STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 05/10/2023			ETED		
	PROVIDER OR SUPPLIER	R LTERNATIVES SOUTH CENTRAL		725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
(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)	TE	(X5) COMPLETION DATE
W 0000							
Bldg. 00	#IN00406967. Complaint #IN0040 related to the allega W104, W122, W14 Survey dates: April and 10, 2023 Facility Number: 00 Provider Number: 100 These deficiencies accordance with 46	15G080 0233870 also reflect state findings in	WO	000			
W 0102 Bldg. 00	The facility must egoverning body are requirements are Based on record reclients (A, C, D, E designated as the refacility failed to me Participation: Gove body failed to ensure exploited by the Ofgoverning body fail oversight of the clie exploitation of their The governing body sufficient checks are	met. view and interview for 5 of 6 and F) the facility was presentative payee, the	W 0	102	W102: The facility failed to exercise general policy, budge and operating direction over the facility to implement its written policies and procedures to ensure the group home was operated clean and sanitary manner. The governing body failed to exercise general policy, budget and operating direction over the factor ensure the facility met the Condition of Participation. The governing body failed to exercise	sure in a ne cise cility	05/27/2023

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

TITLE (X6) DATE

Anna Brison Program Director 05/24/2023

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GOLO11 Facility ID: 000623 If continuation sheet Page 1 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		A. BUILDING <u>00</u> C		COMPI	B) DATE SURVEY COMPLETED 05/10/2023		
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD	_	
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL	-		IN 47031		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG			DATE
	stolen.				general policy, budget and operating direction over the fa	oility	
	Findings include:				to ensure the facility met the	icility	
	i maniga metade.				condition of participation.		
	1) Please refer to V	V104. For 5 of 6 clients (A, C,			oonanion or paraorpanom		
		lity was designated the			Corrective Action:		
	representative paye	e, the governing body failed			· All staff trained on the Al	ouse	
	_	g direction over the facility to			and Neglect Exploitation Police	y.	
		unds were not exploited by the			(Attachment A)		
		The governing body failed to			· All Management staff tra		
	_	versight of the clients' funds			on updated Financial Prevent		
		ion of their funds entrusted to			Measures that were put into p		
		verning body failed to ensure			to prevent further misappropri	ation	
		t checks and balances in place			of client funds and to ensure		
	to prevent the client				financial accuracy to the penr	ıy.	
		olen. The facility's governing unt for the clients' finances to			(Attachment B)	lan	
	the penny.	ant for the chefts finances to			 Area Supervisors trained updated procedures to reques 		
	the penny.				client funds from their RFMS	ot	
	2) Please refer to V	V122. For 5 of 6 clients (A, C,			accounts. (Attachment C)		
		lity was designated as the			Office Coordinator terming	nated	
		e, the governing body failed			from Rescare for the theft of o		
		on of Participation: Client			funds. (Attachment D)		
		overning body failed to ensure			· Rescare Management		
	_	ere not exploited by the Office			created a spreadsheet to trac	k all	1
	_	overning body failed to			client reimbursements to ensu	ıre	
	1 ^	versight of the clients' funds			all client meetings are conduc	ted,	
		ion of their funds entrusted to			reimbursement is received an	d is	
		verning body failed to ensure			deposited into clients RFMS		
		t checks and balances in place			accounts.		
	to prevent the client				Rescare reimbursed clie		
	_	olen. The governing body			for missing money (\$3991.00)).	
		r the clients' finances to the			(Attachment E)	nt C	1
	penny.				Rescare reimbursed clie	III C	
	This federal tag rate	ates to complaint #IN00406967.			for missing money (\$364.00). (Attachment F)		
	This icuciai tag icia	π 100400707.			Rescare reimbursed clie	nt D	
	9-3-1(a)				for missing money (\$156.00).	וווט	1
	, , , , ,				(Attachment G)		
					Rescare reimbursed clie	nt E	

PRINTED: 06/06/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/10/2023
	ROVIDER OR SUPPLIE	R ALTERNATIVES SOUTH CENTR	725 CA	ADDRESS, CITY, STATE, ZIP C ARR ST , IN 47031	OD
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION (X5) HOULD BE COMPLETION PPROPRIATE DATE
				for missing money (\$15) (Attachment H) Rescare reimburs for missing money (\$15) (Attachment I) Financial Audits we conducted by Rescare Management 3 times we no less than 60 days to financials in the facility (Attachment J) Daily calls are conswith Rescare Manager discuss financial procedures, financially suppression (Attack updated to includes clients financials from RFMS and Hand in the facility. (Attack updated in this meeting items as needed, the Angelect Exploitation Poincluded in this meeting included in this meeting inc	sed client F 12.00). vill be veekly for audit all nducted ment to asses and colicies and e policies. Quality weekly de listing each client ell as the hment K) QIDP ummary ancial Cash on tachment ement has o view all nts as ient funds eachment conducts gs to review abuse colicy are

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 3 of 71

PRINTED: 06/06/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMI	e survey Pleted 0/2023
	ROVIDER OR SUPPLIE	ALTERNATIVES SOUTH CENTR	725 CA	ADDRESS, CITY, STATE, ZIP ARR ST I, IN 47031	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ORRECTION I SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
				the finance policy and process. (Attachmen - All client reques completed asking that sent to their funeral transcription of the counts and the chesent certified to ensure supporting document was received. Once client requiporcessed and check an approved signer with bank and deposit the following day an approvial go to the bank and the funds for the client to the office to deposit into the safe until client brought to the office to sign out their funds the requested. The Program Manager will rotate with and sign the safe led acknowledging the arraccurate.	at N) Its that are at funds be rust, ARC or vill be aeir RFMS ecks will be re we have cation that it uests are as are printed, vill go to the checks. The roved signer ad withdraw ants and return it the funds ents are to pick up and anager, d Business veekly and will e safe weekly ger	
				Monitoring of Correct Action: Area Supervisor weekly check that ince balance of the in hour to the Program Mana	r submits cludes the se finances	

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 4 of 71

PRINTED: 06/06/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 15G080	A. BUILDING B. WING	00	COMPLETED 05/10/2023
	RE COMMUNITY A	LTERNATIVES SOUTH CENTRA	725 C	ADDRESS, CITY, STATE, ZIP COD ARR ST I, IN 47031	
(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
				and to ensure completion. Daily calls are conducted during the condition period wire Rescare Management. Observation forms are so to the Program Manager for monitoring, follow up and to ensure completion. Financial Audit will be completed 3 times weekly by Rescare Management and se the Program Manager and Program Director for review a ensure completion. All financial requests for spending will be approved by Executive Director, amounts the exceed \$499 will require Region Director approval for processionally summary and send to IDT team. The monthly summincludes RFMS balances as we as cash balances for each clief in the facility. Completion Date: 5/27/23	th ent nt to nd to the hat onal ng. o the ary
W 0104 Bldg. 00	policy, budget, an	DY dy must exercise general d operating direction over			
	clients (A, C, D, E a designated the repre governing body fail	riew and interview for 5 of 6 and F) the facility was esentative payee, the ed to exercise operating acility to ensure the clients'	W 0104	W104: The governing body m exercise general policy, budge and operating direction over the facility.	et

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 5 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPL A. BUILDING B. WING	E CONSTRUCTION G 00	(X3) DATE SURVEY COMPLETED 05/10/2023	
NAME OF PROVIDE		LTERNATIVES SOUTH CENTRAL	725	EET ADDRESS, CITY, STATE, ZIP COD CARR ST AN, IN 47031	
RES CARE COL (X4) ID PREFIX TAG funds Coord provide to pree the fa there to pree mism body the pe Findin 1) Pl D, E a repres body the pe 2) Pl D, E a repres body proce client	SUMMARY EACH DEFICIENT EQUILATORY OF Were not expl dinator. The go de sufficient of event exploitate cility. The go were sufficient anaged and ste failed to accord enny. The go were sufficient anaged and ste failed to accord enny. The go were sufficient anaged and ste failed to accord enny. The go were sufficient anaged and ste failed to accord enny. The go were sufficient anaged and ste failed to accord enny. The faci is sentative paye failed to accord enny. The faci is sentative paye neglected to in dures to prevent selected to generate the sentative failed to accord enny.		725	CARR ST AN, IN 47031 PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIOE DEFICIENCY) All staff trained on the A and Neglect Exploitation Police (Attachment A) All Management staff to on updated Financial Prevent Measures that were put into to prevent further misappropriof client funds and to ensure financial accuracy to the per (Attachment B) Area Supervisors trained updated procedures to requicient funds from their RFMS accounts. (Attachment C) Office Coordinator term from Rescare for the theft of funds. (Attachment D) Rescare Management created a spreadsheet to tractient reimbursements to ensull client meetings are conducted into clients RFMS accounts. Rescare reimbursed clifor missing money (\$3991.0 (Attachment E) Rescare reimbursed clifor missing money (\$364.00 (Attachment F) Rescare reimbursed clifor missing money (\$156.00	Abuse licy. Abuse licy. rained natative place priation enny. ed on est Soninated ciclent lock all sure lucted, and is lient A (0). sient C ().
				(Attachment G) Rescare reimbursed clifor missing money (\$156.00 (Attachment H) Rescare reimbursed clifor missing money (\$112.00 (Attachment I) Financial Audits will be). ient F).

PRINTED: 06/06/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	(X2) MULTIPLE (A. BUILDING B. WING	00	(X3) DATE COMP! 05/10	
	ROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRA	725 C	r address, city, state, zip co ARR ST N, IN 47031	OD	
(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 CORE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AI DEFICIENCY)	RECTION OULD BE PPROPRIATE	(X5) COMPLETION DATE
				conducted by Rescare Management 3 times we no less than 60 days to financials in the facility. (Attachment J) Daily calls are con- with Rescare Management discuss financial procest procedures, financial procest procedures, financial procest procedures, financial procest procedures, financial procest and are tracked by the Assurance Manager. Area Supervisor of the description of the amount of money endered to include the amount of money endered as in the facility as we RFMS balance. (Attact Area Supervisor/Of completes a monthly subtact includes clients finated totals from RFMS and Off Hand in the facility. (Attact L) Rescare Manage been granted access to clients RFMS statement needed to ensure all clients are accounted for. (Attact M) Area Supervisor of monthly house meeting items as needed, the A Neglect Exploitation Polincluded in this meeting the finance policy and process. (Attachment Notes) All client requests completed asking that for sent to their funeral trust Able trust accounts will	nducted nent to sses and olicies and e policies. Quality weekly de listing ach client ell as the nment K) QIDP ummary ancial Cash on achment ment has o view all outs as itent funds achment conducts go to review abuse and olicy is go as well as procedure that are funds be est, ARC or	

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 7 of 71

PRINTED: 06/06/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 15G080	A. BUILDING B. WING	00	COMPLETED 05/10/2023
	RE COMMUNITY A	LTERNATIVES SOUTH CENTRA	725 CA	ADDRESS, CITY, STATE, ZIP COD ARR ST , IN 47031	
(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
				processed through their RFM accounts and the checks will sent certified to ensure we ha supporting documentation that was received. Once client requests are processed and checks are prian approved signer will go to bank and deposit the checks. following day an approved sig will go to the bank and withdrathe funds for the clients and reto the office to deposit the fundinto the safe until clients are brought to the office to pick upsign out their funds they had requested. The Program Manager, Program Director and Busines Manager will rotate weekly an audit any funds in the safe we and sign the safe ledger acknowledging the amounts a accurate. Monitoring of Corrective Action: Area Supervisor submits weekly check that includes the balance of the in house finance to the Program Manager for respective Program Program Manager for respective Program Pro	Sobe be ve t it nted, the The ner aw eturn ds and ss d will bekly are
				and to ensure completion. Daily calls are conducted during the condition period wire Rescare Management. Observation forms are so to the Program Manager for monitoring, follow up and to ensure completion.	th

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

Event ID:

GOLO11

Facility ID: 000623

If continuation sheet

Page 8 of 71

PRINTED: 06/06/2023 FORM APPROVED OMB NO. 0938-039

	of correction (X1) PROVIDER/SUPPLIER/CLIA (IDENTIFICATION NUMBER (15G080)	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/10/2023
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SOUTH CENTRAL	725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031	
(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
			Financial Audit will be completed 3 times weekly by Rescare Management and set the Program Manager and Program Director for review at ensure completion. All financial requests for spending will be approved by Executive Director, amounts the exceed \$499 will require Region Director approval for processing QIDP will complete a monthly summary and send to IDT team. The monthly summary includes RFMS balances as we as cash balances for each clies in the facility. Completion Date: 5/27/23	the hat conal hig. the ary
W 0122 Bldg. 00	483.420(a) CLIENT PROTECTIONS The facility must ensure the rights of all clients. Therefore the facility must Based on record review and interview for 5 of 6 clients (A, C, D, E and F) the facility was designated as the representative payee, the facility failed to meet the Condition of	W 0122	W122: The facility must ensure that specific client protections met.	
	Participation: Client Protections. The facility failed to ensure the clients' funds were not exploited by the Office Coordinator. The facility failed to provide sufficient oversight of the clients' funds to prevent exploitation of their funds entrusted to the facility. The facility failed to ensure there were sufficient checks and balances in place to prevent the clients' funds from being		Corrective Action: All staff trained on the Aband Neglect Exploitation Police (Attachment A) All Management staff traion updated Financial Preventa Measures that were put into p	y. ined ative

