Tracy Callahan

PRINTED: 05/06/2024 FORM APPROVED OMB NO. 0938-039

04/26/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G749		(X2) MULTIPLE C A. BUILDING B. WING	X3) DATE SURVEY   00		
	ROVIDER OR SUPPLIER		16613	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD YVILLE, IN 47126	
(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)	(X5) COMPLETION DATE
W 0000					
Bldg. 00 W 0102 Bldg. 00	#IN00431589.  Complaint #IN0043 deficiencies related W102, W104, W12 Survey Dates: 4/2/2 Facility Number: 0 Provider Number: 1 AIMS Number: 200 These deficiencies accordance with 46 Quality Review of and #27547 on 4/15 483.410 GOVERNING BO The facility must egoverning body ar requirements are	24 and 4/3/24.  11595 15G749 19905630  also reflect state findings in 0 IAC 9. this report completed by #15068 5/24.  DY AND MANAGEMENT ensure that specific and management	W 0000	1 Unannounced random	•
	failed to meet the C Governing Body fo B), plus 2 additiona The governing body policy, budget and facility to ensure th written policy and p and safety of clients client A's access, po a firearm in the gro	condition of Participation: r 2 of 2 sampled clients (A and all clients (C and D).  y failed to exercise general operating direction over the e facility implemented its procedures to ensure the health is A, B, C and D regarding possession and brandishing of	3132	observations began at the Factor on 4/1/2024 to ensure plans at being implemented by staff. Observers will verify staffing reall vehicle doors parked at the facility secured, gates are clost and latched, staff has positive control of van and med cabine keys, room sweeps are being completed as scheduled, and security system operational. Observers will also verify staff personal belongings are security	cility re atios, sed et the
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE

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

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G749	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/03/2024
	PROVIDER OR SUPPLIE		16613	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD YVILLE, IN 47126	
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION
TAG	<del> </del>	R LSC IDENTIFYING INFORMATION of Participation: Client	TAG	and verify facility window an	
		f 2 sampled clients (A and B),		doors are serviceable. If a deficiency is noted observer	
	Findings include:			immediately contact the Area Supervisor, and Program Ma Weekday daily observations	a anager.
		ody failed to exercise general operating direction over the		remain in effect for 60 days. 60 days monthly, administra	After
	facility to ensure th	e facility implemented its		observations will be conduct	ed.
		procedures to ensure the health s A, B, C and D regarding		2 The management teal began daily update meetings	
	client A's access, p	ossession and brandishing of		March 29, 2024, to ensure	
	a firearm in the gro	oup home. Please see W104.		compliance and implement changes needed developing	a nlan
	2. The governing b	ody failed to ensure the facility		and implementation of those	•
		of Participation: Client f 2 sampled clients (A and B),		changes. Meetings will cont until conditions are lifted.	inue
		ients (C and D). Please see		3 The Program Manage	er and
	W122.			Area Supervisor retrained st	aff on
	This federal tag rel	ates to complaint #IN00431589.		ResCare Weapon in the Fac vehicle security checks, roor	m
	9-3-1(a)			sweeps and security system operation, ANE (Abuse, Neg	
				and Exploitation) Policy disciplinary action will be tak	on if
				the policy is not followed. Ar	
				Supervisor and will ensure the	
				Policy is followed, and corre measures are implemented.	cuve
				Monitoring of will be done by	/ The
				Program Manager, Area Supervisor, and DSL to ensu	ıre all
				compliance.	aro an
				4 Members of the	
				administrative team, includir managers from Quality, Nurs	-
				and Programming, will cond	_
				daily observations on weekd	-
				Any issues will be immediate reported to the Facility Team	-

