 and #8), the facility failed on of Participation: Governing ing body failed to exercise over the facility by failing to were engaged in aggressive, reatment programs including lients' program plans as written, ectual Disabilities Professional were not delegated to another not qualified as a QIDP, the ed in meal preparation, serving	Wo	102	To correct the deficient pract management and all site staf been re-trained on the follow aggressive and continuous a treatment, clients being involumeal preparation, clients prelunches, client #3s updated choking risk plan, client rights regarding access to food iten client finances policy, and appropriate storage of oxyge tanks. Client #3s risk plan habeen updated to reflect the	if have ing: ctive ved in paring s.ns,	10/03/2021

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

themselves, grocery shopping and client #8

packed his own lunch to take to the outside

TITLE

ResCare nursing staff have

swallow study recommendations.

(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.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	A. BUILDING 00 COMPLETED			ETED
		15G194	B. W	'ING	09/03/2021		
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8			ONEGATE		
RES CAF	RE COMMUNITY AI	LTERNATIVES SE IN			PRD, IN 47421		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		m, client #3's choking risk plan			reviewed all client risk plans a	nd	
		e had a swallow study			updated as needed. A qualifie		
		P integrated, coordinated and			QIDP has been assigned to th		
		ts' program plans as evidenced			site to integrate, coordinate ar		
	by the staff failing t	to implement the clients'			monitor. The QIDP will be train		
	program plans as w	ritten, the clients had the right			on all clients and QIDP duties	.	
		gard to storing the food and			Weekly QIDP meetings will be	,	
	soda in the garage,	and oxygen canisters were			held to ensure the QIDP is		
	securely stored in a	temperature controlled area at			completing duties as assigned	l for	
		a manner so they could not be			a period of one month. The Ql	IDP	
	tipped over, and client #3's money was being				will also update each client's o	laily	
	spent on items for the home and not for personal				schedule to reflect current rou	tines	
use without approval from client #3 or his				and ISP goals. The oxygen ta			
guardian.				have been moved inside of the	е		
					home and placed on a rack to		
	Findings include:				secure. A routine weekly ched		
					will be completed to ensure th	е	
	· ·	V104. For 8 of 8 clients living in			oxygen tanks are stored		
		, #2, #3, #4, #5, #6, #7 and #8),			appropriately. Client # 3 will be		
		ing body failed to exercise			reimbursed by ResCare for the	е	
		over the facility by failing to			expense of 935.00. Weekly		
		sters were securely stored in a			administration counts of client		
		led area at the group home in a			funds will be completed for on		
	1	ld not be tipped over and			month, and monthly thereafter	·.	
		vas being spent on items for the			Additional monitoring will be		
	_	ersonal use without approval			achieved by daily administration	on	
	from client #3 or his	s guardian.			observations, and daily administration meetings to		
	2) Please refer to W	V195. For 7 of 7 clients present			discuss the status of the home	for	
		ions (#1, #3, #4, #5, #6, #7 and			a period of 60 days. Ongoing		
	I -	body failed to meet the			monitoring will be achieved		
	1	pation: Active Treatment			through routine monthly		
		rning body failed to ensure the			observations from administrati	ion.	
		ressive, continuous active			and the QIDP. Additionally, a		
		including implementing the			monthly site and record review		
		ans as written. The governing			audit will be completed by	-	
		re the clients were involved in			ResCare supervisory staff.		
	1	erving themselves, grocery					
		#8 packed his own lunch to					
		services day program. The					

STATEMENT OF DEFICIENCIES X1) PROVIDER		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETE.			ETED
		15G194	B. WING 09/03/2021			2021	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	1			ONEGATE		
RES CAF	RE COMMUNITY AI	LTERNATIVES SE IN			RD, IN 47421		
(X4) ID	SUMMARY S	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
		ed to ensure client #3's					
		as revised after he had a					
		pleted. The governing body					
		QIDP integrated, coordinated					
		clients' program plans as					
	_	aff failing to implement the					
		ns as written. The governing					
	-	re the clients had the right to					
		rd to storing the food and					
	soda in the garage.						
	9-3-1(a)						
W 0104	483.410(a)(1)						
	GOVERNING BOI	DY					
Bldg. 00		dy must exercise general					
		d operating direction over					
	the facility.						
		on, interview and record	WO	104	site staff have been re-trained on the following: client finance		10/03/2021
		ients living in the group home					
	,	#6, #7 and #8), the facility's					
		ed to exercise operating			policy, and appropriate storage		
		acility by failing to ensure			oxygen tanks. The oxygen tan		
		ere securely stored in a			have been moved inside of the		
	-	led area at the group home in a			home and placed on a rack to		
	_	ld not be tipped over and vas being spent on items for the			secure. A routine weekly chec will be completed to ensure the		
		ersonal use without approval			oxygen tanks are stored	e	
	from client #3 or his				appropriately. Client # 3 will be		
	Hom enem #3 of ms	s guardian.			reimbursed by ResCare for the		
	Findings include:				expense of 935.00. Weekly	-	
	1 manigo morado.				administration counts of client		
	Observations were	re conducted at the group			funds will be completed for one		
		om 10:58 AM to 12:54 PM,			month, and monthly thereafter		
		PM to 4:50 PM, and 8/31/21 from			Additional monitoring will be		
		M. During the observations at			achieved by daily administration	on	
		ere were 5 oxygen canisters in			observations, and daily		
		tht of the door. The high			administration meetings to		
		degrees Fahrenheit. None of			discuss the status of the home	for	
		one were secured. One			a period of 60 days. Ongoing		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		l í	JILDING	nstruction 00	(X3) DATE : COMPL 09/03/	ETED	
	NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		<u> </u>	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE RD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	floor. Two canister wheels. Neither we could not tip over. a cardboard box. This secured to ensure the This affected clients #8.	directly on the cement garage is were in two holders with the re secured to ensure they. One additional canister was in the canister and box were not the canister did not tip over. In the security of the canister did not tip over. In the security of the canister did not tip over. In the canister did not tip over.			monitoring will be achieved through routine monthly observations from administrati and the QIDP. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	·	
	on 8/30/21 from 10: from 2:04 PM to 4:; AM to 8:09 AM. D outdoor chairs with pillows, and fall dec	conducted at the group home 158 AM to 12:54 PM, 8/30/21 150 PM, and 8/31/21 from 5:58 During these observations two padded seat covers, throw corations were located on the some. The backyard had a large e patio.					
	indicated, when sho canisters, the caniste appropriately. She	indicated the canisters should ne at room temperature and					
	the canisters should medication room in	PM, the Program Manager (PM) be stored securely in the side the house. The PM stated d be secured so they can't tip					
	indicated the canisto temperature and not indicated the canisto could not tip over. "should not be able 2) On 8/30/21 at 12 Consumer Finance	PM, Area Supervisor #1 ers should be in a controlled t in the garage. AS #1 ers should be secured so they She stated the canisters to get knocked over." :36 PM, the August 2021 Chain of Custody Sheet d cash withdrawal of \$935.00,					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       09/03/2021			
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE ORD, IN 47421	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION esidential Manager (RM).	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
	-An 8/23/21 client f purchase for \$718.3 improvement store. outdoor grill, grill c chair cushions, and Supervisor (AS) #2 the RM.  -An 8/25/21 client f purchase for \$67.32 improvement store. decorative pillows a local grocery store it	Fund receipt form indicated a 166 in cash at a local home This purchase included an 160 over, 2 outdoor swivel chairs, 2 a cornhole game. The Area 160 signed as the purchaser and 160 at a 160 to a 160			
	On 8/31/21 at 9:50 discussed the purch Manager (PM) but of guardian. She indictions to purchase she discussed client guardian but was not being purchased. She interdisciplinary teal indicated client #3 spurchases.	AM, AS #2 indicated she ase with the Program did not discuss it with the ated client #3 could not give these items. AS #2 indicated #3's spend down with his of specific on what items were ne indicated no am meeting was held. AS #2 should be reimbursed for these			
	indicated she was n were purchased and discussed. She indic the purchases. The can not give consen On 8/31/21 at 1:02	AM, the guardian of client #3 ot aware the grill and chairs I the purchase was not cated she was concerned with guardian indicated client #3 at to purchase these items.  PM, the PM indicated client #3 of \$900 or so. She stated, "I			

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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	A. BUILDING <u>00</u> COMPLETED			ETED.
		15G194	B. WI	NG		09/03/	/2021
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					ONEGATE		
RES CAF	RE COMMUNITY AI	LTERNATIVES SE IN		BEDFC	DRD, IN 47421		
(X4) ID	SUMMARY	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 APPROPRIA	TE	COMPLETION
TAG				TAG	DEFICIENCY)		DATE
		for him to buy the grill." The					
	PM indicated client #3 needs to be reimbursed.  On 9/1/21 at 12:10 PM, AS #1 indicated client #3					ļ	
		on to spend his money on a					
	grill.	n to spend me meney on a					
	8						
	9-3-1(a)						
W 0125	483.420(a)(3)						
	` , ` ,	CLIENTS RIGHTS					
Bldg. 00	The facility must e	nsure the rights of all					
	clients. Therefore, the facility must allow and						
	encourage individ	ual clients to exercise their					
	_	the facility, and as					
		ted States, including the					
		ints, and the right to due					
	process.						
		on, record review and	W 0	125	To correct the deficient practic		10/03/2021
		clients at the group home			site staff have been re-trained	on	
	-	, #3, #4, #5, #6, #7 and #8), the ure the clients had the right to			the following: client rights	_	
	-	d to storing the soda,			regarding access to food items The QIDP will schedule an ID		
		, cookies, granola bars,			discuss client #1s food seekin		
		g, cheese crackers, oatmeal,			behavior as indicated by staff.	•	
		uit cups, Carnation instant			client plans will be updated if	1110	
		in the non-temperature			determined by the IDT. Addition	onal	
	controlled garage.	-			monitoring will be achieved by		
					daily administration observation		
	Findings include:				and daily administration meeti	ngs	
					to discuss the status of the ho	me	
		conducted at the group home			for a period of one month.		
		58 AM to 12:54 PM, 8/30/21			Ongoing monitoring will be		
		50 PM, and 8/31/21 from 5:58			achieved through routine mon	•	
		uring the observations at the			observations from administrati	on,	
		lowing items were stored in			and the QIDP. Additionally, a		
	_	e controlled garage: soda,			monthly site and record review	/	
		, cookies, granola bars,			audit will be completed by		
		g, cheese crackers, oatmeal,			ResCare supervisory staff.		
	ince cakes, bread, ir	uit cups, Carnation instant			1	Ų	İ

