	OF HEALTH AND HU				PRINTED: 09/28/2022 FORM APPROVED OMB NO. 0938-039	
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/01/2022	
	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
W 0000 Bldg. 00	#IN00378468 and # Complaint #IN003' and state deficienci are cited at W102, W154, W186 and W154,	78468: Substantiated, Federal es related to the allegation(s) W104, W122, W127, W149, W252. 83472: Unsubstantiated, due to evidence. 225/22, 8/26/22, 8/29/22, 8/30/22, 04615 15G723 0528230 also reflect state findings in	W 0000			

W 0102

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

GOVERNING BODY AND MANAGEMENT

Based on record review and interview for 1 of 2

sampled clients (A), the facility failed to meet the

Condition of Participation: Governing Body. The

facility's governing body failed to exercise

client A who sustained injuries on 2/27/22.

operating direction over the facility to prohibit

staff abuse, neglect, and/or the mistreatment of

The facility must ensure that specific governing body and management

requirements are met.

Findings include:

W 0102

Bldg. 00

483.410

TITLE

To correct the deficient practice

the investigation regarding the

re-opened. The following has been

employment has been terminated.

implemented post investigation.

Staff #6 remains suspended

pending the AGO conclusion regarding the incident. Staff #10

2-27-22 incident was

(X6) DATE

10/01/2022

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

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	OF CORRECTION	IDENTIFICATION NUMBER 15G723	A. BUILDING B. WING	00	COMPLETED 09/01/2022
	ROVIDER OR SUPPLIER	TERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	(A), the facility's go operating direction of staff abuse, neglect, client A who sustain 2. Please refer to W (A), the governing be Condition of Particity of 2 sampled clients neglected to implement to ensure their system staff abuse, neglect, implemented concern psychological abuse injuries on 2/27/22.	104. For 1 of 2 sampled clients verning body failed to exercise over the facility to prohibit the and/or the mistreatment of need injuries on 2/27/22. 122. For 1 of 2 sampled clients body failed to meet the pation: Client Protections for 1 (A). The governing body nent its policy and procedures on to prohibit and prevent and/or mistreatment was raining the physical and of client A who sustained test to complaint #IN00378468.		Staff #1 has been removed for the supervisory position over site. All site staff have been re-trained in ResCare's A/N/E policy, incident reporting procedure, and gentle teachin practices. Additionally, the Are Supervisor (AS) will be at the at least three times a week and aily skin assessments have I implemented. Additional monitoring will be achieved through daily administrative observations and daily administrative meetings to distince the activities and needs of the home for a period of one month. All staff responsible for investigations have been train ensure investigations are thor and in how to proceed if a conclusion is not found in the business days required for completing an investigation. Ongoing monitor of investigations will be achieved by the Executive directions and governing bot will be achieved through the AS/QIDP/BC/PM completing syisits at least weekly.	the //M g ea site id opeen cuss r ed to ough five ring //ed ector, e. dy
W 0104	483.410(a)(1) GOVERNING BOI	ΣΥ			
Bldg. 00		dy must exercise general d operating direction over			

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DEPARTMENT OF HEALTH AND HUMAN 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 09/01/2022 15G723 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 13009 HORIZON DR RES CARE COMMUNITY ALTERNATIVES SE IN MEMPHIS, IN 47143 (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 Based on record review and interview for 1 of 2 W 0104 To correct the deficient practice 10/01/2022 sampled clients (A), the facility's governing body the investigation regarding the failed to exercise operating direction over the 2-27-22 incident was facility to prohibit the staff abuse, neglect, and/or re-opened. The following has been the mistreatment of client A who sustained implemented post investigation injuries on 2/27/22. Staff #6 remains suspended pending the AGO conclusion Findings include: regarding the incident. Staff #10 has been employment has been 1. Please refer to W127. For 1 of 2 sampled clients terminated. Staff #1 has been (A), the governing body failed to prevent physical removed from the supervisory and psychological abuse of client A on 2/27/22 position over the site. All site staff who sustained injuries from staff abuse. have been re-trained in ResCare's A/N/E/M policy, incident reporting 2. Please refer to W149. For 1 of 2 sampled clients procedure, and gentle teaching (A), the governing body failed to implement its practices. Additionally, the Area policy and procedures for prohibiting abuse, Supervisor (AS) will be at the site neglect, exploitation, mistreatment and/or at least three times a week and violation of individual's rights to prevent staff daily skin assessments have been physical and psychological abuse of client A who implemented. Additional sustained injuries on 2/27/22. monitoring will be achieved through daily administrative 3. Please refer to W154. For 1 of 2 sampled clients observations and daily (A), the governing body failed to thoroughly administrative meetings to discuss investigate an allegation of physical abuse of the on goings and needs of the client A to expand the scope of the investigation's home for a period of one allegations to include how client A sustained the month. All staff responsible for injuries on 2/27/22 and rule out potential neglect investigations have been trained to from a lack of quality of care. ensure investigations are thorough and in how to proceed if a This federal tag relates to complaint #IN00378468. conclusion is not found in the five business days required for 9-3-1(a) completing an investigation. Ongoing monitoring of investigations will be achieved by all investigations being

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and the peer review

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reviewed by the Executive Director

committee. Ongoing monitoring for client protections and governing

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STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
	15G723	B. Wl	NG		09/01/	2022
NAME OF PROVIDER OR SUPPLIER			13009 I	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143		
(X4) ID SUMMARY S	STATEMENT OF DEFICIENCIE	ID PROVIDER'S PLAN OF CORRECT		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
				body will be achieved through AS/QIDP/BC/PM completing s visits at least weekly.		
W 0122 483.420(a)	483.420(a) CLIENT PROTECTIONS					
	nsure the rights of all					
Based on record rev sampled clients (A). Condition of Partici of 2 sampled clients neglected to implem to ensure their systes staff abuse, neglect, implemented concerpsychological abuse injuries on 2/27/22. Findings include: 1. Please refer to W (A), the facility failor psychological abuse sustained injuries from 2. Please refer to W (A), the facility failor procedures for prohexploitation, mistreatindividual's rights to psychological abuse injuries on 2/27/22. 3. Please refer to W (A), the facility failor procedures for prohexploitation, mistreatindividual's rights to psychological abuse injuries on 2/27/22. 3. Please refer to W (A), the facility failor allegation of physic the scope of the invenience of the invenienc	tiew and interview for 1 of 2 the facility failed to meet the pation: Client Protections for 1 (A). The governing body the tits policy and procedures on to prohibit and prevent and/or mistreatment was straining the staff physical and to of client A who sustained 127. For 1 of 2 sampled clients and to prevent physical and to of client A on 2/27/22 who	W	0122	To correct the deficient practice the investigation regarding the 2-27-22 incident was re-opened. The following has implemented post investigation Staff #6 remains suspended pending the AGO conclusion regarding the incident. Staff #1 has been employment has beeterminated. Staff #1 has been removed from the supervisory position over the site. All site is have been re-trained in ResCa A/N/E/M policy, incident report procedure, and gentle teaching practices. Additionally, the Are Supervisor (AS) will be at the sat least three times a week and daily skin assessments have be implemented. Additional monitoring will be achieved through daily administrative observations and daily administrative meetings to disc the on goings and needs of the home for a period of one month. All staff responsible for investigations have been trainensure investigations are thore and in how to proceed if a conclusion is not found in the business days required for	been n 10 en staff are's ting g asite d been cuss e r ed to ough	10/01/2022

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 09/01/2022	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	of quality of care. This federal tag rela 9-3-2(a)	ates to complaint #IN00378468.		completing an investigation. Ongoing monitor of investigations will be achieved by all investigations being reviewed by the Executive Direction and the peer reviewed committee. Ongoing monitoring client protections and governing body will be achieved through AS/QIDP/BC/PM completing sevisits at least weekly.	ector g for ng the	
W 0127 Bldg. 00	The facility must edients. Therefore that clients are no verbal, sexual or punishment. Based on record revisampled clients (A) physical and psychological a	ensure the rights of all at the facility must ensure to subjected to physical, osychological abuse or view and interview for 1 of 2, the facility failed to prevent ological abuse of client A on med injuries from staff abuse. B PM, a review of the facility's mental Disabilities Services accompanying investigation ducted. The review indicated ent which affected client A: Bort dated 2/28/22 indicated, "It at A] was in his room when staff to the room. A second staff cell and went to the hallway edroom is located. At that time int A's] bedroom slamming the at and left. A few minutes later,	W 0127	To correct the deficient practic site staff have been re-trained ResCare's A/N/E/M policy, reporting incidents procedure, gentle teaching practices. Additionally, the Are Supervisor (AS) will be at the at least three times a week and aily skin assessments have be implemented. Additional monitoring will be achieved through daily administrative observations and daily administrative meetings to disting the on goings and needs of the home for a period of one monitoring monitoring will be achieved through the AS/QIDP/BC/PM completing significant weekly.	in and ea site id been cuss e th.	

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the second staff saw [client A] standing in the