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 9 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE C A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/10/2023	
	PROVIDER OR SUPPLIE	R LTERNATIVES SOUTH CENTRA	725 C	ADDRESS, CITY, STATE, ZIP COD ARR ST I, IN 47031	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROV DEFICIENCY)	BE COMPLETION
TAG	mismanaged and st	r LSC IDENTIFYING INFORMATION colen. The facility failed to ents' finances to the penny.	TAG	to prevent further misappro of client funds and to ensur	·
	Findings include:			financial accuracy to the pe (Attachment B) Area Supervisors train	
	D, E and F) the fac	W140. For 5 of 6 clients (A, C, ility was designated as the		updated procedures to require client funds from their RFM	uest
	for the clients' fina	ee, the facility failed to account nees to the penny.		accounts. (Attachment C) Office Coordinator tent from Rescare for the theft of	
2) Please refer to W149. For 5 of 6 clients (A, C, D, E and F) the facility was designated as the			funds. (Attachment D) Rescare Management	t	
	representative payee, the facility neglected to implement its policies and procedures to prevent financial exploitation of the clients and to conduct			created a spreadsheet to tr client reimbursements to er all client meetings are cond	nsure
	a thorough investig	gation including the names of and the amount of money		reimbursement is received deposited into clients RFMS	and is
	stolen from each cl 3) Please refer to V	ient. W154. For 5 of 6 clients (A, C,		accounts. Rescare reimbursed of for missing money (\$3991.0)	
	D, E and F) the fac representative paye	ility was designated as the ee, the facility failed to conduct		(Attachment E) Rescare reimbursed c	lient C
		gation including the names of and the amount of money		for missing money (\$364.00 (Attachment F) Rescare reimbursed of	
		ates to complaint #IN00406967.		for missing money (\$156.00 (Attachment G)	
	9-3-2(a)			Rescare reimbursed of for missing money (\$156.00 (Attachment H)	
				Rescare reimbursed of for missing money (\$112.00	
				(Attachment I) · Financial Audits will be conducted by Rescare	e
				Management 3 times week no less than 60 days to auc	•
				financials in the facility. (Attachment J) Daily calls are conductive.	tod

PRINTED: 06/06/2023 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	COM	e survey pleted 0/2023
	ROVIDER OR SUPPLIE	R ALTERNATIVES SOUTH CENTRA	725 CA	ADDRESS, CITY, STATE, ZIP C ARR ST , IN 47031	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE
				with Rescare Manager discuss financial procedures, financial procedures and are tracked by the Assurance Manager. Area Supervisor check updated to include amount of money of has in the facility as were RFMS balance. (Attactive Area Supervisor (completes a monthly state includes clients financial from RFMS and Hand in the facility. (Attactive Attactive Area Supervisor of clients RFMS statement accounted for. (Attactive Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed, the Area Supervisor of monthly house meeting items as needed to ensure accounts and the checker of the Area Supervisor of monthly house meeting items as needed to ensure accounts and the checker of the Area Supervisor of the Are	esses and policies and policies and policies and policies. A Quality weekly ade listing each client ell as the ell as th	

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 11 of 71

PRINTED: 06/06/2023 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G080	B. WI	NG		05/10/	/2023
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF I	PROVIDER OR SUPPLIE	R		725 CA	RR ST		
RES CAI	RE COMMUNITY A	ALTERNATIVES SOUTH CENTRAL	_	MILAN,	, IN 47031		
(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 APPROPR		TE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					processed and checks are prin		
					an approved signer will go to t		
					bank and deposit the checks. following day an approved sig		
					will go to the bank and withdra		
					the funds for the clients and re		
					to the office to deposit the fund		
					into the safe until clients are		
					brought to the office to pick up	and	
					sign out their funds they had		
					requested.		
					· The Program Manager,		
					Program Director and Busines		
					Manager will rotate weekly an		
					audit any funds in the safe we	ekly	
					and sign the safe ledger		
					acknowledging the amounts a accurate.	re	
					accurate.		
					Monitoring of Corrective		
					Action:		
					· Area Supervisor submits		
					weekly check that includes the)	
					balance of the in house finance		
					to the Program Manager for re	eview	
					and to ensure completion.		
					Daily calls are conducted		
					during the condition period wit	n	
					Rescare Management. Observation forms are se	nt	
					to the Program Manager for	511L	
					monitoring, follow up and to		
					ensure completion.		
					· Financial Audit will be		
					completed 3 times weekly by		
					Rescare Management and se	nt to	
					the Program Manager and		

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 12 of 71

PRINTED: 06/06/2023 FORM APPROVED

ENTERS FOI	R MEDICARE & MEDIC	AID SERVICES			OM	B NO. 0938-039	
	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction ((X3) DATE SURVEY COMPLETED 05/10/2023		-
	PROVIDER OR SUPPLIEF	LTERNATIVES SOUTH CENTRA	725 CA	ADDRESS, CITY, STATE, ZIP COD ARR ST , IN 47031			
(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 APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE	
				Program Director for review an ensure completion. All financial requests for spending will be approved by the Executive Director, amounts the exceed \$499 will require Region Director approval for processin. QIDP will complete a monthly summary and send to IDT team. The monthly summar includes RFMS balances as we as cash balances for each clier in the facility. Completion Date: 5/27/23	he aat onal eg. the ary		
W 0140 Bldg. 00	system that assur accounting of client entrusted to the fat Based on record revelents (A, C, D, E and designated as the restable facility failed to account the penny. Findings include: On 4/25/23 at 4:06 incident reports was following:	establish and maintain a es a full and complete nts' personal funds ncility on behalf of clients. View and interview for 5 of 6 and F) the facility was presentative payee, the count for the clients' finances to PM, a review of the facility's a conducted and indicated the	W 0140	W140: The facility must establish and maintain a system that assures a full and complete accounting of client's personal funds and entrusted to the facilion behalf of the clients. Corrective Action: All staff trained on the Abit and Neglect Exploitation Policy (Attachment A) All Management staff trained on updated Financial Preventar	lity use /.	05/27/2023	

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A 4/20/23 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "There

has been an allegation of misappropriation of

Event ID:

GOLO11

Facility ID: 000623

If continuation sheet

Measures that were put into place

to prevent further misappropriation

Page 13 of 71

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15G080	B. WI	NG		05/10/	2023
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	2		l			
DEC CAE		I TERMATIVES SOUTH CENTRAL		725 CA			
KES CAR	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL	•	WILAN,	IN 47031		
(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 DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	funds. A full audit	of the account is being			of client funds and to ensure		
	completed and amo	unt of funds is undetermined			financial accuracy to the penn	у.	
at this time. Staff alleged to be responsible for				(Attachment B)	•		
	misappropriation of	f funds has been suspended			 Area Supervisors trained 	on	
	pending investigation	on. In addition, the police have			updated procedures to reques		
	been notified and th	ne initial case number is [case			client funds from their RFMS		
	number]. Any fund	ls proven to be missing will be			accounts. (Attachment C)		
	reimbursed by ResO	Care"			Office Coordinator termin	nated	
					from Rescare for the theft of c	lient	
	On 4/25/23 at 3:17	PM, a review of the clients'			funds. (Attachment D)		
	Resident Fund Man	agement Service (RFMS)			· Rescare Management		
	accounts indicated t	the clients had the following			created a spreadsheet to track	c all	
		ulent" from their accounts:			client reimbursements to ensu		
					all client meetings are conduc	ted.	
	1) Client A: \$3991	.00			reimbursement is received an		
	2) Client C: \$364.0	00			deposited into clients RFMS		
	3) Client D: \$156.0	00			accounts.		
	4) Client E: \$156.0	00			· Rescare reimbursed clie	nt A	
	5) Client F: \$112.0	0			for missing money (\$3991.00)		
	Total: \$4779.00				(Attachment E)		
					Rescare reimbursed cliei	nt C	
	The facility's 4/26/2	23 Investigative Summary			for missing money (\$364.00).		
	indicated in the Cor	nclusion, "It is substantiated			(Attachment F)		
	[Office Coordinator	r/OC] embezzled client and			Rescare reimbursed cliei	nt D	
	ResCare funds from	n [name of bank] 'pass through'			for missing money (\$156.00).		
	account. It is substa	antiated [OC] exploited clients			(Attachment G)		
	through theft of clie	ent funds." The investigation's			Rescare reimbursed cliei	nt E	
	statement from the	Business Office Manager			for missing money (\$156.00).		
	(BOM) indicated, "	[BOM] was asked what			(Attachment H)		
	issue(s) he noticed	with the pass-through			Rescare reimbursed cliei	nt F	
	expenditures accoun	nt and if he had spoken with			for missing money (\$112.00).		
	any other business	office staff about the issue.			(Attachment I)		
	He replied with the	following email: 'When			· Financial Audits will be		
	_	through" account statements			conducted by Rescare		
	on 4/11/2023, I noti	iced previous ending balances			Management 3 times weekly f	or	
		ount of funds ResCare funded			no less than 60 days to audit a		
	the account with. I	knew there had to be an issue			financials in the facility.		
	because the initial b	palance on the account should			(Attachment J)		
	remain the same, gi	ven no bank fees occurred, as			Daily calls are conducted	l	
		and withdrawn in the same			with Rescare Management to		
	1		1				i e

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED		
		15G080	B. WI	NG		05/10/	/2023
	ROVIDER OR SUPPLIER	L LTERNATIVES SOUTH CENTRAL		725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031	•	
(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	amount. As I was r	eviewing the statements and			discuss financial processes ar	nd	
	photocopies of the	deposits and withdrawals, I			procedures, financial policies	and	
	was briefly talking	to [OC]. I made comments			implementation of those polici	es.	
	along the line of, "s	omething is off with the			and are tracked by the Quality	1	
	account." I was sitt	ing at her desk as I was			Assurance Manager.		
	reviewing. [OC] wa	as occupied, signing client			· Area Supervisor weekly		
	funds out to staff. I	Her direct involvement in the			check updated to include listin	ıg	
	conversation at that	time was minimal. I did not			the amount of money each clie	ent	
	have Mar-2023 (Ma	arch 2023) statement, so I			has in the facility as well as the	е	
	stopped reviewing a	and went to the bank to get a			RFMS balance. (Attachment	K)	
	copy. After I got th	e statement, I noticed the			· Area Supervisor/QIDP	•	
	balance was at \$210	0.86. After getting the most			completes a monthly summary	٧	
	recent statement, I v	went back to the office and had			that includes clients financial	•	
	a conversation with	[Quality Assurance			totals from RFMS and Cash o	n	
		asked [QAM] if she had time			Hand in the facility.(Attachme	nt	
		rofessional opinion and brief			L)		
		ns I had. She did have time			· Rescare Management h	as	
	and we spoke in pri				been granted access to view a		
		ined to her what the "pass			clients RFMS statements as		
	_	as and how we utilized it. In			needed to ensure all client fun	nds	
		her the discrepancies we were			are accounted for. (Attachme		
	experiencing.	1			M)		
	1 8				· Area Supervisor conduct	s	
	After the conversati	ion, I explained I was not sure			monthly house meetings to re-		
		were going to be and had to			items as needed, the Abuse a		
	•	ate. This concluded our			Neglect Exploitation Policy is		
	conversation. Short				included in this meeting as we	ell as	
		QAM], I asked [OC] to join me			the finance policy and procedu		
	_	could review it together. As			process.(Attachment N)	-	
	_	table, I pointed out the			· All client requests that ar	e	
		tement. This was the first			completed asking that funds b		
	_	palance dropped below the			sent to their funeral trust, ARC		
		nded it with (\$7000.00). I then			Able trust accounts will be	. - .	
		month showing the influx in			processed through their RFMS	3	
	_	ras about to continue my			accounts and the checks will be		
		at we were looking for, [OC]			sent certified to ensure we have		
	_	d, "I did it. I took the money.			supporting documentation that		
		not say anything right away			was received.	. 11	
	-	She continued to cry and			· Once client requests are		
		te stating she would pay it all			· · · · · · · · · · · · · · · · · · ·		
	previously apologiz	e stanng sne would pay it all	l		processed and checks are pri	niea,	İ

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G080	B. WI	NG		05/10/	2023
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	8		725 CA			
RES CA	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL	_		IN 47031		
	ı		1				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG			DATE
		need to go talk to [Human			an approved signer will go to t		
Resources Manager/HRM]. She explained she wanted to speak with [ED] and she didn't want				bank and deposit the checks.			
	_				following day an approved sign		
	_	ner in the state she was in.			will go to the bank and withdra		
	_	it in [ED's] office. I said that			the funds for the clients and re		
	_	ot to HR, I shut the door and			to the office to deposit the fund	as	
		ig that [OC] and I had just			into the safe until clients are		
		RM]. We then called [ED] and			brought to the office to pick up	and	
		tted to stealing the funds. We next steps would be and went			sign out their funds they had		
		th [ED] on speaker. [OC] and			requested.		
		was apologetic and promised to			The Program Manager,	_	
		k. The conversation ended			Program Director and Busines		
		and me signing her suspension			Managerwill rotate weekly and		
		nt is the best recollection of			audit any funds in the safe we	екіу	
		versation that transpired on			and sign the safe ledger	ro	
	4/11/2023.'	ersation that transpired on			acknowledging the amounts are accurate.		
	4/11/2023.				accurate.		
	During follow-up a	uestioning, [BOM] states that					
		ablished in April 2021 and that					
		with opening the account at					
		states that the initial opening			Monitoring of Corrective		
	_	nd then there was a second			Action:		
		neaning that ResCare funded			· Area Supervisor submits		
		total of \$7000. He states that			weekly check that includes the		
		on the account are himself,			balance of the in house financ		
	_	inager], [former Program			to the Program Manager for re		
		f current Program Director],			and to ensure completion.		
		, [name of former Program			Daily calls are conducted		
	1	ner Office Coordinator for			during the condition period wit		
		that all signers have had			Rescare Management.		
		nt since its opening, however,			Observation forms are se	ent	
		[OC] and he had ever gone to			to the Program Manager for		
		ansactions using the account.			monitoring, follow up and to		
		ecount was used as a			ensure completion.		
	'pass-through' accou				· Financial Audit will be		
		ans for providing clients with			completed 3 times weekly by		
		s in the form of cash. He			Rescare Management and ser	nt to	
	states that anytime	a client needs cash, a check			the Program Manager and		
		Life of Indiana (ResCare). The			Program Director for review ar	nd to	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/10/2023	
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRA	725 C	ADDRESS, CITY, STATE, ZIP COD ARR ST N, IN 47031	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	SIATE COM ELTION
TAG	check can then be d'pass-through' accour amount can be with account should alway (\$7000.00), as fund immediately withdrestates that the accourt the [OC] as deposite. The [BOM] was resulted account by doing resulted the majority of the control of the majority of the control of the account. On a weekly. It was used clients monthly allocash-on-hand month times the account were for special requests. [BOM] describes the pass-through account. Receive request for necessary). 2. Complete check accident name, RFMS wendor (Normal Lift 3. Send spreadsheet team-they queue chest. Office Coordinated 5. Check request spenyelopes (per clier of money enclosed 6. Ledgers are created 7. Deposit and with 8. Drive to bank. 9. Provided deposit sprovided to bank tellor break teller b	ant and the exact deposited drawn. The balance of the ays remain the same is deposited are then awn (in the same amount). He ant was monitored daily by an and withdrawals were made. Sponsible for overseeing the conciliations. He states that elients for whom ResCare have had funds pass through erage, the account is used in regularly for group home owances and waiver client and allowances. Any other was used it would have been where cash is necessary. The process of the limit as follows: For funds for client (if the request spreadsheet (including ID, amount, description, and the of Indiana). To RFMS processing eck. For [OC] prints check. For an are the propriate amount in each. For general propriate amount in each.	TAG	ensure completion. All financial requests fo spending will be approved by Executive Director, amounts exceed \$499 will require Req Director approval for process. QIDP will complete a monthly summary and send IDT team. The monthly summincludes RFMS balances as as cash balances for each clin the facility. Completion Date: 5/27/23	y the that gional sing. to the mary well

