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

FORM APPROVED
OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G194 | A. BUILDING 00<br>B. WING | 05/31/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| RES CARE COMMUNITY ALTERNATIVES SE IN | 115 STONEGATE<br>BEDFORD, IN 47421 |

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| W 0000<br><br>Bldg. 00 | This visit was for a pre-determined full recertification and state licensure survey.<br><br>Dates of Survey: May 28, 29, 30 and 31, 2024<br><br>Facility Number: 000724<br>Provider Number: 15G194<br>AIMS Number: 100243320<br><br>These deficiencies also reflect state findings in accordance with 460 IAC 9.<br>Quality Review of this report completed by #15068 on 6/11/24. | W 0000 | | |
| W 0104<br><br>Bldg. 00 | 483.410(a)(1)<br>GOVERNING BODY<br>The governing body must exercise general policy, budget, and operating direction over the facility.<br>Based on record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the facility's governing body failed to exercise operating direction over the facility by failing to ensure the clients' personal checks were cashed in order for them to have access to money to spend on a regular basis.<br><br>Findings include:<br><br>On 5/28/24 at 12:26 PM, a review of the clients' finances was conducted and indicated clients #1, #2 and #3's cash on hand balance did not change from January 2023 to May 28, 2024.<br><br>-Client #1 had a balance of $6.55 from January 2023 to May 28, 2024. There was no documentation the facility deposited his social | W 0104 | To correct the deficient practice ResCare will ensure clients have access to cash their checks at financial institutions contracted with ResCare. All supervisory staff will be re-trained to ensure the individuals have access to their funds. Ongoing monitoring will be achieved by the AS and QIDP reviewing the client cash ledgers weekly to ensure cash has been deposited and withdrawn appropriately. | 07/01/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Patrick O'Heran | QAM | 06/21/2024 |

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

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security benefits of $52.00 a month into his account during this timeframe.

-Client #2 had a balance of $0.00 from January 2023 to May 28, 2024. There was no documentation the facility deposited his social security benefits of $52.00 a month into his account during this timeframe.

-Client #3 had a balance of $0.00 from January 2023 to May 28, 2024. There was no documentation the facility deposited his social security benefits of $52.00 a month into his account during this timeframe.

On 5/30/24 at 10:07 AM, the facility provided copies of uncashed checks to clients #1, #2 and #3 for January 2024 to May 2024 in the amount of $52.00. Each client had a check in the amount of $104.00 for the months of November and December 2023 combined on one check.

On 5/30/24 at 10:35 AM, the Business Manager (BM) indicated the clients received a monthly check from their social security benefits in the amount of $52.00 a month. The BM indicated she started handling the clients' funds in November 2023. She stated she was told the clients should receive $52.00 per month "so I ensured it happened." She indicated she wrote the checks and gave them to the Program Manager (PM). She indicated she wrote the checks in December for November and December 2023 due to the clients not getting a check in November. The BM stated, "I am supposed to ensure the checks were cashed within 30 days. I was not aware." She indicated the group home staff was supposed to ensure the checks were cashed. She stated, "I thought it was happening." The BM indicated the PM told her the clients previously had bank

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| | accounts but the accounts were closed. The PM indicated she was working on getting the clients new bank accounts so they could cash their checks. The PM indicated the checks should have been cashed and deposited into the clients' Cash on Hand accounts and documented on the ledgers. The BM indicated from March 2023 to November 2023, no checks were issued. The BM indicated the clients should receive the sum of all the checks ($52.00 per month) from March 2023 to May 2024. The BM indicated during the time period, clients #3, #4 and #5 were over-resourced per the Medicaid regulations which require the clients to keep their resources under $2000.00. She indicated client #3 had $2300.00, client #4 had $2370.00 and client #5 had $2006.00. The BM indicated the clients could lose their Medicaid benefits due to being over-resourced. She indicated no one lost the Medicaid benefits.<br><br>On 5/30/24 at 3:23 PM, the Program Manager (PM) indicated around January 2023, she asked what the clients were spending their money on. She indicated she was told the clients did not have bank accounts and could not cash their checks. She indicated she called the bank and was told their accounts were closed due to a lack of activity in the accounts. She indicated she received and did not obtain documentation the clients' accounts were closed. The PM indicated the BM was giving her checks for the clients however she told the BM she was unable to cash the checks. The PM indicated she needed to open bank accounts for the clients in order for the clients to cash their checks. The PM indicated the BM was going to deposit the uncashed checks back into the clients' RFMS accounts. The PM indicated the clients should be accessing their funds weekly or whenever they request money. She indicated she was not aware of any of the | | | |