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	
		15G723	B. W	ING		09/01	/2022
N	DROVINGE OF STATE			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
	•	on his face. The staff did skin					
		und a 1 inch laceration under					
		nt A's] chin, a 1 inch laceration					
	under his bottom lip, two 3/8 inch lacerations on the inside of his lip, and an 8 inch scratch on his left collarbone. Staff contacted nurse and [client						
		-					
	-	to the ER (emergency room) ent A] was evaluated and					
	_	under his chin and 3 stitches					
		p. [Client A] received					
		locaine Gel (topical local					
		e of lip before eating. [Client					
		cin (prevent skin infection) for					
	_	titches should be removed in 7					
	days".						
	Internal incident rep	port dated 2/27/22 indicated,					
	"Location: Home	. Where did the incident occur:					
	In bedroom Cons	sumer(s) involved: [Client A]					
	ResCare Staff or O	ther(s) involved/Witnessed:					
	[Staff #10]						
	What was happenin	ng before the incident? [Client					
		. I (staff #6) was in office. Other					1
	boys (housemates of	of client A) watching TV					
	(television). [Staff #	#10] sitting charging phone.					
	[Staff #10] got up v	while I was cleaning office.					
	What happened dur	ring incident? Heard big					
	* *	llway and [staff #10] was					1
		's] door while saying 'He got					
		nt to give snacks and while					
	doing (that) [staff #	[10] left. After giving snacks I					
	went to put keys up	in office. Seen (sic) [client A]					
	standing in hallway	with blood everywhere on his					
		athroom to clean up. Upon					
	cleaning [client A]	cried out and said '[staff #10]					1
		. I asked several times what					
		vere) still (the) same story,					
	'[Staff #10] hit me t	then chocked (sic) me'. After					1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/01/2022	
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD	•
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		HORIZON DR HIS, IN 47143	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I	
TAG	*	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	
		oticed his lip was bitten			
	through and his chin has a gash. His neck has red marks like being strangled. Scratches on his left				
	colar bone (sic)				
	What was done after the incident? Wiped him off				
		oad to colar bone (sic) and [Staff #1] took him to [name]			
	hospital	[Staff #1] took min to [name]			
		or injuries: Bloody nose, bite			
		Strangle marks around neck.			
	bleeding (right mid	eft colar bone (sic) Finger nail dle)".			
	_	2/28/22 through 5/4/22 etion: An investigation was			
	· ·	nt A] reported that staff [staff			
		him to the floor, and put his			
	hands on [client A's	s] neck.			
		ion: Determine if staff [staff			
	#10] physically abu	sed [client A].			
	Summary of intervi				
		[staff #10] hit him, knocked			
		d put his hands on [client A's] d [staff #10] was mad.			
		terview with [client A], he			
		d at [staff #10] for yelling at nimself on the chest and put			
		s throat and [staff #10] did not			
	do those things. [Cl	ient A] also reported that			
		fall, then [client A] changed			
		and [staff #10] fell to the floor slip and chin were injured.			
		ot elaborate on how the fall			
	happened				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15G723	B. WI	NG		09/01/	2022
		<u> </u>	_	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	8			HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			HS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		2/27/22 he arrived to work at					
		PM and [staff #1] and [staff					
		client A] was in his bedroom					
	_	er behaviors. [Staff #6] was					
		ared in the kitchen and [staff					
	_	ng room. When [staff #6] came					
		th remaining snacks and					
		was not in the living room at					
	_	aff #6] came out of the office cks, he heard [client A] yell,					
		n, and [staff #10] was coming					
		where [client A's] room is					
	1	reported he and [staff #10] were					
		10] said 'he's got life F****					
	_	lid not indicate who he was					
		f #6] reported [staff #10] had					
		room for less than 1 minute.					
		d to prepare snacks and after					
		he day, [client A] came out of					
		lood on his face. [Staff #6]					
		ent A] to the bathroom to clean					
	_	he thought [client A] had a					
		[client A] picks his nose					
		nosebleeds often. While					
		with cleaning up, [client A]					
	said [staff #10] hit	him and hurt him bad. [Staff #6]					
	noticed a laceration	under [client A's] bottom lip.					
	[Client A] also had	scratches on his left upper					
		proximately 8 inches in length.					
	It appeared [client]	A] was also bleeding from his					
	right middle finger	and had faint red marks on his					
	1	ntacted the nurse and [client A]					
		[name] hospital for evaluation.					
		3 stitches under his bottom lip					
		r his chin. [Staff #6] has not					
	1	ically or verbally abuse any					
	client						
	FG: 00 1117 7	1 0/05/00 15 11 11 11 11					
		d on 2/27/22 and [client A] had					
	behaviors that day a	and picked his nose causing it					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	TE SURVEY PLETED 01/2022
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP C HORIZON DR HIS, IN 47143	COD	_
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	yelling and not stop asked [client A] to a [Client A] sat down yell. [Staff #1] assist and [client A] went arrived at that time informed [staff #6] behaviors prior to be called [staff #1] late [client A] had a bac go to ER. [Staff #1] and [staff #6] told [staff #10] hurt him A] to [name] ER for [client A] told him him, and choked him [client A] what hap another client did it. I released from ER. [physically or verbal [Staff #10], worked was in the kitchen physically or verbal [Staff #10] went to check room calming due to was sitting in his reyelled when [staff #10] was not bleeding at [client A] did not go [staff #10] was in the reported he was in the proported he was in the late [staff #10] w	times. [Client A] was also oping. [Staff #8] and [staff #1] go to his room to calm down. In on the floor and continued to sted [client A] from the floor to his bedroom. [Staff #6] had and was in the office. [Staff #1] that [client A] had been having eaving for the day. [Staff #6] er and reported to him that all nosebleed and may need to preturned to the group home staff #1] that [client A] said and [Staff #1] transported [client in treatment. [Staff #1] reported [staff #10] hit him, scratched in Doctors in the ER asked pened and [client A] said and [client A] said and [client A] said and [client A] was treated and [staff #1] has not seen any staff saff #1] has not seen any staff saff which is the truth and again [client A] saff #1] has not seen any staff saff which is the was in his one carlier behaviors. [Client A] client A] to stop picking his said okay. [Client A's] nose that time. [Staff #10] stated et out of his recliner while the bedroom. [Staff #10] [client A's] bedroom less than and [client A] because his nose from picking it. [Staff #10] is not injured when he left the				

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NAME OF I	PROVIDER OR SUPPLIER	·		ADDRESS, CITY, STATE, ZIP CO)D	
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		HORIZON DR HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	OULD BE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	abuse [client A]	I not physically or verbally				
	home at the time of A's] bedroom and [and [staff #10] state bedroom approxima Consult Form and F [client A] sustained lower lip, 2 laceratic closed with 3 suture closed with 4 suture Conclusion: Unsubphysically abused [and December 1] on 8/30/22 at 12:20 dated 2/27/22 indicated 2/27/22 indicated 1] without complication Injury due to altereating and state of A's and sustained the sum of the sum	stantiated [staff #10] client A]".) PM, Medical Consult Form				
	On 8/29/22 at 9:41 Director (AED) was asked about interview and #10. The AED suspended a second received from the Ainvestigation. The Awas investigation. The Awas investigating. Tunknown injury at [clients (client A) at indicated based on a from the AGO, staft time surrounding in injuries sustained on the AGO.	AM, the Assistant Executive interviewed. The AED was ewing staff members #1, #6 indicated staff #10 had been attorney General's Office (AGO) AED was asked what the AGO The AED stated, "The Igroup home]. On one of the Igroup home]". The AED more information received if #10 was suspended a second formation about client A's in 2/27/22. The AED indicated idence was not shared but the				

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STATEMEN	IT 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
		15G723	B. W	ING		09/01/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	₹			HORIZON DR		
DES CAE		LTERNATIVES SE IN			IIS, IN 47143		
INLO UAI	AL COMMONTT A	ETERNATIVES SE IN		IVILIVII			
(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 implemented as a					
	precautionary meas	ure.					
		PM, client A was interviewed.					
		how long he had lived at the					
		A stated, "10 months". Client					
		he moved in. Client A stated,					
	"From [name of previous placement]. It's in [city]						
		was asked how he liked living					
	at the group home. Client A stated, "Good". Client						
	-	one treated him badly. Client A					
		en good all day". Client A was					
		ere at the home ever hit him.					
		o, never hit". Client A was					
		in incident between him and					
		stated, "Yes". Client A was					
		ll the surveyor what staff #10					
		, "Yeah. He threw me down,					
	-	ded the door. Called [staff #1]". does he (staff #10) still work					
		d, "No. Another group home.					
		it". Client A was asked your					
		d, "Yeah". Client A was asked					
		fore. Client A stated, "No".					
		e had a bad day. He would					
		curse". Client A was asked					
		nt A stated, "Yeah. He would					
		revious placement] and here.					
		en described what appeared to					
		with an unknown staff by the					
	_	m a previous placement. Client					
		[name] had seen him bleeding.					
		eah. Mrs. [nurse]". Client A					
		[name] looked at him as well.					
	Client A stated, "Yo	-					
	Ź						
	On 8/29/22 at 1:36	PM, staff #6 was interviewed.					
		about the incident where client					
	A sustained injuries	s to his facial region and chest.					
		e walked into his shift and was					

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

Event ID:

55NM11 Facility ID: 004615

If continuation sheet Page 11 of 49

PRINTED: 09/28/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 156723 A BULDING B WING STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR MEMPHIS, IN 47143 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGILATORY OR LSC IDENTIFYING INFORMATION informed client A had a bad day due to behavior and was in his bedroom coming in and out. Staff #6 indicated staff #1, staff #10 and a 3rd staff he could not recall were present when he started his shift. Staff #6 indicated staff #1 left shift leaving him and staff #10 as the group home. Staff #6 indicated staff #10 was charging his phone and he was in the office to get the keys to get snacks. Staff #6 stated, "I heard a loud scream and said what the h was that. I was giving them snacks. [Staff #10] slammed the door. He was p*****. I wished I would have ween (sie) into [client A's] room then. That was the one dark part of the story. I give (sie) the others their snacks. He left and said, 'He's got life ******* pi'. "Staff #6 was asked how long time had passed from when staff #10 left to when he visually saw client A. Staff #6 stated, "Maybe I minute. He kept saying call [staff #6], call [staff #6], I called [staff #1], I didn't know what to do. I was by myself I wish I would have looked when he slammed it like p*****, like take the door off the hinges. From the time I seen (sic) him (client A) to the time [staff #0] left at most 5 minutes." Staff #6 stated, "I think [client A] maybe come (sic) out to ask for a snack. I think he upper cut him, choked him and scratched him leaving when he heard my boots coming, he (staff #10) came out (leaving client A's bedroom, slamming the door). Staff #6 was asked about a	STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
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leaving when he heard my boots coming, he (staff #10) came out (leaving client A's bedroom,								
#10) came out (leaving client A's bedroom,								
		_						
Stathfilling uic 4001] . Statt #0 was asked about a			_					
history of client to client physical aggression at								
the group home. Staff #6 stated, "No". Staff #6		-						
was asked prior to the 2/27/22 incident of client								
A's injuries, was there any other similar incident		_						
history. Staff #6 stated, "Yeah. He (staff #10) had		-	-					
an issue with his ride late, argument. He was								
punching the front door. You can see knuckle			_					
marks in the door. His (staff #10) little anger								
problem. Straight up, I think he did it (assault of			-					

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	T OF HEALTH AND HU R MEDICARE & MEDIC					ORM APPROVED OMB NO. 0938-039	
	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	ILDING	ONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 09/01/2022	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP	COD		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		HORIZON DR HIS, IN 47143			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CO	PRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	client A)".						
	Staff #1 was asked group home. Staff recently hit himself bathroom and staff Staff #1 was asked Staff #1 stated, "No rash, no major swe asked how often elas he had described normal. It's not daid deescalate. Most of to get a little attent the incident on 2/2' sustained injuries to stated, "Yeah" and home and was about personal residence client A had been he called and said there A) got busted up on asked how client A "Like I said, I was happened". Staff #1 Staff #1 indicated happened to him on home, but staff #6 took him (client A) told me on the ride #10] did it. When we he said that [staff #1 how long the period the group home and	PM, staff #1 was interviewed. about unknown injuries at the #1 indicated client A had f in the face while in the #2 had observed the incident. if client A had hurt himself. b bruising or anything. Just red lling or bruising". Staff #1 was ient A would exhibit self-harm f. Staff #1 stated, "It's not ly. We usually ask him to f the time, I think it's him trying ion". Staff #1 was asked about 7/22 when client A had o his face and chest. Staff #1 indicated he had left the group at 20 minutes away nearing his when staff #6 called to inform nurt. Staff #1 stated, "[Staff #6] are was an incident. He (client in his chin". Staff #1 stated, not there. I don't know what I was asked if he had asked to the group home what had stated, "He (staff #6) did". are did not ask client A what had note he returned to the group had. Staff #1 then stated, "I to to the hospital. He (client A) over to [hospital name] [staff we were waiting for the doctor feld did it". Staff #1 was asked d of time was from when he left d returned due to client A f #1 stated, "20 minutes". Staff					
	//1 1 1 1 1	1 1 0 1 4 4 00					

