DEPARTMENT OF HEALTH AND HUMAN SERVICES

R MEDICARE & MEDI					OMB NO. 0938-039
				. ,	TE SURVEY 1PLETED
or conduction,	15G247	B. WING	<u></u>	02/23/2024	
PROVIDER OR SUPPLIE	P	STREET A	ADDRESS, CITY, STATE, ZIP COD		
1					(X5)
			PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU	TION LD BE	COMPLETION
			CROSS-REFERENCED TO THE APPF DEFICIENCY)	ROPRIATE	DATE
		ino			DITL
		W 0000			
-	gation(s) are cited at W125,				
-					
Certification Revi full annual recertifi survey and the inv #IN00409199, #IN	sit (PCR) to the pre-determined fication and state licensure vestigation of complaints N00418483, and #IN00419787				
Survey dates: 2/20 2/23/24.	0/24, 2/21/24, 2/22/24 and				
Provider Number:	15G247				
accordance with 4 Quality Review of	60 IAC 9. f this report completed by #15068				
The facility must clients. Therefor encourage indivi	ensure the rights of all re, the facility must allow and dual clients to exercise their				
	RE COMMUNITY A SUMMAR (EACH DEFICIE REGULATORY O This visit was for #IN00426039 and Complaint #IN004 related to the alleg W140 and W153. Complaint #IN004 related to the alleg W140 and W153. Complaint #IN004 related to the alleg W153. This visit was in c Certification Revi full annual recerti survey and the inv #IN00409199, #IN conducted on 11/2 Survey dates: 2/20 2/23/24. Facility Number: Provider Number: AIM Number: 100 These deficiencies accordance with 4 Quality Review of and #27547 on 3/3 483.420(a)(3) PROTECTION O The facility must clients. Therefor encourage indivi	OF CORRECTION IDENTIFICATION NUMBER 15G247 PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This visit was for the investigation of complaints #IN00426039 and #IN00427826. Complaint #IN00426039: Federal/state deficiencies related to the allegation(s) are cited at W125, W140 and W153. Complaint #IN00427826: Federal/state deficiencies related to the allegation(s) are cited at W140, W153. This visit was in conjunction with a Post Certification Revisit (PCR) to the pre-determined full annual recertification and state licensure survey and the investigation of complaints #IN00409199, #IN00418483, and #IN00419787 conducted on 11/20/23. Survey dates: 2/20/24, 2/21/24, 2/22/24 and 2/23/24. Facility Number: 000769 Provider Number: 15G247 AIM Number: 100248810 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 and #27547 on 3/5/24.	OF CORRECTION DENTIFICATION NUMBER 15G247 A. BUILDING B. WING PROVIDER OR SUPPLIER STREET / 2401 Cr RE COMMUNITY ALTERNATIVES SE IN JEFFEF SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION D This visit was for the investigation of complaints #IN00426039 and #IN00427826. 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BUILDING D PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, DP COD 24010 CORNWELL DR JEFFERSONVILLE, IN 47130 STREET ADDRESS, CITY, STATE, DP COD 24010 CORNWELL DR JEFFERSONVILLE, IN 47130 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION ID PREFIX PROVIDERS FLAN OF CORREC FLAN OF CORRECTIVE ATTORS AND CORRECTIVE ATTORS AND PERCIENCY This visit was for the investigation of complaints #IN00426039 and #IN00427826. W 0000 Complaint #IN00426039: Federal/state deficiencies related to the allegation(s) are cited at W125, W140 and W153. W 0000 Complaint #IN00427826: Federal/state deficiencies related to the allegation(s) are cited at W140 and W153. W 0000 This visit was in conjunction with a Post Certification Revisit (PCR) to the pre-determined full annual recertification and state licensure survey and the investigation of complaints #IN00401998 #IN004198787 conducted on 11/20/23. Survey dates: 2/20/24, 2/21/24, 2/22/24 and 2/23/24. Facility Number: 000769 Provider Number: 15G247 AIM Number: 10248810 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 and #27547 on 3/5/24. 483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their	OF CORRECTION IDENTIFICATION NUMBER 15G247 A. BUILDING QQ CON PROVIDER OR SUPPLIER STREET ADDRESS.CITY.STATE.ZIP COD 2401 CORNWELL DR JEFFERSONVILLE, IN 47130 CON RE COMMUNITY ALTERNATIVES SE IN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST REPRECEDED DE PULL REGULATORY OR LSC IDENTIFYING INFORMATION ID PRIFIX PROVERE PLAN OF CONSTRUCTION (CACH DEFICIENCY MUST REPRECEDED DE PULL REGULATORY OR LSC IDENTIFYING INFORMATION ID PRIFIX PROVERE PLAN OF CONSTRUCTION (CACH DEFICIENCY MUST REPRECEDED DE PULL REGULATORY OR LSC IDENTIFYING INFORMATION ID PROVERE PLAN OF CONSTRUCTION (CACH DEFICIENCY MUST REPRECEDED DE PULL REGULATORY OR LSC IDENTIFYING INFORMATION ID PROVERE PLAN OF CONSTRUCTION (CACH DEFICIENCY MUST RATION) ID PROVERE PLAN OF CONSTRUCTION (CACH DEFICIENCY AND INFORMATION) This visit was for the investigation of complaints related to the allegation(s) are cited at W125, W140 and W153. W 0000 ID PROVERE PLAN OF CONSTRUCTION (CACH DEFICIENCY AND INFORMATION) This visit was in conjunction with a Post Certification Revisit (PCR) to the pre-determined fill annual recertification and state licensure survey and the investigation of complaints #1N00401919; #1N00419787 ID PROVER NUMBER: 150247 Survey dates: 2/20/24, 2/21/24, 2/22/24 and 2/23/24. ID PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Mark Slaughter AED 03/18/2024