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	(X2) MULT A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE COMPI 05/10	LETED
	PROVIDER OR SUPPLIEF	LTERNATIVES SOUTH CENTRA	7	25 CAF	DDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PR	D EFIX AG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(X5) COMPLETION DATE
	returns to office wir per client showing into the office safe. 13. Staff are then not be picked up. 14. Staff come to provide to the ledger. 15. Funds are then a ledger in the home [BOM] states he car procedures for man been provided to his conversations regar account. He states copy of any policies the pass-through account monthly discrepancies in ear admits he had not be account monthly. At to [Program Director private, noting his conversations regar admits he had not be account monthly. At the pass-through account monthly is seemingly not balant to keep the convers [OC] know that he her assistance with this point, he was we remaining statement complete a thorough mentioned to [ED] up' and that he wou had completed his reasonable to [QAM], [OC], [HR] had verified discreptive the octors of the octo	ator or Business Manager th cash. Ledgers are completed funds have been deposited orified that funds are ready to the ck up funds and sign them out either spent or signed into a for tracking cash-on-hand. Innot recall if any policies or aging the new account had mover the phone in ding the establishing of the the does not have a physical sor procedures for managing count. He states [Treasurer crives for the account to be the states he noticed dly January 2023, however, the fully reconciling the further his discovery, he spoke for and [Program Manager] in concern for the account the ing correctly. He asked them that or the concept of the states that at the tracking on getting the the states that at the tracking on getting the that he thought 'something was and follow-up with her once he that he thought 'something was and follow-up with her once he the states he informed M], and [ED] on 4/11/23 that he tracking on getting the that he facility's investigation are contacted via phone and					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 18 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	LDING	00	COMPLETED	
		15G080	B. WIN	G		05/10/	2023
		<u></u>	'	STREET A	DDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	8		725 CAF			
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL			IN 47031		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	Pl	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		vere any other accounts					
		dmission to taking money that					
did not belong to her. She stated that it was only							
		ccount. She was asked if any					
		en taken during the process					
		lients received their money					
		cted. An appointment was cerview following collection of					
		initially agreed to meet, but					
		changed her mind and					
	declined."	changed her mind and					
	decimed.						
	The ED's statement	in the facility's investigation					
		uesday approximately 2:31pm, I					
		[BOM] to let me know he					
		im because he has a problem					
		what to do. He called me					
		ith [HRM] on speaker phone					
	and relayed that he	wanted to reconcile the					
	'pass-through' accou	unt at [name of bank] before					
	the new Business M	Sanager starts but noticed a					
	problem. He suspec	cted some fraudulent activity					
	_	OC] for the bank statements.					
		had put him off and then					
		she had taken money. They					
		y office and took the phone in					
	1	ner that she was suspended					
		gizing and said she had a					
		She said she started online					
		one. I asked if there was any					
		ved and she said no, only					
		m the 'pass-through' account at					
	1	ne states, '[OC] was suspended					
	· ·	investigation started.' She					
		y morning on my way into					
		and said, 'It wasn't just the					
		ccount was it? It was client					
	· ·	de checks for cash that was					
		to the ARC (Association of					
	Kemarkabie Citizen	ns) and took them, you took					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 19 of 71

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/10/2023	
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRA	725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION [OC] replied with, 'Yes.' I then	TAG	DEFICIENCY)	DATE
		re we talking about, [OC]? She			
	· ·	t know, maybe \$20,000.' The			
	_	tion consisted of her			
	apologizing and say	ring she would take it all back			
	(if she could)."				
	The PD's statement	in the facility's investigation			
		s asked to describe the			
		en she, [BOM], and [PM]			
		em to speak about a potential			
		l with the balance of the			
		unt. She states, 'I can't recall if ptember (2022) but [BOM] had			
	_	e and said he had a feeling			
		in the cash account at [name			
	-	tated that he was thinking the			
		and if the checks weren't ran			
	_	t could cause the balance to be			
	off. I never heard a	ny more about the			
		ant until 4/11/23 when the			
	current investigation	n was initiated."			
		gs section of the facility's			
		ted, "During the investigative			
	•	FMS statements from 4/1/21			
		th account opening) through			
	_	audited. Suspicious sted and flagged for review			
		cumentation. Documentation			
		ify which of the flagged			
		raudulent or executed correctly			
		ents. A spreadsheet was			
		ll transactions flagged for			
	review and their ver	rification status. Review if (sic)			
		nents confirms checks were			
		ife of Indiana (ResCare) on			
		weekly/monthly spending,			
	ARC, Funeral, and				
	(tax-advantaged sav	vings and investment accounts			

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 20 of 71

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	(X2) MULTIPLE CO A. BUILDING B. WING	nstruction 00	COM	TE SURVEY IPLETED 10/2023
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRAL	725 CA	ADDRESS, CITY, STATE, ZIP RR ST IN 47031	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION disabilities) and other client	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	spending needs. Re statements confirms Life of Indiana (Res Stimulus funds for ymentioned above. Faccount (pass-through issued to Normal Lideposited in the 'pass of the [name of band [OC] was the only puthe account. Review ABLE accounts conto the accounts for the intheir RFMS state. Resource Ledger Streceive all funds iss for weekly/monthly ABLE trust funds, an needs. Client lists/swill be added to the auditing has been conginame of bank] pass. ResCare funds total to open the account should result in a reads of April 2023, the spokes of the state of the stat	onclusion indicated, "It is embezzled client and ResCare ne of bank] 'pass through' entiated [OC] exploited clients				

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 21 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	Ĵ	00	COMPL	
		15G080	B. WING			05/10/	2023
NAME OF P	DROWNER OF GURPLIES		STRE	EET AI	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	C	725	CAR	RR ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL	_ MIL	AN, I	N 47031		
(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
		PM, the PD indicated the total					
	1	tolen from all the clients					
involved was over \$260,000.00.							
	On 5/4/23 at 3:48 PM, the Program Director (PD)						
		a Financial Investigation					
		The Factual Findings section					
		the investigative process, all					
	_	nents from 4/1/21 (date of pass					
		ening) through April of 2023					
		cious transactions were listed					
	and flagged for revi						
		cumentation was obtained to					
	verify which of the	flagged transactions were					
		ted correctly on behalf of the					
	clients. A spreadshe	eet was generated to track all					
	transactions flagged	d for review and their					
	verification status.	Review of client RFMS					
	statements confirms	s checks were issued to Normal					
	Life of Indiana (Res	sCare) on behalf of clients for					
	weekly/monthly spe	ending, ARC, Funeral, and					
	ABLE trust funds, a	and other client spending					
	needs. Review of cl	ient RFMS statements					
	confirms checks we	ere issued to Normal Life of					
	Indiana (ResCare) o	on behalf of clients for Stimulus					
	funds for various no	eeds including those					
		Review of the [name of bank]					
	account (pass throu	gh) confirms client checks					
		ife of Indiana (ResCare) were					
		ss through' account. Review					
	_	k] withdrawal slips confirms					
		person withdrawing funds from					
		v of client Funeral, ARC, and					
		nfirms deposits were not made					
		the designated amounts noted					
		ements. Review of client					
		neets confirms clients did not					
		sued from their RFMS accounts					
		spending, ARC, Funeral, and					
	ABLE trust funds, a	and other client spending					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 22 of 71

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	(X2) MULT: A. BUILD B. WING		NSTRUCTION 00	(X3) DATE COMPI 05/10	LETED
	PROVIDER OR SUPPLIEF	LTERNATIVES SOUTH CENTRA	7:	25 CAF	DDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		D EFIX AG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
	will be added to the auditing has been coof bank] pass through the account and ser result in a remainin April 2023, the bala confirming a deficit was not reconciling thoroughly each mode and client specific of bank] 'pass-through denied taking client Conclusion: It is such client and ResCare 'pass through' account exploited clients that The summary indication final audit the follo from the [name of § [Client F] - \$112.00 [Client E] - \$156.00 [Client A] - \$3991.00 [Client D] - \$156.00 [Cl	0 00 0					
	the investigation wi	ith the following Addendum,					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 23 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/10/2023	
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRAI	725 CA	ADDRESS, CITY, STATE, ZIP COD IRR ST IN 47031	
(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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	"[BOM] and [OC company. Recomm Implement Pass The Retrain all manager Funds Policy, Imple ABLE, ARC, and Fall management star process, and Report to Quality Assurance On 5/5/23 at 9:19 A was going to be term was an issue with the account in February resolve the issue at the OSS a text he (ED irector (ED) on 2/through account ball should have been and did not report his concept to Assurance department issue. The BOM did ED. Neither of the ED indicated to the was not aware of the until April 2023. On 4/27/23 at 9:17 the QAM was conducted 4/26/23 Investigation and the ResCare funds has been recommendations of the employment for [Out to substantiated expression on 5/4/23 at 1:17 Per substantiated expression on 5/4/23 at 1:17 Per substantiated expression on 5/4/23 at 1:17 Per substantiated expression of the complex substantiated expression on 5/4/23 at 1:17 Per substantiated expression of the complex substantiated	are no longer with the mendations Being Implemented: rough Account Procedure, ment staff on Client Trust ement review process for uneral Trust Accounts, Retrain ff on RFMS statement review all discrepancies immediately are Dept for investigation." M, the OSS indicated the BOM minated due to knowing there are ResCare pass through are 2023 but not taking action to the time. The BOM showed BOM) sent to the Executive 1/23 indicating the pass ance was \$93.00 when it round \$6,800.00. The BOM concerns to the Quality ent for them to investigate the direport his concerns to the mit took action at the time. The OSS during her interview she e pass through account issues AM, a review of an email from functed. The email included a sin Peer Review (administrative windicated, "The allegations of the of client funds and theft of			

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 24 of 71

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
		15G080	B. WI	NG		05/10/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	t .		725 CAI			
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL			IN 47031		
(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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		itation and theft of client funds					
	and theft of ResCar						
		has been terminated of her					
		deemed ineligible for rehire					
		exploitation and theft. Her					
		noved from all ResCare					
		ns/accounts. She has been					
	_	sentative on all ARC and ABLE					
		with our clients. All clients					
		arsed by ResCare. ResCare has					
	_	ective measures until corporate					
	associated with clie	icies and/or procedures					
	associated with the	nt imances.					
	On 4/25/23 at 12:43	3 PM, the Program Director (PD)					
		misappropriated by the former					
		The police are involved.					
		estigation. Many thousands					
		en from the RFMS accounts.					
		ere also taken. Discovered on					
	4/11/23." The PD i	ndicated the OC was an					
	employee for 17 year	ars. When the Business					
	Manager asked her	to reconcile the account, she					
	admitted to taking t	he clients' money. The PD					
	indicated approxima	ately 131 clients were affected					
	totaling over \$200,0	000. The PD indicated Rescare					
		len from a pass through					
	account created in A	April 2021. The PD stated the					
		by using "fake requests" of					
		going to ARC, funeral trusts					
		s. The PD indicated the OC					
		gambling problem. The PD					
		ll be reimbursing the clients					
	I -	stantiated exploitation without					
		23 at 2:46 PM, the PD indicated					
		the ED, BOM and her (PD) she					
	1	ne PD indicated the OC started					
	1 - ' '	rs ago when the pass through					
		d. The PD stated the BOM					
	told her and the Pro	gram Manager "something					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 25 of 71

	ENT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	A. B	MULTIPLE CO UILDING VING	nstruction <u>00</u>	(X3) DATE COMPL 05/10/	ETED
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRA			AL.	725 CAI	DDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
(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 APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	like he was reporting wasn't adding up. It money at the time.' aware of the clients purchases due to the clients purchases due to the compact of the clients purchases due to the compact of the clients purchases due to the compact of the compact o	PM, Qualified Intellectual ional (QIDP) #1 stated clients QIDP #1 indicated the clients a negative way and did not					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 26 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULT	TIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI	DING	00	COMPLETED	
		15G080	B. WING	i		05/10/	2023
			S	STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8		725 CAF			
RES CAF	RE COMMUNITY AI	LTERNATIVES SOUTH CENTRAL			IN 47031		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE]	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	Т	ΓAG	DEFICIENCY)		DATE
		PM, Qualified Intellectual					
		ional (QIDP) #2 stated clients					
	-	QIDP #2 indicated the clients					
		a negative way and did not					
	miss out on purchas	sing anything.					
	On 4/25/23 at 1:47	PM, the BOM stated, "My [OC]					
	_	om ResCare and the clients."					
		C was stealing funds through					
		count. He indicated in					
		oticed discrepancies in the pass					
	_	he balance should be close to					
		ney goes into the account and					
		ithdrawn and distributed to the					
		2023, the balance was around					
		dicated at the time he spoke to					
		e stated he "got busy" and did					
		w balance until last week. He					
		speak to the OC and she					
		funds from ResCare. He					
		ot say anything about client					
		touching the clients' funds.					
		e the money with fake check					
	requests and forgery						
		cated the OC took check					
		rust funds or funeral trusts and					
		e out to Normal Life of Indiana					
		. She could take the checks					
		Life to the bank and cash the					
		stated the OC needed to					
		irector approval was obtained					
		100.00. He stated the OC					
	_	rs." He indicated the RFMS					
		the vendor (where the checks					
		indicated she started taking the					
	_	when the pass through					
		. He indicated he started					
		ity in January 2021. He stated					
		ounts." He indicated he asked					
	the OC to get staten	nents for the accounts and she					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 27 of 71