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#1 was asked when he left what staff were present at the home with client A. Staff #1 stated, "[Staff

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		15G723	B. WI	NG		09/01/	2022	
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIEF	R			HORIZON DR			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			HS, IN 47143			
1120 0/11	·			IVILIVII	110, 114 47 140			
(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	ΓE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		staff #10]". Staff #1 was asked						
	-	n the provider investigation						
	did not include the additional staff name of staff							
	-	ent A during the wait for the						
		ted, "It did not come to my						
		asked when did the interview						
		urance investigator occur						
	_	's injuries. Staff #1 stated, "I						
		#1 was asked why he did not						
	_	vider's investigator about a						
		by client A as the person that						
		the injuries. Staff #1 stated, "I						
		taff #1 was asked about his						
		to the provider's investigator						
		ent A informed the doctor						
		ised his injuries and why he						
		A with identifying a name.						
		on't know. I did not know what						
		ff #1 was asked if there was						
		ession occurring at the home. ". Staff #1 was asked how						
		been injured. Staff #1 stated,						
		r if [staff #6] done it. From what						
		nt picked him up, he was gone						
		Staff #1 was asked what he						
		nt A's allegations of staff #6						
		using his injuries. Staff #1						
		was suspended". Staff #1 was						
		5. Staff #1 stated, "I spent						
		ff #6] at night". Staff #1 was						
	_	y staff #6 had caused the						
		Staff #1 stated, "No. The only						
		me with [staff #6] was when						
	_	(former staff #11) was						
		#1 was asked if additional						
	_	ed to protect client A beside						
	_	raff #10. Staff #1 stated, "No.						
	_	Staff #1 was asked if						
	-	ng had occurred. Staff #1						
		#1 was asked if there was						
	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	r í	a. building <u>00</u>		COMPL	X3) DATE SURVEY COMPLETED 09/01/2022	
	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN	1:	3009 ⊢	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II	D	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΔTE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	T	AG	DEFICIENCY)	112	DATE	
	blood in client A's	bedroom when he returned to						
	the group home on	2/27/22. Staff #1 stated, "Yes						
	there was". Staff #1	l was asked if client A's blood						
	was on his bed fran	ne or furniture in his room. Staff						
	#1 stated, "No". Sta	aff #1 was asked if the blood he						
	saw was in the mid	dle of client A's bedroom. Staff						
	#1 stated, "Yes".							
	On 8/29/22 at 4:15	PM, staff #10 was interviewed.						
		d about the incident on 2/27/22						
		ies. Staff #1 stated, "Early that						
	-	was picking his nose. [Staff						
	#1] sent him to his room. [Staff #1] left around 7							
	_	s asked if client A was hurt						
		group home. Staff #10 stated,						
		ossible nosebleed". Staff #10						
		osebleed. Staff #10 stated,						
		Staff #10 was asked if he						
	_	am. Staff #10 stated, "No sir".						
		d what staff #6 was doing. Staff						
		t me in the hallway. I guess he						
		elient A] if he wanted a snack.						
		[staff #6] went. The next						
		pended about 6:30 AM. 3/1/22						
		hone call from the sheriff's						
		vanted to know about the						
		ormed me he was taken to the						
	-	pictures. That's not hurt. That's						
	not right. I know th	ne abuse allegations did not						
	stop. The police she	owed me the pictures". Staff						
	#10 was asked wha	at he felt had occurred to cause						
	the injuries to clien	t A. Staff #10 stated, "After						
	getting the police re	eport, I'm conflicted with [staff						
	#1] being called ba	ck to the group home. Maybe						
	the two beat him up	o. Who can they blame for this,						
	I believe heavily th	at they're friends." Staff #10						
	stated, "When I spo	oke with the Attorney General,						
	it looked like it was	s by force (client A's injuries)".						
		d "Abuse". Staff #10 stated,						
		0 was asked "Who". Staff #10						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î ´	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		15G723	B. WING		09/01/2022
NAME OF T	DOMDED OF CURRING		STREE	Γ ADDRESS, CITY, STATE, ZIP COD	•
NAME OF F	PROVIDER OR SUPPLIER		13009	HORIZON DR	
	RE COMMUNITY A	LTERNATIVES SE IN	MEM	PHIS, IN 47143	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG		LISC IDENTIFYING INFORMATION Either [staff #1] or [staff #6]".	TAG	BEIGHNETT	DATE
		l about his transfer to another			
		e provider's investigation was			
		0 stated, "They said they were			
		to the situation around [client			
	-	t there (sic) was another			
	incident or allegation	on. After I left, I heard [staff #1]			
	was suspended for a	another allegation, but they			
		lead". Staff #10 was asked if he			
		en abused. Staff #10 stated,			
		houldn't happen". Staff #10			
		buse client A. Staff #10 stated,			
	"No sir". Staff #10 was asked if he knew who abused client A. Staff #10 stated, "No".				
	abused chent A. Sta	III #10 stated, "No".			
	On 8/30/22 at 12:24	PM, the Investigator for the			
		ffice was interviewed. The			
	-	ed evidence of inappropriate			
	-	th client A during the incident			
	on 2/27/22 when cli	ent A sustained injuries had			
	been obtained. The	Investigator indicated further			
		evidence were being reviewed			
	by the AGO and the				
		vestigator indicated the			
	_	ued and was not concluded at			
	the time of this inte	rview.			
	On 8/31/22 at 5:32	PM, the AED was interviewed.			
		staff #1 and staff #6 had been			
	suspended and the p	provider reopened their			
		ne incident of 2/27/22 when			
	client A had sustain	ed injuries. The AED			
	indicated during the	provider's interview with staff			
		ed the AGO had interviewed			
	-	22. Staff #6 indicated he had			
		a polygraph lie detector test			
	with the AGO on 9/	-			
		owledge of the incident on			
		A sustained injuries. The AED			
	indicated further fol	llow up was being pursued			

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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 09/01/2022 15G723 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 13009 HORIZON DR RES CARE COMMUNITY ALTERNATIVES SE IN MEMPHIS. IN 47143 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE concerning the incident on 2/27/22 where client A had sustained injuries. This federal tag relates to complaint #IN00378468. 9-3-2(a) W 0149 483.420(d)(1) STAFF TREATMENT OF CLIENTS Bldg. 00 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 2 W 0149 To correct the deficient practice all 10/01/2022 sampled clients (A), the facility neglected to site staff have been re-trained in implement its policy and procedures for ResCare's A/N/E/M policy, prohibiting abuse, neglect, exploitation, reporting incidents procedure, and mistreatment and/or violation of individual's rights gentle teaching to prevent physical and psychological abuse of practices. Additionally, the Area client A who sustained injuries on 2/27/22. Supervisor (AS) will be at the site at least three times a week and Findings include: daily skin assessments have been implemented. Additional On 8/26/22 at 12:03 PM, a review of the facility's monitoring will be achieved Bureau of Developmental Disabilities Services through daily administrative (BDDS) reports and accompanying investigation observations and daily summaries was conducted. The review indicated administrative meetings to discuss the following incident which affected client A: the activities and needs of the home for a period of one month. -BDDS incident report dated 2/28/22 indicated, "It Ongoing monitoring will be was reported [client A] was in his room when staff achieved through the [staff #10] went into the room. A second staff AS/QIDP/BC/PM completing site (staff #6) heard a yell and went to the hallway visits at least weekly. where [client A's] bedroom is located. At that time [staff #10] left [client A's] bedroom slamming the door and clocked out and left. A few minutes later, the second staff saw [client A] standing in the hallway with blood on his face. The staff did skin assessments and found a 1 inch laceration under

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the left side of [client A's] chin, a 1 inch laceration under his bottom lip, two 3/8 inch lacerations on

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ì ´		l í		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		15G723	B. W	ING		09/01/	/2022
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		13009 H	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE N. AM OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA)TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	112	DATE
		and an 8 inch scratch on his					
		f contacted nurse and [client					
	A] was transported to the ER (emergency room)						
	_	ent A] was evaluated and					
		ander his chin and 3 stitches					
	-	o. [Client A] received					
		ocaine Gel (topical local e of lip before eating. [Client					
		cin (prevent skin infection) for					
	_	titches should be removed in 7					
	days".	mones should be femoved in 7					
	,						
	Internal incident report dated 2/27/22 indicated,						
	"Location: Home	Where did the incident occur:					
	In bedroom Cons	sumer(s) involved: [Client A]					
		ther(s) involved/Witnessed:					
	[Staff #10]						
	3371 4 1 '	1 6 4 : 1 49 [6]: 4					
		g before the incident? [Client					
	_	I (staff #6) was in office. Other f client A) watching TV					
		#10] sitting charging phone.					
		while I was cleaning office.					
	[[
	What happened dur	ing incident? Heard big					
		llway and [staff #10] was					
	~ -	's] door while saying 'He got					
	_	nt to give snacks and while					
	0 \ / 2	10] left. After giving snacks I					
		in office. Seen (sic) [client A]					
		with blood everywhere on his					
		athroom to clean up. Upon					
		cried out and said '[staff #10] . I asked several times what					
		vere) still (the) same story,					
	* *	hen chocked (sic) me'. After					
	_	oticed his lip was bitten					
		n has a gash. His neck has red					
	_	rangled. Scratches on his left					
	colar bone (sic)	angita, seratence on me tert					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	COM	E SURVEY PLETED 1/2022
	PROVIDER OR SUPPLIEI	R LTERNATIVES SE IN	13009 H	ADDRESS, CITY, STATE, ZIP CO HORIZON DR HIS, IN 47143	DD .	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	and applied gauze p	er the incident? Wiped him off bad to colar bone (sic) and [Staff #1] took him to [name]				
	through bottom lip.	or injuries: Bloody nose, bite Strangle marks around neck. left colar bone (sic) Finger nail dle)".				
	indicated, "Introduc initiated when [clie	2/28/22 through 5/4/22 ction: An investigation was nt A] reported that staff [staff him to the floor, and put his s] neck.				
	Scope of Investigat #10] physically abu	ion: Determine if staff [staff ased [client A].				
	him on the floor an	iews: [staff #10] hit him, knocked d put his hands on [client A's] id [staff #10] was mad.				
	reported he was mathim and scratched his own hand on his do those things. [Classiff #10] saw him his statement to he and that is when his	terview with [client A], he and at [staff #10] for yelling at himself on the chest and put as throat and [staff #10] did not lient A] also reported that a fall, then [client A] changed and [staff #10] fell to the floor is lip and chin were injured. The properties of the content of the fall is				
	approximately 7:18 #10] reported that [2/27/22 he arrived to work at PM and [staff #1] and [staff client A] was in his bedroom ber behaviors. [Staff #6] was				