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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000769

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/23/2024 15G247 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2401 CORNWELL DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE right to file complaints, and the right to due process. Based on record review and interview for 1 of 3 W 0125 The facility will ensure the 03/17/2024 sampled clients (B), the facility failed to ensure rights of all clients allowing and client B's needs concerning a Health Care encourage individual clients to Representative (HCR) were assessed for supports exercise their rights as clients of and services to assist him with medical decision the facility, and as citizens of the making. United States, including the right to file complaints, and the right to Findings include: due process. An IDT comprised of Confidential Interview (CI #1) indicated client B's paraprofessionals was conducted required gall bladder surgery was delayed due to and determined Client B's need for no Health Care Representative (HCR) being in a Health Care Representative place for client B to advocate for him. CI #1 (HCR). indicated a concern for client B's medical supports The QIDP obtained a Health and services due to no HCR to advocate for his Care Representative (HCR) for Client B. medical needs. A review of all clients in the On 2/20/23 at 12:30 PM, a review of the facility's facility was conducted by the IDT Bureau of Disabilities Services (BDS) reports and to determine the need for a Health accompanying investigation summaries was Care Representative. conducted. The review indicated the following A member of the affecting client B: administrative team will conduct a monthly site reviews for all clients BDS incident report dated 12/22/23 indicated, in facility and the administrator will "Staff reported [client B] complained of stomach hold a weekly ICF meeting to pain and he didn't want to eat. ResCare LPN discuss issues that arise in the (licensed practical nurse) was contacted, and facility. [client B] was transported to Urgent Care. Once at Urgent Care, [client B] was assessed, and he was transported by ambulance to hospital for further Persons Responsible: AED, evaluation and treatment. Plan to Resolve: A CT Quality Assurance Manager, QA (imagining scan) was completed and showed Coordinator/QIDP Manager, gallstones and distended gallbladder. [Client B] Program Manager, Area was admitted, surgery is scheduled for 12/24/23 to Supervisor, QIDP, Direct Support have his gallbladder removed. ResCare will Lead, and DSP. maintain contact with the hospital and plan for discharge". 0BX911

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

Event ID:

Facility ID: 000769

If continuation sheet

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03/27/2024

PRINTED:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247		 VILDING NG	NSTRUCTION 00	(X3) DATE COMPI 02/23	LETED
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	2401 C	ADDRESS, CITY, STATE, ZIP COD ORNWELL DR RSONVILLE, IN 47130		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	ATE	DATE
	record was conduc following:	4 PM, a review of client B's ted. The review indicated the				
	indicated, "Name: Team (IDT) Memb	Plan (ISP) dated 10/16/2023 [Client B] Interdisciplinary bers:". Client B's ISP did not Care Representative (HCR) listed members.				
	Disabilities Profes The QIDP was ask surgery and his neu indicated client B d indicated the hospi gall bladder surger could provide cons "I don't recall how particular about the client B required a see if he has the pa (hospital) were not called them, me an hospital with [clien had the ability to m indicated questions were asked of clien	PPM, the Qualified Intellectual sional (QIDP) was interviewed. ted about client B's gall bladder ed for a HCR. The QIDP did not have a HCR. The QIDP did not want to perform the y without ensuring client B sent for the surgery and stated, we got them to agree. They're at". The QIDP was asked if HCR. The QIDP stated, "I will uperwork. At first, they t going to, due to consent. I d two of the nurses from the nt B] on the phone, asked if he nake decisions". The QIDP s such as, who is your brother, nt B to answer before the ee to perform his gall bladder				
	follow up and a for Health Care Repre review. Client B's people identified a [client B], voluntar whose telephone n contact information	⁷ PM, the QIDP provided more rm titled "Appointment of a sentative" dated 4/12/2010 for HCR form listed two names of s his HCRs and indicated, "I rily appoint [HCR names], umber and address are: [HCR n] respectively, as my health is who is (sic) authorized to act				

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

Event ID:

0BX911 Facility ID: 000769

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OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/23/2024 15G247 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2401 CORNWELL DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE for me in all matters of health care ... ". The QIDP indicated further follow up was needed and stated, "I need to follow up. I've never seen this paper before". On 2/22/24 at 2:10 PM, the QIDP was interviewed. The QIDP stated, "I called the people on the form. They said they do want to be his health care rep (representatives). It's a [family member] that wants to do that. I've never heard from them before. No holidays or anything". The QIDP was asked if client B had a HCR in place at the time of the gall bladder surgery. The QIDP stated, "Yes". The QIDP was asked if client B's HCR should have been notified of his need for a gallbladder surgery. The QIDP stated, "Yes. I should have told them about it". The QIDP indicated she was going to send a new HCR form to update client B's record and stated, "They want me to call when I send the new letter". The QIDP indicated she was going to discuss his recent gall bladder surgery and provide an update on client B's health status with his HCR when she made this phone call. On 2/22/24 at 2:23 PM, the Nurse was interviewed. The Nurse was asked about client B's health care representative and their interest in continuing to be client B's representative. The Nurse stated, "I had no idea he (client B) had a health care rep (representative). They (hospital) asked me, and I couldn't, a conflict of interest. I was not aware [QIDP] had reached out". The Nurse was asked if client B's HCRs should have been notified at the time of client B's gall bladder surgery. The Nurse stated, "Yeah". On 2/23/24 at 10:13 AM, the Quality Assurance Manger (QAM) was interviewed. The QAM was asked about client B's gall bladder surgery, if his health care representative should have been Event ID: 0BX911 Facility ID: 000769 Page 4 of 15 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

03/27/2024

PRINTED:

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247			A. BUILDING B. WING	00	(3) DATE SURVEY COMPLETED 02/23/2024
	PROVIDER OR SUPPLI RE COMMUNITY	^{ER} ALTERNATIVES SE IN	2401 (f address, city, state, zip cod CORNWELL DR ERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0140 Bldg. 00	representative. The situation I would information got d were not here in 2 from them. This i explore it more. I from that point (2 following up and well". This federal tag re 9-3-2(a) 483.420(b)(1)(i) CLIENT FINANC The facility must system that assu accounting of cli entrusted to the Based on record r sampled clients (A clients (D, E, F, C ensure a full and A, B, C, D, E, F, entrusted to the fa Findings include: Confidential Inter with the finances, clothes and food i the home had bee been missing. CI safe and got into a safe had been unl- understand why th (staff) money who	t establish and maintain a ures a full and complete ents' personal funds facility on behalf of clients. eview and interview for 3 of 3 A, B and C) and 5 additional G and H), the facility failed to complete accounting of clients G and H's personal funds acility.	W 0140	The facility will establish and maintain a system that assures a full and complete accounting of clients' personal funds. The Facility will retrain sta on the standard of maintaining t system of accounting for client's funds entrusted to the facility. A receipts for the purchases must be returned to the facility and identify which client funds were spent on. The DSL will conduct weekly reviews of the Client Financial Record's to ensure all transactions have been recorde and account is balanced. The Program Manager will in-service the Area Supervisor, and Direct	he ; II d