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| | clients being over-resourced. The PM indicated she was aware the clients did not access their funds in 2023 and 2024.<br><br>On 5/29/24 at 11:25 AM, the Quality Assurance Manager indicated the clients' checks are not being cashed due to the clients not having a bank account. The QAM indicated the clients' November 2023 to May 2024 checks were at the provider's office.<br><br>9-3-1(a) | | | |
| W 0126<br><br>Bldg. 00 | 483.420(a)(4)<br>PROTECTION OF CLIENTS RIGHTS<br>The facility must ensure the rights of all clients. Therefore, the facility must allow individual clients to manage their financial affairs and teach them to do so to the extent of their capabilities.<br>Based on record review and interview for 3 of 3 clients in the sample (#1, #2 and #3), the facility failed to ensure the clients accessed their funds on a regular basis over the past year and a half.<br><br>Findings include:<br><br>On 5/28/24 at 12:26 PM, a review of the clients' finances was conducted and indicated clients #1, #2 and #3's cash on hand balance did not change from January 2023 to May 28, 2024.<br><br>-Client #1 had a balance of $6.55 from January 2023 to May 28, 2024.<br><br>-Client #2 had a balance of $0.00 from January 2023 to May 28, 2024.<br><br>-Client #3 had a balance of $0.00 from January 2023 to May 28, 2024. | W 0126 | To correct the deficient practice ResCare will ensure clients have access to cash their checks at financial institutions contracted with ResCare. All supervisory staff will be re-trained to ensure the individuals have access to their funds. Additional monitoring will be achieved by the BM/QAM reviewing the uncashed checks report monthly, for a period of three months, to ensure clients have cashed their checks. The QIDP will review the client cash ledgers, for a period of three months, to ensure clients are spending their money at least monthly. Ongoing monitoring will be achieved by the AS and QIDP reviewing the client cash ledgers | 07/01/2024 |

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| | On 5/29/24 at 11:25 AM, the Associate Executive Director indicated the clients should access their funds at least monthly.<br><br>On 5/29/24 at 11:25 AM, the Qualified Intellectual Disabilities Professional stated the clients should access their funds "at a minimum once a month."<br><br>On 5/29/24 at 11:25 AM, the Quality Assurance Manager indicated the clients should access their funds at their request or at least monthly.<br><br>On 5/30/24 at 3:23 PM, the Program Manager (PM) indicated the clients should be accessing their funds weekly or whenever they request money.<br><br>9-3-2(a) | | weekly to ensure cash has been deposited and withdrawn appropriately. | |
| W 0259<br><br>Bldg. 00 | 483.440(f)(2)<br>PROGRAM MONITORING & CHANGE<br>At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed.<br>Based on record review and interview for 1 of 3 clients in the sample (#1), the facility failed to review and update client #1's Comprehensive Functional Assessment (CFA) at least annually.<br><br>Findings include:<br><br>On 5/29/24 at 9:04 AM, a review of client #1's record was conducted. Client #1's CFA was dated 5/1/23. There was no documentation in his record the CFA was reviewed and updated since 5/1/23.<br><br>On 5/29/24 at 11:10 AM, the Associate Executive Director indicated client #1's CFA should be reviewed and updated annually. | W 0259 | To correct the deficient practice the CFA has been updated. The QIDP will be re-trained to ensure all CFAs are updated at least annually. To ensure no others were affected the QIDP will review all clients' CFAs to ensure they have been updated at least annually. Ongoing monitoring will be achieved by a quarterly record review completed by the PM. | 07/01/2024 |

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| | On 5/29/24 at 11:10 AM, the Qualified Intellectual Disabilities Professional indicated client #1's CFA should be reviewed and updated annually.<br><br>On 5/29/24 at 11:10 AM, the Quality Assurance Manager indicated client #1's CFA should be reviewed and updated annually.<br><br>9-3-4(a) | | | |
| W 0263<br><br>Bldg. 00 | 483.440(f)(3)(ii)<br>PROGRAM MONITORING & CHANGE<br>The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian.<br>Based on observation, record review and interview for 1 of 3 clients in the sample (#3), the facility failed to obtain written informed consent for client #3's restrictive program plans.<br><br>Findings include:<br><br>On 5/28/24 from 10:43 AM to 2:12 PM and 5/29/24 from 5:50 AM to 7:59 AM, observations were conducted at the group home. During the observations, there were audible alarms on the two bathroom doors and the pantry door. This affected client #3.<br><br>On 5/29/24 at 10:14 AM, a review of client #3's record was conducted and indicated the following:<br><br>-Client #3's 10/29/23 Individualized Support Plan (ISP) indicated client #3 had a guardian. The ISP indicated, "...Kitchen knives will be locked up except when needed for cooking... The use of physical restraint as trained in You're Safe, I'm | W 0263 | To correct the deficient practice the written informed consent has been obtained. The QIDP will be re-trained to ensure all plans have written informed consent prior to implementation. To ensure no others were affected will review all plans to ensure written informed consent has been obtained. Ongoing monitoring will be achieved by a quarterly record review completed by the PM. | 07/01/2024 |