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

Event ID:

55NM11 Facility ID: 004615

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PRINTED: 09/28/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPLETED	
		15G723	B. WINC	G		09/01/	/2022
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹			IORIZON DR		
RES CA	RE COMMUNITY A	LTERNATIVES SE IN			IIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ared in the kitchen and [staff					
	_	ng room. When [staff #6] came					
		th remaining snacks and					
		was not in the living room at					
	_	aff #6] came out of the office					
	with remaining snacks, he heard [client A] yell,						
	which he does often, and [staff #10] was coming out of the hallway where [client A's] room is						
	-	reported he and [staff #10] were					
		10] said 'he's got life F****					
	_	lid not indicate who he was					
		f #6] reported [staff #10] had					
		room for less than 1 minute.					
		d to prepare snacks and after					
		he day, [client A] came out of					
	-	lood on his face. [Staff #6]					
		ent A] to the bathroom to clean					
	up. [Staff #6] stated	he thought [client A] had a					
	nosebleed because	[client A] picks his nose					
	frequently and has	nosebleeds often. While					
	assisting [client A]	with cleaning up, [client A]					
	said [staff #10] hit l	him and hurt him bad. [Staff #6]					
		under [client A's] bottom lip.					
		scratches on his left upper					
		proximately 8 inches in length.					
		A] was also bleeding from his					
	1 -	and had faint red marks on his					
		ntacted the nurse and [client A]					
	-	[name] hospital for evaluation.					
		3 stitches under his bottom lip					
		r his chin. [Staff #6] has not					
		ically or verbally abuse any					
	client						
	[Staff#1] I worked	d on 2/27/22 and [client A] had					
		and picked his nose causing it					
		times. [Client A] was also					
	_	oping. [Staff #8] and [staff #1]					
		go to his room to calm down.					
		on the floor and continued to					
	Chom H Bat down	. on the froot and continued to					

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

Event ID:

55NM11

Facility ID: 004615

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	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING B. WING	L i	00		
		15G723	B. WING	_		09/01/	12022
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
RES CAE	RE COMMUNITY A	LTERNATIVES SE IN			HORIZON DR HIS, IN 47143		
	Т			VII- [110, 111 47 140		ı
(X4) ID		STATEMENT OF DEFICIENCIE	ID	.,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		sted [client A] from the floor	TAG				DATE
	• • •	to his bedroom. [Staff #6] had					
		and was in the office. [Staff #1]					
		that [client A] had been having					
	behaviors prior to le	eaving for the day. [Staff #6]					
	called [staff #1] late	er and reported to him that					
		nosebleed and may need to					
		returned to the group home					
		staff #1] that [client A] said					
		. [Staff #1] transported [client					
		r treatment. [Staff #1] reported					
	[client A] told him [staff #10] hit him, scratched him, and choked him. Doctors in the ER asked						
		pened and [client A] said					
		. [Staff #1] said he told [client					
		the truth and again [client A]					
	_	Client A] was treated and					
	_	Staff #1] has not seen any staff					
	_	lly abuse any client					
	[Staff #10], worked	on 2/27/22 and stated [staff #6]					
		oreparing snacks and [staff					
	_	on [client A] as he was in his					
	I -	o earlier behaviors. [Client A]					
		cliner picking his nose and					
		[10] went into his bedroom.					
		elient A] to stop picking his					
		said okay. [Client A's] nose					
	_	that time. [Staff #10] stated et out of his recliner while					
		ne bedroom. [Staff #10]					
		client A's] bedroom less than					
)] left the bedroom and told					
	_	client A] because his nose					
		rom picking it. [Staff #10]					
	1	s not injured when he left the					
	1	I not physically or verbally					
	abuse [client A]						
	Factual Findings: [S	Staff #101 was at the group					

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STATEMEN	VT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPI	
		15G723	B. WI	NG		09/01	/2022
NAME OF P	PROVIDER OR SUPPLIE	R	_		ADDRESS, CITY, STATE, ZIP COD	-	
		LTERNATIVES SE IN			HORIZON DR HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		f the incident, went into [client					
		client A] did yell [Staff #6]					
		ed [staff #10] was in [client A's]					
		ately 1 minute or less Medical					
		ResCare Nursing note confirms					
		l a small laceration on inner					
		ions on chin, one on upper chin es and one on lower chin					
	closed with 3 sutur						
	Closed with 4 sutur	Co					
	Conclusion: Unsub	stantiated [staff #10]					
	physically abused [client A]".					
	On 8/30/22 at 12:20 PM, Medical Consult Form						
	dated 2/27/22 indic						
		mpression: Laceration of chin					
		on, Abrasion of chest wall,					
	_	ation Laceration/Wound					
	1	lial face Number of sutures: 3					
		Sumber of sutures: 4".					
	0 9/20/22 -+ 0.41	AM 41 - Ai-t-ut Eti					
		AM, the Assistant Executive as interviewed. The AED was					
		ewing staff members #1, #6					
		indicated staff #10 had been					
		d time based on information					
	_	Attorney General's Office (AGO)					
		AED was asked what the AGO					
	I -	The AED stated, "The					
		[group home]. On one of the					
		[group home]". The AED					
		more information received					
		ff #10 was suspended a second					
		nformation about client A's					
	· ·	on 2/27/22. The AED indicated					
	1 -	ridence was not shared but the					
	second suspension	was implemented as a					
	precautionary meas						
	On 8/25/22 at 4:19	PM, client A was interviewed.					

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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
		15G723	B. W	ING		09/01/	/2022
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			HS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		how long he had lived at the					
		A stated, "10 months". Client					
		he moved in. Client A stated,					
	"From [name of previous placement]. It's in [city]						
	Indiana". Client A was asked how he liked living at the group home. Client A stated, "Good". Client A was asked if anyone treated him badly. Client A						
	1	en good all day". Client A was					
		ere at the home ever hit him.					
		o, never hit". Client A was					
		an incident between him and					
		stated, "Yes". Client A was					
		ell the surveyor what staff #10					
		l, "Yeah. He threw me down,					
	got mad and slamm	ned the door. Called [staff #1]".					
	Client A was asked	does he (staff #10) still work					
	here. Client A state	d, "No. Another group home.					
	There was blood or	n it". Client A was asked your					
	chin. Client A state	d, "Yeah". Client A was asked					
	if had happened bet	fore. Client A stated, "No".					
	Client A stated, "He	e had a bad day. He would					
		curse". Client A was asked					
	1	nt A stated, "Yeah. He would					
		revious placement] and here.					
		en described what appeared to					
	_	vith an unknown staff by the					
		m a previous placement. Client					
		[name] had seen him bleeding.					
		eah. Mrs. [nurse]". Client A					
	Client A stated, "Ye	[name] looked at him as well.					
	Chem A stated, 1	ean .					
	On 8/29/22 at 1.36	PM, staff #6 was interviewed.					
		about the incident where client					
	_	s to his facial region and chest.					
		ne walked into his shift and was					
		and a bad day due to behavior					
		oom coming in and out. Staff					
		1, staff #10 and a 3rd staff he					
		re present when he started his					
		*					

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Event ID:

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STATEMEN	STATEMENT 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	
		15G723	B. W	ING		09/01/	/2022
N	AN OLUMBIA OR STURM			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	t .			HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	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
		ated staff #1 left shift leaving					
		t the group home. Staff #6					
		was charging his phone and he					
	was in the office to get the keys to get snacks. Staff #6 stated, "I heard a loud scream and said						
		at. I was giving them snacks. d the door. He was p*****. I					
	1 -	re went (sic) into [client A's]					
		s the one dark part of the					
		e others their snacks. He left					
		ife f***** up'." Staff #6 was					
		the had passed from when staff					
		visually saw client A. Staff #6					
		inute. He kept saying call					
	1	f #6]. I called [staff #1]. I didn't					
		was by myself I wish I would					
		ne slammed the door. This was					
		He slammed it like p****, like					
		e hinges. From the time I seen					
		to the time [staff #10] left at					
		aff #6 was asked what he felt					
		#6 stated, "I think [client A]					
		out to ask for a snack. I think he					
		xed him and scratched him					
		ard my boots coming, he (staff					
	_ ~	ving client A's bedroom,					
	· '	". Staff #6 was asked about a					
		client physical aggression at					
	the group home. Sta	aff #6 stated, "No". Staff #6					
	was asked prior to t	he 2/27/22 incident of client					
	A's injuries, was the	ere any other similar incident					
	history. Staff #6 sta	ted, "Yeah. He (staff #10) had					
	an issue with his ric	le late, argument. He was					
	punching the front	door. You can see knuckle					
	marks in the door. I	His (staff #10) little anger					
	problem. Straight u	p, I think he did it (assault of					
	client A)".						
	0.00000	DN 6					
		PM, staff #1 was interviewed. about unknown injuries at the					
	∟ Statt #T Was asked.	adoul unknown infliries at the		J			1

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PRINTED: 09/28/2022 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 15G723	A. BUILDING B. WING	00	COMPLETED 09/01/2022
NAME OF I	PROVIDER OR SUPPLIEF	- {		ADDRESS, CITY, STATE, ZIP COD	
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		HORIZON DR HIS, IN 47143	
(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
		†1 indicated client A had			
	-	in the face while in the #2 had observed the incident.			
		if client A had hurt himself.			
		bruising or anything. Just red			
		ling or bruising". Staff #1 was			
		ent A would exhibit self-harm			
		. Staff #1 stated, "It's not			
	normal. It's not dail	y. We usually ask him to			
	deescalate. Most of	the time, I think it's him trying			
	to get a little attenti	on". Staff #1 was asked about			
	the incident on 2/27	7/22 when client A had			
	_	his face and chest. Staff #1			
		indicated he had left the group			
		at 20 minutes away nearing his			
	_	when staff #6 called to inform			
		urt. Staff #1 stated, "[Staff #6]			
		e was an incident. He (client			
		h his chin". Staff #1 was			
		was injured. Staff #1 stated, not there. I don't know what			
		was asked if he had asked			
		the group home what had			
		stated, "He (staff #6) did".			
		e did not ask client A what had			
		ice he returned to the group			
		nad. Staff #1 then stated, "I			
	took him (client A)	to the hospital. He (client A)			
		over to [hospital name] [staff			
	#10] did it. When w	ve were waiting for the doctor			
	he said that [staff #6	6] did it". Staff #1 was asked			
		d of time was from when he left			
		l returned due to client A			
		#1 stated, "20 minutes". Staff			
		he left what staff were present			
		ient A. Staff #1 stated, "[Staff			
		staff #10]". Staff #1 was asked			
	-	n the provider investigation additional staff name of staff			
		ent A during the wait for the			
	"o malcalca by the	in 11 during the wait for the			