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	R MEDICARE & MEDIC	X1) PROVIDER/SUPPLIER/CLIA		CONCEDUCTION		OMB NO. 0938-039
	ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247		(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	CON	te survey Mpleted 23/2024
NAME OF I	PROVIDER OR SUPPLIE	R		T ADDRESS, CITY, STATE, ZIP COI CORNWELL DR)	
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		ERSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC	TION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	ILD BE ROPRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY		DATE
	it (money) was the	re or had been". CI #1 was		Support Lead on the use	of client	
	asked if client A's	money had been in cash or a		finance book.		
	debit/gift card. CI #	#1 stated, "I don't know. It was		All employees will	be	
	just no documentat	ion of it being there or spent".		trained on the revised sta	andard	
				and disciplinary action w	ill be	
	On 2/20/24 at 12:3	0 PM, a review of the facility's		given if the standard is n		
	Bureau of Disabilit	ties Services (BDS) reports and		followed.		
	accompanying invo	estigation summaries was		The Facility will en	sure that	
	conducted. The rev	view indicated the following		the abuse neglect and ex	ploitation	
	affecting clients A,	B, C, D, E, F, G and H:		policy is followed.		
	_			A member of the		
	1) BDS incident re	port dated 2/5/24 indicated,		Administrative team will of	conduct a	
	"During a financial	audit it was discovered, [client		monthly site reviews for a	all clients	
	B] has \$1.00 in mis	ssing funds, [client C] had \$13.00		in facility and the adminis		
	in missing funds, a	nd [client A] had \$23.00 in		hold a weekly ICF meetir		
	missing funds. Plan	n to Resolve: Staff will be		discuss issues that arise		
	retrained on the fin	ancial audit policy and		facility.		
	procedure and tran	saction logs. Bill of Rights and				
	Grievance will be o	completed with [client B], [client				
	C], and [client A].	ResCare will reimburse [client B]		Persons Responsible: A	ED,	
	\$1.00, [client C] \$1	13.00, and [client A] \$7.24".		Quality Assurance Mana		
				Coordinator/QIDP Manag	-	
	Investigation Summary dated 1/29/ 2/5/24 with an amendment date of 2 "Introduction: On 1/27/24, the Qua Department received an incident re [client B], [client C], [client E], [cl	nary dated 1/29/24 through		Program Manager, Area		
		endment date of 2/9/24 indicated,		Supervisor, QIDP, Direct	Support	
		1/27/24, the Quality Assurance		Lead, and DSP.		
		ed an incident report indicating				
], [client E], [client F], [client G],				
		had funds from their finance				
	books that may be	unaccounted for. An				
	investigation was i	nitiated in an attempt to				
	determine what hap	opened to funds				
	Conclusion: It is su	ıbstantiated [client B] has \$1.00				
	unaccounted for	It is substantiated [client C]				

\$23.00 unaccounted for... It cannot be determined what happened to the funds...". FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:

[client E] had \$31.00 unaccounted for; the money was found in an enveloped marked with his name in the safe... It is substantiated [client A] has