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	T OF DEFICIENCIES  OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G749	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/03/2024	
	ROVIDER OR SUPPLIE		16613	ADDRESS, CITY, STATE, ZIP CO SIMA GRAY RD YVILLE, IN 47126	D	
(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 CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	CHON	
				5 An IDT comprises paraprofessionals was hapril 1, 2024, to develop to address client issues. Nurse and a Member of Programming Managem retrain all staff in the facupdated BSPs ISP and needed. 6 The Facility Main Manger will inspect the sweekly at a minimum to environmental issue tha arise. The Maintenance scheduled repair of the security system on Marc 2024, repairs were made Koorsen Fire and Secur March 29, 2024. The se professional recommencupgrades to the system installed no later than Al 2024. 7 Facility Staff will home activities and clier interactions daily to ensitis plans are followed if a noted the appropriate administrative personne Supervisor, Program Manager, Area Supervisor, Facility Nurse, QIDP or AED imand correction will be made and the supervisor of the supe	neld on o strategies QIPD,  nent will ility on HRP as tenance site once identify the may of Manager facility shall be by ity on curity shall be be oril 26, monitor and the principle of the manager, mediately hade. Insultant, the se and onitor or the staff will we staff will will be a staff will be a staff will will be a staff w	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G749		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  (X3) DATE SURVEY  COMPLETED  04/03/2024			
	ROVIDER OR SUPPLIER		16613	SIMA GRAY RD	
RES CAF	RE SOUTHEAST IN	IDIANA	HENR	YVILLE, IN 47126	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
				enforcement to ensure they remain up to date, and client follows release agreement.  Persons Responsible: Execu Director, AED, Program Mana Maintenance Manager, Quality Assurance, Quality Assurance, Quality Assurance, Manager Director of Nursing, Nurse, Area Supervisor, QIDF DSL, and DSP.	ger, /
W 0104 Bldg. 00	policy, budget, and the facility.  Based on record revisampled clients (A aclients (C and D), the exercise general policiection over the faimplemented its writensure the health and D regarding client Abrandishing of a first Findings include:  The governing body implemented its politic health and safety the home regarding and brandishing of Please see W149.	dy must exercise general doperating direction over view and interview for 2 of 2 and B), plus 2 additional ne governing body failed to dicy, budget and operating acility to ensure the facility itten policy and procedures to ad safety of clients A, B, C and A's access, possession and earm in the group home.  If failed to ensure the facility licy and procedures to ensure y of clients A, B, C and D in client A's access, possession a firearm in the group home.	W 0104	1 Unannounced random observations began at the Facton 4/1/2024 to ensure plans a being implemented by staff. Observers will verify staffing rall vehicle doors parked at the facility secured, gates are clost and latched, staff has positive control of van and med cabine keys, room sweeps are being completed as scheduled, and security system operational. Observers will also verify staff personal belongings are secured and verify facility window and doors are serviceable. If a deficiency is noted observers immediately contact the Area Supervisor, and Program Manager. Weekday daily observations will remain in efforts.	cility re atios, ed tt the
	9-3-1(a)			for 60 days. After 60 days	501

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		15G749	B. WING		04/03/2024
NAME OF T	DDOMINED OD GUDDI IEI		STREET A	ADDRESS, CITY, STATE, ZIP COD	
	PROVIDER OR SUPPLIEF		16613 \$	SIMA GRAY RD	
RES CAF	RE SOUTHEAST IN	IDIANA	HENRY	VILLE, IN 47126	
(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
				monthly, administrative	
				observations will be conducted	
				2 The management team	
				began daily update meetings	on
				March 29, 2024, to ensure	
				compliance and implement	nlon
			1	changes needed developing a and implementation of those	i hiai i
				changes. Meetings will contin	
				until conditions are lifted.	
				3 The Program Manager	and
				Area Supervisor retrained stat	
				ResCare Weapon in the Facili	
				vehicle security checks, room	,,
				sweeps and security system	
				operation, ANE (Abuse, Negle	ect,
				and Exploitation) Policy	
				disciplinary action will be take	n if
				the policy is not followed. Area	
				Supervisor and will ensure that	ıt 📗
				Policy is followed, and correct	ive
				measures are implemented.	
				Monitoring of will be done by	Γhe
				Program Manager, Area	
			1	Supervisor, and DSL to ensur	e all
				compliance.	
				4 Members of the	
				administrative team, including	
			1	managers from Quality, Nursi	~
				and Programming, will conduct	
				daily observations on weekda  Any issues will be immediately	
				reported to the Facility Team.	′
				5 An IDT comprised of	
				paraprofessionals was held or	,
				April 1, 2024, to develop strate	
				to address client issues QIPD	_
				Nurse and a Member of	,
				Programming Management w	ill

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retrain all staff in the facility on