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/10/2023	
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRAL	725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
(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	
	did not get them. So then never provided September 2022, he below \$6,600.00. He do a full reconciliat things and didn't do reconciled the according stated, "I feel some responsibility to reconciled there was September 2022 who issue. He stated, "I and tell her what I for the BOM stated, "I would have never the it. The total funds in \$282,000." He indicated there was from the client funds. The "room for improven reimbursed. There substantiate exploits (ED) indicated there more than \$250,000 were four clients from the ED stated, "De exploitation. She windicated she received 4/11/23 asking her to went to reconcile the "something was off admitted to stealing approximately \$6,60 (OC) admitted it to	the indicated she forgot and them to him. He indicated in noticed the balance dropped He stated, "I told them I would iton. I got caught up in other it until this month when I cants for the new BOM." He responsibility. It was my oncile the account. I failed to s." He stated the OC was be "committed a crime." The BC no investigation conducted in men he first noticed there was an told [ED] I would review it found." She admitted to taking it. I hought she would have taken missing is approximately cated he was not sure what an ResCare and what was from the BOM stated there was ment. Clients will be its enough evidence to action of the clients' funds." PM, the Executive Director were 112 clients involved and obstolen. The ED indicated there can the group home affected. Similely going to substantiate will be terminated." The ED ed a text from the BOM on to call him (BOM). He said he e pass through account and "The ED stated the OC				

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 28 of 71

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	JILDING	instruction 00	(X3) DATE COMPL 05/10/	ETED
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL			725 CAI	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
(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
	She said it was just was going to pay it indicated the facility. The ED stated, "she and ResCare's mone was taking money it making the check of cash the check and stated on 4/13/23, the taking the clients' fit \$20,000.00 and proof the ED indicated the discovered missing indicated the RFMS certain ways did not others could not see out to. The ED indicated the record in the ED indicated the RFMS certain ways did not others could not see out to. The ED indicated the RFMS certain ways did not others could not see out to. The ED indicated the RFMS pass through account and their own bank the BOM was support through account modidn't do it for a long he figured out the phe reconciled it." Sthe BOM's job respending had access the issues noted. She in the issue on 4/11/23 [BOM] had access the issue on 4/11/23 [BOM] had access the issue on 4/11/23 and the information where information where information where information where information where of any clients of the the missing for the figure of the	ResCare money. She said she back." On 4/12/23, she y checked the clients' finances. It (OC) was taking the clients' ey." The ED indicated the OC intended for the ARC trust but the total Normal Life so she could keep the money. The ED independence of "admitted she was unds. She said it was around mised to pay the money back." In a amount of money grew from there. The ED is statements when printed it show the vendor therefore is who the checks were made it at the OC worked at the intended to reconcile the pass on the indicated prior to the intended to the indicated the Image. The ED indicated besent to reconcile the pass on the indicated it was not part of it indicated it was not part of it indicated she was first aware of its indicated she was first aware of its indicated it was not part of its indicated she was first aware of its indicated it was not part of its indicated she was first aware of its indicated she was first aware of its indicated it was not part of its indicated she was first aware of its indicated she was not its indicated she was not its who couldn't know all the indicated she was not is who couldn't buy something				

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 29 of 71

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	î í	JILDING	instruction 00	(X3) DATE (COMPL 05/10/	ETED		
	NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL			STREET ADDRESS, CITY, STATE, ZIP COD 725 CARR ST AL MILAN, IN 47031					
(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)	ΓE	(X5) COMPLETION DATE		
IAU	initially opened with CSO indicated the asigners on the account funds going into an amount in the account the CSO indicated should not have been without corporate as happen. The CSO statements however the account a monthly basis. The forgot his password check it. The BOM statements however the BOM. The BOI did not follow up to BOM went to the barrian January 2023. When he realized the account several times. The ED indicated she that care of the issue. The busy" and after a feet through the statements with the ResCare's money. It amount between Refunds was \$280,000. The CSO stated the directed to do" regar through account more ED should have foll taking care of the is BOM initially reported it to the Quantum separate in the ported it to the Quantum separate in the p	h \$500.00 and 5 signers. The account should not have had 5 ant. Due to the amount of d out of the account, the total ant was increased to \$7000.00. The amount in the account on increased to \$7000.00 approval, which did not stated the BOM "did not not like he was supposed to" on the CSO indicated the BOM on the account and did not asked the OC to get asked the OC to get asked the got busy and to get the statements until the ank to request statements in the BOM got the statements, and dropped below \$7000.00 approved the BOM was taking the CSO stated the BOM "got we months, started to go nts. While going through the OC, the OC admitted to taking The CSO indicated the total ascCare's money and client		IAU			DATE		

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 30 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	<u>00</u> co		LETED
		15G080	B. WI	NG		05/10/2023	
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRA	L	725 CA	ADDRESS, CITY, STATE, ZIP COD ARR ST , IN 47031		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DECLIPED IN AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY 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 OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
W 0149	9-3-2(a) 483.420(d)(1)	ates to complaint #IN00406967.					
Bldg. 00	The facility must of written policies and mistreatment, need Based on record recilients (A, C, D, E, designated as the refacility neglected to procedures to preved clients and to conditional including the name amount of money s. Findings include: On 4/25/23 at 4:06 incident reports was following: A 4/20/23 Bureau of Services (BDDS) in has been an allegating funds. A full audit completed and amount this time. Staff all	develop and implement and procedures that prohibit glect or abuse of the client. View and interview for 5 of 6 and F) the facility was expresentative payee, the primplement its policies and ent financial exploitation of the fact a thorough investigation as of the clients affected and the tolen from each client. PM, a review of the facility's as conducted and indicated the for Developmental Disabilities ancident report indicated, "There is in of misappropriation of the account is being bunt of funds is undetermined alleged to be responsible for funds has been suspended	WO	149	W149: The facility must develor and implement written policies procedures that prohibit mistreatment, neglect or abust the client. Corrective Action: All staff trained on the All and Neglect Exploitation Polici (Attachment A) All Management staff trained on updated Financial Prevent: Measures that were put into p to prevent further misappropri of client funds and to ensure financial accuracy to the penni (Attachment B) Area Supervisors trained updated procedures to requesicient funds from their RFMS accounts. (Attachment C)	s and be of buse by. ined ative lace ation	05/27/2023
	pending investigation been notified and the number]. Any function reimbursed by Reson On 4/25/23 at 3:17 Resident Fund Mar	on. In addition, the police have ne initial case number is [case ds proven to be missing will be			Office Coordinator termine from Rescare for the theft of confunds. (Attachment D) Rescare Management created a spreadsheet to track client reimbursements to ensuall client meetings are conductive reimbursement is received an	k all ure sted,	

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
		15G080	B. WI	NG		05/10/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	L		725 CA			
RES CAF	RE COMMUNITY AI	LTERNATIVES SOUTH CENTRAL			IN 47031		
							(NE)
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LISC IDENTIFYING INFORMATION ulent" from their accounts:	\vdash	TAG	deposited into clients RFMS		DATE
	Transaction Fraudi	ment from their accounts.			accounts.		
	1) Client A: \$3991.	00			Rescare reimbursed clier	at A	
	2) Client C: \$364.0				for missing money (\$3991.00)		
	3) Client D: \$156.0				(Attachment E)	•	
	4) Client E: \$156.0				Rescare reimbursed clier	nt C	
	5) Client F: \$112.0				for missing money (\$364.00).	0	
	Total: \$4779.00	•			(Attachment F)		
	- σ ψ . / / / / / / / / / / / / / / /				Rescare reimbursed clier	nt D	
	The facility's 4/26/2	23 Investigative Summary			for missing money (\$156.00).	5	
		nclusion, "It is substantiated			(Attachment G)		
		/OC] embezzled client and			Rescare reimbursed clier	nt E	
	-	[name of bank] 'pass through'			for missing money (\$156.00).		
		antiated [OC] exploited clients			(Attachment H)		
		ent funds." The investigation's			· Rescare reimbursed clier	nt F	
	statement from the	Business Office Manager			for missing money (\$112.00).		
	(BOM) indicated, "	[BOM] was asked what			(Attachment I)		
	issue(s) he noticed v	with the pass-through			· Financial Audits will be		
	expenditures accour	nt and if he had spoken with			conducted by Rescare		
	any other business of	office staff about the issue.			Management 3 times weekly f	or	
	He replied with the	following email: 'When			no less than 60 days to audit a	all	
	reviewing the "pass	through" account statements			financials in the facility.		
	on 4/11/2023, I noti	ced previous ending balances			(Attachment J)		
		ount of funds ResCare funded			 Daily calls are conducted 		
		knew there had to be an issue			with Rescare Management to		
		palance on the account should			discuss financial processes ar		
		ven no bank fees occurred, as			procedures, financial policies a		
		and withdrawn in the same			implementation of those polici		
		eviewing the statements and			and are tracked by the Quality		
		deposits and withdrawals, I			Assurance Manager.		
		to [OC]. I made comments			· Area Supervisor weekly		
	-	omething is off with the			check updated to include listin	-	
		ing at her desk as I was			the amount of money each clie		
	~	as occupied, signing client			has in the facility as well as the		
		Her direct involvement in the			RFMS balance. (Attachment	K)	
	conversation at that time was minimal. I did not				· Area Supervisor/QIDP		
	· ·	arch 2023) statement, so I			completes a monthly summary	/	
	stopped reviewing and went to the bank to get a				that includes clients financial		
		e statement, I noticed the			totals from RFMS and Cash or		
	balance was at \$210	0.86. After getting the most	l		Hand in the facility.(Attachme	nt	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLE	ETED
		15G080	B. W	ING		05/10/2	2023
		ı		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	8		725 CA			
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRA	\L		IN 47031		
(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	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	recent statement, I v	went back to the office and had			L)		
	a conversation with	[Quality Assurance			 Rescare Management h 	nas	
	Manager/QAM]. I	asked [QAM] if she had time			been granted access to view	all	
	so I could get her pr	rofessional opinion and brief			clients RFMS statements as		
	her on the suspicior	ns I had. She did have time			needed to ensure all client fur	nds	
	and we spoke in pri	vate in the ResCare			are accounted for. (Attachme	nt	
	lunchroom. I expla	ined to her what the "pass			M)		
	through" account w	as and how we utilized it. In			· Area Supervisor conduc	ts	
	addition, I showed l	her the discrepancies we were			monthly house meetings to re		
	experiencing.				items as needed, the Abuse a		
					Neglect Exploitation Policy is		
	After the conversati	ion, I explained I was not sure			included in this meeting as we	ell as	
	what the next steps	were going to be and had to			the finance policy and proced		
	bring [ED], up to da	ate. This concluded our			process.(Attachment N)		
	conversation. Shor				All client requests that a	re	
		QAM], I asked [OC] to join me			completed asking that funds b		
	_	could review it together. As			sent to their funeral trust, AR0		
	_	table, I pointed out the			Able trust accounts will be		
		tement. This was the first			processed through their RFM	s l	
	-	balance dropped below the			accounts and the checks will		
		nded it with (\$7000.00). I then			sent certified to ensure we ha		
		month showing the influx in			supporting documentation that		
		vas about to continue my			was received.		
		at we were looking for, [OC]			Once client requests are		
	_	d, "I did it. I took the money.			processed and checks are pri		
	* *	not say anything right away			an approved signer will go to		
	-	She continued to cry and			bank and deposit the checks.		
		ze stating she would pay it all			following day an approved sig		
		need to go talk to [Human			will go to the bank and withdra		
		r/HRM]. She explained she			the funds for the clients and re		
	_	th [ED] and she didn't want			to the office to deposit the fun	ds	
	_	ner in the state she was in.			into the safe until clients are		
	1	it in [ED's] office. I said that			brought to the office to pick up	and	
		ot to HR, I shut the door and			sign out their funds they had		
	_	ng that [OC] and I had just			requested.		
		RM]. We then called [ED] and			· The Program Manager,		
	told her [OC] admitted to stealing the funds. We				Program Director and Busines	ss	
	discussed what the next steps would be and went				Manager will rotate weekly ar		
	to [ED's] office, with [ED] on speaker. [OC] and				audit any funds in the safe we		
	to [ED's] office. with	th [ED] on speaker. [OC] and			I audit any junos in the sale we	ekiv	

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/10/2023		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY AI	LTERNATIVES SOUTH CENTRAL	_	725 CAI MILAN,	RR ST IN 47031		
(X4) ID	SUMMARY S	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)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	-	TAG			DATE
		x. The conversation ended and me signing her suspension			acknowledging the amounts a accurate.	ire	
		nt is the best recollection of			accurate.		
		ersation that transpired on					
	4/11/2023.'	•					
		uestioning, [BOM] states that ablished in April 2021 and that			Monitoring of Corrective Action:		
		with opening the account at			Action: Area Supervisor submits		
		states that the initial opening			weekly check that includes th		
		nd then there was a second			balance of the in house finance		
	deposit of \$6500, m	eaning that ResCare funded			to the Program Manager for r		
	the account with a to	otal of \$7000. He states that			and to ensure completion.		
	_	on the account are himself,			 Daily calls are conducted 	b	
		nager], [former Program			during the condition period wi	th	
		current Program Director],			Rescare Management.		
		, [name of former Program			Observation forms are s	ent	
		ner Office Coordinator for			to the Program Manager for		
		that all signers have had			monitoring, follow up and to		
		nt since its opening, however, [OC] and he had ever gone to			ensure completion. Financial Audit will be		
		ansactions using the account.			completed 3 times weekly by		
		ecount was used as a			Rescare Management and se	nt to	
	'pass-through' accou				the Program Manager and	10	
		ans for providing clients with			Program Director for review a	nd to	
		s in the form of cash. He			ensure completion.		
	states that anytime a	a client needs cash, a check			All financial requests for		
		Life of Indiana (ResCare). The			spending will be approved by	the	
	check can then be d	-			Executive Director, amounts t		
		ant and the exact deposited			exceed \$499 will require Reg		
		drawn. The balance of the			Director approval for processi	ng.	
	account should alway (\$7000.00), as funds	-			· QIDP will complete a	a tha	
	* **	s deposited are then awn (in the same amount). He			monthly summary and send to IDT team. The monthly summ		
	-	ant was monitored daily by			includes RFMS balances as v	•	
		s and withdrawals were made.			as cash balances for each cli		
		ponsible for overseeing the			in the facility.	J. 11.	
		conciliations. He states that					
		clients for whom ResCare			Completion Date: 5/27/23		
		have had funds pass through	1				1