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	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	r í	LDING	nstruction <u>00</u>	(X3) DATE COMPL 09/01/	ETED
NAME OF I	PROVIDER OR SUPPLIER	· {			DDRESS, CITY, STATE, ZIP COD	_	
					IORIZON DR		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	IIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ted, "It did not come to my					
		asked when did the interview					
	with the quality assurance investigator occur concerning client A's injuries. Staff #1 stated, "I						
	_	#1 was asked why he did not					
		vider's investigator about a					
	_	by client A as the person that					
		the injuries. Staff #1 stated, "I					
		taff #1 was asked about his					
		to the provider's investigator					
		ent A informed the doctor					
	"another client" cau						
	did not assist client A with identifying a name. Staff #1 stated, "I don't know. I did not know what						
		ff #1 was asked if there was					
		ession occurring at the home.					
	·	". Staff #1 was asked how					
		been injured. Staff #1 stated,					
		r if [staff #6] done it. From what					
		ant picked him up, he was gone					
		Staff #1 was asked what he					
		ent A's allegations of staff #6					
		using his injuries. Staff #1 was suspended". Staff #1 was					
		6. Staff #1 stated, "I spent					
		of #6] at night". Staff #1 was					
	_	y staff #6 had caused the					
		Staff #1 stated, "No. The only					
	_	me with [staff #6] was when					
	_	t (former staff #11) was					
	_	#1 was asked if additional					
	_	ed to protect client A beside					
		taff #10. Staff #1 stated, "No.					
	1	. Staff #1 was asked if					
	additional monitori	ng had occurred. Staff#1					
	stated, "No". Staff #	#1 was asked if there was					
	blood in client A's l	pedroom when he returned to					
		2/27/22. Staff #1 stated, "Yes					
		was asked if client A's blood					
	was on his bed fran	ne or furniture in his room. Staff					

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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. BUILDING <u>00</u> COMPLETED			ETED	
	15G723		B. WING 09/01/2022			/2022	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			IIS, IN 47143		
	1						
(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		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAU		R LSC IDENTIFYING INFORMATION off #1 was asked if the blood he		IAU			DATE
	· · · · · · · · · · · · · · · · · · ·	dle of client A's bedroom. Staff					
	#1 stated, "Yes".	die of elicit A's bedroom. Staff					
	"I stated, Tes.						
	On 8/29/22 at 4:15	PM, staff #10 was interviewed.					
	Staff #10 was asked	d about the incident on 2/27/22					
	and client A's injuri	ies. Staff #1 stated, "Early that					
	morning, [client A]	was picking his nose. [Staff					
	#1] sent him to his	room. [Staff #1] left around 7					
	PM". Staff #10 was	asked if client A was hurt					
		group home. Staff #10 stated,					
		ossible nosebleed". Staff #10					
		osebleed. Staff #10 stated,					
	_	Staff #10 was asked if he					
		am. Staff #10 stated, "No sir".					
		d what staff #6 was doing. Staff					
		t me in the hallway. I guess he					
		lient A] if he wanted a snack.					
		[staff #6] went. The next					
		ended about 6:30 AM. 3/1/22					
		none call from the sheriff's					
		vanted to know about the					
	-	ormed me he was taken to the					
		pictures. That's not hurt. That's					
		e abuse allegations did not owed me the pictures". Staff					
		t he felt had occurred to cause					
		t he left had occurred to cause t A. Staff #10 stated, "After					
	-	eport, I'm conflicted with [staff					
		ck to the group home. Maybe					
		b. Who can they blame for this,					
		at they're friends." Staff #10					
	stated, "When I spoke with the Attorney General, it looked like it was by force (client A's injuries)".						
		d "Abuse". Staff #10 stated,					
		0 was asked "Who". Staff #10					
		Either [staff #1] or [staff #6]".					
		d about his transfer to another					
		ne provider's investigation was					
		0 stated, "They said they were					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		A. BUILDING B. WING	00 00	COMPLETED 09/01/2022			
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR MEMPHIS, IN 47143				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	A]. In the event that incident or allegatic was suspended for a made him the team felt client A had been "Yes. Yes, I do. It is was asked did he at "No sir". Staff #10 abused client A. Statorney General Of Investigator indicates staff interactions with on 2/27/22 when client and the outcomes from this by the AGO and the misconduct. The Interaction in the time of this interaction with the time of this interaction continuity that the AGO and the provide the provided and the provi	vestigator indicated the aued and was not concluded at rview. PM, the AED was interviewed. staff #1 and staff #6 had been provider reopened their the incident of 2/27/22 when the injuries. The AED to provider's interview with staff and the AGO had interviewed the aued injuries. Staff #6 indicated he had a polygraph lie detector test					

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CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		A. BUILDING	00	COMPLETED	
		B. WING		09/01/2022	
NAME OF E	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
				HORIZON DR	
RES CAF	RE COMMUNITY A	ALTERNATIVES SE IN	MEMP	HIS, IN 47143	
(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 APPROPRIAT	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	implemented at all	times.			
	On 8/29/22 at 1:04	PM, the 5/5/21 Abuse, Neglect,			
		reatment and/or Violation of			
	_	(ANE) policy was reviewed.			
	_	dicated, "ResCare staff actively			
		ghts and safety of all			
	-	Care strictly prohibits abuse,			
		on, mistreatment, or violation of			
	an Individual's rights". This federal tag relates to complaint #IN00378468. 9-3-2(a)				
W 0154	483.420(d)(3)				
	` ' ' '	ENT OF CLIENTS			
Bldg. 00		have evidence that all			
9		are thoroughly investigated.			
		view and interview for 1 of 2	W 0154	To correct the deficient practice	e 10/01/2022
), the facility failed to	,, 0131	the investigation regarding the	
		gate an allegation of physical		2-27-22 incident was	
		expand the scope of the		re-opened. The following has b	peen
	investigation's alleg	gations to include how client A		implemented post investigation	
	sustained the injuri	es on 2/27/22 and rule out		Staff #6 remains suspended	
	potential neglect fr	om a lack of quality of care.		pending the AGO conclusion	
				regarding the incident. Staff #1	0
	Findings include:			employment has been	
				terminated. Staff #1 has been	
		3 PM, a review of the facility's		removed from the supervisory	
	-	mental Disabilities Services		position over the site. All site si	
		d accompanying investigation		have been re-trained in ResCa	
		nducted. The review indicated		A/N/E/M policy, incident reporti	·
	the following incid	ent which affected client A:		procedure, and gentle teaching	
	,			practices. Additionally, the Area	
		port dated 2/28/22 indicated, "It		Supervisor (AS) will be at the s	
		at A] was in his room when staff		at least three times a week and	
[staff #10] went		to the room. A second staff	1	daily skin assessments have be	een

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(staff #6) heard a yell and went to the hallway

where [client A's] bedroom is located. At that time

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implemented. Additional

monitoring will be achieved

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	of Correction identification number 15G723	A. BUILDING B. WING	00	COMPLETED 09/01/2022
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	13009 ⊢	DDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	[staff #10] left [client A's] bedroom slamming the door and clocked out and left. A few minutes later, the second staff saw [client A] standing in the hallway with blood on his face. The staff did skin assessments and found a 1 inch laceration under the left side of [client A's] chin, a 1 inch laceration under his bottom lip, two 3/8 inch lacerations on the inside of his lip, and an 8 inch scratch on his left collarbone. Staff contacted nurse and [client A] was transported to the ER (emergency room) for evaluation. [Client A] was evaluated and received 3 stitches under his chin and 3 stitches under his bottom lip. [Client A] received prescription for Lidocaine Gel (topical local anesthetic) on inside of lip before eating. [Client A] is to use Bacitracin (prevent skin infection) for other lacerations. Stitches should be removed in 7 days". Internal incident report dated 2/27/22 indicated, "Location: Home Where did the incident occur: In bedroom Consumer(s) involved: [Client A] ResCare Staff or Other(s) involved/Witnessed: [Staff #10] What was happening before the incident? [Client A] was in his room. I (staff #6) was in office. Other boys (housemates of client A) watching TV (television). [Staff #10] sitting charging phone. [Staff #10] got up while I was cleaning office. What happened during incident? Heard big scream. Went to hallway and [staff #10] was slamming [client A's] door while saying 'He got life f***** up'. Went to give snacks and while doing (that) [staff #10] left. After giving snacks I went to put keys up in office. Seen (sic) [client A] standing in hallway with blood everywhere on his face. Took him to bathroom to clean up. Upon cleaning [client A] cried out and said '[staff #10]		through daily administrative observations and daily administrative meetings to disc the activities and needs of the home for a period of one mont All staff responsible for investigations have been trainensure investigations are thorough, and in how to proced a conclusion is not found in the five business days required for completing an investigation. Ongoing monitor will be achieved by all investigations being reviewed the Executive Director and the peer review committee.	ed to ed if e r ring

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING (0) COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G723	A. BUILDING 00 COMPLETED B. WING 09/01/2022		
				`ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF I	PROVIDER OR SUPPLIER	2		HORIZON DR	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		PHIS, IN 47143	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE
IAG		. I asked several times what	IAG		DATE
		vere) still (the) same story,			
		hen chocked (sic) me'. After			
		oticed his lip was bitten			
	_	n has a gash. His neck has red			
		rangled. Scratches on his left			
	colar bone (sic)				
		er the incident? Wiped him off			
		oad to colar bone (sic) and			
	_	[Staff #1] took him to [name]			
	hospital				
	Describe the injury	or injuries: Bloody nose, bite			
		Strangle marks around neck.			
	_	eft colar bone (sic) Finger nail			
	bleeding (right mid	dle)".			
	Investigation dated	2/28/22 through 5/4/22			
	indicated, "Introduc	etion: An investigation was			
	initiated when [clie	nt A] reported that staff [staff			
	_	him to the floor, and put his			
	hands on [client A's	s] neck.			
	Scope of Investigat	ion: Determine if staff [staff			
	#10] physically abu	-			
	Summary of intervi	ews.			
	-	[staff #10] hit him, knocked			
		d put his hands on [client A's]			
		d [staff #10] was mad.			
	During a second interview with [client A], he reported he was mad at [staff #10] for yelling at				
	_	nimself on the chest and put			
		s throat and [staff #10] did not			
		ient A] also reported that			
	-	fall, then [client A] changed			
		and [staff #10] fell to the floor			
l	I and that is when his	s lip and chin were injured.	1	I	1