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G749				(X3) DATE SURVEY  COMPLETED  04/03/2024	
NAME OF P	PROVIDER OR SUPPLIEF				DDRESS, CITY, STATE, ZIP COD		
RES CAF	RE SOUTHEAST IN	IDIANA			IMA GRAY RD /ILLE, IN 47126		
(X4) ID		STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PRE TA	AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
					updated BSPs ISP and HRP a needed.  6 The Facility Maintenant Manger will inspect the site or weekly at a minimum to identicenvironmental issue that may arise. The Maintenance Manascheduled repair of the facility security system on March 28, 2024, repairs were made by Koorsen Fire and Security on March 29, 2024. The security professional recommended upgrades to the system to be installed no later than April 26 2024.  7 Facility Staff will monitor home activities and client interactions daily to ensure the is plans are followed if an issurnoted the appropriate administrative personnel i.e. A Supervisor, Program Manager Nurse, QIDP or AED immedia and correction will be made.  8 The Behavior Consulta Program Manager, Area Supervisor, Facility Nurse and QIDP will proactively monitor clients to ensure plan implementation.  9 The Administrative staff continue to work with local law enforcement to ensure they remain up to date, and client follows release agreement.  10 The Administrative team worked with BDDS to arrange emergency alternative placement to meet the release order.	ce nce fy ager  or ere e is tely nt, f will or	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER A.		r í	(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. BUILDING       00       COMPLETED         B. WING       04/03/2024		ED	
NAME OF F	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP COD		
RES CAF	RE SOUTHEAST IN	IDIANA	HEN	IRYVILLE, IN 47126		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		OMPLETION DATE
				Persons Responsible: Exe Director, AED, Program Ma Maintenance Manager, Qua Assurance, Quality Assuran Manager Director of Nursin Nurse, Area Supervisor, QI DSL, and DSP.	nnager, ality nce g,	
W 0122	483.420(a)	PIONS				
Bldg. 00	clients. Therefore Based on record rev failed to meet the C Protections for 2 of plus 2 additional cli The facility neglect procedures to ensur clients A, B, C and A's access, possessi firearm in the group Findings include:  The facility neglect procedures to ensur clients A, B, C and A's access, possessi firearm in the group	ensure the rights of all the facility must view and interview, the facility ondition of Participation: Client 2 sampled clients (A and B), ents (C and D).  ed to implement its policy and e the health and safety of D in the home regarding client on and brandishing of a	W 0122	1 Unannounced rando observations began at the I on 4/1/2024 to ensure plans being implemented by staff Observers will verify staffing all vehicle doors parked at facility secured, gates are cand latched, staff has positic control of van and med cab keys, room sweeps are being completed as scheduled, as security system operational Observers will also verify stages personal belongings are seand verify facility window at doors are serviceable. If a deficiency is noted observed immediately contact the Are Supervisor, and Program Manager. Weekday daily observations will remain in for 60 days. After 60 days monthly, administrative observations will be conducted.	Facility s are . g ratios, the closed ive inet ng nd the l. taff cure nd rs will ea effect	4/26/2024

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G749	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/03/2024
NAME OF P	PROVIDER OR SUPPLIEF	2		ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD	
RES CAF	RE SOUTHEAST IN	IDIANA		YVILLE, IN 47126	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE
				March 29, 2024, to ensure compliance and implement changes needed developing and implementation of those changes. Meetings will contuntil conditions are lifted.  3 The Program Manage Area Supervisor retrained st ResCare Weapon in the Fact vehicle security checks, root sweeps and security system operation, ANE (Abuse, Negand Exploitation) Policy disciplinary action will be taken the policy is not followed. Ar Supervisor and will ensure the Policy is followed, and corremeasures are implemented. Monitoring of will be done by Program Manager, Area Supervisor, and DSL to ensure compliance.  4 Members of the administrative team, including managers from Quality, Nurse and Programming, will conducted ally observations on weeked Any issues will be immediated reported to the Facility Team 5 An IDT comprised of paraprofessionals was held April 1, 2024, to develop strato address client issues QIP Nurse and a Member of Programming Management retrain all staff in the facility updated BSPs ISP and HRF needed.  6 The Facility Maintena Manager will inspect the site of the site of the staff in the facility updated BSPs ISP and HRF needed.	cinue cinue cr and aff on cility, m cylect, den if ea chat ctive / The ure all ag sing uct lays. cely n. on ategies D, will on o as