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	ND PLAN OF CORRECTION IDENTIFICATION NUMBER A. B			MULTIPLE CONSTRUCTION BUILDING <u>00</u> WING		(X3) DATE SURVEY COMPLETED 02/23/2024	
	PROVIDER OR SUPPLIE	ER ALTERNATIVES SE IN	2401 C	ADDRESS, CITY, STATE, ZIP C CORNWELL DR RSONVILLE, IN 47130	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE SNCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
	2) No BDS incide review.	nt report was available for					
	8/31/23 indicated, (sic/exploitation) it was reported du for [client B], [clie	investigation was initiated when ring a financial audit, finances ent E], [client H], [client F], [client ient A] and [client C's] did not					
	has receipts totalin	[Client B] with total of \$100.00 ng \$38.27 with \$18.00 cash on 73 unaccounted for					
		tal of \$50.00 has receipts totaling 2 cash on hand leaving \$5.31					
		tal of \$100.00 has receipts ith \$0.00 cash on hand leaving d for					
		tal of \$100.00 has receipts ith \$0.27 cash on hand leaving d for					
		al of \$100.00 has receipts ith \$10.94 cash on hand leaving ed for					
		tal of \$100.00 has receipts ith \$2.00 cash on hand leaving ed for					
		tal of \$50.00 has receipts totaling cash on hand leaving \$21.97					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 02/23/2024	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	2	401 CC	DDRESS, CITY, STATE, ZIP COD DRNWELL DR SONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
		tal of \$100.00 has receipts th \$20.57 cash on hand leaving					
	June 2023 shows:	nventories updated from 2022 to Due to inability to locate wn how much the items cost urchased or how					
	clients pocket mot they needed it. [For witnessed a forme a client from a dif [Former staff #1]	stated she witnessed staff give ney to take to day program when ormer staff #1] stated she r site supervisor give money to ferent client's money envelope. is unaware if any money given to v was deducted from the l) ledger					
	show staff did not expenditures as th for pocket change Staff responsible f through 4/28/23 w	es, including ledgers and receipts properly document ey should have, not accounting or cash to go to day program. For client finances from 9/1/22 when the last receipt was nger employed with ResCare					
	has \$43.73 unacco H] \$6.81, [client F	been determined that: [Client B] punted for, [client E] \$2.54, [client [] \$10.03, [client D] \$18.50, [client ient C] \$5.31. [Client A] has \$7.02					
	staff on client fina	s: Reimburse all clients. Retrain nces and accounting. Weekly rect support lead). Biweekly Supervisor)".					
	finances was com	5 PM, a review of the clients' pleted. The review indicated , E, F, G and H's financial ledgers					

		x1) provider/supplier/clia identification number 15G247	IA (X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 02/23/2024	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		2401 C0	DDRESS, CITY, STATE, ZIP DRNWELL DR RSONVILLE, IN 47130		
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	DRRECTION SHOULD BE	(X5) COMPLETIO
	on hand financial l review. On 2/21/24 at 4:03 Manager and Qual Professional (QID) and QIDP were as for a lack of accou funds and the revia financial ledgers fa accounting had occ QAM indicated a r incident report) ha	 v 2023. No February 2024 cash edgers were available for PM, the Quality Assurance ified Intellectual Disabilities P) were interviewed. The QAM ced about the incident history nting for the clients' personal ew of the cash on hand or all the clients indicating no curred since January 2024. The ecent financial audit (2/5/24 d found accounting issues. The 5 the clients' personal funds 					
	accurately and acc "Yes, maintained of "Site leads do it we would make sense write her audit on she had spoken wi documenting her f more follow up wa accounting, audits, properly document	sility should be maintained ounted for. The QAM stated, on the ledger". The QIDP stated, eekly". The QAM stated, "It that [Area Supervisor] should the ledger". The QAM indicated th the Area Supervisor about inancial audits and indicated as needed to ensure all and transactions were being ted to ensure all client personal the facility were accurate and					
	Manager (QAM) w asked about the ind money indicated in QAM indicated a l available for revier as missing money audit found it (mis the investigation." incident was also a	3 AM, the Quality Assurance was interviewed. The QAM was cident history for missing a the 8/24/23 investigation. The BDS incident report was not w and stated, "We looked at it and not exploitation. A financial sing money) and we initiated The QAM indicated the 2/5/24 a situation where a financial g money, was reported and an					

PRINTED: 03/27/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 02/23/2024	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	2401	T ADDRESS, CITY, STATE, ZIP COD CORNWELL DR ERSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
W 0153 Bldg. 00	investigations into exploitation had or accounting for the QAM was asked h should be maintain QAM stated, "At a This federal tag re and #IN00427826. 9-3-2(a) 483.420(d)(2) STAFF TREATM The facility must mistreatment, ne injuries of unknow immediately to the officials in accord established proce Based on record re sampled clients (A clients (D, E, F, G immediately repor Bureau of Disabili hours, in accordan B, C, D, E, F, G ar and 2) alleged neg of client C's progra while on duty. Findings include: 1) Confidential Inte concerns with the purchasing of cloth indicated the safe a unlocked and mon	lates to complaints #IN00426039 ENT OF CLIENTS ensure that all allegations of glect or abuse, as well as wn source, are reported e administrator or to other lance with State law through	W 0153	 The facility must ensure the all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials accordance with State law throut established procedures. The Area Supervisor will train all Facility Staff on the BDI Reporting Standard. The Facility will retrain state at the site on the Abuse, Neglect and Exploitation Policy and disciplinary action will be given the policy is not followed. Area Supervisor and Direct Support Lead will ensure that the Abuse Neglect and Exploitation Policy 	s in ligh DS ff ct if	