	OF CORRECTION	IDENTIFICATION NUMBER 15G080	l í	UILDING	00	COMPL 05/10	ETED
	NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL			725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
(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)	ATE	(X5) COMPLETION DATE
IAU	the account. On aveweekly. It was used clients monthly allo cash-on-hand month times the account w for special requests [BOM] describes th 'pass-through' account. Receive request for necessary). 2. Complete check to client name, RFMS vendor (Normal Lift.) 3. Send spreadsheet team-they queue check request spenyelopes (per client of money enclosed for the following for the following for the following for the following for the office Safe. 13. Staff are then not be picked up. 14. Staff come to pion the ledger. 15. Funds are then of the following for the ledger. 15. Funds are then of the following for the ledger. 15. Funds are then of the following for the ledger. 15. Funds are then of the following for the ledger. 15. Funds are then of the following for the ledger. 15. Funds are then of the following for the ledger. 15. Funds are then of the following for the ledger. 15. Funds are then of the following for the ledger.	erage, the account is used a regularly for group home wances and waiver client ally allowances. Any other as used it would have been where cash is necessary. e process of the ant as follows: For funds for client (if request spreadsheet (including ID, amount, description, and re of Indiana). to RFMS processing eck. for [OC] prints check. freadsheet used to label money at with the appropriate amount in each. ed per client in the batch. drawal slips completed.		IAU			DATE
	[BOM] states he can	nnot recall if any policies or					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 35 of 71

T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/10/2023
ROVIDER OR SUPPLIER	TERNATIVES SOUTH CENTRAL	725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031	
SUMMARY S (EACH DEFICIEN REGULATORY OR procedures for manabeen provided to his conversations regard account. He states I copy of any policies the pass-through acc Director] gave direct reconciled monthly, discrepancies in ear admits he had not be account monthly. At to [Program Director private, noting his esseemingly not balant to keep the conversations of the conversation of the	TERNATIVES SOUTH CENTRAL STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION aging the new account had mover the phone in ding the establishing of the ne does not have a physical sor procedures for managing count. He states [Treasurer tives for the account to be He states he noticed ly January 2023, however, een fully reconciling the offer his discovery, he spoke or and [Program Manager] in concern for the account using correctly. He asked them nation private and to not let was reviewing. [PM] offered reviewing. He states that at orking on getting the ts and check copies in order to on review. He states he hat he thought 'something was d follow-up with her once he eview. He states he informed M], and [ED] on 4/11/23 that he ancies" in the facility's investigation as contacted via phone and were any other accounts mission to taking money that r. She stated that it was only ecount. She was asked if any	725 CA	RR ST	(X5) COMPLETION DATE
and stated that all cl and none were affect made for further intevidence and [OC]	in taken during the process ients received their money sted. An appointment was erview following collection of sinitially agreed to meet, but changed her mind and			

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 36 of 71

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

PRINTED: 06/06/2023 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES N OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	l í	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 05/10/	ETED
	PROVIDER OR SUPPLIEF	LTERNATIVES SOUTH CENTRAL		725 CAI	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
(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
	The ED's statement indicated, "On Tureceived a text from needed me to call hand doesn't know with shortly thereafter with and relayed that he pass-through account the new Business Myroblem. He suspe and said he asked [He told me that she finally relayed that had [OC] go into mithere. I relayed to hand she kept apologing gambling problem. gambling on her phiclient money involved ResCare money from [name of bank]. Shimmediately and an states, 'On Thursday work, I called [OC] 'passthrough (sic) a funds tooyou may (sic) supposed to go Remarkable Citizer spending money? 'asked,'How much a replied with, 'I don' rest of the conversa apologizing and say (if she could)."	in the facility's investigation resday approximately 2:31pm, I in [BOM] to let me know he im because he has a problem that to do. He called me ith [HRM] on speaker phone wanted to reconcile the unt at [name of bank] before fanager starts but noticed a cted some fraudulent activity OC] for the bank statements. had put him off and then she had taken money. They yo office and took the phone in mer that she was suspended gizing and said she had a She said she started online one. I asked if there was any red and she said no, only m the 'pass-through' account at the states, '[OC] was suspended investigation started.' She your morning on my way into and said, 'It wasn't just the eccount was it? It was client de checks for cash that was be to the ARC (Association of as) and took them, you took [OC] replied with, 'Yes.' I then re we talking about, [OC]? She t know, maybe \$20,000.' The tion consisted of her ring she would take it all back in the facility's investigation as asked to describe the en she, [BOM], and [PM] em to speak about a potential d with the balance of the					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 37 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/10/2023	
	PROVIDER OR SUPPLIER		725 CA		•
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRA	L MILAN,	, IN 47031	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE
TAG		unt. She states, 'I can't recall if	TAG		DATE
		ptember (2022) but [BOM] had			
	_	e and said he had a feeling			
	something was 'off'	in the cash account at [name			
	of bank]. [BOM] st	tated that he was thinking the			
	I	and if the checks weren't ran			
	` '	t could cause the balance to be			
	off. I never heard a	-			
		ant until 4/11/23 when the			
	current investigation	n was initiated.			
	The Factual Finding	gs section of the facility's			
		ted, "During the investigative			
	process, all client R	FMS statements from 4/1/21			
	(date of pass throug	th account opening) through			
		audited. Suspicious			
		sted and flagged for review			
		cumentation. Documentation			
		ify which of the flagged			
		raudulent or executed correctly			
		ents. A spreadsheet was			
		Il transactions flagged for rification status. Review if (sic)			
		nents confirms checks were			
		ife of Indiana (ResCare) on			
		weekly/monthly spending,			
	ARC, Funeral, and	ABLE trust funds			
		rings and investment accounts			
		disabilities), and other client			
		eview if (sic) client RFMS			
		s checks were issued to Normal			
	,	sCare) on behalf of clients for			
		various needs including those			
		Review of the [name of bank]			
	-	gh) confirms client checks ife of Indiana (ResCare) were			
		ss through' account. Review			
		k] withdrawal slips confirms			
	_	person withdrawing funds from			
		w of client Funeral, ARC, and			

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 38 of 71

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	A. BU	2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/10/2023	
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRAL		725 CAF	.ddress, city, state, zip cod RR ST IN 47031		
(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)	TE	(X5) COMPLETION DATE
	to the accounts for in their RFMS state Resource Ledger Streceive all funds iss for weekly/monthly ABLE trust funds, a needs. Client lists/will be added to the auditing has been c [name of bank] pas ResCare funds total to open the account should result in a re As of April 2023, the spoke stated he was not reaccount thoroughly she took ResCare finaccount funds and the [name of bank] initially denied taking recanted" The C substantiated [OC] funds from the [name account. It is substantiated for client through theft of client cancel denied the exploitation. Not identifying the each client. Not identifying the was going to be reint cancel and for the client.	e clients involved in the e amount of money stolen from e amount of money each client					
	stated the investiga	tion was "very, very large. g is the ResCare money					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 39 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 05/10/2023			PLETED	
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRA	725 CA	ADDRESS, CITY, STATE, ZIP CO ARR ST , IN 47031	D	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION
TAG	portion and it menti is not the final for e portion is the clients get her (OC) termin investigation." The facility did not in the investigation On 5/4/23 at 12:58 a thorough investigation Support was a small piece at	ons client funds were taken. It very bit of it. The other s' tally. Took a small piece to ated. This is not the final include additional information as of 5/4/23 at 12:13 PM. PM, the PD indicated it was not ation. The PD indicated the Specialist (OSS) told her it and additional information was	TAG	DEFICIENCY		DATE
	The PD indicated no included in the investigation ne number of clients at was stolen from each	d in the final investigation. o additional information was stigation. The PD indicated eded to include the total ffected and how much money the client. The PD indicated the ney stolen from all the clients \$260,000.00.				
	add client informati	M, the OSS stated "we need to on. Need to add an addendum break it out by client. It is not the information."				
	sent an email with a Summary attached. indicated, "During to client RFMS statement through account open were audited. Suspin and flagged for revidocumentation. Documentation of the fraudulent or execuclients. A spreadshed	M, the Program Director (PD) a Financial Investigation The Factual Findings section the investigative process, all tents from 4/1/21 (date of pass tening) through April of 2023 teious transactions were listed the with supporting tumentation was obtained to flagged transactions were ted correctly on behalf of the tet was generated to track all I for review and their				

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

Event ID:

GOLO11 Facility ID: 000623

Page 40 of 71 If continuation sheet

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/10/2023
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRAL	725 CA	ADDRESS, CITY, STATE, ZIP COD ARR ST , IN 47031	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
	verification status. statements confirms Life of Indiana (Re weekly/monthly spaneds. Review of cloor confirms checks we Indiana (ResCare) of funds for various nementioned above. Faccount (pass through issued to Normal Legosited in the 'page of the [name of bane [OC] was the only of the accounts conto the accounts for in their RFMS states. Resource Ledger Streevive all funds issued for weekly/monthly. ABLE trust funds, and send confirming has been confirmed by the account and send the account and	Review of client RFMS is checks were issued to Normal scare) on behalf of clients for ending, ARC, Funeral, and and other client spending lient RFMS statements are issued to Normal Life of on behalf of clients for Stimulus are desired including those deview of the [name of bank] gh) confirms client checks are of Indiana (ResCare) were ass through account. Review k] withdrawal slips confirms person withdrawing funds from a confirms deposits were not made the designated amounts noted are the designated amounts noted are the designated amounts noted and other client spending preadsheets of audit results are investigation file when final completed. Review of the [name gh account confirms ResCare 100.00 were deposited to open vice fees of \$134.63 should ghe balance of \$6,865.37. As of ance of the account is \$95.86 at of \$6,769.51. [BOM] stated he at the 'pass-through' account continus (ARC account conding funds) from the [name gh' account. [OC] initially a funds then recanted. In the lates of the			

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 41 of 71

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 15G080	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	СОМ	e survey pleted 0/2023
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SOUTH CENTRAI	725 CA	ADDRESS, CITY, STATE, ZIP COI IRR ST , IN 47031)	
(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 CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	'pass through' account. It is substantiated [OC] exploited clients through theft of client funds." The summary indicated, "ADDENDUM: Upon final audit the following funds were embezzled from the [name of group home] clients: [Client F] - \$112.00 [Client E] - \$156.00 [Client A] - \$3991.00 [Client C] - \$364.00 [Client D] - \$156.00 Additionally, it was determined that collectively, \$253,305.59 was embezzled from 106 clients. All financial documentation reviewed for this investigation is being released to the [name of city] PD (police department)/Prosecutor, and the Attorney General for prosecution of [OC] for the embezzlement. ResCare will comply with all requests/directives from the above entities as received." On 5/9/23 at 12:08 PM, the OSS emailed a copy of the investigation with the following Addendum, "[BOM] and [OC] are no longer with the company. Recommendations Being Implemented: Implement Pass Through Account Procedure, Retrain all management staff on Client Trust Funds Policy, Implement review process for ABLE, ARC, and Funeral Trust Accounts, Retrain all management staff on RFMS statement review process, and Report all discrepancies immediately to Quality Assurance Dept for investigation." On 5/5/23 at 9:19 AM, the OSS indicated the BOM was going to be terminated due to knowing there was an issue with the ResCare pass through account in February 2023 but not taking action to resolve the issue at the time. The BOM showed the OSS a text he (BOM) sent to the Executive Director (ED) on 2/1/23 indicating the pass				

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 42 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 05/10/2023			ETED	
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRA	725 CA	ADDRESS, CITY, STATE, ZIP COD ARR ST , IN 47031		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	through account bases should have been as did not report his considerable. Assurance departments issue. The BOM did ED. Neither of their ED indicated to the was not aware of the until April 2023. On 4/27/23 at 9:17 the QAM was conducted 4/26/23 Investigation and the ResCare funds has a Recommendations employment for [O to substantiated expression of explosing and theft of ResCare substantiated. [OC] employment and is due to substantiated access has been ren financial application removed as a repression and the fully reimburs added internal protestablishes new pol associated with clies. On 4/25/23 at 12:42 stated "funds were stated"	lance was \$93.00 when it round \$6,800.00. The BOM oncerns to the Quality ent for them to investigate the d report his concerns to the m took action at the time. The OSS during her interview she e pass through account issues AM, a review of an email from ucted. The email included a on Peer Review (administrative w indicated, "The allegations of eff of client funds and theft of been substantiated. include termination of C] and ineligible for rehire due doloitation and theft. Additional will be added upon final audit." M, a review of 5/3/23 eview indicated, "The intation and theft of client funds to funds has been has been terminated of her deemed ineligible for rehire deemed ineligible for rehire deemed ineligible for rehire deemed ineligible for rehire deemed ineligible for ResCare ins/accounts. She has been sentative on all ARC and ABLE with our clients. All clients arsed by ResCare. ResCare has excitive measures until corporate icies and/or procedures				
l		The police are involved.	1	1		

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 43 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/10/2023	
NAME OF PROVIDER OR SUPPLIER	TERNATIVES SOUTH CENTRAL	725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031	•	
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE COMPLETION	
PREFIX TAG REGULATORY OR Working on the inverse of dollars were stole Stimulus checks were 4/11/23." The PD in employee for 17 year Manager asked her to admitted to taking the indicated approximate totaling over \$200,00 funds were also stole account created in A OC took the money the clients' money grown and ABLE accounts indicated she had a grown stated, "ResCare will their money Substantial doubt." On 4/25/2 the OC admitted to took the money. The taking money 2 years account was created told her and the Program wasn't right in Augulike he was reporting wasn't adding up. Homoney at the time." aware of the clients purchases due to the On 4/25/23 at 1:26 F. Specialist (OSS) indiving in the group here.			(EACH CORRECTIVE ACTION SHOULD I	DE COMPLETION	
OSS indicated the si when the facility sta account for the clien the account from the	of \$250,000 to \$300,000. The tuation started in June 2021 rted using a pass through tts' money. Money came to e clients' RFMS accounts. He tat this point." The OSS				