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION 15G723		l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPI 09/01	LETED	
NAME OF I	PROVIDER OR SUPPLIEI	R	-		ADDRESS, CITY, STATE, ZIP COD		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN			IORIZON DR IIS, IN 47143		
(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 B) CROSS-REFERENCED TO THE APPROPE	E RIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	[Client A] would not happened	ot elaborate on how the fall					
	[Staff #6] stated on approximately 7:18 #10] reported that [calming from earlie getting snacks prep #10] was in the livi out of the office wi noticed [staff #10] that time. When [st with remaining sna which he does ofter out of the hallway located. [Staff #6] alone when [staff # up' but [staff #10] of talking about. [Staff been in [client A's] [Staff #6] continue. [staff #10] left for this room and had be then went with [clieup. [Staff #6] stated nosebleed because	2/27/22 he arrived to work at 3 PM and [staff #1] and [staff client A] was in his bedroom er behaviors. [Staff #6] was ared in the kitchen and [staff ing room. When [staff #6] came th remaining snacks and was not in the living room at aff #6] came out of the office cks, he heard [client A] yell, in, and [staff #10] was coming where [client A's] room is reported he and [staff #10] were 10] said 'he's got life F***** lid not indicate who he was ff #6] reported [staff #10] had room for less than 1 minute. In the day, [client A] came out of lood on his face. [Staff #6] ent A] to the bathroom to clean the thought [client A] had a [client A] picks his nose					
	assisting [client A]	nosebleeds often. While with cleaning up, [client A]					
		him and hurt him bad. [Staff #6]					
		under [client A's] bottom lip.					
		scratches on his left upper					
	~ ·	proximately 8 inches in length. A] was also bleeding from his					
	* * *	and had faint red marks on his					
		ntacted the nurse and [client A]					
		[name] hospital for evaluation.					
	_	3 stitches under his bottom lip					
	1	r his chin. [Staff #6] has not					
		ically or verbally abuse any					
	client						

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		A. BUILDING B. WING	00	COMPLETED 09/01/2022	
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	13009	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	behaviors that day a to bleed 2 separate i yelling and not stop asked [client A] to g [Client A] sat down yell. [Staff #1] assis and [client A] went arrived at that time informed [staff #6] behaviors prior to le called [staff #1] late [client A] had a bad go to ER. [Staff #1] and [staff #6] told [[staff #10] hurt him A] to [name] ER fo [client A] told him him, and choked him [client A] what hap another client did it. A] to tell the doctor said a client did it. [released from ER. [physically or verbal [Staff #10], worked was in the kitchen p #10] went to check room calming due t was sitting in his re yelled when [staff # [Staff #10] asked [c nose and [client A] was not bleeding at [client A] did not ge [staff #10] was in th reported he was in [I on 2/27/22 and [client A] had and picked his nose causing it times. [Client A] was also uping. [Staff #8] and [staff #1] go to his room to calm down. It on the floor and continued to sted [client A] from the floor to his bedroom. [Staff #6] had and was in the office. [Staff #1] that [client A] had been having eaving for the day. [Staff #6] er and reported to him that I nosebleed and may need to returned to the group home staff #1] that [client A] said . [Staff #1] transported [client er treatment. [Staff #1] reported [staff #10] hit him, scratched em. Doctors in the ER asked pened and [client A] said . [Staff #1] said he told [client er the truth and again [client A] the truth and again [client A] is client A] was treated and [Staff #1] has not seen any staff ally abuse any client on 2/27/22 and stated [staff #6] or [client A] as he was in his or earlier behaviors. [Client A] client A] to stop picking his said okay. [Client A's] nose that time. [Staff #10] stated et out of his recliner while ne bedroom. [Staff #10] client A's] bedroom less than of left the bedroom and told			

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>			LETED
15G723		B. WING			09/01/2022		
		<u> </u>					
NAME OF	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
DE0.04		1 TEDNIA TIV (EQ. QE IN			HORIZON DR		
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		MEMPF	HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION	ī	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFTY (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	MATE	DATE
	[staff #6] to watch	[client A] because his nose					
		from picking it. [Staff #10]					
		as not injured when he left the					
		l not physically or verbally					
	abuse [client A]	1 3 3					
	Factual Findings: [5	Staff #10] was at the group					
	· ·	the incident, went into [client					
		client A] did yell [Staff #6]					
	1 -	ed [staff #10] was in [client A's]					
	bedroom approximately 1 minute or less Medical Consult Form and ResCare Nursing note confirms [client A] sustained a small laceration on inner						
		ons on chin, one on upper chin					
	_	es and one on lower chin					
	closed with 4 suture						
	Conclusion: Unsub	stantiated [staff #10]					
	physically abused [
	On 8/30/22 at 12:20	0 PM, Medical Consult Form					
	dated 2/27/22 indic						
		npression: Laceration of chin					
		on, Abrasion of chest wall,					
	_	ation Laceration/Wound					
	1 -	lial face Number of sutures: 3					
	_	umber of sutures: 4".					
	On 8/29/22 at 9:41	AM, the Assistant Executive					
		s interviewed. The AED was					
		ewing staff members #1, #6					
		indicated staff #10 had been					
		I time based on information					
	_	Attorney General's Office (AGO)					
		AED was asked what the AGO					
	-	The AED stated, "The					
		[group home]. On one of the					
	1 .						
clients (client A) at [group home]". The AED			1		İ		1

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indicated based on more information received from the AGO, staff #10 was suspended a second

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		r í	ILDING	nstruction <u>00</u>	(X3) DATE COMPL 09/01/	ETED	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN		13009 H	DDRESS, CITY, STATE, ZIP COD HORIZON DR HS, IN 47143		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	injuries sustained of the nature of the ev- second suspension precautionary meas	offormation about client A's in 2/27/22. The AED indicated idence was not shared but the was implemented as a ure. PM, client A was interviewed.					
	Client A was asked group home. Client A was asked when "From [name of pre Indiana". Client A at the group home.	how long he had lived at the A stated, "10 months". Client he moved in. Client A stated, evious placement]. It's in [city] was asked how he liked living Client A stated, "Good". Client					
	stated, "No. I've bed asked if the staff he Client A stated, "No asked if there was a staff #10. Client A	one treated him badly. Client A en good all day". Client A was ere at the home ever hit him. e, never hit". Client A was en incident between him and estated, "Yes". Client A was ll the surveyor what staff #10					
	got mad and slamm Client A was asked here. Client A state There was blood on chin. Client A state	, "Yeah. He threw me down, led the door. Called [staff #1]". does he (staff #10) still work d, "No. Another group home. a it". Client A was asked your d, "Yeah". Client A was asked					
	Client A stated, "Ho throw things, juice, "[Staff #10]"? Clien with, at [name of pi	fore. Client A stated, "No". he had a bad day. He would curse". Client A was asked ht A stated, "Yeah. He would revious placement] and here. he described what appeared to					
	name of [name] fro A was asked if this Client A stated, "Yo	with an unknown staff by the maprevious placement. Client [name] had seen him bleeding. eah. Mrs. [nurse]". Client A [name] looked at him as well. eah".					
	On 8/29/22 at 1:36	PM, staff #6 was interviewed.					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		A. BUILDING B. WING	00	COMPLETED 09/01/2022	
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	13009 I	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
TAG	Staff #6 was asked A sustained injuries Staff #6 indicated h informed client A h and was in his bedr #6 indicated staff # could not recall were shift. Staff #6 indicated staff #10 a indicated staff #10 was in the office to Staff #6 stated, "I h what the h was th [Staff #10] slamme wished I would hav room then. That was story. I give (sic) the and said, 'He's got I asked how long tim #10 left to when he stated, "Maybe I m [staff #6], call [staff know what to do. I have looked when h like a hurt scream. I know the door off the (sic) him (client A) most 5 minutes". Staff maybe come (sic) of the group home. Staff was asked prior to the group home. Staff #6 staff was asked prior to the group home. Staff was asked prior to the group home. Staff #6 staff was asked prior to the group home. Staff #6 staff #6 staff #6 staff #6 staff #6 staff #6 indicated had a subject which was asked prior to the group home. Staff #6 staff #6 staff #6 indicated had a subject was a sked prior to the group home. Staff #6 staff #6 indicated had a subject was a sked prior to the group home.	about the incident where client to to his facial region and chest. It was ad a bad day due to behavior from coming in and out. Staff 1, staff #10 and a 3rd staff here present when he started his facial staff #1 left shift leaving to the group home. Staff #6 was charging his phone and he get the keys to get snacks. It was giving them snacks. It was the early shad given to facility of the early shad given to facility was be had passed from when staff visually saw client A. Staff #6 inute. He kept saying call of #6]. I called [staff #1]. I didn't was by myself I wish I would not slammed the door. This was the slammed it like p*****, like the hinges. From the time I seen to the time [staff #10] left at aff #6 was asked what he felt #6 stated, "I think [client A] tut to ask for a snack. I think he to the time [staff #6 was asked about a client physical aggression at aff #6 stated, "No". Staff #6 he 2/27/22 incident of client the early other similar incident the early	TAG	DEPLIENCY	DATE