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/23/2024 15G247 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2401 CORNWELL DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE other clients' money. I guess the safe had been followed. Monitoring of ANE will unlocked and that's how... I don't understand why done by The Program Manager, they (staff) were spending their money when the Area Supervisor and Direct P-card was in there (safe). [Client A] received Support Lead to ensure all \$100.00 and no documentation it (money) was incidents of possible abuse. there or had been". CI #1 was asked if client A's neglect and exploitation are money had been in cash or a debit/gift card. CI #1 reported to the QA department. stated, "I don't know. It was just no 4 The Program Manager will documentation of it being there or spent". ensure the Area Supervisor will retrain staff on the Abuse, Neglect On 2/20/24 at 12:30 PM, a review of the facility's and Exploitation Policy and Bureau of Disabilities Services (BDS) reports and disciplinary action will be given if accompanying investigation summaries was the policy is not followed. conducted. The review indicated the following Area Supervisor and 5 affecting clients A, B, C, D, E, F, G and H: Program Manager will ensure that the Abuse, Neglect and No BDS incident reports were available for review. Exploitation Policy is followed through random monitoring. Investigation Summary dated 8/24/23 through 6 The area supervisor in 8/31/23 indicated, "An exploration serviced facility staff on ResCare (sic/exploitation) investigation was initiated when anonymous compliance line it was reported during a financial audit, finances allowing an additional resource for for [client B], [client E], [client H], [client F], [client staff to report outside the D], [client G], [client A] and [client C's] did not Administrative chain, and on balance with cash on hand ... ResCare's non-retaliation and Zero Violence policy Factual Findings:... [Client B] with total of \$100.00 A member of the has receipts totaling \$38.27 with \$18.00 cash on administrative team will conduct a hand leaving \$43.73 unaccounted for... monthly site review for all clients in facility and the administrator will [Client C] with total of \$50.00 has receipts totaling hold a weekly ICF meeting to \$22.57 with \$22.12 cash on hand leaving \$5.31 discuss issues that arise in the unaccounted for... facility. [Client E] with total of \$100.00 has receipts totaling \$97.46 with \$0.00 cash on hand leaving \$2.54 unaccounted for... Persons Responsible: AED, Quality Assurance Manager, QA [Client H] with total of \$100.00 has receipts Coordinator/QIDP Manager, totaling \$92.92 with \$0.27 cash on hand leaving Program Manager, Area 0BX911

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

Event ID:

Facility ID: 000769

If continuation sheet

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03/27/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OMB NO. 0938-039