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 09/03/2021			PLETED		
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	breakfast and chips #4, #5, #6, #7 and #	This affected clients #1, #3, #8.					
	groceries straight ir garage. Staff #1 in the soda, sweetener bars, applesauce, pro oatmeal, rice cakes, instant breakfast an the garage.	4 PM, staff #1 unloaded new to containers on a shelf in the dicated she was unsure why crackers, cookies, granola adding, cheese crackers, bread, fruit cups, Carnation d chips were being stored in 4 PM, the Residential Manager food and drinks stored in the					
	garage were moved client #1's food see	l since the last survey due to king. The RM indicated the 1 the garage keeps client #1					
	record was conduct Individualized Supp Behavior Support F	O AM, a review of client #1's led. Client #1's 10/29/20 port Plan (ISP) and 10/29/20 Plan (BSP) did not indicate the led drinks to be stored in the					
	record was conduct and 11/14/20 BSP	9 AM, a review of client #2's red. Client #2's 11/14/20 ISP did not indicate the need for the person of the garage.					
	record was conduct and 11/14/20 BSP of	O PM, a review of client #3's ed. Client #3's 11/14/20 ISP did not indicate the need for the person of the garage.					
	stated she was "not were moved from in	PM, Area Supervisor #1 (AS) aware" the food and drinks nside the group home to the dicated none of the clients'					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE  A. BUILDING  B. WING	construction <u>00</u>	(X3) DATE SURVEY  COMPLETED  09/03/2021			
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421				
(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 APPROPE DEFICIENCY)	(X5) COMPLETION DATE		
W 0140 Bldg. 00	garage. The AS stal have the food out in "staff don't want to know if they are do 9-3-2(a)  483.420(b)(1)(i) CLIENT FINANCE The facility must esystem that assuraccounting of clier entrusted to the fa Based on record reclients living in the failed to assure full the client's finances  Findings include:  On 8/30/21 at 12:36 finances entrusted to and indicated the form that the failed to assure full the client's finances.  Findings include:  On 8/30/21 at 12:36 finances entrusted to and indicated the form that the failed to assure full the client's finances.  On 8/30/21 at 12:36 finances entrusted the failed to assure full that the failed to assure full that the failed to assure full the client's finances.	establish and maintain a es a full and complete ents' personal funds cility on behalf of clients. Fiew and interview for 1 of 8 group home (#3), the facility and complete accounting of to the penny.  6 PM, a review of client #3's of the facility was conducted llowing.  cash ledger indicated client #3 a. When the money was dential Manager (RM), client th.  AM, Area Supervisor (AS) #2 any have added client #3's a petty cash ledger. At 10:09 and money should be accounted  PM, the Program Manager (PM) a cash ledger should be	W 0140	To correct the deficient pract site staff have been re-traine ResCare client finances polic procedure. Client # 3 will be reimbursed by ResCare for texpense of 935.00. Weekly administration counts of clier funds will be completed for omonth, and monthly thereafte Additional monitoring will be achieved by daily administration observations, and daily administration meetings to discuss the status of the hona period of one month. Ongmonitoring will be achieved through routine monthly observations from administration and the QIDP. Additionally, monthly site and record revisaudit will be completed by ResCare supervisory staff.	d on cy and he nt ne er. tion ne for ping ation, a		

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

PRINTED: 10/04/2021 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G194		A. BUILDING 00  B. WING		COMPLETED 09/03/2021	
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  9-3-2(a)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by				
	a qualified intellectual disability professional.  Based on observation, record review and interview for 8 of 8 clients observed at the group home (#1, #2, #3, #4, #5, #6, #7 and #8), the facility failed to ensure the Qualified Intellectual  Disabilities Professional (QIDP) functions were not delegated to another employee who was not qualified as a QIDP. The QIDP failed to integrate, coordinate and monitor the clients' program plans as evidenced by the staff failing to implement the clients' program plans as written. The QIDP failed to ensure oxygen canisters were securely stored in a temperature controlled area at the group home in a manner so they could not be tipped over. The QIDP failed to ensure the clients had the right to due process in regard to storing the soda, sweetener, crackers, cookies, granola bars, applesauce, pudding, cheese crackers, oatmeal, rice cakes, bread, fruit cups, Carnation instant breakfast and chips in the non-temperature controlled garage. The QIDP failed to ensure a full and complete accounting of client #3's finances to the penny. The QIDP failed to ensure client #3's choking risk plan was revised after he had a swallow study completed.  Findings include:  1) On 8/30/21 at 11:55 AM, a review of the Qualified Mental Retardation Professional (QMRP) sheet indicated Qualified Intellectual Disabilities Professional (QIDP) #1 was assigned to the home.	W 0159	To correct the deficient practic qualified QIDP has been assig to the site to integrate, coordinand monitor. The QIDP will be trained on all clients and QIDF duties. Weekly QIDP meeting will be held to ensure the QIDI completing duties as assigned a period of one month. The QI will also update each client's dischedule to reflect current rou and ISP goals. Additional monitoring will be achieved by daily administration observation and daily administration meeting to discuss the status of the hofor a period of one month. Ongoing monitoring will be achieved through routine mon observations from administration the QIDP. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	gned nate e o is P is I for IDP daily tines ons, ngs me thly ion,	

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Event ID:

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Facility ID: 000724

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COM	TE SURVEY  MPLETED  03/2021
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZII ONEGATE DRD, IN 47421	P COD	
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	signed off on Area sincluding the clients (ISPs), Behavior Sureviews, and quarte she was not part of team meetings (IDT QIDP #1 stated, "I j she had not visited months. She stated months. She stated stated the AS was "she had "never cont spoken to them." Son paper. [AS] doe She stated "it would was delegating her AS.  On 9/1/21 at 12:08 "acting as the QIDF not have a 4 year dethe clients' plans in She indicated QIDF indicated the assign the home. She indicated the assign the home. She indicated meetings or their annual meetings or their annual meetings or their annual meetings or the group home (#1 the QIDP failed to esecurely stored in a the group home in a tipped over.  3) Please refer to W group home during #7 and #8), the QID had the right to due	AM, QIDP #1 indicated she Supervisor (AS) #1's work s' Individual Support Plans apport Plans (BSPs), monthly rly reviews. QIDP #1 indicated the clients' interdisciplinary s's) or their annual meetings. Sust sign off." She indicated the home in approximately 6, "I am not involved." She very competent." She stated acted the guardians. Never he stated she was the "QIDP is all the day to day things." If appear so" when asked if she QIDP responsibilities to the stated she was the "QIDP is all the day to day things." If appear so when asked if she QIDP responsibilities to the stated she was the "QIDP is all the day to day things." If appear so when asked if she QIDP responsibilities to the stated she was the stat				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/03/2021	
	PROVIDER OR SUPPLIER		115 ST	ADDRESS, CITY, STATE, ZIP COD TONEGATE DRD, IN 47421	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	oatmeal, rice cakes, instant breakfast and controlled garage.  4) Please refer to W the group home (#3	adding, cheese crackers, bread, fruit cups, Carnation d chips in the non-temperature V140. For 1 of 8 clients living in ), the QIDP failed to ensure full unting of the client's finances			
	observed at the grou and #8), the QIDP f received aggressive	W196. For 7 of 7 clients up home (#1, #3, #4, #5, #6, #7 railed to ensure the clients, continuous active treatment implementing the clients' ritten.			
	sample (#3), the QI	W240. For 1 of 3 clients in the DP failed to ensure client #3's ras revised after he had a pleted.			
	observed at the grou and #8), the QIDP f received a continuo	W249. For 7 of 7 clients up home (#1, #3, #4, #5, #6, #7 ailed to ensure the clients us active treatment program plans			
	9-3-3(a)				
W 0192	483.430(e)(2) STAFF TRAINING	G PROGRAM			
Bldg. 00	must focus on skill directed toward cli Based on record rev clients living in the #6, #7 and #8), the	no work with clients, training ls and competencies ients' health needs. view and interview for 8 of 8 group home (#1, #2, #3, #4, #5, facility failed to ensure staff ovid-19 vaccine received	W 0192	To correct the deficient practic site staff have been trained or benefits and risks of the vacci and those who declined the	n the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPP		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		15G194	B. WING		09/03/2021		
NAME OF D	PROVIDER OR SUPPLIER	?		ADDRESS, CITY, STATE, ZIP COD			
			115 STONEGATE				
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	BEDFC	DRD, IN 47421			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	(X5)			
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
		he benefits, risks and potential		Covid-19 Vaccine have signed			
		vaccine and there was		refusal statements indicating s	SO.		
		staff members received the		Covid-19 vaccine risks and			
		receive it due to medical		benefits have been added to r			
	contraindications of	r refusal.		employee orientation. Ongoir	_		
	E' 1' ' 1 1			monitoring will be achieved by	′		
	Findings include:			human resources reviewing			
	O. 9/21/21 + 9.47	AM		employee files to ensure they	nave		
		AM, a review of the staff who d the Covid-19 vaccination was		been trained.			
conducted. Staff #4 and #5 both declined to							
	receive the vaccination. There was no documentation the facility trained the staff on the						
		potential side effects of the					
		There was no documentation					
		ned appropriate documentation					
		sion of the required COVID-19					
	-	and offering and whether the					
		ved the vaccine or did not					
		edical contraindications or					
		ted clients #1, #2, #3, #4, #5, #6,					
	#7 and #8.						
	On 8/31/21 at 10:17	7 AM, the Associate Executive					
	Director indicated t	there was no documentation					
	the staff was trained	d on the benefits, risks and					
	potential side effect	ts of the Covid-19 vaccine.					
		mentation indicating whether					
		not receive the vaccine due to					
	medical contraindic	cation or refusal.					
	O:: 0/1/21 / 12 00	DM A C					
		PM, Area Supervisor (AS) #1					
		decision of the staff whether					
		the vaccine. The AS					
		no documentation the staff					
	received training.						
	9-3-3(a)						
	γ·3-3(a)						
			1	1	1		

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G194	B. WI	NG		09/03/	/2021
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER			l	ONEGATE		
DES CAE		TEDNIATIVES SE INI			ONEGATE DRD, IN 47421		
KES CAP	RE COMMUNITY AL	LTERNATIVES SE IN		BEDFO	JRD, IN 47421		
(X4) ID	SUMMARY S	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
W 0195	483.440						
	ACTIVE TREATM	ENT SERVICES					
Bldg. 00	g. 00 The facility must ensure that specific active						
	treatment services	requirements are met.					
	Based on observation	on, interview and record	$\mathbf{W}_{0}$	195	To correct the deficient practic	e	10/03/2021
	review for 8 of 8 cli	ents living in the group home			management and all site staff have		
	(#1, #2, #3, #4, #5, #	#6, #7 and #8), the facility failed			been re-trained on the following		
	to meet the Condition	on of Participation: Active			aggressive and continuous ac	-	
	Treatment Services.	The facility failed to ensure			treatment, clients being involve		
	the clients received	an aggressive, continuous			meal preparation, clients preparation		
	active treatment pro	gram including implementing			lunches, clients serving	J	
	the clients' program plans as written. The facility failed to ensure the clients were involved in meal				themselves at meals, clients		
					participating in grocery shoppi	ng,	
	preparation, serving	themselves, grocery			client #3s updated choking risl	•	
	shopping and client #8 packed his own lunch to				plan. Client #3s risk plan has		
	take to the outside s	ervices day program. The			been updated to reflect the		
	facility failed to ens	sure client #3's choking risk		swallow study recommendations.		ns.	
	plan was revised aft	er he had a swallow study			ResCare nursing staff have		
	completed. The fac	ility failed to ensure the QIDP			reviewed all client risk plans a	nd	
	integrated, coordina	ted and monitored the clients'			updated as needed. A qualifie		
	program plans as ev	ridenced by the staff failing to			QIDP has been assigned to th		
	implement the clien	ts' program plans as written.			site to integrate, coordinate an		
					monitor. The QIDP will be trai		
	Findings include:				on all clients and QIDP duties.		
					Weekly QIDP meetings will be		
	1) Please refer to W	V159. For 8 of 8 clients			held to ensure the QIDP is		
	observed at the grou	up home (#1, #2, #3, #4, #5, #6,			completing duties as assigned	for	
	#7 and #8), the facil	lity failed to ensure the			a period of one month. The QI		
	Qualified Intellectua	al Disabilities Professional			will also update each client's d		
	(QIDP) functions w	ere not delegated to another			schedule to reflect current rou	-	
	employee who was	not qualified as a QIDP. The			and ISP goals. Additional		
	QIDP failed to integ	grate, coordinate and monitor			monitoring will be achieved by		
	the clients' program	plans as evidenced by the			daily administration observation		
		ement the clients' program			and daily administration meeti		
	plans as written. The	e QIDP failed to ensure client			to discuss the status of the ho	-	
	•	an was revised after he had a			for a period of 60 days. Ongo		
	swallow study comp				monitoring will be achieved	J	
					through routine monthly		
	2) Please refer to W	V196. For 7 of 7 clients			observations from administrati	on,	
		up home (#1, #3, #4, #5, #6, #7			and the QIDP. Additionally, a	•	