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2)		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLET			ETED	
		15G749	B. WI	NG		04/03/	2024
NAME OF F			_	STREET.	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R		16613	SIMA GRAY RD		
RES CAF	RE SOUTHEAST IN	NDIANA		HENR	YVILLE, IN 47126		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	.TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
					weekly at a minimum to identi	fy	
					environmental issue that may		
					arise. The Maintenance Mana	-	
					scheduled repair of the facility		
					security system on March 28,		
					2024, repairs were made by		
					Koorsen Fire and Security on		
					March 29, 2024. The security		
					professional recommended		
					upgrades to the system to be		
					installed no later than April 26	,	
					2024.		
					7 Facility Staff will monito	r	
					home activities and client		
					interactions daily to ensure the		
					is plans are followed if an issu	e is	
					noted the appropriate		
					administrative personnel i.e. A		
					Supervisor, Program Manager Nurse, QIDP or AED immedia		
					and correction will be made.	lely	
					8 The Behavior Consulta	nt	
					Program Manager, Area	111,	
					Supervisor, Facility Nurse and		
					QIDP will proactively monitor		
					clients to ensure plan		
					implementation.		
					9 The Administrative staf	f will	
					continue to work with local law		
					enforcement to ensure they		
					remain up to date, and client		
					follows release agreement.		
					10 The Administrative tean	n l	
					worked with BDDS to arrange		
					emergency alternative placem		
					to meet the release order.		
					Porcone Poenoneible: Evecu	tive	
					Persons Responsible: Execu Director, AED, Program Mana		
					Maintenance Manager Qualit	·	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00  B. WING			COMPLETED 04/03/2024	
		15G749	B. WI	NG _		04/03	/2024	
	PROVIDER OR SUPPLIE			16613	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD YVILLE, IN 47126			
(VA) ID	CUMMADY	CTATEMENT OF DEFICIENCIE		ID	1		(V5)	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE  NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	-	R LSC IDENTIFYING INFORMATION		PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF T		ATE	DATE	
				0	Assurance, Quality Assurance Manager Director of Nursing, Nurse, Area Supervisor, QIDF DSL, and DSP.		5.115	
W 0149	483.420(d)(1)							
Bldg. 00	STAFF TREATM The facility must of written policies are mistreatment, neg Based on record resampled clients (A clients (C and D), to implement its policible health and safety of home regarding client brandishing of a find Findings include:  The facility's BDS reports were review review indicated the above reported [client A] courtyard being and the window. [Client [client A] even where redirected [client A] walked inside. When he had a firearm in towards [client B]. A] for the weapon,	3/29/24 indicated, "Staff was standing outside in the tagonized by [client B] through at B] continued to antagonize en prompted to stop. Staff a] away from the window and he en [client A] returned outside, his hand, making threats Staff immediately asked [client and he relinquished it without tacted police and monitored	WO	0149	1 Unannounced random observations began at the Facon 4/1/2024 to ensure plans a being implemented by staff. Observers will verify staffing rall vehicle doors parked at the facility secured, gates are closs and latched, staff has positive control of van and med cabine keys, room sweeps are being completed as scheduled, and security system operational. Observers will also verify staff personal belongings are seculand verify facility window and doors are serviceable. If a deficiency is noted observers immediately contact the Area Supervisor, and Program Manager. Weekday daily observations will remain in eff for 60 days. After 60 days monthly, administrative observations will be conducted. The management team began daily update meetings.	cility are atios, esed et the fre will	04/26/2024	
	And, "[Client A] stated l	ne found the weapon in a staff			March 29, 2024, to ensure compliance and implement changes needed developing a			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		15G749	B. WING		04/03/2024
	PROVIDER OR SUPPLIER		16613	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD VILLE, IN 47126	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
TAG	•	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	<del> </del>	id it in the house. [Client A]		and implementation of those	
		ken to [county jail]. There is		changes. Meetings will contin	ue
		this time. Initial exploration		until conditions are lifted.	
		termined the weapon belonged		3 The Program Manager	and
		ad)] and was in the vehicle of		Area Supervisor retrained staf	<b>I</b>
		staff. Both employees were		ResCare Weapon in the Facili	<b>I</b>
		rative leave pending		vehicle security checks, room	·,
	investigation."			sweeps and security system	
				operation, ANE (Abuse, Negle	ect
	A focused review o	f client A's record was		and Exploitation) Policy	
		4 at 9:45 AM. Client A's BSP		disciplinary action will be taken	n if
	_	Plan) dated 3/26/24 indicated		the policy is not followed. Area	<b>I</b>
	the following:			Supervisor and will ensure that	<b>I</b>
				Policy is followed, and correcti	
	-"[Name and date o	f birth] is transitioning from		measures are implemented.	
	_	escare ESN (Extra Support		Monitoring of will be done by 1	The I
		wn and state]. Due to recent		Program Manager, Area	
		nt and homelessness, [client A]		Supervisor, and DSL to ensure	e all
		itil a more suitable placement is		compliance.	
	available."	on a more summere processors is		4 Members of the	
				administrative team, including	
	-"[Client A] can be	easily influenced by others		managers from Quality, Nursir	
		trouble. According to		and Programming, will conduc	-
	_	referral packet, he does not		daily observations on weekday	<b>I</b>
		ble judgement in safety and		Any issues will be immediately	•
		He will need frequent		reported to the Facility Team.	
	^	itoring of his attention to		5 An IDT comprised of	
		sing what is being asked or		paraprofessionals was held or	1
	prompted."			April 1, 2024, to develop strate	
				to address client issues QIPD,	
	-"When out in the c	ommunity, [client A] needs to		Nurse and a Member of	
		osely as he has a history of		Programming Management wi	11
		iding knives and vape		retrain all staff in the facility or	<b>I</b>
	supplies."			updated BSPs ISP and HRP a	
				needed.	
	-"[Client A] does ha	ave a few close friends but		6 The Facility Maintenand	ce
		ew friends or maintain		Manger will inspect the site on	
		doesn't get along with most of		weekly at a minimum to identif	
		im a long time to develop trust		environmental issue that may	´
	_	has a long history of physical		arise. The Maintenance Mana	ager
					-