DEPARTMENT OF HEALTH AND HUMAN S	ERVICES

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CARDEN SHOULD BE COMPLETED TO THE APPROPRIATE COMPLETED TO THE APPROPRIATE		NT OF DEFICIENCIES	x1) provider/supplier/clia identification number 15G247	(X2) MULTIPL A. BUILDING B. WING	e construction G <u>00</u>	СОМ	te survey Ipleted 2 3/2024
PREFX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REDULATORY OR LSC IDENTIFYING INFORMATION PREFX TAG (Latrongment as the strength of the precedent of the APROPRIATE DAT COMPLI- TAG \$6.81 unaccounted for [Client F] with total of \$100.00 has receipts totaling \$79.03 with \$10.94 cash on hand leaving \$10.03 unaccounted for Supervisor, QIDP, Direct Support Lead, and DSP. ComPLI- Lead, and DSP. [Client D] with total of \$100.00 has receipts totaling \$79.50 with \$2.00 cash on hand leaving \$18.50 unaccounted for [Client G] with total of \$100.00 has receipts totaling \$79.50 with \$2.00 cash on hand leaving \$18.50 unaccounted for [Client G] with total of \$100.00 has receipts totaling \$27.49 with \$0.54 cash on hand leaving \$7.02 in excess [Client A] with total of \$100.00 has receipts totaling \$86.45 with \$20.57 cash on hand leaving \$7.02 in excess [Client A] with total of \$100.00 has receipts totaling \$86.45 with \$20.57 cash on hand leaving \$7.02 in excess [Client A] with total of \$100.00 has receipts totaling \$86.45 with \$20.57 cash on hand leaving \$7.02 in excess [Client A] with total of \$100.00 has receipts totaling \$86.45 with \$20.57 cash on hand leaving \$7.02 in excess [Former staff #1] stated she witnessed staff give clients pocket money to take to day program when they needed it. [Former staff #1] stated she witnessed a former site supervisor give money to a client from a different client's morey envelope. [Former staff #1] is unavare if any money given to the clients to earry was deducted from the [Envelope to take to t				240	1 CORNWELL DR		
Image: Client F] with total of \$100.00 has receipts totaling \$79.03 with \$10.94 cash on hand leaving \$10.03 unaccounted forLead, and DSP.[Client D] with total of \$100.00 has receipts totaling \$79.50 with \$2.00 cash on hand leaving \$18.50 unaccounted for[Client G] with total of \$100.00 has receipts totaling \$27.49 with \$0.54 cash on hand leaving \$21.97 unaccounted for[Client A] with total of \$100.00 has receipts totaling \$86.45 with \$20.57 cash on hand leaving \$7.02 in excess[Client A] with total of \$100.00 has receipts totaling \$86.45 with \$20.57 cash on hand leaving \$7.02 in excessReview of client inventories updated from 2022 to June 2023 shows: Due to inability to locate receipts, its unknown how much the items cost when they were purchased or howReview of client inventories updated from 2022 to June 2023 shows: Due to table?[Former staff #1] stated she witnessed staff give clients pocket money to take to day program when they needed it. [Former staff #1] stated she witnessed a former site supervisor give money to a client from a different client's money envelope. [Former staff #1] stated she witnessed a former site supervisor give noney to the clients to carry was deducted from the	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO T	ON SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
Review of finances, including ledgers and receipts show staff did not properly document expenditures as they should have, not accounting for pocket change or cash to go to day program. Staff responsible for client finances from 9/1/22 through 4/28/23 when the last receipt was received are no longer employed with ResCare		 \$6.81 unaccounted [Client F] with totaling \$79.03 with \$10.03 unaccounted [Client D] with total totaling \$79.50 with \$18.50 unaccounted [Client G] with total \$27.49 with \$0.54 clunaccounted for [Client A] with total totaling \$86.45 with \$7.02 in excess Review of client im June 2023 shows: receipts, its unknow when they were pure [Former staff #1] st clients pocket mone they needed it. [For witnessed a former a client from a diffee [Former staff #1] is the clients to carry resource (financial) Review of finances show staff did not p expenditures as they for pocket change of through 4/28/23 when they and they have a staff responsible for through 4/28/23 when they are a staff responsible for through 4/28/23 when they are a staff responsible for through 4/28/23 when they are a staff responsible for through 4/28/23 when they are a staff responsible for through 4/28/23 when they are a staff responsible for through 4/28/23 when they are a staff are a staff responsible for through 4/28/23 when they are a staff ar	for I of \$100.00 has receipts a \$10.94 cash on hand leaving d for I of \$100.00 has receipts a \$2.00 cash on hand leaving d for I of \$50.00 has receipts totaling cash on hand leaving \$21.97 I of \$100.00 has receipts a \$20.57 cash on hand leaving ventories updated from 2022 to Due to inability to locate vn how much the items cost rehased or how ated she witnessed staff give ey to take to day program when mer staff #1] stated she site supervisor give money to crent client's money envelope. unaware if any money given to was deducted from the ledger , including ledgers and receipts properly document y should have, not accounting or cash to go to day program. r client finances from 9/1/22 ten the last receipt was		Supervisor, QIDP, I	Direct Support	

OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/23/2024 15G247 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2401 CORNWELL DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Conclusion: It has been determined that: [Client B] has \$43.73 unaccounted for, [client E] \$2.54, [client H] \$6.81, [client F] \$10.03, [client D] \$18.50, [client G] \$21.97, and [client C] \$5.31. [Client A] has \$7.02 over his amount ... Recommendations: Reimburse all clients. Retrain staff on client finances and accounting. Weekly audits by DSL (direct support lead). Biweekly audit by AS (Area Supervisor)". 2) BDS incident report dated 2/2/24 indicated, "On 2/1/24, staff reported when she arrived at the house, staff was asleep and snoring in the office and [client C] was sitting in the living (room). It was also reported that on 1/25 (2024), when staff arrived back at the site after dropping clients off, another staff was asleep then as well and [client C] was sitting in the living room. Plan to Resolve: Staff have been placed on leave pending the outcome of the investigation. Staff will continue to monitor [client C] and provide all necessary supports". Investigation Summary dated 2/2/24 through 2/9/24 indicated, "On 2/1/24, the Quality Assurance Department received an incident report indicating when staff arrived at the house, staff [staff #11] was asleep and snoring in the office while [client C] was sitting in the living room. Staff also reported on 1/25/24, staff [staff #12] was asleep then as well while [client C] sat in the living room... Summary of Interviews:... [Staff #9] reported when she arrived back at [name of group home] staff [staff #11] was asleep and snoring in the office while [client C] was sitting in the living room. [Staff #9] reported that on 1/25/24, after dropping clients off at workshop and arriving back to the 0BX911 Facility ID: 000769 Page 13 of 15 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	A. BUILDING B. WING	construction 00	(X3) DATE SUR COMPLETE 02/23/202	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		2401 0	TADDRESS, CITY, STATE, ZIP CORNWELL DR ERSONVILLE, IN 47130	COD		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION Y CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
	room while [clien room. [Staff #9] s 1/25/24 incident u afraid of the staff. Factual Findings: working at [name transition to a wai worked at the hom reported [staff #1] office when she at This is the second for allegations of [Staff #9] stated s After [staff #9] re sleeping, and (sic) was received, on 2 from [staff #9] (th separately) 6 of witnessing staff sl shift or coming or Conclusion: It car slept while on shi determined if [sta 1/25/24". On 2/21/24 at 1:4. reviewed. The rev	[Staff #9] was temporarily of group home] pending ver location and had only he since 1/24/24 [Staff #9] 1] was asleep and snoring in the rrived at the house on 2/1/24. suspension and investigation [staff #11] sleeping on shift he was afraid of [staff #11] ported the allegations of staff a anonymous compliance call 2/1/24, alleging verbal abuse is is being investigated C 6 staff interviewed denied eeping when they have been on a shift unot be determined if [staff #11] ft on 2/1/24. It cannot be ff #12] slept while on shift on 5 PM, client C's record was iew indicated the following: t Plan (ISP) dated 4/29/23				
	team recommends supervision while activities, as he ha skills. He requires activities Needs	arge Plan: The interdisciplinary s that he (client C) have participating in community as not acquired safe pedestrian s structure for leisure time : To learn IL (independent spend time with staff on eech".				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ENTERS FOR MEDICARE & MEDICAID SERVICES							OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247			A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 02/23/2024	
	PROVIDER OR SUPPLIEI RE COMMUNITY A	۲ LTERNATIVES SE IN		2401 C	ADDRESS, CITY, STATE, ZIP COD ORNWELL DR RSONVILLE, IN 47130			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	Manager (QAM) w asked about reporti and H's missing per suspected neglect f C's program plan co on shift. The QAM date was 8/24/23 (r BDS (incident) rep accounting issue, ra QAM indicated the funds and suspected have immediately b administrator and E "I can't disagree with	3 AM, the Quality Assurance as interviewed. The QAM was ng 1) clients A, B, C, D, E, F, G rsonal funds on 8/24/24 and 2) for the implementation of client oncerning staff sleeping while stated, "I believe the incident missing money). I don't see a ort filed. We looked at it as an ather than exploitation". The clients' missing personal d neglect of client C should been reported to the BDS within 24 hours and stated, th you on that one". attes to complaints #IN00426039						

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