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTII A. BUILDI B. WING		instruction 00	(X3) DATE : COMPL <b>09/03</b> /	ETED
	ROVIDER OR SUPPLIER	TERNATIVES SE IN		115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE RD, IN 47421		
(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
	received aggressive	failed to ensure the clients continuous active treatment implementing the clients' ritten.			monthly site and record review audit will be completed by ResCare supervisory staff.	I	
	sample (#3), the fac	7240. For 1 of 3 clients in the ility failed to ensure client #3's as revised after he had a pleted.					
	observed at the grou and #8), the facility received a continuou	7249. For 7 of 7 clients up home (#1, #3, #4, #5, #6, #7 failed to ensure the clients us active treatment program ting the clients' program plans					
	group home during #5, #6, #7 and #8), t clients were involve themselves, grocery	7488. For 7 of 7 clients at the the observations (#1, #3, #4, the facility failed to ensure the d in meal preparation, serving shopping and client #8 the to take to the outside m.					
	9-3-4(a)						
W 0196	483.440(a)(1) ACTIVE TREATM	ENT					
Bldg. 00	treatment program aggressive, consist program of special treatment, health services described directed toward:  (i) The acquisition necessary for the segment of the segmen	eceive a continuous active n, which includes stent implementation of a lized and generic training, services and related d in this subpart, that is n of the behaviors client to function with as nation and independence					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15G194	B. W	ING		09/03	/2021
		1		STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			ONEGATE		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			ORD, IN 47421		
	ı		1		, 		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENC! )		DATE
		on or deceleration of					
	functional status.	of current optimal					
		on, record review and	W (	)196	To correct the deficient practic	الد م	10/03/2021
		clients observed at the group	W (	1170	site staff have been re-trained		10/03/2021
		5, #6, #7 and #8), the facility			the following: aggressive and		
	· ·	clients received aggressive,			continuous active treatment a		
		reatment programs including			implementing plans as written		
		lients' program plans as written.			including utilizing program		
	'				supplies as indicated in the pla	an.	
	Findings include:				A baby monitor has been		
					purchased for client #6. A qua	lified	
	1a) On 8/30/21 from	m 11:00 AM until 1:00 PM and			QIDP has been assigned to th		
	from 2:00 PM until 6:15 PM, observations were				site to integrate, coordinate ar		
	conducted at the gro	oup home by surveyor #1 and			monitor. The QIDP will be train	ined	
	indicated the follow	ving:			on all clients and QIDP duties		
					Weekly QIDP meetings will be	;	
		ats #1, #3, #4, #6, and #7 were			held to ensure the QIDP is		
	_	n table preparing to eat lunch.			completing duties as assigned		1
		at #6 was sitting on the couch			a period of one month. The Ql		
	watching television				will also update each client's o	-	
		ats #1 and #6 were sitting on the			schedule to reflect current rou	tines	
	couch watching tele				and ISP goals. Additional	_	
		t #1 was sitting on the small			monitoring will be achieved by		
		n area twirling a sock and			daily administration observation		
		nd #7 were helping staff #3 ag from the garage. Client #3			and daily administration meeti	-	
	l	cliner in the living room.			to discuss the status of the ho		
	11 0	nt #4 was sitting at the kitchen			for a period of 60 days. Ongo monitoring will be achieved	ıı ıy	
		chips. He was coughing			through routine monthly		
		#1 gave him a second glass of			observations from administrati	ion	
	kool-aid.				and the QIDP. Additionally, a	,	
		nt #6 walked out the front door			monthly site and record review	v	1
	·	ted him to come back inside.			audit will be completed by		
		#6 was in his bedroom. Client			ResCare supervisory staff.		
	•	a recliner in the living room			·		
		, and #5 were at the kitchen					1
	table coloring pictu						1
		#6 came into the kitchen and					
		ff #1 gave client #6 paper to					

	TOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/03/2021	
	PROVIDER OR SUPPLIEF	R LTERNATIVES SE IN	•	115 STC	DDRESS, CITY, STATE, ZIP COD DNEGATE RD, IN 47421		
(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	TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY		DATE
TAG	shredAt 2:36 PM, client kitchen table. Clien kitchen table colori napping in a recliner was in a recliner in and shirt. Client #5 houseAt 2:55 PM, client from the kitchen tal room by staff #1At 3:00 PM, client recliner in the living Manager (RM) to u used the bathroom the living roomAt 3:13 PM, client -At 3:26 PM, client kitchen twirling a sitting on the couch television. Clients frecliners in the living watching television. At 3:32 PM, client can located in the k client and he return roomAt 3:36 PM, client can located in the k client and he return roomAt 3:36 PM, client watching television portable music play recliner in the living room listenir portable music play recliner in the living room gleent watching television.	the was shredding paper at the state #3 and #4 were at the state in the living room. Client #1 the living room twirling a sock was wandering around the #3 was taken by a wheelchair ble to a recliner in the living #4 was assisted out of a groom by the Residential see the bathroom. Client #4 and returned to a recliner in #4 and returned to a recliner in ock and t-shirt. Client #6 was in the living room watching #3, #4, and #7 were napping in sing room. Client #5 was in the living room.  #6 was getting into the trash sitchen. Staff #1 redirected the sed to the couch in the living to a compact disc (CD) on a ver. Client #3 was napping in a		TAG	DEFICIENCY		DATE
	-At 4:09 PM, client program. -At 4:34 PM, client kitchen.	#8 returned home from the day as #5 and #8 were helping in the tients were present at the kitchen					
	-At J. 25 Pivi, all Cli	iems were present at the kitchen					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction  00	(X3) DATE SURVEY  COMPLETED  09/03/2021
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE PRD, IN 47421	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  table preparing to eat supper	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	table preparing to eat supper.  On 8/31/21 from 6:00 AM until 8:15 AM an observation was conducted at the group home by surveyor #1 and indicated the following:  -At 6:00 AM, clients #3, #4, #6 and #7 were at the kitchen table with the RM. Client #8 was getting dressed and ready for the day programAt 6:09 AM, staff #2 was taking client #6 to the bathroom. Client #1 was walking around in the kitchen areaAt 6:30 AM, client #3 was finishing his breakfast at the kitchen table. Client #8 was in the bathroom brushing his teeth with staff #2 At 6:50 AM, clients #3, #4, #7 and #8 were in recliners in the living room watching televisionAt 7:21 AM, clients #3, #4, #7 and #8 were in recliners in the living room watching televisionAt 7:35 AM, client #3 was in a recliner in the living room nappingAt 7:53 AM, client #1 was on a small couch in the kitchen area twirling a sock and t-shirt. Clients #3, #4, #5, #7, and #8 were in recliners in the living	TAG	DEFICIENCY	DATE
	room watching television. Client #6 was in his bedroom sitting in a recliner watching television.  - At 8:05 AM, clients #1, #3, #4, #5, #7, and #8 were in recliners in the living room watching television. Client #6 was in his bedroom watching television.  - At 8:07 AM, client #8 left with staff #2 for the day program.  1b) On 8/30/21 from 10:58 AM to 12:54 PM, an observation was conducted at the group home by surveyor #2 and indicated the following: At 11:34 AM after client #6 finished his lunch, he went to his room and went to bed. He was not redirected to engage in activities. At 11:36 AM after client #1 finished his lunch, he sat on a couch and			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		15G194	B. WING		09/03/2021
Manage of the	DROLUDED OF CLUBY		STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIER	t .	115 S	TONEGATE	
	RE COMMUNITY A	LTERNATIVES SE IN	BEDF	ORD, IN 47421	· · · · · · · · · · · · · · · · · · ·
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		ock. At 12:14 PM, client #1			
		the couch and twirl a shirt and			
		d #7 sat at the dining room es were being put away. Clients			
	_	prompted to assist with the			
		when staff #1 was in the garage			
		ins, clients #1, #3, #4, #5, #6,			
		prompted to assist her. At			
		returned to his room with no			
	· ·	ut the observation, clients #1,			
		ere not prompted to engage in			
		es. A majority of the			
	_	ents were sitting in the living			
		ision on as their activity.			
		·			
	On 8/30/21 from 2:	04 PM to 4:50 PM, an			
	observation was con	nducted at the group home.			
	At 2:38 PM, clients	#5 and #7 were sitting in the			
	_	ng TV. Client #1 sat on the			
	1	2:55 PM, client #5 exited his			
		in his room since 2:04 PM			
		55 PM, client #6 was on the			
	_	ent #3 was sitting in a recliner			
		no activity. At 3:07 PM,			
	_	g on the couch with no activity.			
		g on the couch with no			
	1	M, clients #3 and #7 were			
		room. At 3:23 PM, client #1			
	I -	ouch with no activity. Client			
		h with no activity. At 3:31 PM, to eat donuts out of the			
	1	M, client #6 was food seeking.			
		#1 was on the couch rocking			
		t 4:30 PM, client #7 was sitting			
		blanket over his head. Client			
		e recliner. Client #4 was asleep			
		ent #6 was sitting on the couch			
		t 4:31 PM, staff #1 used a food			
	1	Food. No clients were			
	1 -	PM, client #4 was asleep in his			
		, <b>-</b> F			

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G194	B. W	ING		09/03	/2021
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ONEGATE		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN			RD, IN 47421		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		was rocking on the couch.					
	Client #3 was sittin	g in his recliner.					
	Throughout the obs	servation, there were no formal					
	-	es conducted. The RM, staff #1					
		engage the clients in active					
	treatment. There were no meaningful activities						
	offered or provided	_					
	0 9/21/21 6 5	50 AM ( 0 00 AM					
		58 AM to 8:09 AM, an					
		nducted at the group home.					
		#5 went back to bed. At 6:30					
		on the couch rocking and					
		a shirt. At 6:48 AM, clients #3,					
		in the living room watching					
		ff #2 cleaned off the dining					
		0 AM, client #5 was sleeping.					
		s #3 and #7 were watching AM, client #7 was in the					
		ket over his head. At 6:59 AM,					
		ng a shirt and sock. At 7:03					
		e out of his room with his shirt					
		shirt from 8/30/21). At 7:09					
		ed from one couch to another.					
		ing a shirt and sock. At 7:19					
		asleep in a recliner in the living					
		as sitting in a recliner in the					
		t #1 was in a recliner rocking.					
		hing television. Client #8 was					
		a. At 8:04 AM, client #1 was					
		shirt while sitting on the					
		ras watching television. Client					
		levision. Client #3 was asleep.					
	Client #4 was sittin						
	_	servation, there were no formal					
		es conducted. The RM and					
		age the clients in active					
		vere no meaningful activities					
	offered or provided	to the clients.					

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		15G194	B. W	ING		09/03/	/2021
NAME OF D	PROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				ONEGATE		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		BEDFO	RD, IN 47421		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	0 0/1/21 -4 10-25	AM					
	On 9/1/21 at 10:35 AM, a review of the clients' active treatment schedules was conducted. The schedules were the same for all 7 clients (#1, #3, #4, #5, #6, #7 and #8):  6:00-7:00a - sleep						
	7:00-8:00a - breakfa	ast/meds					
	8:00-9:00a - hygien	ne/exercise					
	9:00-10:00a - a.m. g	goals					
	10:00-11:00a - snac						
	11:00-12:00p - table						
	12:00-1:00p - lunch						
	1:00-2:00p - group	_					
		Health and Safety Discussion					
	3:00-4:00p - activity	-					
	4:00-5:00p - p.m. g						
	5:00-6:00p - dinner						
	6:00-7:00p - dinner	clean up					
	The following goals	s and objectives for the clients					
	were not implement	ted during the observations					
	conducted at the gro	oup home:					
	O., 9/21/21 + 10 20	) AM					
		O AM, a review of client #1's red. Client #1's 10/29/20					
		Plan (ISP) indicated, "[Client					
		keeping eye contact and					
		es. He also requires hand over					
		h completing his ADL's					
		iving). [Client #1] is unable to					
	`	ry. He is at risk of exploitation					
	•	o understanding of stranger					
		is unable to communicate					
		o to what he wants and simply					
	grab the desired iter	m. [Client #1] wears adult					
	briefs and needs ass	sistance with toileting. He will					
		s fingers and requires verbal					
		utensils. He does not like to					
	be told 'no.'" Client	t #1's goals and training					