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 44 of 71

f ´		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			
		15G080	B. WING		05/10/2023	
NAME OF B			STREE	T ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	C	725 C	CARR ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL	MILA	N, IN 47031		
(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 APPROPR DEFICIENCY)	IATE CONTINUE	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
		antiated exploitation by [OC]." he was recommending the OC				
		OSS indicated the BOM				
		ation prior to this situation				
		The BOM was conducting an				
	-	overed the issues. The OC				
		M she stole the money from				
		taking any of the clients'				
		indicated the OC took money				
	from ResCare and t	he clients by using the pass				
	through account. T	the OSS indicated the BOM				
	was not reconciling	the pass through account as				
		e OSS stated the BOM "will				
	-	inated." The OSS indicated the				
	_	oney going to funeral trusts,				
	ARC trusts and AB	LE trusts.				
	On 4/26/23 at 1:55	PM, Qualified Intellectual				
		ional (QIDP) #1 stated clients				
		QIDP #1 indicated the clients				
	-	a negative way and did not				
	miss out on purchas	-				
	On 4/26/22 at 1.55	DM Qualified Intellectual				
		PM, Qualified Intellectual ional (QIDP) #2 stated clients				
		QIDP #2 indicated the clients				
	-	a a negative way and did not				
	miss out on purchas					
	miss out on purchas	gg.				
	On 4/25/23 at 1:47	PM, the BOM stated, "My [OC]				
		om ResCare and the clients."				
		C was stealing funds through				
	the pass through acc	count. He indicated in				
		oticed discrepancies in the pass				
	_	he balance should be close to				
		ney goes into the account and				
		ithdrawn and distributed to the				
	_	2023, the balance was around				
		dicated at the time he spoke to				
	the PM and PD. He	e stated he "got busy" and did				

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 45 of 71

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	(X2) MULTIPLE CONSTRUCTIO A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/10/2023	
	ROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRAL		725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
77.0.75	27.7.0.4.7.Y.		1	-			77.5
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	CROSS-REFERENCED TO THE APPROPRIA		TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENC!)		DATE
		w balance until last week. He					
		o speak to the OC and she					
		g funds from ResCare. He					
		ot say anything about client					
		touching the clients' funds. e the money with fake check					
	requests and forger						
		cated the OC took check					
		rust funds or funeral trusts and					
	-	le out to Normal Life of Indiana					
		. She could take the checks					
		l Life to the bank and cash the					
		stated the OC needed to					
	ensure Executive Director approval was obtained						
		100.00. He stated the OC					
		ers." He indicated the RFMS					
	_	the vendor (where the checks					
	-	indicated she started taking the					
	funds in April 2021	when the pass through					
	account was started	. He indicated he started					
	working at the facil	ity in January 2021. He stated					
	"I reconcile the acc	ounts." He indicated he asked					
	the OC to get staten	nents for the accounts and she					
		the indicated she forgot and					
	•	d them to him. He indicated in					
	-	e noticed the balance dropped					
	below \$6,600.00. I	He stated, "I told them I would					
		ion. I got caught up in other					
	-	o it until this month when I					
		unts for the new BOM." He					
		responsibility. It was my					
		concile the account. I failed to					
		ns." He stated the OC was					
	•	e "committed a crime." The BC					
		no investigation conducted in					
	-	nen he first noticed there was an					
		told [ED] I would review it					
	and tell her what I f	ound.					
	The BOM stated, "S	She admitted to taking it. I					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 46 of 71

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	
		15G080	B. WING			05/10/	2023
			Si	TREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8		25 CAF			
RES CAF	RE COMMUNITY AI	LTERNATIVES SOUTH CENTRAL			IN 47031		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
		hought she would have taken					
		missing is approximately					
		cated he was not sure what					
		n ResCare and what was from					
		ne BOM stated there was					
		ment. Clients will be					
		is enough evidence to					
	substantiate exploita	ation of the clients' funds."					
		PM, the Executive Director					
	` /	e were 112 clients involved and					
	1	stolen. The ED indicated there					
		om the group home affected.					
		finitely going to substantiate					
		vill be terminated." The ED					
		yed a text from the BOM on					
	_	to call him (BOM). He said he					
		e pass through account and					
	_	The ED stated the OC					
	· ·	ResCare money of					
		00.00. The ED stated, "She					
	1 1	me and HR that she stole the					
	1	ne had a gambling problem.					
	1	ResCare money. She said she					
		back." On 4/12/23, she					
	· ·	y checked the clients' finances.					
		e (OC) was taking the clients'					
		ey." The ED indicated the OC					
		ntended for the ARC trust but					
	_	ut to Normal Life so she could					
		keep the money. The ED					
		he OC "admitted she was unds. She said it was around					
	_	mised to pay the money back." ne amount of money					
		grew from there. The ED					
	1	_					
		S statements when printed					
		t show the vendor therefore who the checks were made					
		icated the OC worked at the					
	out to. The ED indi	icated the OC worked at the					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 47 of 71

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/10/2023	
NAME OF P	ROVIDER OR SUPPLIER		STREET <i>A</i> 725 CA	ADDRESS, CITY, STATE, ZIP COD		
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL		IN 47031		
(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 LSC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
		. The ED indicated prior to the				
		nt being instituted, the clients				
		accounts. The ED indicated				
		osed to reconcile the pass				
	-	onthly. She stated the "[BOM] g while. Over a year. When				
		ass through account was low				
		he indicated it was not part of				
		onsibility. She indicated the				
	BOM reconciled the	e account for awhile with no				
		ndicated she was first aware of				
		S. She stated "just [OC] and				
		to the RFMS accounts." The				
		C) was printing and providing ents in a format that did not				
		rmation. Didn't know all the				
	_	as available. Easily detected				
	now that I know."	She indicated she was not				
	_	who couldn't buy something				
	due to the missing f	unds.				
	On 5/9/23 at 2:11 P	M, the Chief Security Officer				
		pass through account was				
		h \$500.00 and 5 signers. The				
		account should not have had 5				
	_	ant. Due to the amount of d out of the account, the total				
		and out of the account, the total and was increased to \$7000.00.				
		the amount in the account				
		en increased to \$7000.00				
	without corporate a	pproval, which did not				
		stated the BOM "did not				
		nt like he was supposed to" on				
	-	ne CSO indicated the BOM				
	-	on the account and did not asked the OC to get				
		she never provided them to				
		M indicated he got busy and				
		get the statements until the				
	BOM went to the ba	ank to request statements in				

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 48 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	_ COM	(X3) DATE SURVEY COMPLETED 05/10/2023			
	PROVIDER OR SUPPLIEF	LTERNATIVES SOUTH CENTRA	STREET ADDRESS, CITY, STATE, ZIP COD 725 CARR ST MILAN, IN 47031					
(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 CORI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
IAU	January 2023. Who he realized the accorseveral times. The ED indicated she the care of the issue. The busy" and after a fethrough the statements with the ResCare's money. It is amount between Refunds was \$280,000. The CSO stated the directed to do" regathrough account modern ED should have fol taking care of the is BOM initially reported it to the Quantity The CSO stated the requests."	en the BOM got the statements, bunt dropped below \$7000.00 BOM informed the ED. The ought the BOM was taking he CSO stated the BOM "got w months, started to go ents. While going through the OC, the OC admitted to taking The CSO indicated the total esCare's money and client 0.00. BOM, "didn't do what he was rrding reconciling the pass onthly. The CSO indicated the lowed up to ensure he was use in January 2023 when the reted his concerns. The CSO there were staff who had be clients' funds, no one mality Assurance department. OC "falsified documents and	IAU			DAIE		
	BOM's Job Descrip form indicated, "" monitors client fund ccount balances. responsible for the	PM, a review of the undated tion Form was conducted. The The Business Manager d disbursements and a The Business Manager is the oversight of Purchase cation and collections						
	administrative ar including Reven responsibilities, record maintenar purchase card pr	nd business support functions ue Cycle accounts receivable client financial and benefits nee, accounts payable, ogram, client funds d payroll. Acts as liaison to						

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 49 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPL	
		15G080	B. WI	NG		05/10/	2023
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
				725 CAI			
RES CAF	RE COMMUNITY AI	LTERNATIVES SOUTH CENTRAL		MILAN,	IN 47031		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, The state of the	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCE		DATE
	1	departments. Works under					
	_	. Supervises Office					
		nsures client funds are					
	managed as per ResCare policy"On						
	4/28/23 at 5:05 PM, a review of the						
		Coordinator's (OC) Job					
	1 *	n was conducted. The form					
	· ·	sist with processing of client					
	funds requests as	s required"On 4/27/23 at					
	4:28 PM, a review of the facility's 2/16/22						
	Client Finance Policy and Procedures was						
	conducted. The	policy indicated, "It is the					
	policy of this ope	eration to responsibly					
	manage and mon	nitor consumer finances at all					
	site locations"	The General Practice					
	section indicated	, "1. No client shall have an					
	outside banking	account other than their					
	residential manag	gement trust fund account.					
	This includes, bu	it is not limited to checking,					
	· · · · · · · · · · · · · · · · · · ·	s of credit. 2. Checks,					
	_	paychecks, Social Security					
	1	necks, etc., are to be					
		client's personal RFMS					
	_	eck received will be					
	-	e account within 24 hours					
	of the receipt of						
	_	thin the individuals account					
	_						
	will be reported to the Business Office Manager and the Program Manager						
	_						
	immediately. These discrepancies include but						
		e: missing deposits, missing					
	runds, and cash v	withdrawals from the					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 50 of 71

	TOF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA DEFICIENCIES IDENTIFICATION NUMBER 15G080	(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/10/2023				
	ROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SOUTH CENTRAL	STREET ADDRESS, CITY, STATE, ZIP COD 725 CARR ST MILAN, IN 47031					
(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			
	individual's account that are not recorded nor are there any receipts for the withdrawal. 4. In the event of missing funds, discrepancies, or suspected policy violations within an individual's account, an audit or review will be conducted. All discrepancies with regards to individuals finance will be reviewed. 5. Please be advised in regard to policy 7.1A.5 that Direct Support Personnel can be subject to corrective action for purchasing items while shopping with an individual and the individual pays for those items even if the Direct Support Personnel pays the individual back for those items. The agency will not tolerate any negligence or carelessness by staff regarding the finances of individuals. 6. As per ResCare's Human Resources Manual Policy 7.1A.5 theft, unauthorized removal, wrongful possession, or deliberate destruction of property, merchandise, equipment, or possessions belonging to the individuals we serve; applies to financial management as well. Violating this policy is subject to corrective action up to and including termination. 7. An employee that uses an individual's money/identity for any other purpose than what was approved or		CROSS-REFERENCED TO THE APPROPRIA	IE			
	intended for that individual can/will be prosecuted and may serve time either in jail or prison" The Funds Overview section indicated, "ResCare has established policy						

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 51 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/10/2023	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD	
		LTERNATIVES SOUTH CENTRAL		ARR ST , IN 47031	
				, IIV 47001 T	avs.
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	``	LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE DATE
	and procedures the	hat govern how we will			
	execute our fiduo	ciary responsibilities for a			
	client who has au	uthorized us to manage their			
	funds - includes	how to safeguard assets,			
	how to authorize	deposits/withdrawals,			
		3 at 4:28 PM, a review of			
	_	3/11 Reporting Violations of			
		cedures was conducted.			
		ated, "ResCare strictly			
		neglect, exploitation,			
	mistreatment, or violation of an Individual's				
	_	w of an undated Abuse,			
	-	loitation policy indicated,			
		l persons served are free			
	_	ect, or exploitation			
		t tolerate abuse, neglect, or			
	-	ny persons served. All			
		equired to report allegations			
	•	dents of abuse, neglect, and			
	-	alleged or suspected abuse,			
	_	xploitation will be			
	,	estigated. Appropriate			
		will be taken to ensure			
	-	y further occurrence			
	-	eans the fraudulent or			
	•	, unauthorized, or improper			
	-	an individual, including a			
		ciary, that uses the			
	-	erson we support for			
		sonal benefit, profit, or gain,			
		depriving a person we			
	support of rightfo	ul access to, or use of,			