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| | Safe... Staff will monitor [client #3] by a sensory alarm while he is in his bedroom because of restriction on roommate... Freedom from access to bathroom doors without alarms... Sensory Alarms will be placed on the pantry door of the home to alert staff when an individual is entering the pantry...." There was no documentation the facility obtained written informed consent for client #3's restrictive ISP.<br><br>-Client #3's 10/29/23 Behavior Support Plan (BSP) included the use of 4 psychotropic medications for insomnia and Autism Spectrum Disorder. The BSP indicated, "...Kitchen knives will be locked up except when needed for cooking... The use of physical restraint as trained in You're Safe, I'm Safe... Staff will monitor [client #3] by a sensory alarm while he is in his bedroom because of restriction on roommate... Freedom from access to bathroom doors without alarms... Sensory Alarms will be placed on the pantry door of the home to alert staff when an individual is entering the pantry...." There was no documentation the facility obtained written informed consent for client #3's restrictive ISP. There was no documentation the facility obtained written informed consent for client #3's restrictive BSP.<br><br>On 5/30/24 at 1:20 PM, the Quality Assurance Manager indicated the facility should have written informed consent for client #3's restrictive program plans.<br><br>9-3-4(a) | | | |
| W 0312<br><br>Bldg. 00 | 483.450(e)(2)<br>DRUG USAGE<br>be used only as an integral part of the client's individual program plan that is directed specifically towards the reduction of and | | | |

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| | eventual elimination of the behaviors for which the drugs are employed.<br>Based on record review and interview for 1 of 3 clients in the sample (#2), the facility failed to ensure client #2 had a plan to reduce the use of his psychotropic medication.<br><br>Findings include:<br><br>On 5/29/24 at 9:45 AM, a review of client #2's record was conducted and indicated the following:<br><br>-Client #2's 4/7/23 Medical Consult Record indicated Risperidone was added at the appointment. No purpose for the medication was documented.<br><br>-Client #2's 4/7/23 Nurses Observation Record indicated he had a psychiatric consult adding Risperidone at an initial appointment. The purpose of the medication was not indicated.<br><br>-Client #2's May 2024 Medication Administration Record indicated client #2 was prescribed and taking Risperidone.<br><br>-Client #2's 1/6/24 Behavior Support Plan (BSP) did not indicate client #2 was prescribed a psychotropic medication. The section addressing psychotropic medications was blank. Client #2's BSP did not include a plan to reduce the use of the Risperidone.<br><br>On 5/29/24 at 10:09 AM, the Quality Assurance Manager (QAM) indicated client #2 took Risperidone however the medication was not included in his BSP. The QAM indicated client #2 should have a plan to reduce the use of his psychotropic medication. | W 0312 | To correct the deficient practice the medication reduction plan has been updated. The QIDP will be re-trained to ensure each client has a plan to reduce psychotropic medications. To ensure no others were affected the QIDP will review all clients' plans to ensure appropriate medication reduction plans are in place. Additional monitoring will be achieved by ResCare Behavior clinician review all plans prior to HRC submission to ensure medication plans of reduction are in place. Ongoing monitoring will be achieved by a quarterly record review completed by the PM. | 07/01/2024 |

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| | On 5/29/24 at 11:12 AM, the Associate Executive Director indicated client #2 should have a plan to reduce the use of his psychotropic medication.<br><br>On 5/29/24 at 11:12 AM, the Qualified Intellectual Disabilities Professional indicated client #2 should have a plan to reduce the use of his psychotropic medication.<br><br>9-3-5(a) | | | |
| W 9999<br><br>Bldg. 00 | State Findings<br><br>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met.<br><br>460 IAC 9-3-2(c)(3) Resident Protections<br><br>(c) The residential provider shall demonstrate that its employment practices assure that no staff person would be employed where there is: (3) conviction of a crime substantially related to a dependent population or any violent crime. The provider shall obtain, as a minimum, a bureau of motor vehicles record, a criminal history check as authorized in IC 5-2-5-5 [IC 5-2-5 was repealed by P.L.2-2003, Section 102, effective July 1, 2003. See IC 10-13-3-27.], and three (3) references. Mere verification of employment dates by previous employers shall not constitute a reference in compliance with this section.<br><br>This State Rule is not met as evidenced by:<br><br>Based on record review and interview for 1 of 3 | W 9999 | To correctt practice the criminal history and reference checks have been completed. All parties responsible for employee files will be re-trainedn the requirements needed for each employee. . Additional monitoring will be achieved by HR completing the New Hire Compliance checklist. The checklist will be reviewed by the ED for each employee. Ongoing monitoring will be achieved by the HRM completing yearly audits of eachs file. | 07/01/2024 |

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employee files reviewed (#6), the facility failed to obtain three references and a criminal history check prior to staff #6 working in the group home.

Findings include:

On 5/28/24 at 3:36 PM, a review of the facility's employee files was conducted and indicated the following:

-The facility did not obtain reference checks for staff #6. There were zero reference checks completed.

-The facility did not obtain a criminal history check for staff #6. There was no documentation the criminal history check was completed.

On 5/28/24 at 4:06 PM, the Quality Assurance Manager indicated the facility should obtain three references and a criminal history check prior to staff working in the home.

On 5/29/24 at 9:34 AM, the Associate Executive Director indicated the facility should obtain three references and a criminal history check prior to staff working in the home.

9-3-2(c)(3)