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

PRINTED: 10/04/2021 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER  15G194	r í	UILDING	00	COMPL 09/03/	ETED
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE RD, IN 47421		
(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
	his money when pubrush his teeth for the access kitchen knive.  On 8/31/21 at 12:10 record was conduct indicated, "He is limited ability to compare the form of the second was and object brush his teeth for the second was attended in the second was attended to the second was attended to the second was attended to the second was also does not enjoy be territorial and may provide the second was also does not enjoy be territorial and may provide the second was also does not enjoy be territorial and may provide the second was also does not enjoy be territorial and may provide the second workshop" Clier objectives included for two minutes, ide it, unlock box to accompare the second workshop without second workshop w	the following: hand cashier rechasing items at the store, wo minutes, and unlock box to es with physical assistance.  OPM, a review of client #3's ed. Client #3's 11/14/20 ISP hearing impaired and has very mmunicate his needs." Client etives included the following: wo minutes, identify a quarter Ill unlock box to access kitchen ag utensil down between bites, ral discussion of the hazards of ering without staff in  OAM, a focused review of client ducted. Client #4's 3/13/21 ISP res to eat fish and spend time. [Client #4] enjoys singing, and assisting staff with small ot like to complete chores. He being read to by staff. He can any become physically violent if by housemates/ peers at at #4's goals and training the following: brush his teeth entify a Quarter by pointing to be provided a quarter by pointing to be provided as a complete chores at a the staff in attendance, not have one sip at a time when pate in a verbal discussion of sing his walker when					

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Facility ID: 000724

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII		00	COMPL	
		15G194	B. WIN	G		09/03/	/2021
NAME OF F	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
DEC CVE		LTERNATIVES SE IN			ONEGATE RD, IN 47421		
	CE COMMONTT A	LIERNATIVES SE IN		BEDFO	ND, IN 47421		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		REFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	COMPLETION DATE
TAG		e following goals and		IAG			DATE
		is teeth for two minutes,					
	I -	e, wash his hands prior to					
		stration, unlock box to access					
		e a drink after three (3) bites,					
		l discussion of the hazards of					
	1 -	icipate in verbal discussion of					
		pervised bathing without staff					
	l	earn the sign for music.					
		-					
	On 8/31/21 at 10:15	5 AM, a focused review of client					
	#6's record was con	nducted. Client #6's 3/11/21 ISP					
	indicated, "[client	t #6] is dependent on staff for					
	toileting, basic livir	ng skills such as bathing and					
	_	ough [client #6] participates in					
		progress in these areas. [Client					
	_	ut is able to communicate his					
		rough pointing or leading staff					
	_	[Client #6] is able to feed					
	_	atly. [Client #6] is able to dress					
		physical assistance. He needs					
	_	ating fasteners and getting his					
	shoes on. [Client #	-					
		he is on a toileting schedule					
	_	communicating his need to					
		requently uses the toilet when					
		lient #6] has a seizure disorder, staff closely supervise [client					
		addition, [client #6] must have					
	_	h his room at all times in order					
		ures during times where [client					
		m" Client #6's ISP indicated					
		g goals and objectives: brush					
		inutes, hand cashier his money,					
		ems at the store, unlock box to					
		res, with hand over hand,					
		, chew and swallow one bite					
		ext bite, practice having a					
		hysical assistance, participate					
		on of the hazards of					
	l -		1				I

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

PRINTED: 10/04/2021 FORM APPROVED OMB NO. 0938-039

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G194	B. W	ING		09/03/	2021
NAME OF I	DROWDER OF CURRING		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF	C		115 ST	ONEGATE		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		BEDFO	RD, IN 47421		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION ering without staff in		TAG	DEFICIENCE)		DATE
		ticipate in a gestural					
	_	ason he has a sensory alarm					
	on his bedroom doo						
	On 8/31/21 at 11:09	AM, a focused review of client					
		iducted. Client #7's 5/15/21 ISP					
	indicated he had the following training goals and						
	objectives: brush te	eth for two minutes, identify a					
		to it, unlock box to access					
		e a drink after three (3) bites,					
		ace with verbal assistance,					
		l discussion of the hazards of					
	unsupervised showering without staff in						
	_	e having a dental exam with					
		discuss food seeking with					
	food thoroughly.	nd take small bites and chew					
	100d thoroughly.						
	On 8/31/21 at 11:20	AM, a focused review of client					
		iducted. Client #8's 1/16/21 ISP					
	indicated, "He red	quires physical or verbal					
	prompts to complet	e most adult daily life skills,					
	hygiene, and chores	s. [Client #8] enjoys playing					
	most sports, attendi	ng church, and accessing the					
		t #8] often behaves helpless					
		nfused in lieu of completing					
		s" His ISP goals and					
	I -	the following: brush his teeth					
	1	e change for one dollar, unlock					
		en knives, state one way of					
		te a drink after three (3) bites,					
		erbal discussion of the hazards owering without staff in					
	attendance.	owering without stall ill					
	attoridance.						
	On 8/31/21 at 12:33	3 PM, Area Supervisor #2					
		atment was getting the clients					
	engaged to do as m	uch as possible to become as					
	independent as poss	sible. The clients should be					

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15G194		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/03/2021
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE RD, IN 47421	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	engaged in their goals and chores. The staff should engage the clients. AS #2 stated "staff are there to teach and train" the clients. They should be going outside to do activities like the sandbox, kicking the ball around, and playing basketball. The clients did not need to be sleeping. The staff could take them on a car ride. She stated, "Staff need to be prompting" the clients to engage in meaningful activities. The clients' goals and training objectives should be implemented as written.  On 8/31/21 at 1:02 PM, the Program Manager (PM) indicated active treatment was engaging the clients and attempting to get them to do as much as possible for themselves. The PM stated "teaching them to be as independent as possible." The PM stated, "Do with but not for." The PM indicated the staff should teach and train the clients both formally and informally. The PM indicated the clients should be encouraged to engage in activities. The clients should be provided activities to engage in. The clients should be provided choices of activities to engage in. The clients should be implemented as written.  On 9/1/21 at 12:08 PM, Area Supervisor #1 (AS #1) indicated active treatment was keeping the clients engaged in structured activities at least every 15 minutes. AS #1 stated active treatment was "not watching TV all day." AS #1 stated "staff is worn out." The clients' goals and training objectives should be implemented as written.			
	On 8/30/21 at 10:58 AM, staff #1 was in the			

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IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/03/2021
ROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE ORD, IN 47421	
SUMMARY SUMMARY SEACH DEFICIENT REGULATORY OR kitchen making lund applesauce and chip asked to participate containers and place 11:21 AM, lunch staclients' food onto the #5, #6, #7 and #8 di lunches. At 11:34 A eating. Both left the table when they left client #1 and #6's di them in the sink. A empty cup in the air (RM) got up, took of Kool Aid for him. A the group home with #1 unloaded groceri and #7 brought in general #5 assisted with put #1, #3, #4, #6, #7 ar with putting away general eating their breat left the dining room his dishes to the sin to take his dishes to took client #7's dish the RM removed client and put them into the cleaned off the dining staff #2 started to make a plastic cor packed a plastic cor started to make a plastic cor started to make a plastic cor packed a plastic cor started to make a plastic cor started to make a plastic cor packed a plastic cor started to make a plastic cor started to make a plastic cor packed a plastic cor started to make a plastic cor packed a plastic cor started to make a plastic cor packed a	ETERNATIVES SE IN  STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION Ch (vienna sausages, as) with no clients involved or . Staff #1 opened the ed the sausages on plates. At arted. Staff #1 served the eir plates. Clients #1, #3, #4, d not serve themselves their AM, clients #1 and #6 finished eir dishes and utensils on the the table. Staff #1 cleared ishes from the table and put tt 11:54 AM, client #4 held his . The Residential Manager client #4's cup and poured more At 12:00 PM, staff #3 arrived to the groceries. Staff #3 and staff ties from her car. Clients #5 roceries. At 12:16 PM, client ting away groceries. Clients and #8 were not asked to assist	115 ST	ONEGATE	(X5) COMPLETION DATE
saltine crackers as c staff #2 continued to	ndwich bag and filled it with lient #7 watched. At 7:43 AM, o pack client #7's lunch. Client hat he wanted. Client #7 was			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	 UILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/03/	ETED
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 ST	DDRESS, CITY, STATE, ZIP COD DNEGATE RD, IN 47421		
(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 APPROPRI, DEFICIENCY)	ATE	(X5) COMPLETION DATE
mo	On 8/31/21 at 7:51 asked what he pack Client #8 indicated	AM, client #8 stated when ed for lunch, "My staff do it." the staff packed his lunch 8 indicated he did not pack his	me			5.112
	[client #7] to do not	AM, the RM stated, "can't get hing." The RM stated clients derstand." The RM stated nything."				
	was at the store buy indicated clients #1	AM, the RM indicated staff #3 ing groceries. The RM ,#3, #4, #5, #6, #7 and #8 were assisting with the grocery				
	indicated the staff's he packed his lunch "should participate" him." AS #1 indicathe clients to serve the drinks, and clean up	PM, Area Supervisor (AS) #1 hould monitor client #8 while . AS #1 stated client #8 and "staff should watch ted the staff needed to prompt themselves, pour their own their dishes. She indicated the involved with meal				
	clients should be en serving themselves	PM, AS #2 indicated the gaged with meal preparation, and clean up. AS #2 indicated packing his own lunch.				
	indicated the clients preparation, serving	PM, the Program Manager (PM) should be engaged with meal themselves and clean up. AS \$8 should be packing his own				
		ore conducted at the group om 10:58 AM to 12:54 PM,				

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction  00	(X3) DATE SURVEY  COMPLETED  09/03/2021
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE PRD, IN 47421	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	8/30/21 from 2:04 PM to 4:50 PM, and 8/31/21 from 5:58 AM to 8:09 AM. During meal observations at the group home (lunch and dinner on 8/30/21 and breakfast on 8/31/21), staff did not prompt client #3 to alternate small bites and sips of liquids.			
	On 8/31/21 at 12:10 PM, a review of client #3's record was conducted. Client #3's 10/19/20 Choking Risk Plan indicated, "4. Staff will encourage [client #3] to take small bites alternating nectar liquids and solids"			
	On 9/1/21 at 12:08 PM, Area Supervisor #1 (AS #1) indicated the client's goal and training objective should be implemented as written.			
	On 8/31/21 at 12:33 PM, Area Supervisor #2 indicated the client's goal should be implemented as written.			
	4) On 8/31/21 at 10:20 AM, a review of client #1's record was conducted. Client #1's 10/29/20 Individual Support Plan (ISP) indicated he had a goal to hand a cashier his money when purchasing items at the store. The goal was to be implemented every other Monday during 2nd shift.			
	On 8/30/21 at 12:36 PM, a review of client #1's finances was conducted. Client #1 did not have money in his personal account. Client #1 did not have money in his personal account since his admission on 9/30/20.			
	On 8/30/21 at 12:36 PM, the Residential Manager (RM) indicated client #1 did not have money and had not had money since his admission.			
	5) Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM,			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/03/	ETED
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 ST	DDRESS, CITY, STATE, ZIP COD DNEGATE RD, IN 47421		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	5:58 AM to 8:09 Al	PM to 4:50 PM, and 8/31/21 from M. During the observations, the ox in the pantry was				
	record was conduct indicated he had a g access kitchen kniv Client #1's 10/29/20 be modified section	O AM, a review of client #1's ed. Client #1's 10/29/20 ISP goal to unlock the box to es with physical assistance. O ISP indicated in the Rights to a, "Manner in which the right itchen knives will be locked up d for cooking."				
	record was conduct	PPM, a review of client #3's ed. Client #3's 11/14/20 ISP goal to unlock the box to es.				
	#4's record was con	5 AM, a focused review of client ducted. Client #4's 3/13/21 ISP goal to unlock the box to es.				
	#5's record was con	O AM, a focused review of client ducted. Client #5's 5/7/21 ISP goal to unlock the box to es.				
	#6's record was con	5 AM, a focused review of client ducted. Client #6's 3/11/21 ISP goal to unlock the box to es.				
	#7's record was con	O AM, a focused review of client ducted. Client #7's 5/15/21 ISP goal to unlock the box to es.				
	On 8/31/21 at 11:20	) AM, a focused review of client				

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CO A. BUILDING B. WING	instruction 00	(X3) DATE SURVEY COMPLETED 09/03/2021
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE RD, IN 47421	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  #8's record was conducted. Client #8's 1/16/21 ISP	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	indicated he had a goal to unlock the box to access kitchen knives.			
	On 8/31/21 at 12:33 PM, Area Supervisor #2 indicated the clients' goals should be implemented as written. AS #2 indicated the staff should work on the clients' goals both formally and informally.			
	6) Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM, 8/30/21 from 2:04 PM to 4:50 PM, and 8/31/21 from 5:58 AM to 8:09 AM. Client #6 did not have a divided high sided plate during lunch and breakfast. Client #6 did not have a long handled small spoon at lunch, dinner and breakfast. Client #6 did not have a picture placemat to help			
	communicate his wants and needs.  On 8/31/21 at 10:15 AM, a focused review of client #6's record was conducted. Client #6's 3/5/21  Dining Plan indicated, "[Client #6] feeds himself without difficulty. [Client #6] uses a divided high-sided plate with special eating utensils (long handled small spoon). He also uses a picture placemat during dining times to help communicate his wants and needs"			
	On 9/2/21 at 12:23 PM, Area Supervisor #1 indicated client #6 should have a divided plate, long handled small spoon and placement as indicated in his plan.			
	7) Observations were conducted at the group home on 8/30/21 from 10:58 AM to 12:54 PM, 8/30/21 from 2:04 PM to 4:50 PM, and 8/31/21 from 5:58 PM to 8:09 AM. During the observations, client #6 did not have an audio monitor in his bedroom.			