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 52 of 71

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. building <u>00</u>			COMPLETED	
		15G080	B. WI	NG	_	05/10/	/2023
	ROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRAL	STREET ADDRESS, CITY, STATE, ZIP COD 725 CARR ST MILAN, IN 47031				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	benefits, resource	es, belongings, or					
	assets"This fee	deral tag relates to					
	complaint #IN00	406967.9-3-2(a)					
W 0154 483.420(d)(3)							
	STAFF TREATME	ENT OF CLIENTS					
Bldg. 00		ave evidence that all					
	alleged violations	are thoroughly investigated.					
		riew and interview for 5 of 6	W_0	154	W154: Staff Treatment of Clie	nts	05/27/2023
	· ·	and F) the facility was					
	designated as the representative payee, the				Corrective Action:		
	facility failed to conduct a thorough investigation				· The Operation Support		
		s of the clients affected and the			Specialist was trained on Ensi	uring	
	amount of money st	colen from each client.			a thorough investigation is		
	Findings include:				completed on all investigations	S	
	Findings include:				that involve multiple	toilo	
	On 4/25/23 at 4:06 1	PM, a review of the facility's			clients/locations, to ensure de are provided for the individual		
		s conducted and indicated the			client/locations in separate		
	following:	oondacted and marcated the			investigations for each location	n	
					(Attachment O)	••	
	A 4/20/23 Bureau o	f Developmental Disabilities			· The Operation Support		
	Services (BDDS) in	cident report indicated, "There			Specialist trained the Quality		
	has been an allegation	on of misappropriation of			Assurance Manager and the		
	funds. A full audit	of the account is being			Quality Assurance Coordinato	r on	
		unt of funds is undetermined			Ensuring a thorough investiga	tion	
		leged to be responsible for			is completed on all investigation	ons	
		funds has been suspended			that involve multiple		
		on. In addition, the police have			clients/locations, to ensure de		
		e initial case number is [case			are provided for the individual		
		s proven to be missing will be			client/locations in separate		
	reimbursed by ResC	Care"			investigations for each location	n.	
	On 4/25/22 at 2.171	DM a ravious of the alignment			(Attachment P)	aar	
		PM, a review of the clients' agement Service (RFMS)			Quality Assurance Management Quality Assurance	ger	
					and Quality Assurance		
	accounts indicated the clients had the following				Coordinator will conduct investigations for all allegation	s of	
	"Transaction Fraudulent" from their accounts:				Abuse Neglect and Exploitation		
	1) Client A: \$3991.	.00			Rescare Management wi		
	1) Client A: \$3991.00 2) Client C: \$364.00				neer review all investigations t		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		15G080	B. WI	NG		05/10/	/2023
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹		l			
DEC CAI		LTERNATIVES SOUTH CENTRAL		725 CA			
KES CAR	RE COMMUNITY A	LIERNATIVES SOUTH CENTRAL	•	WILAN,	IN 47031		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	3) Client D: \$156.0	00			ensure they are		
	4) Client E: \$156.0	00			thorough.(Attachment R)		
	5) Client F: \$112.0	00			 Observations are being 		
	Total: \$4779.00				conducted by Rescare		
					Management 3 times weekly f	or	
	The facility's 4/26/2	23 Investigative Summary			no less than 60 days to audit a	all	
	indicated in the Cor	nclusion, "It is substantiated			financials. (Attachment S)		
	[Office Coordinator/OC] embezzled client and				 Daily calls are conducted 		
	ResCare funds from [name of bank] 'pass through'				with Rescare Management to		
	account. It is substantiated [OC] exploited clients				discuss financial processes ar	nd	
	through theft of client funds." The investigation's				procedures, financial policies a	and	
	statement from the Business Office Manager				implementation of those policion	es.	
	(BOM) indicated, "[BOM] was asked what				and are tracked by the Quality	,	
	issue(s) he noticed with the pass-through				Assurance Manager.		
	expenditures accou	nt and if he had spoken with					
	any other business	office staff about the issue.					
	He replied with the	following email: 'When					
	reviewing the "pass	s through" account statements					
	on 4/11/2023, I not	iced previous ending balances			Monitoring of Corrective		
	were below the amo	ount of funds ResCare funded			Action:		
	the account with. I	knew there had to be an issue			 All investigations of ANE 	will	
	because the initial b	palance on the account should			be peer reviewed by the Progr	am	
	remain the same, gi	ven no bank fees occurred, as			Manager, Human Resource		
		and withdrawn in the same			Manager, Quality Assurance		
		reviewing the statements and			Manager, Program Director ar	nd	
		deposits and withdrawals, I			Executive Director.		
		to [OC]. I made comments			· After the investigation is		
	_	something is off with the			reviewed by the internal peer		
		ting at her desk as I was			review the investigation will the	en	
		as occupied, signing client			be sent to the Regional Direct	or	
		Her direct involvement in the			and Corporate Human Resour		
		time was minimal. I did not			for further review to ensure the	9	
	1	arch 2023) statement, so I			investigation is thorough and		
	stopped reviewing and went to the bank to get a				complete.		
	copy. After I got the statement, I noticed the				 Daily Calls are tracked by 	•	
	balance was at \$210.86. After getting the most				the Quality Assurance Manage	er	
	recent statement, I went back to the office and had				and include discussion of any		
	a conversation with [Quality Assurance				allegations of ANE and the		
		asked [QAM] if she had time	investigation into those				
	so I could get her professional opinion and brief				allegations.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G080	B. W	NG		05/10/	2023
		l .		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	₹		725 CA			
RES CAR	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL			IN 47031		
INLO OAI	NE COMMONTT A	ETERNATIVEO OCOTTI CENTRAL					
(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	ΓE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	ns I had. She did have time					
	and we spoke in pri						
	_	ined to her what the "pass					
	-	as and how we utilized it. In			Completion Date: 5/27/23		
		her the discrepancies we were					
	experiencing.						
	After the conversati	ion, I explained I was not sure					
	what the next steps were going to be and had to						
	•	ate. This concluded our					
	conversation. Short						
		QAM], I asked [OC] to join me					
	in the lounge so we could review it together. As						
	we sat down at the table, I pointed out the						
	September 2022 statement. This was the first						
	month the account b	balance dropped below the					
	amount ResCare fur	nded it with (\$7000.00). I then					
	went through each i	month showing the influx in					
	the balance. As I w	as about to continue my					
	-	at we were looking for, [OC]					
		d, "I did it. I took the money.					
	-	not say anything right away					
		She continued to cry and					
		e stating she would pay it all					
		need to go talk to [Human					
	_	/HRM]. She explained she					
	_	th [ED] and she didn't want					
		ner in the state she was in.					
	_	it in [ED's] office. I said that					
	_	ot to HR, I shut the door and					
		g that [OC] and I had just RM]. We then called [ED] and					
	-	tted to stealing the funds. We					
		next steps would be and went					
		th [ED] on speaker. [OC] and					
		was apologetic and promised to	1				
		k. The conversation ended					
		and me signing her suspension					
		nt is the best recollection of					
		rersation that transpired on					
	the events and conversation that transpired on		1				

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 55 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/10/2023				
		ROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRAL	STREET ADDRESS, CITY, STATE, ZIP COD 725 CARR ST MILAN, IN 47031					
	(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 APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
		During follow-up queries account was esta [Treasury] assisted [name of bank]. He balance was \$500 a deposit of \$6500, must the account with a trauthorized signers of [OC], [Program Ma Manager], [name of [Program Manager] Director], and [form payroll]. He states access to the account of those listed, only the bank to make trauther than the states that the access to their funds states that anytime a was cut to Normal I check can then be dupass-through account should alway (\$7000.00), as fund immediately with drattes that the account should alway (\$7000.00), as fund immediately with account by doing rethe majority of the content of	ans for providing clients with s in the form of cash. He a client needs cash, a check Life of Indiana (ResCare). The						

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 56 of 71

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
		15G080	B. Wl	ING		05/10/	2023
				STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	₹		725 CA			
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL	-	MILAN,	IN 47031		
(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	ГЕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		vas used it would have been					
	for special requests	where cash is necessary.					
	[BOM] describes th	ne process of the					
	'pass-through' accor	-					
	Receive request for funds for client (if necessary).						
		request spreadsheet (including					
		ID, amount, description, and					
	vendor (Normal Lif	fe of Indiana).					
	3. Send spreadsheet to RFMS processing						
	team-they queue check.						
	4. Office Coordinator [OC] prints check.5. Check request spreadsheet used to label money						
		nt) with the appropriate amount					
	of money enclosed						
		ted per client in the batch.					
		drawal slips completed.					
	8. Drive to bank.						
	_	slip(s) and/or check(s)					
	provided to bank te						
	_	provided with exact amount.					
		lks up cash into money tin the exact amount.					
		ator or Business Manager					
		th cash. Ledgers are completed					
		funds have been deposited					
	into the office safe.	-					
		otified that funds are ready to					
	be picked up.	3					
		ick up funds and sign them out					
	on the ledger.	-					
	15. Funds are then either spent or signed into a						
	ledger in the home for tracking cash-on-hand.						
	[BOM] states he cannot recall if any policies or						
	procedures for managing the new account had]
	been provided to him over the phone in						
	_	ding the establishing of the					
	account. He states he does not have a physical						

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 57 of 71

AND PLAN OF CORRECTION AND PLAN OF CORRECTION 15G080		r í	JILDING	nstruction 00	(X3) DATE : COMPL 05/10/	ETED		
	PROVIDER OR SUPPLIEF	LTERNATIVES SOUTH CENTRAL	STREET ADDRESS, CITY, STATE, ZIP COD 725 CARR ST AL MILAN, IN 47031					
(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)	TE	(X5) COMPLETION DATE	
	the pass-through ac Director] gave director gave director reconciled monthly discrepancies in ear admits he had not be account monthly. At to [Program Director private, noting his conservate, noting his con	s or procedures for managing count. He states [Treasurer ctives for the account to be and the states he noticed and January 2023, however, seen fully reconciling the after his discovery, he spoke or and [Program Manager] in concern for the account acing correctly. He asked them atton private and to not let was reviewing. [PM] offered reviewing. He states that at working on getting the tts and check copies in order to the review. He states he that he thought 'something was ld follow-up with her once he review. He states he informed and [ED] on 4/11/23 that he concies" It in the facility's investigation as contacted via phone and were any other accounts draision to taking money that ear. She stated that it was only ecount. She was asked if any en taken during the process lients received their money ceted. An appointment was derview following collection of initially agreed to meet, but changed her mind and in the facility's investigation are sday approximately 2:31pm, I in [BOM] to let me know he im because he has a problem						

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 58 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		A. BUILDING <u>00</u> COM				survey eted 2023	
	ROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRAL		725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
(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)	TE	(X5) COMPLETION DATE
IAU	and doesn't know we shortly thereafter we and relayed that he 'pass-through' according the new Business Meroblem. He suspended and said he asked [Offended He told me that she finally relayed that had [OC] go into me there. I relayed to he and she kept apolog gambling problem. gambling on her pholient money involved ResCare money from [name of bank]. She immediately and an states, 'On Thursday work, I called [OC] 'passthrough (sic) and funds too you made (sic) supposed to go Remarkable Citizen spending money? 'lasked,'How much a replied with, 'I don't rest of the conversa apologizing and say (if she could)." The PD's statement indicated, "[PD] was conversation between when he came to the issue he had notice of the conversal	that to do. He called me ith [HRM] on speaker phone wanted to reconcile the ant at [name of bank] before fanager starts but noticed a cted some fraudulent activity OC] for the bank statements. had put him off and then she had taken money. They y office and took the phone in mer that she was suspended gizing and said she had a She said she started online one. I asked if there was any red and she said no, only must be pass-through account at the states, '[OC] was suspended investigation started.' She y morning on my way into and said, 'It wasn't just the account was it? It was client de checks for cash that was to to the ARC (Association of as) and took them, you took [OC] replied with, 'Yes.' I then re we talking about, [OC]? She taknow, maybe \$20,000.' The tion consisted of her ring she would take it all back in the facility's investigation as asked to describe the en she, [BOM], and [PM] em to speak about a potential divith the balance of the ant. She states, 'I can't recall if ptember (2022) but [BOM] had e and said he had a feeling in the cash account at [name		IAU			DATE

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 59 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/10/2023		
	PROVIDER OR SUPPLIEF	LTERNATIVES SOUTH CENTRAL		725 CAI	DDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA TAG DEFICIENCY)			(X5) COMPLETION DATE
TAG	of bank]. [BOM] so account may be off (sic) through right in off. I never heard a 'pass-through' account investigation. The Factual Finding investigation indicated process, all client R (date of pass through April of 2023 were transactions were limited with supporting downwas obtained to vert transactions were fron behalf of the cliegenerated to track a review and their verties are the verties and their v	tated that he was thinking the and if the checks weren't ran t could cause the balance to be any more about the ant until 4/11/23 when the n was initiated." gs section of the facility's ated, "During the investigative FMS statements from 4/1/21 the account opening) through audited. Suspicious sted and flagged for review cumentation. Documentation iffy which of the flagged redudlent or executed correctly tents. A spreadsheet was all transactions flagged for rification status. Review if (sic) ments confirms checks were iffe of Indiana (ResCare) on the weekly/monthly spending,		TAG			DATE
	of the [name of ban [OC] was the only puther account. Review ABLE accounts conto the accounts for in their RFMS states	k] withdrawal slips confirms person withdrawing funds from w of client Funeral, ARC, and infirms deposits were not made the designated amounts noted ements. Review of client heets confirms clients did not					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 60 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/10/2023	
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRA	725 CA	ADDRESS, CITY, STATE, ZIP COD ARR ST , IN 47031	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE COMPLETION PRIATE
TAG	receive all funds iss for weekly/monthly ABLE trust funds, a needs. Client lists/s will be added to the auditing has been con [name of bank] pass ResCare funds total to open the account should result in a reads of April 2023, the sps. 86 confirming a stated he was not reaccount thoroughly she took ResCare funds and of the [name of bank] initially denied taking recanted" The Consubstantiated [OC] funds from the [name account. It is substathrough theft of client. The facility's invested evidenced by: Not identifying the exploitation. Not identifying the exploitation. Not identifying the exploitation. On 4/27/23 at 9:34 stated the investigat What you are seeing portion and it menticing is not the final for exportion is the clients.	LESC IDENTIFYING INFORMATION used from their RFMS accounts spending, ARC, Funeral, and and other client spending spreadsheets of audit results investigation file when final completed. Review of the sthrough account confirms ing \$7,000.00 were deposited and service fees of \$134.63 maining balance of \$6,865.37. The balance of the account is a deficit of \$6,769.51. [BOM] conciling the 'pass-through' reach month. [OC] admitted ands and client funds (ARC) relient spending funds) from repass-through' account. [OC] ring client funds then conclusion indicated, "It is rembezzled client and ResCare reach of bank] 'pass through' rentiated [OC] exploited clients rent funds." igation was not thorough as reclients involved in the reamount of money stolen from reamount of money each client mbursed. AM, the Program Director (PD) rion was "very, very large. g is the ResCare money ons client funds were taken. It very bit of it. The other s' tally. Took a small piece to	TAG		
	get ner (OC) termin	ated. This is not the final	İ		

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 61 of 71

PRINTED: 06/06/2023 FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC					JMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DA'	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COM		
		15G080	B. WING		05/	10/2023	
			STREET	ADDRESS, CITY, STATE, Z	TP COD		
NAME OF 1	PROVIDER OR SUPPLIEF	₹		ARR ST	ii cob		
RES CA	RE COMMUNITY A	LTERNATIVES SOUTH CENTR		, IN 47031			
	AND THE STATE OF T			,			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX	, and the second	ICY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO T	THE APPROPRIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENC	11	DATE	
	investigation."						
	The facility did not	include additional information					
	-	as of 5/4/23 at 12:13 PM.					
	in the investigation	as 61 5/ 1/25 at 12.13 1141.					
	On 5/4/23 at 12:58	PM, the PD indicated it was not					
		ation. The PD indicated the					
	Operations Support	Specialist (OSS) told her it					
	was a small piece a	nd additional information was					
	going to be include	d in the final investigation.					
	The PD indicated n	o additional information was					
	included in the investigation. The PD indicated						
	the investigation needed to include the total						
		ffected and how much money					
		ch client. The PD indicated the					
		ney stolen from all the clients					
	involved was over S	\$260,000.00.					
	On 5/4/23 at 1:02 B	M, the OSS stated "we need to					
		ion. Need to add an addendum					
		break it out by client. It is not					
	thorough without th	-					
	liferedgii wiliiedi ti						
	On 5/4/23 at 3:48 P	M, the Program Director (PD)					
	sent an email with a	a Financial Investigation					
	Summary attached.	The Factual Findings section					
	indicated, "During	the investigative process, all					
	client RFMS statem	nents from 4/1/21 (date of pass					
	through account op	ening) through April of 2023					
	_	icious transactions were listed					
	1 00	iew with supporting					
		cumentation was obtained to					
	1 -	flagged transactions were					
		ted correctly on behalf of the					
	•	eet was generated to track all					
		d for review and their					
		Review of client RFMS					
		s checks were issued to Normal					
	Life of Indiana (Re	sCare) on behalf of clients for					