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	ì	UILDING	nstruction <u>00</u>	(X3) DATE COMPI 09/01	LETED		
	PROVIDER OR SUPPLIE	R LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR MEMPHIS, IN 47143						
INLO UAI	TE COMMONTT A	ETERNATIVES SE IN		IVILIVII					
(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 APPROPR	IATE	COMPLETION		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
		door. You can see knuckle							
		His (staff #10) little anger							
		p, I think he did it (assault of							
	client A)".								
	On 8/20/22 at 2:30	PM, staff #1 was interviewed.							
		about unknown injuries at the							
		#1 indicated client A had							
		f in the face while in the							
	· ·	#2 had observed the incident.							
		if client A had hurt himself.							
	Staff #1 stated, "No	bruising or anything. Just red							
	rash, no major swe	lling or bruising". Staff #1 was							
	asked how often cl	ient A would exhibit self-harm							
	as he had described	I. Staff #1 stated, "It's not							
	normal. It's not dail	ly. We usually ask him to							
		the time, I think it's him trying							
	_	ion". Staff #1 was asked about							
		7/22 when client A had							
	1	o his face and chest. Staff #1							
		indicated he had left the group							
		at 20 minutes away nearing his							
	_	when staff #6 called to inform							
		urt. Staff #1 stated, "[Staff #6]							
		re was an incident. He (client							
		n his chin". Staff #1 was was injured. Staff #1 stated,							
		not there. I don't know what							
	· /	I was asked if he had asked							
		o the group home what had							
		stated, "He (staff #6) did".							
	* *	ne did not ask client A what had							
		nce he returned to the group							
	* *	had. Staff #1 then stated, "I							
	· ·	to the hospital. He (client A)							
		over to [hospital name] [staff							
		we were waiting for the doctor							
	he said that [staff #	6] did it". Staff #1 was asked							
	how long the period	d of time was from when he left							
	the group home and	d returned due to client A							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	
		15G723	B. WI	NG		09/01/	/2022
		!		STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF	₹		13009 F	HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		*#1 stated, "20 minutes". Staff					
		he left what staff were present					
		ient A. Staff #1 stated, "[Staff					
		staff #10]". Staff #1 was asked					
		n the provider investigation					
		additional staff name of staff					
	· ·	ent A during the wait for the					
		ted, "It did not come to my					
		asked when did the interview urance investigator occur					
		L's injuries. Staff #1 stated, "I					
	_	#1 was asked why he did not					
		vider's investigator about a					
		by client A as the person that					
		the injuries. Staff #1 stated, "I					
		taff #1 was asked about his					
		t to the provider's investigator					
		ent A informed the doctor					
		used his injuries and why he					
		A with identifying a name.					
		on't know. I did not know what					
		ff #1 was asked if there was					
		ession occurring at the home.					
		o". Staff #1 was asked how					
	·	been injured. Staff #1 stated,					
		r if [staff #6] done it. From what					
		ant picked him up, he was gone					
	•	Staff #1 was asked what he					
	had done about clie	ent A's allegations of staff #6					
	and/or staff #10 cau	using his injuries. Staff #1					
		was suspended". Staff #1 was					
	asked about staff #6	5. Staff #1 stated, "I spent					
	more time with [sta	ff #6] at night". Staff #1 was					
	asked if it was likel	y staff #6 had caused the					
	injuries to client A.	Staff #1 stated, "No. The only					
	time I spent more ti	me with [staff #6] was when					
	the other night shift	t (former staff #11) was					
	running late". Staff	#1 was asked if additional					
	changes had occurr	ed to protect client A beside					
	the suspension of st	taff #10. Staff #1 stated, "No.					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G723	, ,	LDING	onstruction <u>00</u>	(X3) DATE COMPI 09/01	LETED
	PROVIDER OR SUPPLIEI	R LITERNATIVES SE IN		13009 F	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	P	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ΔTF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	AIL	DATE
	Body assessments"	. Staff #1 was asked if					
	additional monitori	ng had occurred. Staff #1					
	stated, "No". Staff	#1 was asked if there was					
	blood in client A's	bedroom when he returned to					
	the group home on	2/27/22. Staff #1 stated, "Yes					
	there was". Staff #1	l was asked if client A's blood					
		ne or furniture in his room. Staff					
	#1 stated, "No". Sta	aff #1 was asked if the blood he					
	saw was in the mid	dle of client A's bedroom. Staff					
	#1 stated, "Yes".						
	On 8/29/22 at 4:15	PM, staff #10 was interviewed.					
		d about the incident on 2/27/22					
		ies. Staff #1 stated, "Early that					
	-	was picking his nose. [Staff					
		room. [Staff #1] left around 7					
	_	s asked if client A was hurt					
		group home. Staff #10 stated,					
		ossible nosebleed". Staff #10					
		osebleed. Staff #10 stated,					
		Staff #10 was asked if he					
	_	am. Staff #10 stated, "No sir".					
		d what staff #6 was doing. Staff					
		t me in the hallway. I guess he					
		elient A] if he wanted a snack.					
		[staff #6] went. The next					
		pended about 6:30 AM. 3/1/22					
		hone call from the sheriff's					
		vanted to know about the					
		ormed me he was taken to the					
	-	pictures. That's not hurt. That's					
		ne abuse allegations did not					
	-	owed me the pictures". Staff					
		at he felt had occurred to cause					
	the injuries to clien	t A. Staff #10 stated, "After					
	•	eport, I'm conflicted with [staff					
		ck to the group home. Maybe					
		p. Who can they blame for this,					
	-	at they're friends." Staff #10					
		oke with the Attorney General.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 09/01/2022	
	ROVIDER OR SUPPLIER		13009 H	ADDRESS, CITY, STATE, ZIP COD HORIZON DR	-
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	MEMP	HIS, IN 47143	
(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 APPROPR	
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		by force (client A's injuries)".			
		l "Abuse". Staff #10 stated,			
		0 was asked "Who". Staff #10			
		Either [staff #1] or [staff #6]".			
		l about his transfer to another			
		e provider's investigation was			
		0 stated, "They said they were			
	_	to the situation around [client there (sic) was another			
	_	on. After I left, I heard [staff #1]			
	_	another allegation, but they			
	*	lead". Staff #10 was asked if he			
		en abused. Staff #10 stated,			
	"Yes. Yes, I do. It s	houldn't happen". Staff #10			
		ouse client A. Staff #10 stated,			
	"No sir". Staff #10	was asked if he knew who			
	abused client A. Sta	aff #10 stated, "No".			
		PM, the Quality Assurance			
		as interviewed. The QAM was			
		estigation process of an			
		l why only staff #10 had been			
		the investigation process.			
		I the original report was of buse of client A. The QAM			
	_	off #1 not sharing information			
		A of potentially staff #6 also			
		ausing the injuries and the			
		doctor being informed another			
		jury, without identifying the			
		through the provider's			
	_	dures. The QAM stated, "I			
		uld have been changed to			
	include how did he	(client A) get those injuries.			
	•	ave included how did [client			
		ies". The QAM was asked			
		or an unsubstantiated finding			
		been concluded given the			
		injuries when a lack of current			
	history for client to	client and/or self-inflicted			

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AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723			JILDING	00	COMPL 09/01/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR					
RES CAF	RE COMMUNITY AI	LTERNATIVES SE IN		MEMPH	IIS, IN 47143			
(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	
	harm by client A waindicated the unsubstitute of the last of the group home casked if physical every QAM indicated the was not known to the last of th				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE		
W 0186 Bldg. 00	The AED indicated suspended and the prinvestigation into the client A had sustain. This federal tag related 9-3-2(a) 483.430(d)(1-2) DIRECT CARE South The facility must proposed to manage and suspending the proposed suspending to th	ates to complaint #IN00378468.						
	•							

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AND PLAN OF CORRECTION 15G723 A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR MEMPHIS, IN 47143 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure there was sufficient direct care staff to manage A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR MEMPHIS, IN 47143 STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR MEMPHIS, IN 47143 (X5) COMPLETION DATE W 0186 To correct the deficient practice the administrative team will determine what waking hours are	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN (X4) ID PREFIX TAG Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure STREET ADDRESS, CITY, STATE, ZIP COD 13009 HORIZON DR MEMPHIS, IN 47143 PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OCMPLETION DATE W 0186 To correct the deficient practice the administrative team will	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
RES CARE COMMUNITY ALTERNATIVES SE IN (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure 13009 HORIZON DR MEMPHIS, IN 47143 (X5) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure 13009 HORIZON DR MEMPHIS, IN 47143 (X5) (CMPLETION DEFICIENCY) COMPLETION DATE TO correct the deficient practice the administrative team will			15G723	B. W	ING		09/01	/2022
RES CARE COMMUNITY ALTERNATIVES SE IN (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure 13009 HORIZON DR MEMPHIS, IN 47143 (X5) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure 13009 HORIZON DR MEMPHIS, IN 47143 (X5) (CMPLETION DEFICIENCY) COMPLETION DATE TO correct the deficient practice the administrative team will					STREET	ADDRESS CITY STATE ZIP COD		
RES CARE COMMUNITY ALTERNATIVES SE IN (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure MEMPHIS, IN 47143 MEMPHIS, IN 47143 (X5) PREFIX PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE W 0186 To correct the deficient practice the administrative team will	NAME OF P	PROVIDER OR SUPPLIEF	₹					
(X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure	RES CAR	RE COMMUNITY A	I TERNATIVES SE IN					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure PREFIX TAG TO CORPLETION DATE 10/01/2022		T COMMONT TO			I WIEIWII I	10, 11, 11, 110		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure TAG CROSS-REFERENCED TO THE APPROPRIATE DATE CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG TAG TAG TAG TO COPPER THE APPROPRIATE DATE DATE TO COPPER THE APPROPRIATE DATE DATE 10/01/2022	1 1							
Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. W 0186 To correct the deficient practice the administrative team will						CROSS-REFERENCED TO THE APPROPRIA	TE	
on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure W 0186 To correct the deficient practice the administrative team will	TAG				TAG	DEFICIENCY)		DATE
24-hour period for each defined residential living unit. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure W 0186 To correct the deficient practice the administrative team will			•					
living unit. Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure W 0186 To correct the deficient practice the administrative team will		-						
Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to ensure W 0186 To correct the deficient practice the administrative team will		-	each defined residential					
sampled clients (A), the facility failed to ensure the administrative team will				337.6	1106	T		10/01/2022
				W ()186	-	ce	10/01/2022
there was sufficient direct care start to manage								
and supervise client A during an incident on based on the client's needs and a			_			l a		
2/27/22 when client A sustained injuries from schedule will be implemented		_	_				iu a	
abuse, neglect and/or mistreatment. abuse, neglect and/or mistreatment. based on this determination. All			-			· ·	ΔII	
staff responsible for scheduling will		abuse, negreet and/	or mistreament.					
Findings include: be re-trained in the staffing ratio		Findings include:				1	-	
requirement for ESN homes.		i mamga maraas				_		
On 8/26/22 at 12:03 PM, a review of the facility's Additional monitoring will be		On 8/26/22 at 12:03	3 PM, a review of the facility's			I = = = = = = = = = = = = = = = = = = =		
Bureau of Developmental Disabilities Services achieved by the PM reviewing the			-			_	the	
(BDDS) reports and accompanying investigation schedule each week, daily		_				-		
summaries was conducted. The review indicated administrative observations, and						-	nd	
the following incident which affected client A: daily administrative meetings for a		the following incide	ent which affected client A:					
period of one month. Ongoing						period of one month. Ongoing		
-BDDS incident report dated 2/28/22 indicated, "It monitoring will be achieved by the		-BDDS incident rep	port dated 2/28/22 indicated, "It			monitoring will be achieved by	the	
was reported [client A] was in his room when staff AS and PM reviewing the monthly		was reported [client	t A] was in his room when staff			AS and PM reviewing the mor	nthly	
[staff #10] went into the room. A second staff schedule to ensure each shift is		[staff #10] went into	o the room. A second staff			schedule to ensure each shift	is	
(staff #6) heard a yell and went to the hallway within ratio.						within ratio.		
where [client A's] bedroom is located. At that time								
[staff #10] left [client A's] bedroom slamming the								1
door and clocked out and left. A few minutes later,								
the second staff saw [client A] standing in the								
hallway with blood on his face. The staff did skin								
assessments and found a 1 inch laceration under								
the left side of [client A's] chin, a 1 inch laceration		-						
under his bottom lip, two 3/8 inch lacerations on		_	•					
the inside of his lip, and an 8 inch scratch on his		_						
left collarbone. Staff contacted nurse and [client A] was transported to the ER (emergency room)			-					
for evaluation. [Client A] was evaluated and			`					
received 3 stitches under his chin and 3 stitches		_	=					
under his bottom lip. [Client A] received								
prescription for Lidocaine Gel (topical local		_						
anesthetic) on inside of lip before eating. [Client			· -					
A] is to use Bacitracin (prevent skin infection) for								

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/01/2022 15G723 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 13009 HORIZON DR RES CARE COMMUNITY ALTERNATIVES SE IN MEMPHIS, IN 47143 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (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 DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE other lacerations. Stitches should be removed in 7 davs". Investigation dated 2/28/22 through 5/4/22 indicated, "Introduction: An investigation was initiated when [client A] reported that staff [staff #10] hit him, threw him to the floor, and put his hands on [client A's] neck. Scope of Investigation: Determine if staff [staff #10] physically abused [client A]. Investigative Procedure:... Time Detail dated 2/27/22 ... Summary of interviews: [Staff #6] stated on 2/27/22 he arrived to work at approximately 7:18 PM ... Conclusion: Unsubstantiated [staff #10] physically abused [client A]. ResCare Investigation Peer Review: ... Inservice staff on contacting supervisor if out of ratio ... Inservice staff on arriving late for shift and clocking out and leaving immediately after shift ...". On 8/29/22 at 1:36 PM, staff #6 was interviewed. Staff #6 was asked about the incident where client A sustained injuries to his facial region and chest.