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G194	A. BUILDING B. WING	00	COMPLETED 09/03/2021	
		130194			09/03/2021	
NAME OF P	PROVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY AI	TERNATIVES SE IN		BEDFORD, IN 47421		
(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)		
TAG W 0240 Bldg. 00	On 8/31/21 at 10:15 #6's record was conindicated in the Rigi "Right to be modified Manner in which the will monitor [client he is in his bedroom needed: To monitor staff if and when he  On 9/2/21 at 12:23 indicated client #6 s as indicated in his p  9-3-4(a)  483.440(c)(6)(i) INDIVIDUAL PRO The individual proprelevant intervention toward independe Based on observation interview for 1 of 3 facility failed to ensplan was revised after completed and clien were added to his ri  Findings include:  1. On 8/31/21 at 12: record was conducted following:  -Client #3's 10/19/2 "Staff will prepare low-fat high fiber diduring meals. Staff take small bites alter	GRAM PLAN gram plan must describe ons to support the individual ence. on, record review and clients in the sample (#3), the ure client #3's choking risk er he had a swallow study tt #3's compression stockings sk plan.	W 0240	To correct the deficient practic nursing staff have been re-tra on the importance of updating plans as the clients' needs change. Client #3s risk plans have been updated to include swallow study recommendatic and compression socks. All s staff have been trained on the updated plans. The nursing shave reviewed all clients risk to ensure they are accurate a up to date. Ongoing monitorin will be achieved through week review of all client appointmer and updating the plan at that time. Additionally, a periodic review of client risk plans and medical documentation will be	the ons dite of the plans of th	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		15G194	B. W	ING		09/03/2021	
				CED FIFT	A DED FOR COTAL OT A TEL SID COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
DE0.044	DE OOMANALINIETY A	1 TEDNIA TIV (EQ. QE IN)			ONEGATE BB IN 47404		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		BEDLO	RD, IN 47421		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	following a 1/22/21	swallow study.			completed by the DoN to ensu	ıre	
					accuracy.		
	-Client #3's 1/22/21	swallow study indicated, in			•		
	part, "Downgrade	to honey-thick/moderately					
	thick liquids Alternate puree with honey-thick liquids/moderately thick liquids"						
	On 8/31/21 at 1:49	PM, the nurse indicated he was					
	confused as to what client #3's liquids needed to						
	be thickened to. The nurse indicated client #3's						
	risk plan needed to	be revised. On 8/31/21 at 1:51					
	PM, the nurse indicated the Residential Manager						
	told him client #3 had a swallow study in 2021						
	however he did not	have the results. The nurse					
	stated, "I did not se	e the results of the swallow					
	study. Should have	e them in the record."					
	2 On 8/31/21 at 12	:10 PM, a review of client #3's					
		red. Client #3's 8/27/21					
	Medical Consult Re						
		ckings," prescribed by the					
	-	#3 did not have a health risk					
	-	ma (swelling) addressing the					
	need for compression						
	On 9/2/21 at 12:32	PM, the nurse indicated in an					
		ompression socks will need to					
		F (congestive heart failure -					
		condition that affects the					
		your heart muscle) plan and					
	instructions will ne						
	On 8/31/21 at 1:33	PM, the Program Manager (PM)					
	indicated client #3	should be wearing					
	compression stocki	ngs as ordered. She indicated					
	she bought client #3	3 compression stockings					
	recently.						
	On 8/31/21 at 1:49	PM, the Nurse indicated client					
	#3's plans need to b	e revised to include the use of					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU B. WI	JILDING	00	COMPLETED 09/03/2021	
		15G194	B. WI			09/03/	ZUZ I
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE ORD, IN 47421		
(X4) ID	SUMMARY S	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
	compression stockir	ngs.					
	9-3-4(a)						
W 0249	483.440(d)(1)						
Dida 00	PROGRAM IMPLE						
Bldg. 00		erdisciplinary team has					
		t's individual program plan, eceive a continuous active					
	treatment program consisting of needed interventions and services in sufficient number and frequency to support the						
achievement of the objectives identified in the individual program plan.							
		on, record review and	wo	249	To correct the deficient practic	e all	10/03/2021
		clients observed at the group	'' 0	2 17	site staff have been re-trained		10/03/2021
		5, #6, #7 and #8), the facility			the following: aggressive and		
	· ·	clients received a continuous			continuous active treatment ar	nd	
	active treatment pro	gram including implementing			implementing plans as written		
	the clients' program	plans as written.			including utilizing program		
					supplies as indicated in the pla	an.	
	Findings include:				A room monitor has been		
	1 ) 0 0/00/01 6	11.00.416			purchased for client #6. A qua		
		n 11:00 AM until 1:00 PM and			QIDP has been assigned to the		
		6:15 PM, observations were			site to integrate, coordinate ar		
	indicated the follow	oup home by surveyor #1 and			monitor. The QIDP will be train		
	indicated the follow	ing:			on all clients and QIDP duties.		
	_At 11:21 AM alian	ts #1, #3, #4, #6, and #7 were			Weekly QIDP meetings will be held to ensure the QIDP is	;	
		table preparing to eat lunch.			completing duties as assigned	for	
	_	t #6 was sitting on the couch			a period of one month. The QI		
	watching television.	_			will also update each client's o		
		ts #1 and #6 were sitting on the			schedule to reflect current rou	-	
	couch watching tele	2			and ISP goals. Additional		
		t #1 was sitting on the small			monitoring will be achieved by	,	
		n area twirling a sock and			daily administration observation		
		nd #7 were helping staff #3			and daily administration meeti		
		ag from the garage. Client #3			to discuss the status of the ho	_	
		cliner in the living room.			for a period of 60 days. Ongo		
		at #4 was sitting at the kitchen			monitoring will be achieved	J	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2		(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETE			ETED
		15G194	B. W	NG		09/03/2021	
				·			
NAME OF I	PROVIDER OR SUPPLIER	<b>t</b>			ADDRESS, CITY, STATE, ZIP COD		
DE0.041		1 TERMATINES OF IN			ONEGATE		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		BEDLO	RD, IN 47421		
(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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	table eating potato	chips. He was coughing			through routine monthly		
	frequently so staff #	‡1 gave him a second glass of			observations from administrat	tion,	
	kool-aid.				and the QIDP. Additionally, a	l	
	-At 12:13 PM, clier	nt #6 walked out the front door			monthly site and record review	N	
	and staff #3 redirec	ted him to come back inside.			audit will be completed by		
		#6 was in his bedroom. Client			ResCare supervisory staff.		
	** •	a recliner in the living room					
	area. Clients #3, #4, and #5 were at the kitchen table coloring pictures.  -At 2:16 PM, client #6 came into the kitchen and						
		If #1 gave client #6 paper to					
	shredAt 2:36 PM, client #6 was shredding paper at the						
		ts #3 and #4 were at the					
		ng a picture. Client #7 was					
		er in the living room. Client #1					
		the living room twirling a sock					
	and shirt. Client #5	was wandering around the					
	house.						
		#3 was taken by a wheelchair					
		ole to a recliner in the living					
	room by staff #1.						
	· ·	#4 was assisted out of a					
		g room by the Residential					
		se the bathroom. Client #4					
		and returned to a recliner in					
	the living room.						
		#1 went into his bedroom.					
		#1 was on small couch in					
	_	ock and t-shirt. Client #6 was					
	-	in the living room watching					
		#3, #4, and #7 were napping in					
		ng room. Client #5 was					
	watching television	_					
		#6 was getting into the trash					
		itchen. Staff #1 redirected the					
	client and he returned to the couch in the living						
	room.	<i>u</i>					
		#4 was in a recliner in the					
	living room listenin	g to a compact disc (CD) on a					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	ľ	JILDING	NSTRUCTION 00	(X3) DATE COMPL 09/03/	ETED
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		115 ST	DDRESS, CITY, STATE, ZIP COD DNEGATE RD, IN 47421		
(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	тЕ	(X5) COMPLETION
PREFIX TAG	portable music play recliner in the living -At 4:03 PM, client watching television small couch in the lit-shirtAt 4:09 PM, client programAt 4:34 PM, client kitchenAt 5:25 PM, all client table preparing to e  On 8/31/21 from 6: observation was consurveyor #1 and incomplete table with the consumption of the c	R LSC IDENTIFYING INFORMATION  rer. Client #3 was napping in a g room.  #6 was sitting on the couch  Client #1 was sitting on a kitchen area twirling a sock and  #8 returned home from the day  s #5 and #8 were helping in the  ents were present at the kitchen at supper.  00 AM until 8:15 AM an inducted at the group home by licated the following:  ts #3, #4, #6 and #7 were at the the RM. Client #8 was getting		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	DATE DATE
	-At 6:09 AM, staff bathroom. Client #1 kitchen areaAt 6:30 AM, client at the kitchen table. brushing his teeth v - At 6:50 AM, client recliners in the livin -At 7:21 AM, client recliners in the livin -At 7:35 AM, client living room napping -At 7:53 AM, client kitchen area twirlin #4, #5, #7, and #8 v room watching tele bedroom sitting in a - At 8:05 AM, client were in recliners in	ats #3, #4, #7 and #8 were in ag room watching television.  ts #3, #4, #7 and #8 were in ag room watching television.  t #3 was in a recliner in the					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	l í	JILDING	nstruction 00	(X3) DATE COMPL <b>09/03</b> /	ETED
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		115 ST	DDRESS, CITY, STATE, ZIP COD DNEGATE RD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	television At 8:07 AM, clier day program.	at #8 left with staff #2 for the					
	observation was co At 11:34 AM after went to his room ar redirected to engag after client #1 finish couch and twirled a client #1 continued shirt and sock. Clie room table while gr Clients #6 and #7 v with the task. At 12 the garage putting i #4, #5, #6, #7 and # her. At 12:41 PM, with no activity. To clients #1, #3, #4, # engage in meaning observation, the clients	m 10:58 AM to 12:54 PM, an inducted at the group home. Client #6 finished his lunch, he ad went to bed. He was not it in activities. At 11:36 AM inced his lunch, he sat on a shirt and sock. At 12:14 PM, to sit on the couch and twirl a cents #6 and #7 sat at the dining roceries were being put away. Were not prompted to assist 2:24 PM when staff #1 was in teems into bins, clients #1, #3, #8 were not prompted to assist client #6 returned to his room throughout the observation, #6 and #7 were not prompted to ful activities. A majority of the cents were sitting in the living ision on as their activity.					
	observation was con At 2:38 PM, clients living room watching couch rocking. At room. He had been taking a nap. At 2: couch rocking. Client his feet up and client #1 was sitting activity. At 3:17 Pl asleep in the living was sitting on the c	04 PM to 4:50 PM, an inducted at the group home.  #5 and #7 were sitting in the ing TV. Client #1 sat on the 2:55 PM, client #5 exited his in his room since 2:04 PM in his ro					