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

weekly/monthly spending, ARC, Funeral, and

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 62 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/10/2023	
	PROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRAL	725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	
TAG	ABLE trust funds, a needs. Review of cl confirms checks we Indiana (ResCare) of funds for various nementioned above. R account (pass through issued to Normal Liddeposited in the 'pass of the [name of ban [OC] was the only puth account. Review ABLE accounts conto the accounts for tin their RFMS state Resource Ledger Shreceive all funds iss for weekly/monthly ABLE trust funds, a needs. Client lists/s will be added to the auditing has been confirming a deficit was not reconciling thoroughly each more result in a remaining April 2023, the balanconfirming a deficit was not reconciling thoroughly each more ResCare funds and funds and client spends of bank] 'pass-through denied taking client Conclusion: It is suiclient and ResCare 'pass through' account and server in the summary indicated	and other client spending ient RFMS statements re issued to Normal Life of on behalf of clients for Stimulus eds including those eview of the [name of bank] gh) confirms client checks fe of Indiana (ResCare) were st through' account. Review k] withdrawal slips confirms berson withdrawing funds from the designated amounts noted ments. Review of client funds different clients did not used from their RFMS accounts spending, ARC, Funeral, and and other client spending preadsheets of audit results investigation file when final completed. Review of the [name gh account confirms ResCare 100.00 were deposited to open the designated amount is \$95.86 at of \$6,769.51. [BOM] stated he the 'pass-through' account confirms (ARC) account miding funds) from the [name gh' account. [OC] admitted she took client funds (ARC account anding funds) from the [name gh' account. [OC] initially funds then recanted. Sestantiated [OC] cough theft of client funds." atted, "ADDENDUM: Upon wing funds were embezzled	TAG	DEFICIENCY)	DATE

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 63 of 71

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00		COMPLETED	
		15G080	B. W	ING		05/10/	2023	
NAME OF F	PROVIDER OR SUPPLIER	· }	•		ADDRESS, CITY, STATE, ZIP COD			
			_	725 CA				
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRA	L	MILAN,	IN 47031			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE	
	[Client F] - \$112.00	group home] clients:						
	[Client F] - \$112.00							
	[Client A] - \$3991.0							
	[Client C] - \$364.00							
	[Client D] - \$156.0							
	_							
		determined that collectively,						
	· ·	mbezzled from 106 clients. All						
		ation reviewed for this						
	investigation is being released to the [name of							
	city] PD (police department)/Prosecutor, and the							
	Attorney General for prosecution of [OC] for the							
	embezzlement. ResCare will comply with all requests/directives from the above entities as							
	received."	nom the above entities as						
	100011001							
	On 5/9/23 at 12:08	PM, the OSS emailed a copy of						
	the investigation wi	th the following Addendum,						
	"[BOM] and [OC] are no longer with the						
		nendations Being Implemented:						
	-	rough Account Procedure,						
	_	nent staff on Client Trust						
		ement review process for						
		Funeral Trust Accounts, Retrain ff on RFMS statement review						
	-	t all discrepancies immediately						
		ce Dept for investigation."						
	Z	1						
	On 5/5/23 at 9:19 A	AM, the OSS indicated the BOM						
	was going to be terr	minated due to knowing there						
		ne ResCare pass through						
		2023 but not taking action to						
		the time. The BOM showed						
	,	BOM) sent to the Executive						
		1/23 indicating the pass						
	-	lance was \$93.00 when it						
		round \$6,800.00. The BOM oncerns to the Quality						
	-	ent for them to investigate the						

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 64 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/10/2023	
	PROVIDER OR SUPPLIEF	LTERNATIVES SOUTH CENTRA	725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL D LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
TAG	issue. The BOM di ED. Neither of the ED indicated to the was not aware of the until April 2023. On 4/27/23 at 9:17 the QAM was cond 4/26/23 Investigation and the ResCare funds has Recommendations employment for [O to substantiated exprecommendations value of the commendation of the substantiated exprecommendation of the commendation of the com	include termination of C] and ineligible for rehire due cloitation and theft. Additional will be added upon final audit." PM, a review of 5/3/23 review indicated, "The contation and theft of client funds re funds has been has been terminated of her deemed ineligible for rehire d exploitation and theft. Her moved from all ResCare ins/accounts. She has been sentative on all ARC and ABLE with our clients. All clients arsed by ResCare. ResCare has ective measures until corporate icies and/or procedures	TAG	DEFICIENCY)	DATE

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 65 of 71

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/10/2023	
	PROVIDER OR SUPPLIER	TERNATIVES SOUTH CENTRAL	725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	employee for 17 year	Ars. When the Business to reconcile the account, she	TAG	Da loaner.	DATE
	indicated approxima	he clients' money. The PD ately 131 clients were affected 100. The PD indicated Rescare			
	funds were also stol account created in A	en from a pass through April 2021. The PD stated the			
	the clients' money g	by using "fake requests" of oing to ARC, funeral trusts s. The PD indicated the OC			
	indicated she had a	gambling problem. The PD Il be reimbursing the clients			
l	a doubt." On 4/25/2	tantiated exploitation without 23 at 2:46 PM, the PD indicated the ED, BOM and her (PD) she			
	took the money. The taking money 2 year	ne PD indicated the OC started rs ago when the pass through			
	told her and the Pro	l. The PD stated the BOM gram Manager "something ast/September 2022. Wasn't			
	like he was reportin	g exploitation, just said money le wasn't reporting missing			
	aware of the clients	The PD indicated she was not missing out on making theft of the clients' money.			
		PM, the Operations Support			
	living in the group l	licated some of the clients nome were affected by the OC. approximately 100 clients were			
	affected with a total OSS indicated the s	of \$250,000 to \$300,000. The ituation started in June 2021			
	account for the clien	arted using a pass through nts' money. Money came to e clients' RFMS accounts. He			
	stated it was "substa	t at this point." The OSS antiated exploitation by [OC]." the was recommending the OC			
	be terminated. The	OSS indicated the BOM ation prior to this situation			

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

Event ID:

GOLO11 Facility ID: 000623

Page 66 of 71 If continuation sheet

i i		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		15G080	B. WING	<u> </u>		05/10/	2023
NAME OF P	DOMNED OF CLIPPLIED		<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER			725 CAF	RR ST		
RES CAF	RE COMMUNITY AI	LTERNATIVES SOUTH CENTRAL	<u> </u>	MILAN,	IN 47031		
(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 APPROPRIATE DEFICIENCY)		TE	COMPLETION	
TAG		LISC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY		DATE
	-	The BOM was conducting an					
		overed the issues. The OC M she stole the money from					
		taking any of the clients'					
		indicated the OC took money					
		he clients by using the pass					
		he OSS indicated the BOM					
	~	the pass through account as					
	_	e OSS stated the BOM "will					
		inated." The OSS indicated the					
	-	oney going to funeral trusts,					
	ARC trusts and AB						
	On 4/25/23 at 1:47	PM, the BOM stated, "My [OC]					
	_	om ResCare and the clients."					
		C was stealing funds through					
		count. He indicated in					
	•	oticed discrepancies in the pass					
	-	he balance should be close to					
		ney goes into the account and					
		ithdrawn and distributed to the					
		2023, the balance was around					
		dicated at the time he spoke to e stated he "got busy" and did					
		w balance until last week. He					
		o speak to the OC and she					
		funds from ResCare. He					
	-	ot say anything about client					
		couching the clients' funds.					
		e the money with fake check					
	requests and forgery	-					
		cated the OC took check					
	_	ust funds or funeral trusts and					
	had the checks mad	e out to Normal Life of Indiana					
	instead of the trusts	. She could take the checks					
	made out to Normal	Life to the bank and cash the					
		stated the OC needed to					
		irector approval was obtained					
		100.00. He stated the OC					
	created "false ledge	rs." He indicated the RFMS					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 67 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/10/2023	
NAME OF P	ROVIDER OR SUPPLIER		STREET A 725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST	
RES CAF	RE COMMUNITY A	LTERNATIVES SOUTH CENTRAL		IN 47031	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		the vendor (where the checks	TAG	DETERMINET.	DATE
	-	indicated she started taking the			
		when the pass through			
		. He indicated he started			
		ity in January 2021. He stated			
	"I reconcile the acco	ounts." He indicated he asked			
		nents for the accounts and she			
		he indicated she forgot and			
	_	them to him. He indicated in			
		noticed the balance dropped			
	· ·	He stated, "I told them I would			
		ion. I got caught up in other			
	things and didn't do it until this month when I reconciled the accounts for the new BOM." He				
		responsibility. It was my			
		concile the account. I failed to			
		s." He stated the OC was			
		"committed a crime." The BC			
	indicated there was	no investigation conducted in			
	September 2022 wh	en he first noticed there was an			
		told [ED] I would review it			
		ound." The BOM stated, "She			
		t. I would have never thought			
		en it. The total funds missing			
		82,000." He indicated he was			
	_	ntage was from ResCare and client funds. The BOM stated			
		improvement. Clients will be			
		is enough evidence to			
		ation of the clients' funds."			
	On 4/25/23 at 2:59	PM, the Executive Director (ED)			
		e 112 clients involved and more			
	than \$250,000 stole	n. The ED indicated there were			
		e group home affected. The			
		ely going to substantiate			
		rill be terminated." The ED			
		red a text from the BOM on			
		to call him (BOM). He said he			
	went to reconcile th	e pass through account and			

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 68 of 71

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		ì í	JILDING	instruction 00	(X3) DATE COMPL 05/10/	ETED	
	PROVIDER OR SUPPLIEF	LTERNATIVES SOUTH CENTRAL		725 CA	ADDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION "The ED stated the OC		TAG	DEFICIENCY)		DATE
	_	ResCare money of					
	-	00.00. The ED stated, "She					
		me and HR that she stole the					
		ne had a gambling problem.					
	-	ResCare money. She said she					
	-	back." On 4/12/23, she					
	indicated the facilit	y checked the clients' finances.					
	The ED stated, "she	e (OC) was taking the clients'					
	and ResCare's mon-	ey." The ED indicated the OC					
		ntended for the ARC trust but					
	-	ut to Normal Life so she could					
	cash the check and keep the money. The ED						
	stated on 4/13/23, the OC "admitted she was						
	_	ands. She said it was around					
	-	mised to pay the money back."					
		ne amount of money					
		grew from there. The ED					
		S statements when printed t show the vendor therefore					
	-	who the checks were made					
		icated the OC worked at the					
		The ED indicated prior to the					
		nt being instituted, the clients					
		accounts. The ED indicated					
		osed to reconcile the pass					
	through account mo	onthly. She stated the "[BOM]					
	didn't do it for a lor	ng while. Over a year. When					
		ass through account was low					
		the indicated it was not part of					
		onsibility. She indicated the					
		e account for awhile with no					
		ndicated she was first aware of					
		3. She stated "just [OC] and					
		to the RFMS accounts." The					
		C) was printing and providing ents in a format that did not					
		rmation. Didn't know all the					
	-	vas available. Easily detected					
		She indicated she was not					
	115 W MIGHT KITOW	mareacea one was not					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet Page 69 of 71

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G080		î í	JILDING	nstruction <u>00</u>	(X3) DATE (COMPL 05/10/	ETED		
		ROVIDER OR SUPPLIER	LTERNATIVES SOUTH CENTRAL		725 CAI	DDRESS, CITY, STATE, ZIP COD RR ST IN 47031		
	(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)	ΓE	(X5) COMPLETION DATE
		due to the missing f						
		(CSO) indicated the initially opened with CSO indicated the asigners on the according funds going into an amount in the according the CSO indicated should not have been without corporate a happen. The CSO is reconcile the according a monthly basis. The forgot his password check it. The BOM statements however the BOM. The BOM did not follow up to BOM went to the burst and a few according to the several times. The ED indicated she the care of the issue. The busy" and after a few through the statements with the ResCare's money.	M, the Chief Security Officer e pass through account was h \$500.00 and 5 signers. The account should not have had 5 ant. Due to the amount of d out of the account, the total ant was increased to \$7000.00. the amount in the account en increased to \$7000.00 pproval, which did not stated the BOM "did not nt like he was supposed to" on the CSO indicated the BOM d on the account and did not I asked the OC to get eshe never provided them to M indicated he got busy and to get the statements until the the ank to request statements in the BOM got the statements, bunt dropped below \$7000.00 BOM informed the ED. The tought the BOM was taking the CSO stated the BOM "got w months, started to go ents. While going through the OC, the OC admitted to taking The CSO indicated the total escare's money and client 0.00.					
		directed to do" regathrough account mo ED should have fol- taking care of the is	BOM, "didn't do what he was rding reconciling the pass onthly. The CSO indicated the lowed up to ensure he was sue in January 2023 when the rted his concerns. The CSO					

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

Event ID:

GOLO11 Facility ID: 000623

If continuation sheet

Page 70 of 71

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

PRINTED: 06/06/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G080	Î ´	JILDING	ONSTRUCTION 00	(X3) DATE COMPI 05/10 ,	LETED
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL				725 CA	ADDRESS, CITY, STATE, ZIP COD IRR ST IN 47031		
(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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE
	suspicions about the reported it to the Qu The CSO stated the requests."	here were staff who had e clients' funds, no one hality Assurance department. OC "falsified documents and here to complaint #IN00406967.					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: GOLO11 Facility ID: 000623 If continuation sheet Page 71 of 71