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Staff #6 indicated he walked into his shift and was informed client A had a bad day due to behavior and was in his bedroom coming in and out. Staff #6 indicated staff #1, staff #10 and a 3rd staff he could not recall were present when he started his shift. Staff #6 indicated staff #1 left shift leaving him and staff #10 at the group home. Staff #6 indicated staff #10 was charging his phone and he

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/01/2022	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	1	3009 H	ADDRESS, CITY, STATE, ZIP COD HORIZON DR HIS, IN 47143			
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		D EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	(X5) COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	T	'AG	DEFICIENCY)		DATE	
		get the keys to get snacks.						
	· · · · · · · · · · · · · · · · · · ·	heard a loud scream and said						
		hat. I was giving them snacks.						
		ed the door. He was p*****. I						
		ve went (sic) into [client A's]						
		as the one dark part of the						
		he others their snacks. He left						
	_	life f**** up'." Staff #6 was						
		ne had passed from when staff e visually saw client A. Staff #6						
		ninute. He kept saying call						
	-	ff #6]. I called [staff #1]. I didn't						
	1	was by myself".						
	Know what to do. I	was by mysem						
	On 8/29/22 at 2:39	PM, staff #1 was interviewed.						
		l about the incident on 2/27/22						
		sustained injuries to his face						
		stated, "Yeah" and indicated						
		up home and was about 20						
	_	ring his personal residence						
	_	ed to inform client A had been						
	hurt. Staff #1 state	d, "[Staff #6] called and said						
	there was an incide	ent. He (client A) got busted up						
	on his chin". Sta	ff #1 was asked how client A						
	was injured. Staff	#1 stated, "Like I said, I was not						
	there. I don't know	what happened".						
		PM, the Quality Assurance						
		vas asked about the clock in						
		affs #1, #6 and #10 on 2/27/22.						
		'[Staff #6] clocked in at 7:18						
		cked out at 7:19 PM and then						
		I. [Staff #10] clocked out at 7:21						
		dicated staff #6 was alone with 2 and had to call staff #1 for						
	for medical treatm	ient A's injuries were identified						
	for medical treatm	CIII.						
	On 8/31/22 at 5:32	PM, the Assistant Executive						
		as interviewed. The AED was						

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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	ETED
		15G723	B. W	ING		09/01/	2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			HORIZON DR		
RES CAR	RE COMMUNITY A	LTERNATIVES SE IN			HIS, IN 47143		
	(L GOIMMONTT 7)			IVILIVII	110, 114 47 140		ı
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		s working alone on 2/27/22 at					
		's injuries. The AED stated,					
		other staff (former staff #11)					
	-	hat was in February. Now we					
		". The AED indicated staff #1					
		group home to assist both					
	client A and staff #	6 with medical treatment.					
	On 8/31/22 at 5:47	PM. the undated					
		idelines for the 24 hour					
		Needs Residences were					
	* *	rd indicated, "Individuals					
		under this category must be					
	-	nes and the staffing pattern at					
	_	be a minimum of: three (3)					
		ft; three (3) staff on the					
		wo (2) staff on the night shift".					
	This federal tag rela	ates to complaint #IN00378468.					
	9-3-3(a)						
W 0252	483.440(e)(1)						
	PROGRAM DOCI	UMENTATION					
Bldg. 00	Data relative to ac	ccomplishment of the					
	criteria specified i	n client individual program					
	plan objectives mi	ust be documented in					
	measurable terms	S.					
	Based on record rev	view and interview for 1 of 2	W ()252	To correct the deficient practic	e all	10/01/2022
	sampled clients (A)	, the facility failed to ensure			site staff have been re-trained	to	
	direct care staff doc	cumented client A's			complete all needed		
	self-injurious behav	vior of picking his nose on			documentation before leaving	their	
	2/27/22.				shift. Additional monitoring wil	be	
					achieved through daily		
	Findings include:				administrative observations ar	ıd	
					documentation review for a pe		
		3 PM, a review of the facility's			of one month. To ensure no o		
	-	mental Disabilities Services			were affected the QIDP will re	view	
		d accompanying investigation			documentation and incident		
	summaries was con	ducted. The review indicated			reports for the past six months	3 .	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/28/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	ING	00	COMPL	ETED
		15G723	B. WING			09/01/	/2022
		_	ST	TREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R	13	3009 H	IORIZON DR		
	RE COMMUNITY A	LTERNATIVES SE IN	М	IEMPH	HIS, IN 47143		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
	the following incid	ent which affected client A:			Ongoing monitoring will be		
	DDDG ' '1 4	. 1 . 12/29/22 : 1: 1 !!!.			achieved by the QIDP/BC		
		port dated 2/28/22 indicated, "It			reviewing documentation at le	ast	
		at A] was in his room when staff to the room. A second staff			monthly.		
		ell and went to the hallway					
		pedroom is located. At that time					
		ent A's] bedroom slamming the					
		out and left. A few minutes later,					
		w [client A] standing in the					
		on his face. The staff did skin					
	1 *	und a 1 inch laceration under					
	the left side of [clie	ent A's] chin, a 1 inch laceration					
	under his bottom li	p, two 3/8 inch lacerations on					
	the inside of his lip	, and an 8 inch scratch on his					
	left collarbone. Sta	ff contacted nurse and [client					
	A] was transported	to the ER (emergency room)					
	for evaluation. [Cli	ent A] was evaluated and					
		under his chin and 3 stitches					
		p. [Client A] received					
		docaine Gel (topical local					
	· · · · · · · · · · · · · · · · · · ·	le of lip before eating. [Client					
		ncin (prevent skin infection) for					
		stitches should be removed in 7					
	days".						
	Investigation dated	2/28/22 through 5/4/22					
	_	ction: An investigation was					
	· ·	ent A] reported that staff [staff					
	_	him to the floor, and put his					
	hands on [client A's	_					
		-1 -					
	Scope of Investigat	tion: Determine if staff [staff					
	#10] physically abu	-					
	Investigative Proce	edure: Behavior Tracking for					
	February 2022	-					

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Summary of interviews:

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G723	B. W	ING		09/01/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			HS, IN 47143		
	1		_		,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		2/27/22 he arrived to work at					
	1 **	PM and [staff #1] and [staff					
		client A] was in his bedroom					
	_	er behaviors [Staff #6] stated					
		A] had a nosebleed because					
	nosebleeds often	nose frequently and has					
	nosebleeds often						
	[Staff#1] Lworked	l on 2/27/22 and [client A] had					
		and picked his nose causing it					
	1	times. [Client A] was also					
		oping. [Staff #8] and [staff #1]					
		go to his room to calm down.					
	[Client A] sat down	on the floor and continued to					
	yell. [Staff #1] assis	sted [client A] from the floor					
	and [client A] went	to his bedroom. [Staff #6] had					
	arrived at that time	and was in the office. [Staff #1]					
	informed [staff #6]	that [client A] had been having					
	behaviors prior to le	eaving for the day. [Staff #6]					
	called [staff #1] late	er and reported to him that					
	[client A] had a bad	I nosebleed and may need to					
	go to ER (emergeno	ey room)					
	1	on 2/27/22 and stated [staff #6]					
	_	preparing snacks and [staff					
	_	on [client A] as he was in his					
	1	o earlier behaviors. [Client A]					
		cliner picking his nose and					
	1 -	*10] went into his bedroom.					
		elient A] to stop picking his					
		said okay. [Client A's] nose that time. [Staff #10] stated					
	_	et out of his recliner while					
		ne bedroom. [Staff #10]					
		client A's] bedroom less than					
)] left the bedroom and told					
	l -	[client A] because his nose					
		rom picking it. [Staff #10]					
		s not injured when he left the					
	bedroom						
	l		1				

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G723	B. W	ING		09/01/	/2022
en en r			•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF			13009 F	HORIZON DR		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		MEMPH	HIS, IN 47143		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY		DATE
		stantiated [staff #10]					
	physically abused [client AJ.					
	_	on Peer Review: Inservice					
	staff on completing	documentation".					
		PM, a focused review of client					
		ducted. The record indicated					
	the following:						
		Plan (BSP) dated 4/20/22					
		Behaviors: Self-Injurious					
		deation (SIB): any occurrence g self, banging his own head,					
	_	ing body parts in the door, and					
	_	entionally done to harm/hurt					
		om negative self-talk if the					
		his negative self-talk. It is					
		ent all observed SIB and					
	report to the nurse.	Goal: [Client A] will have 0					
		injurious behavior per month					
	for three consecutiv	ve months by 4/20/2023".					
		PM, the Quality Assurance					
		as interviewed. The QAM was					
		behavior tracking for					
		for picking his nose on 2/27/22					
	_	For review. The QAM reviewed					
	_	e and stated, "It was not in the have been in the factual					
		estigation)". The QAM					
		llow up was needed into client					
	A's behavior tracking						
		AM, the QAM indicated					
	_	t A did not have any					
	1	vior documented during the					
	-	2022 and his self-injurious					
	behavior described	by staff interviews for the day					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G723		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 09/01/2022		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN				13009 H	ADDRESS, CITY, STATE, ZIP COD HORIZON DR		
RES CARE COMMUNITY ALTERNATIVES SE IN			MEMPHIS, IN 47143				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
	On 8/31/22 at 5:32 Director (AED) wa asked about the em- which indicated sta A's self-injurious be described through t AED indicated clien not documented on provided for review	PM, the Assistant Executive is interviewed. The AED was all received by the QAM iff had not documented client chavior of picking his nose their interview statements. The int A's behavior tracking was 2/27/22 and could not be in the AED stated, "Right".					

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