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G749		(X2) MULTIPLE ( A. BUILDING B. WING	<u></u>		
NAME OF I	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD	
RES CAF	RE SOUTHEAST IN	NDIANA		YVILLE, IN 47126	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		urious behavior, property		scheduled repair of the facility	
	_	nent, stealing, homicidal		security system on March 28,	
	statements and verb	oal aggression."		2024, repairs were made by	
	WII ::11C4 4			Koorsen Fire and Security on	
		nents: anytime he states or		March 29, 2024. The security	
		going to 'kill' others. luded threats to cut or shoot		professional recommended	
	others."	fuded inreals to cut or shoot		upgrades to the system to be	
	others.			installed no later than April 26, 2024.	
	-"Stealing: any time	e he takes items that do not		7 Facility Staff will monito	r
	belong to him with	out consent of the owner. This		home activities and client	
	includes stealing ite	ems from stores in the		interactions daily to ensure the	ere
	community, stealing	g housemates or staffs		is plans are followed if an issu	
	possessions. These	items can include knives,		noted the appropriate	
	vapes."			administrative personnel i.e. A	rea
				Supervisor, Program Manager	,
	Quality Assurance	Manger (QAM) was		Nurse, QIDP or AED immediat	ely
	interviewed on 4/2/	24 at 8:26 AM.		and correction will be made.	
				8 The Behavior Consultar	nt,
	1	facility's ANE (Abuse,		Program Manager, Area	
		on) policy should be		Supervisor, Facility Nurse and	
		vent incidents of ANE. QAM		QIDP will proactively monitor	
	· ·	aff were trained on the ANE		clients to ensure plan	
		nnually and throughout the		implementation.	
	1 -	nsure the policy was		9 The Administrative staff	will
	implemented to pre	event ANE.		continue to work with local law	
		- 444 4 222		enforcement to ensure they	
		sCare prohibited staff from		remain up to date, and client	
		on the facility property.		follows release agreement.	
	1	was aware of an allegation of	1	10 The Administrative team	
	_	andgun in the group home on		worked with BDDS to arrange	
	· ·	QAM indicated client A was		emergency alternative placem	ent
	"	ained the handgun from a staff		to meet the release order.	
		vehicle. QAM indicated two		Barrana Baagaarathia E	.i
		ed while the allegations were		Persons Responsible: Execut	
		indicated client A was		Director, AED, Program Mana	-
		of the incident and had		Maintenance Manager, Quality	
		AM was not aware of formal	1	Assurance, Quality Assurance	
		r release from the jail. QAM		Manager Director of Nursing,	
l	indicated no clients	or staff were injured during	1	Nurse, Area Supervisor, QIDP	,