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 09/03/2021
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE DRD, IN 47421	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	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 B CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
	garbage. At 3:57 PAt 4:05 PM, client with no activity. At in a recliner with a #3 was sitting in the in his recliner. Clie with no activity. A processor to puree for involved. At 4:37 If recliner. Client #6 Client #3 was sitting. Throughout the obsor informal activities and staff #3 did not treatment. There we offered or provided. On 8/31/21 from 5: observation was con At 6:03 AM, client #1 was of twirling a sock and #4, #7 and #8 were television while star room table. At 6:52 AM, clients television. At 6:57 recliner with a blanch client #1 was twirling AM, client #1 was twirling the star on backward (same AM, client #1 moved Client #1 was twirling the star of the star	ervation, there were no formal es conducted. The RM, staff #1 engage the clients in active ere no meaningful activities			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY  COMPLETED  09/03/2021	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE ORD, IN 47421	-
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE  CY MUST BE PRECEDED BY FULL  LLSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE COMPLETION
TAG	twirling a sock and couch. Client #5 w #7 was watching tel Client #4 was sitting. Throughout the obsor informal activities staff #2 did not eng treatment. There w offered or provided.  On 9/1/21 at 10:35 active treatment sels schedules were the #4, #5, #6, #7 and #6:00-7:00a - sleep 7:00-8:00a - breakfi 8:00-9:00a - hygien 9:00-10:00a - a.m. g 10:00-11:00a - snact 11:00-12:00p - table 12:00-1:00p - lunch 1:00-2:00p - group 2:00-3:00p - Snack 3:00-4:00p - activit 4:00-5:00p - p.m. g 5:00-6:00p - dinner 6:00-7:00p - dinner fo:00-7:00p - dinner conducted at the ground was conducted at the ground was conducted Individual Support #1] struggles with k engaging in activition	ervation, there were no formal as conducted. The RM and age the clients in active ere no meaningful activities to the clients.  AM, a review of the clients' nedules was conducted. The same for all 7 clients (#1, #3, 18):  ast/meds e/exercise goals ek/leisure e activity //leisure reading //Health and Safety Discussion by of choice oals prep //clean up	TAG	DEFICIENCY	DATE

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/03/2021	
	ROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE DRD, IN 47421	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
IAU	(activities of daily I use pedestrian safet and demonstrates medanger. [Client #1] verbally. He will gerab the desired iter briefs and needs asseat his food with his prompts to use his use told 'no." Client objectives included his money when push his teeth for the access kitchen knive. Client #1's 7/19/21 Assessment indicated in 3 months.  On 8/31/21 at 12:10 record was conduct indicated, "He is I limited ability to compare ability to compare a between bites, parting of the hazards of unstaff in attendance. Nutrition Assessment pounds in 5 months  On 8/31/21 at 10:55 #4's record was conindicated, "He low with preferred staff, and projects. He does meals of does not enjoy	iving). [Client #1] is unable to y. He is at risk of exploitation to understanding of stranger is unable to communicate to to what he wants and simply m. [Client #1] wears adult distance with toileting. He will stranger and requires verbal attensils. He does not like to at #1's goals and training the following: hand cashier rehasing items at the store, wo minutes, and unlock box to see with physical assistance. Quarterly Nutrition and he had gained 22.5 pounds  OPM, a review of client #3's and Client #3's and has very minutes his needs." Client attives included the following: wo minutes, identify a quarter all unlock the box to access put his eating utensil down cipate in gestural discussion assupervised showering without Client #3's 7/19/21 Quarterly nt indicated he had gained 18	IAG		DATE

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	l í	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 09/03/	ETED
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	workshop" Clier objectives included for two minutes, ide it, unlock box to accibites and chew food verbal discussion of showering without consecutive drinks, drinking and particithe importance of u ambulating. Client Assessment indicate 2 months.  On 8/31/21 at 10:59 #5's record was con indicated he had the objectives: brush hi complete a purchase medication adminis kitchen knives, take participate in verbal using caffeine, partithe hazards of unsurin attendance, and 1 On 8/31/21 at 10:15 #6's record was con indicated, "[client toileting, basic livit tooth brushing, alth formal training to p #6] is non-verbal bu wants and needs that to what he wants. [himself independen himself with some p	by housemates/ peers at at #4's goals and training the following: brush his teeth entify a Quarter by pointing to cess kitchen knives, take small a thoroughly, participate in a the hazards of unsupervised staff in attendance, not have one sip at a time when pate in a verbal discussion of sing his walker when #4's 7/19/21 Quarterly Nutrition ed he had gained 5 pounds in  DAM, a focused review of client ducted. Client #5's 5/7/21 ISP et following goals and is teeth for two minutes, e., wash his hands prior to tration, unlock box to access a drink after three (3) bites, a discussion of the hazards of dicipate in verbal discussion of pervised bathing without staff the earn the sign for music.  DAM, a focused review of client ducted. Client #6's 3/11/21 ISP #6] is dependent on staff for a geskills such as bathing and bough [client #6] participates in rogress in these areas. [Client at it is able to communicate his rough pointing or leading staff Client #6] is able to dress onlysical assistance. He needs string fasteners and getting his 6] wears depends					

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	OF CORRECTION	IDENTIFICATION NUMBER  15G194	A. BU	A. BUILDING 00  B. WING		COMPLETED 09/03/2021	
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY AL	TERNATIVES SE IN			RD, IN 47421		
(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 BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION he is on a toileting schedule		TAG	DEFICIENCY)		DATE
	_	ommunicating his need to equently uses the toilet when					
	taken Because [cl	lient #6] has a seizure disorder,					
	-	staff closely supervise [client addition, [client #6] must have					
	_	his room at all times in order					
		ares during times where [client					
	_	m" Client #6's ISP indicated					
	he had the following goals and objectives: brush his teeth for two minutes, hand cashier his money,						
		ems at the store, unlock box to					
	access kitchen knives, with hand over hand,						
	physical assistance, chew and swallow one bite before taking the next bite, practice having a						
	-	xt bite, practice having a hysical assistance, participate					
	in gestural discussion						
	-	ering without staff in					
	attendance, and part	_					
		ason he has a sensory alarm					
		r. Client #6's 7/19/21					
	•	Assessment indicated he had					
	gained 15 pounds in	6 months.					
		AM, a focused review of client ducted. Client #7's 5/15/21 ISP					
		following training goals and					
		eth for two minutes, identify a					
		o it, unlock box to access					
		a drink after three (3) bites,					
	discuss personal spa	ace with verbal assistance,					
		discussion of the hazards of					
	_	ering without staff in					
	_	having a dental exam with					
		discuss food seeking with nd take small bites and chew					
		lient #7's 7/19/21 Quarterly					
		nt indicated he had gained 8					
	pounds in one mont						

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	of correction (X1) provider/supplier/clia (IDENTIFICATION NUMBER (15G194)	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/03/2021
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE PRD, IN 47421	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	On 8/31/21 at 11:20 AM, a focused review of client #8's record was conducted. Client #8's 1/16/21 ISP indicated, "He requires physical or verbal prompts to complete most adult daily life skills, hygiene, and chores. [Client #8] enjoys playing most sports, attending church, and accessing the community. [Client #8] often behaves helpless (sic), robotic, or confused in lieu of completing adult daily life skills" His ISP goals and objectives included the following: brush his teeth for 2 minutes, make change for one dollar, unlock box to access kitchen knives, state one way of being exploited, take a drink after three (3) bites, and participate in verbal discussion of the hazards of unsupervised showering without staff in attendance. Client #8's 7/19/21 Quarterly Nutrition Assessment indicated he had gained 20 pounds in 3 months.  On 8/31/21 at 12:33 PM, Area Supervisor #2 indicated active treatment was getting the clients engaged to do as much as possible to become as independent as possible. The clients should be engaged in their goals and chores. The staff should engage the clients. AS #2 stated "staff are there to teach and train" the clients. They should be going outside to do activities like the sandbox, kicking the ball around, and playing basketball. The clients did not need to be sleeping. The staff could take them on a car ride. She stated, "Staff need to be prompting" the clients to engage in meaningful activities. The clients goals and training objectives should be implemented as written.  On 8/31/21 at 1:02 PM, the Program Manager (PM) indicated active treatment was engaging the clients and attempting to get them to do as much as possible for themselves. The PM stated "teaching them to be as independent as possible."			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 09/03/2021		
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421			
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE	
	The PM stated, "Do indicated the staff siclients both formally indicated the clients engage in activities provided activities thould be provided engage in. The clie objectives should be provided engage in. The clie objectives should be "Indicated active clients engaged in severy 15 minutes." was "not watching "staff is worn out." objectives should be "Indicated active clients engaged in severy 15 minutes." A "Indicated active clients engaged in severy 15 minutes. A "Indicated active clients engaged in severy 15 minutes." A "Indicated active clients engaged in severy 15 minutes. A "Indicated active clients should be "Indicated active clients and placed and chip asked to participate containers and placed 11:21 AM, lunch stacked to participate containers and	with but not for." The PM hould teach and train the y and informally. The PM should be encouraged to The clients should be o engage in. The clients choices of activities to ints' goals and training e implemented as written.  PM, Area Supervisor #1 (AS treatment was keeping the tructured activities at least AS #1 stated active treatment TV all day." AS #1 stated The clients' goals and training e implemented as written.  The clients' goals and training e implemented as written.				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/03/2021	
	ROVIDER OR SUPPLIER		115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE	
RES CAR	RE COMMUNITY AI	LTERNATIVES SE IN	BEDEC	DRD, IN 47421	
(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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	#5 assisted with put #1, #3, #4, #6, #7 ar with putting away g On 8/31/21 upon ar	roceries. At 12:16 PM, client ting away groceries. Clients and #8 were not asked to assist proceries. rival, the clients were sitting akfast. At 6:13 PM, client #7			
	his dishes to the sin to take his dishes to took client #7's dish the RM removed cli and put them into the	table. Client #7 did not take k. Client #7 was not prompted the sink. At 6:14 PM, staff #2 ses to the sink. At 6:36 AM, sent #3's dishes from the table the sink. At 6:48 AM, staff #2 ang room table. At 7:36 AM,			
	staff #2 started to m packed a plastic cordinner while client a staff #2 got out a sa saltine crackers as c staff #2 continued to	hake client #8's lunch. Staff #2 htainer with leftovers from #8 watched him. At 7:40 AM, hndwich bag and filled it with helient #7 watched. At 7:43 AM, ho pack client #7's lunch. Client hat he wanted. Client #7 was			
	asked what he pack Client #8 indicated	AM, client #8 stated when ed for lunch, "My staff do it." the staff packed his lunch 8 indicated he did not pack his			
	[client #7] to do not	6 AM, the RM stated, "can't get hing." The RM stated clients derstand." The RM stated nything."			
	was at the store buy indicated clients #1,	ing groceries. The RM #3, #4, #5, #6, #7 and #8 were assisting with the grocery			