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			COMPL	COMPLETED		
		15G749	B. WING		04/03/2024			
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					SIMA GRAY RD			
RES CARE SOUTHEAST INDIANA					VILLE, IN 47126			
NEO CARE OCUTIDENOT INDIANA				TILINIXI VILLE, IIN 47 120				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		TE.	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	`	indicated the clients were			DSL, and DSP.			
		the Bill of Rights and						
		AM indicated the clients had						
		ional distress since the						
		cated the facility had						
		administrative monitoring at the						
		home's exterior monitoring						
		ne home's interior door and						
		tems and retrained staff on the solicy and ensuring they keep						
	their vehicles locked at all times. QAM indicated client A's BSP (Behavior Support Plan) should be							
	· ·	'						
	implemented by staff to prevent ANE. QAM indicated she was not specifically aware of client							
	A's BSP protocols.	or specifically aware of elicit						
	As BSI protocois.							
	QIDP (Qualified Intellectual Disabilities							
	Professional) was interviewed on 4/2/24 at 9:38							
	AM.							
	QIDP indicated there had been an incident of							
	client A brandishing	g a handgun at the group						
	home on Thursday, 3/28/24. QIDP indicated client							
	A was arrested after the incident and had							
	remained in jail. QI	DP indicated client A was						
	formally charged with felony brandishing a							
	weapon and felony	intimidation. QIDP indicated						
	no staff or clients were injured as a result of the							
	incident. QIDP stated the facility had a "zero							
	tolerance policy" regarding weapons on the							
	premises. QIDP indicated the incident was under							
		oreliminary findings of client A						
		gun from the shared vehicle of	1				1	
		rt Professional) #1 and LS						
	(Lead Staff). QIDP indicated DSP #1 and LS were							
		investigation. QIDP indicated						
		otocol to ensure staff locked						
		on the premises. QIDP						
		BSP included restrictions from						
	weapons and should be implemented by staff.		1				1	

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			l	COMPLETED			
15G749		15G749	B. WING			04/03/2024			
NAME OF I	DOMDED OD CHIDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•			
NAME OF PROVIDER OR SUPPLIER				16613 SIMA GRAY RD					
RES CARE SOUTHEAST INDIANA				HENRY	VILLE, IN 47126				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
		ewed on 4/2/24 at 10:08 AM.							
		he was working at the home on							
		f3 and DSP #4 with clients A, B,							
		ndicated client A had become B and entered client D's							
	-	ndicated when client A exited							
		he had a handgun in his hand.							
		ient A] said 'I'm going to							
		"." DSP #2 indicated she, DSP #3							
		utside to the home's patio area							
	and continued trying to talk to client A to calm								
		indicated client A had his							
	finger on the trigger of the gun with the safety in								
	the off position. DSP #2 indicated client A was able to calm and released the weapon with no								
	clients or staff being injured. DSP #2 indicated								
	there should be no weapons on the property and								
	staff's vehicles should be locked at all times. DSP								
	#2 indicated she had participated in retraining on								
	3/28/24 regarding the facility's weapons policy								
	and vehicle protocol.								
	DSP #3 was interviewed on 4/2/24 at 10:22 AM.								
	DSP #3 indicated she was in the home working								
		#4 and clients A, B, C and D on							
	_	incident. DSP #3 was							
		and expressed being							
		g the incident. DSP #3 ed DSP #2 when DSP #2							
		e. DSP #3 indicated she							
	_	(facing client A), on the patio							
		ris left hand (hand with gun)							
		to talk to him and de-escalate							
		#3 indicated client A did							
	eventually release the weapon to staff and no								
		e injured as a result of the							
	incident. DSP #3 indicated the facility had a no weapons policy and staff vehicles should be								
	locked at all times.								

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AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G749	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE COMPI	(X3) DATE SURVEY COMPLETED 04/03/2024		
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 16613 SIMA GRAY RD HENRYVILLE, IN 47126					
(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 E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	I E RIATE	(X5) COMPLETION DATE		
	QIDP indicated clie the home he had the the incident. QIDP the weapon in clien client A told police dresser because he routine room sweep described in detail t dismantled the alarn entered staff's vehic vaping/smoking iter weapon.  The facility's polici- reviewed on 4/2/24  The facility's ANE policy dated 11/10/2  -"ResCare staff acti and safety of all ind  -"ResCare strictly p exploitation, mistre Individual's rights."  The facility's Stand 1/2/15 indicated the  -"ResCare maintain regulations regardin necessary for the ef Company and for the employees and the	es and procedures were at 9:30 AM.  (Abuse, Neglect, Exploitation) 23 indicated the following:  vely advocate for the rights lividuals."  prohibits abuse, neglect, atment, or violation of an						

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-"9. Possession or use of a firearm, illegal knife,

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G749	` ′	ILDING	onstruction 00	(X3) DATE COMPL <b>04/03</b> /	ETED	
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 16613 SIMA GRAY RD HENRYVILLE, IN 47126					
(X4) ID PREFIX TAG	(EACH DEFICIEN	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)	ΓE	(X5) COMPLETION DATE	
	kind while on Comp -controlled property owned, -leased, or - vehicles."	her prohibited weapon of any pany-owned, -leased, or or while operating Company-controlled equipment or attest to complaint #IN00431589.						

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