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AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15G194		r í	JILDING	<u></u>		COMPLETED 09/03/2021	
	F PROVIDER OR SUPPLIEF ARE COMMUNITY A	LTERNATIVES SE IN		115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE RD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)		ΝΤΕ	(X5) COMPLETION DATE
	indicated the staff's he packed his lunch "should participate" him." AS #1 indicathe clients to serve drinks, and clean up the clients should be preparation.  On 8/31/21 at 12:53 clients should be enserving themselves client #8 should be  On 8/31/21 at 1:02 indicated the clients preparation, serving #2 indicated client #1 lunch.  3) Observations we home on 8/30/21 from 2:04 If 8/30/21 from 2:04 If 5:58 AM to 8:09 AI the group home (lubreakfast on 8/31/2 #3 to alternate small On 8/31/21 at 12:10 record was conduct Choking Risk Plan encourage [client #2 alternating nectar limited on 9/1/21 at 12:08 #1) indicated the clients who indicated the clients which is the properties of the propertie	PM, Area Supervisor (AS) #1 hould monitor client #8 while a. AS #1 stated client #8 'and "staff should watch sted the staff needed to prompt themselves, pour their own to their dishes. She indicated e involved with meal  B PM, AS #2 indicated the legaged with meal preparation, and clean up. AS #2 indicated packing his own lunch.  PM, the Program Manager (PM) should be engaged with meal gethemselves and clean up. AS #8 should be packing his own  PM to 4:50 PM, and 8/31/21 from M. During meal observations at each and dinner on 8/30/21 and 1), staff did not prompt client Il bites and sips of liquids.  PM, a review of client #3's ed. Client #3's 10/19/20 indicated, "4. Staff will 3] to take small bites quids and solids"  PM, Area Supervisor #1 (AS ient's goal and training implemented as written.  B PM, Area Supervisor #2					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY  COMPLETED  09/03/2021			
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION S goal should be implemented	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	as written. 4) On 8/31/21 at 10 record was conduct	0:20 AM, a review of client #1's ed. Client #1's 10/29/20 Plan (ISP) indicated he had a					
	_	er his money when the store. The goal was to be other Monday during 2nd					
	finances was condu money in his persor	5 PM, a review of client #1's cted. Client #1 did not have nal account. Client #1 did not personal account since his 20.					
	(RM) indicated clie	o PM, the Residential Manager nt #1 did not have money and since his admission.					
	home on 8/30/21 fro 8/30/21 from 2:04 F 5:58 AM to 8:09 Al	ere conducted at the group om 10:58 AM to 12:54 PM, PM to 4:50 PM, and 8/31/21 from M. During the observations, the ox in the pantry was					
	record was conduct indicated he had a g access kitchen kniv Client #1's 10/29/20 be modified section	O AM, a review of client #1's ed. Client #1's 10/29/20 ISP goal to unlock the box to es with physical assistance. O ISP indicated in the Rights to , "Manner in which the right itchen knives will be locked up if for cooking."					
	record was conduct	PM, a review of client #3's ed. Client #3's 11/14/20 ISP goal to unlock the box to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		r í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/03/	ETED	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		115 ST	DDRESS, CITY, STATE, ZIP COD DNEGATE RD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
IAG	access kitchen kniv On 8/31/21 at 10:55 #4's record was con indicated he had a g access kitchen kniv On 8/31/21 at 10:55 #5's record was con indicated he had a g access kitchen kniv On 8/31/21 at 10:15 #6's record was con indicated he had a g access kitchen kniv On 8/31/21 at 11:09 #7's record was con indicated he had a g access kitchen kniv On 8/31/21 at 11:20	es.  5 AM, a focused review of client ducted. Client #4's 3/13/21 ISP goal to unlock the box to es.  6 AM, a focused review of client ducted. Client #5's 5/7/21 ISP goal to unlock the box to es.  6 AM, a focused review of client ducted. Client #6's 3/11/21 ISP goal to unlock the box to es.  6 AM, a focused review of client ducted. Client #6's 3/15/21 ISP goal to unlock the box to es.		TAU			DATE
	indicated he had a gaccess kitchen kniv  On 8/31/21 at 12:33 indicated the clients as written. AS #2 i	goal to unlock the box to					
	home on 8/30/21 fr 8/30/21 from 2:04 I 5:58 AM to 8:09 A divided high sided p breakfast. Client #6 small spoon at lunc	ere conducted at the group om 10:58 AM to 12:54 PM, PM to 4:50 PM, and 8/31/21 from M. Client #6 did not have a plate during lunch and 6 did not have a long handled h, dinner and breakfast. Client icture placemat to help					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G194		A. BUILDING 00 COME			(X3) DATE ( COMPL 09/03/	ETED	
	ROVIDER OR SUPPLIER	TERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		T	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1110							2.112
	#6's record was combining Plan indicated without difficulty. [high-sided plate with handled small spoor placemat during din his wants and needs  On 9/2/21 at 12:23 I indicated client #6 s long handled small sindicated in his plan.  7) Observations we home on 8/30/21 from 2:04 P 5:58 AM to 8:09 AM client #6 did not have bedroom.  On 8/31/21 at 10:15 #6's record was consindicated in the Righ "Right to be modified Manner in which the will monitor [client he is in his bedroom needed: To monitor staff if and when he	AM, a focused review of client ducted. Client #6] feeds himself (Client #6] uses a divided h special eating utensils (long n). He also uses a picture ing times to help communicate"  PM, Area Supervisor #1 hould have a divided plate, spoon and placement as  re conducted at the group om 10:58 AM to 12:54 PM, PM to 4:50 PM, and 8/31/21 from M. During the observations, re an audio monitor in his  AM, a focused review of client ducted. Client #6's 3/11/21 ISP het to be Modified section, ed: Rights of Privacy Bedroom. e right will be modified: Staff #6] by an audio monitor while a. Reason the modification is [client #6] in his room to alert has a possible seizure."					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	A. BUILDING <u>00</u> COMPLE			ETED
		15G194	B. W	B. WING 09/03/2021			/2021
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L					
RES CAE	RE COMMUNITY AI	LTERNATIVES SE IN		115 STONEGATE BEDFORD, IN 47421			
INEO OAI	(L GOMMONTT AL	LIERWATIVES SE IIV		DEDI O			_
(X4) ID	SUMMARY S	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
W 0268	483.450(a)(1)(i)						
	CONDUCT TOWA	ARD CLIENT					
Bldg. 00	These policies and	d procedures must promote					
	the growth, develo	ppment and independence of					
	the client.						
		on and interview for 2 of 8	W (	0268	To correct the deficient practic		10/03/2021
	_	group home (#5 and #7), the			site staff have been re-trained	on	
		sure the clients' dignity in			client dignity regarding being		
	-	wearing their clothes			appropriately dressed. Addition		
	backwards.				monitoring will be achieved by		
					daily administration observation		
	Findings include:				and daily administration meetings		
				to discuss the status of the ho			
	On 8/30/21 from 11:00 AM until 1:00 PM and from				for a period of 60 days. Ongo	ing	
		PM, observations were			monitoring will be achieved		
		oup home. During the			through routine monthly		
		#5 was wearing a sports jersey			observations from administration,		
	shirt backwards.				and the QIDP. Additionally, a		
	0 0/21/21 6 6/	00 435 (10 10 435			monthly site and record review	V	
		00 AM until 8:10 AM an			audit will be completed by		
	observation was cor	nducted at the group home.			ResCare supervisory staff.		
	-At 6:00 AM client	#5 was wearing the same					
		s the day prior and was					
	wearing it backward						
	-At 7:29 AM client	#7's long athletic pants were					
		nt #7 was walking around the					
		ls in his pants pockets					
		pulling up the pants					
	On 8/31/21 at 12:33	3 PM, Area Supervisor (AS) #2					
	indicated staff should	ld ensure clothes are put on					
	the correct way and	that this was a dignity issue.					
		ne thing happened last week					
		ents should dress like we					
	dress."						
		PM, the Program Manager (PM)					
	indicated staff should	ld have directed the clients to					

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00		00	COMPLETED			
		15G194	B. W	NG		09/03	3/2021
NAME OF A		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		115 ST	ONEGATE		
RES CARE COMMUNITY ALTERNATIVES SE IN			BEDFC	PRD, IN 47421			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI.	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	^	s correctly and this was a					
	dignity issue.						
	On 9/1/21 at 12:10	PM, AS #1 indicated staff					
		ents dress correctly. She					
	indicated this was a						
	9-3-5(a)						
W 0382	483.460(I)(2)						
		E AND RECORDKEEPING					
Bldg. 00	The facility must keep all drugs and biologicals locked except when being						
	prepared for adm	inistration.	117.6	202	T	0	10/02/2021
	Based on observati	ion and interview for 7 of 8	I w c	382	To correct the deficient practi site staff have been re-trained		10/03/2021
		e group home (#1, #3, #4, #5, #6,			ensuring the medications are	1 011	
		cility failed to ensure staff kept			always secured. Additional		
	· ·	d and secured at all times.			monitoring will be achieved by	V	
					daily administration observati	-	
	Findings include:				and daily administration meet		
					to discuss the status of the ho	ome	
	On 8/30/21 from 1	1:00 AM until 1:00 PM and from			for a period of 60 days. Ongo	oing	
		PM, observations were			monitoring will be achieved		
		roup home. At 11:51 AM, the			through routine monthly		
		r was open and accessible. The			observations from administra	•	
	_	cabinets against the wall were			and the Nurse. Additionally,		
		ssible. A cardboard box was			monthly site and record revie	N	
		in the office with several oral			audit will be completed by		
		ccessible and unsecured. This			ResCare supervisory staff.		
	affected clients #1,	, #3, #4, #5, #6, #7, and #8.					
	On 8/31/21 from 6	:00 AM until 8:10 AM an					
		onducted at the group home.					
		ation the medical office door					
	_	ssible. The last medication					
	_	s unlocked and accessible.					
	_	ts #1, #3, #4, #5, #6, #7, and #8.					

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On 8/31/21 at 11:13 AM, the Nurse indicated all of

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G194	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 09/03/2021
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE ORD, IN 47421	
(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 0436	times unless preparimedication. He indithe floor should hav  On 8/31/21 at 1:02 indicated medicatio times unless being p  On 9/1/21 at 12:10	cated the box of medication on the been put up and secured.  PM, the Program Manager and should be locked at all prepared.  PM, Area Supervisor #1 and should be locked at all times and should be locked at all t			
Bldg. 00	repair, and teach of informed choices a eyeglasses, hearing communications and devices identified team as needed by Based on observation interview for 1 of 3 one additional client ensure client #3 word client #6 used approplacemat during mediate Findings include:  On 8/30/21 from 11 PM until 6:15 PM and until 8:10 AM, obsetthe group home. Dutil #3 had noticeably symajority of his time.	ids, braces, and other by the interdisciplinary y the client. on, record review and clients in the sample (#3) and t (#6), the facility failed to the compression stockings and opriate utensils and a picture	W 0436	To correct the deficient practic site staff have been trained or ensuring adaptive equipment utilized as written in the plan. Client #3 risk plan has been updated to include the use of compression stockings. Clien #6s IDT will meet to discuss h current dining plan and update plan as needed. Staff will be trained on any changes made the plan. Additional monitoring be achieved by daily administration observations, a daily administration meetings discuss the status of the home	t is e the to g will and to

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		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED				
		15G194	B. W	B. WING 09/03/2021				
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD			
					ONEGATE			
RES CAF	KE COMMUNITY A	LTERNATIVES SE IN		REDLO	RD, IN 47421			
(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		LISC IDENTIFYING INFORMATION Cidd not prompt client #6 to		TAG			DATE	
	_	out on his compression			a period of 60 days. Ongoing monitoring will be achieved			
		e observations. Client #6 did			through routine monthly			
		ial eating utensils or picture			observations from administrati	ion.		
		eal times. Client #6 was not			and the Nurse. Additionally, a			
		any special eating utensils or			monthly site and record review			
	picture placemat du	ring meal times.			audit will be completed by			
					ResCare supervisory staff.			
		:10 PM, a review of client #3's						
		ed. Client #3's 8/27/21						
	Medical Consult Re	*						
		ckings," prescribed by the #3 did not have a health risk						
		ma (swelling) addressing the						
	need for compression							
	1	5						
	On 9/2/21 at 12:32	PM, the nurse indicated in an						
		empression socks will need to						
		F (congestive heart failure -						
		condition that affects the						
		your heart muscle) plan and						
	instructions will nee	ed to be listed."						
	On 8/31/21 at 1:33	PM, the Program Manager (PM)						
	indicated client #3 s							
		ngs as ordered. She indicated						
	1 -	3 compression stockings						
	recently.							
	0 0/01/01	Date de la Transitation de la Constitución de la Co						
		PM, the Nurse indicated client						
	_	e revised to include the use of						
	compression stocking	ngs.						
	2. On 9/1/21 at 12:4	45 PM, a focused review of						
		as conducted. Client #6's						
		and 2/21/21 HRP indicated,						
		igh-sided plate with special						
	eating utensil (long	handled small spoon) Uses a						
	picture placemat du	ring dining times"						

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	NT OF DEFICIENCIES OF CORRECTION	DRRECTION IDENTIFICATION NUMBER A. BUILDING 00 B. WING		(X3) DATE SURVEY COMPLETED 09/03/2021			
	PROVIDER OR SUPPLIE RE COMMUNITY A	R ALTERNATIVES SE IN		115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE ORD, IN 47421		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
W 0455	On 9/1/21 at 12:10 indicated staff shortimes.  9-3-7(a)  483.470(I)(1)	PM, the Area Supervisor ald follow dining plans at all					
Bldg. 00	prevention, control infection and com  Based on observation interview for 7 of 8 home (#1, #3, #4, #4, #4, #4, #4, #4, #4, #4, #4, #4	n active program for the ol, and investigation of nmunicable diseases.  Son, record review and clients living in the group (#5, #6, #7 and #8), the facility	W 0	455	To correct the deficient practic site staff have been re-trained frequent hand washing, the us a mask, ResCare COVID	on	10/03/2021
	implemented proac control measures in sanitizing high tou-	ff working in the home ctive and preventative infection including hand washing, ich areas, and staff not wearing on and protection of Covid-19.			protocols and COVID screening protocols. Additional monitoring will be achieved by daily administration observations, a daily administration meetings discuss the status of the home a period of 60 days. Ongoing	ng nd to	
	2:00 PM until 6:15 conducted at the grand phome, staff a wearing a facial mask on. At put on their facial no staff cleaned or There was no hand kitchen area, or in dry hands. The clicencouraged to was meal times and after	1:00 AM until 1:00 PM and from PM, observations were roup home. Upon arrival at the #1 opened the front door not ask. The Residential Manager to the kitchen table without a 11:03 AM staff #1 and the RM masks. During the observations sanitized any high touch areas. It is soap or paper towels in the the bathroom areas to wash and ents were not prompted or the or sanitize hands prior to be rusing the restroom. This #3, #4, #5, #6, #7 and #8.			monitoring will be achieved through routine monthly observations from administrati and the Nurse. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.		
	On 8/31/21 from 6	:00 AM until 8:15 AM an					

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PRINTED: 10/04/2021 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  15G194		A. BU	A. BUILDING <u>00</u> B. WING			COMPLETED 09/03/2021	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				115 STC	NDDRESS, CITY, STATE, ZIP COD ONEGATE RD, IN 47421			
(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	observation was cor 7:09 AM, staff #2 whis chin. During the or sanitized any hig not encourage hand prior to meal times of 5/18/21 at 12:17 policies and procede 5/18/21 Use of Face part, "In care setti is required unless of situation to use an M treating a COVID-pclient/patient exhibit 4/10/20 Cleaning Cleanty and Hygiene St. The checklist include Out), Medication Capront Door Lock, B Hoyer Lifts, Medica Pump, Percussion Weyboards or Touch Device Controls, Li Head Phones or Ear Receivers, Security Van Door Handles, Arm Rests, and Loc Chains." The 5/1/20 "Fever greater than (Fahrenheit), and or muscle aches, shortinew or changed coutaste or smell (new father the control of the control	aducted at the group home. At grore his facial mask underneath observation no staff cleaned in touch areas. The staff did washing or hand sanitizing or after using the restroom.  PM, a review of the facility's ares was conducted. The coverings policy indicated, in ings, the use of surgical masks therwise required by the 195 or KN95 mask (e.g., ositive client/patient or ting symptoms)" The thecklist indicated, in part, applies Stocked & Available." Ited, "Door Knobs (Inside and lart Top Surface and Handles, oxes/Key Chains/Alarm Boxes, all Devices (CPAP, Feeding Yest, etc.), Computer/Laptop Screens, Stereo / Music ght Switches, Lamp Switches, Buds, Phone Key Pad and or Safe Key Pads, Company Seat Belts, Steering Wheel and k/Window Controls/Key D Screening Tool indicated,		TAG			DATE	
	in your household h	14 days? Have you or anyone ad close (within 6 feet) ne who is under investigation y-confirmed COVID-19 within						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  15G194		A. BUILDING 00 COMPLETED  B. WING 09/03/2021			
	ROVIDER OR SUPPLIER	TERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE PRD, IN 47421	
(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 0460	surveyors should be entrance. Staff shou complete the screen sure guests wear a facial clients. He indicated high touch areas like switches. The Nurse promote hand hygie towels available.  On 8/31/21 at 12:33 indicated staff shoul at all times when in during each shift stacleaning and sanitiz  On 9/1/31 at 12:10 likitchen and bathroo towels for handwash this before." AS #1 into the home should mask, including all separations.	AM, the Nurse indicated screened for Covid-19 upon ld take guests' temperature, ing questionnaire, and make acial mask. Staff should I mask while working with I staff should be sanitizing to doorknobs, handles, and to indicated staff should ne by having hand soap and  PM, Area Supervisor (AS) #2 ld be wearing their face masks the home. She indicated iff should be doing extra ing high touch areas.  PM, AS #1 indicated the ms should have soap and hing. She stated, "I've noticed indicated anybody that comes d be screened and wear a staff.			
W 0460 Bldg. 00	Each client must r	RITION SERVICES eceive a nourishing, including modified and ed diets.			
	interview for 2 of 3 #3) and 5 additional #8), the facility failed	on, record review and clients in the sample (#1 and clients (#4, #5, #6, #7, and ed to ensure all clients in the d the menu items or a lent substitution.	W 0460	To correct the deficient practic site staff have been re-trained following the menu and utilizin appropriate substitutions. Additional monitoring will be achieved by daily administratic observations, and daily	on g

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2021		
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE DRD, IN 47421	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
IAU	Findings include:  On 8/30/21 from 11 PM until 6:15 PM a at the group home.  - At 11:21 AM, lun #1, #3, #4, #5, #6, # sausages, a bag of r applesauce cup and were not provided v  - At 5:36 PM, dinne were served spaghe beans, garlic bread, tea or kool-aid. Clie offered fruit or milk On 8/30/21 at 10:39 menu dated 6/17/19 the following.  - "Week 1, Monday sandwich 2 oz. (our carrot & celery stick (fat-free) ranch dres (diet) beverage 8 fl.  - "Week 1, Monday oz (ounce), oven ba coleslaw 1/2 c. (cup 1/2 c. (cup), skim n On 8/30/21 at 11:33 (RM) stated, "we do On 8/31/21 at 12:33 #2 indicated staff sl	2:00 AM until 1:00 PM and 2:00 an observation was conducted self-was served by staff. Clients 27, and #8 were served Vienna egular potato chips, an a glass of kool-aid. Clients with any vegetables.  2. Extra was served by staff. Clients tit, salad with dressing, green pudding cup and a glass of ents were not provided or constant.  2. AM, a review of the monthly was conducted and indicated elunch. LF (low-fat) egg salad aces), baked potato chips 1 oz., as with 1 serv. (serving) FF ssing 2 tbs (tablespoon), DT	IAG	administration meetings to discuss the status of the hom a period of 60 days. Ongoing monitoring will be achieved through routine monthly observations from administrational and the Nurse. Additionally, monthly site and record review audit will be completed by ResCare supervisory staff.	ne for g ition, a

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G194		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE COMPLETED  B. WING (09/03/2021)			ETED	
	ROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 115 STONEGATE BEDFORD, IN 47421				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
W 0488 Bldg. 00	On 8/31/21 at 1:02 dindicated menus sho nutritionally equivary 9-3-8(a)  483.480(d)(4)  DINING AREAS AThe facility must at in a manner considevelopmental level Based on observation clients at the group (#1, #3, #4, #5, #6, #ensure the clients were preparation, serving shopping and client take to the outside service. Observations were con 8/30/21 from 10: from 5:58 AM to 8:  On 8/30/21 at 10:58 kitchen making lund applesauce and chip asked to participate. Containers and placed 11:21 AM, lunch standing lund applesauce and chip asked to participate. Containers and placed 11:21 AM, lunch standing lund applesauce and chip asked to participate. Containers and placed 11:21 AM, lunch standing lund applesauce and chip asked to participate. Containers and placed 11:21 AM, lunch standing. Both left the table when they left client #1 and #6's di	PM, the Program Manager (PM) pull be followed with lent substitutions.  AND SERVICE assure that each client eats stent with his or her rel.  on and interview for 7 of 7 home during the observations #7 and #8), the facility failed to rere involved in meal at themselves, grocery #8 packed his own lunch to rervices day program.  conducted at the group home restand to the standard of the sausages, with no clients involved or staff #1 was in the ch (vienna sausages, but how clients involved or staff #1 opened the related the sausages on plates. At related. Staff #1 served the reir plates. Clients #1, #3, #4, and not serve themselves their AM, clients #1 and #6 finished reir dishes and utensils on the related ishes from the table and put	W 04		To correct the deficient practice site staff have been re-trained the following: aggressive and continuous active treatment, clients being involved in meal preparation, clients preparing lunches, clients serving themselves at meals, clients participating in grocery shoppid Additional monitoring will be achieved by daily administration be achieved by daily administration meetings to discuss the status of the home a period of 60 days. Ongoing monitoring will be achieved through routine monthly observations from administration and the Nurse. Additionally, a monthly site and record review audit will be completed by ResCare supervisory staff.	ng. on e for on,	10/03/2021
		t 11:54 AM, client #4 held his  : The Residential Manager					

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
15G194		B. WING 09/03/2021				
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	₹		ONEGATE		
DES CVI		LTERNATIVES SE IN		ORD, IN 47421		
INLO OAI	· · · · · · · · · · · · · · · · · · ·	ETERNATIVES SE IIV	, DEDIC		<u> </u>	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
		client #4's cup and poured more				
		At 12:00 PM, staff #3 arrived to				
		th groceries. Staff #3 and staff				
		ies from her car. Clients #5				
		proceries. At 12:16 PM, client				
	_	tting away groceries. Clients				
		nd #8 were not asked to assist				
	with putting away g	groceries.				
	On 8/31/21 upon ar	rival, the clients were sitting				
	and eating their bre	akfast. At 6:13 PM, client #7				
		table. Client #7 did not take				
	his dishes to the sin	k. Client #7 was not prompted				
	to take his dishes to	the sink. At 6:14 PM, staff #2				
		nes to the sink. At 6:36 AM,				
		ient #3's dishes from the table				
	_	he sink. At 6:48 AM, staff #2				
		ng room table. At 7:36 AM,				
		nake client #8's lunch. Staff #2				
		ntainer with leftovers from				
		#8 watched him. At 7:40 AM,				
	_	indwich bag and filled it with				
		elient #7 watched. At 7:43 AM,				
		o pack client #7's lunch. Client				
		that he wanted. Client #7 was				
	not asked to assist.					
	On 8/31/21 at 7:51	AM, client #8 stated when				
		ted for lunch, "My staff do it."				
	•	the staff packed his lunch				
		8 indicated he did not pack his				
	lunch.	1				
	On 8/30/21 at 11:56 AM, the RM stated, "can't get					
		thing." The RM stated clients				
		derstand." The RM stated				
	client #3 "can't do a					
	Chencing Cant do a	my mmg.				
	On 8/30/21 at 11:10	6 AM, the RM indicated staff #3				
		ving groceries. The RM				

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NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		<u> </u>	115 ST	ADDRESS, CITY, STATE, ZIP COD ONEGATE PRD, IN 47421	<u>,                                      </u>		
(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 APPROPR		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	INIL	DATE
	in the home and no shopping.	, #3, #4, #5, #6, #7 and #8 were t assisting with the grocery					
		PM, staff #3 indicated she took nen it was not so hot out.					
	On 9/1/21 at 12:08	PM, Area Supervisor (AS) #1					
	indicated the staff s	should monitor client #8 while					
		n. AS #1 stated client #8					
		and "staff should watch"					
		ated the staff needed to prompt					
		themselves, pour their own					
		p their dishes. She indicated					
	preparation.	e involved with meal					
	On 8/31/21 at 12:57	3 PM, AS #2 indicated the					
		ngaged with meal preparation,					
		and clean up. AS #2 indicated					
	_	packing his own lunch.					
	On 8/31/21 at 1:02	PM, the Program Manager (PM)					
	indicated the client	s should be engaged with meal					
		g themselves and clean up. AS					
		#8 should be packing his own					
	lunch.						
	9-3-8(a)						

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