PRINTED:	03/26/2024
FORM API	PROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

ENTERS FOR MEDICARE & ME STATEMENT OF DEFICIENCIE		(X2) MULTIPLE C	ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247		A. BUILDING B. WING	00	COMPLETED 02/23/2024	
NAME OF PROVIDER OR SUPP		2401 0	ADDRESS, CITY, STATE, ZIP COD CORNWELL DR RSONVILLE, IN 47130		
(X4) ID SUMMA	RY STATEMENT OF DEFICIENCIE	ID		(X5)	
	TENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	COMPLETION	
TAG REGULATOR	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
N 0000					
(PCR) to the pro- recertification a investigation of	or a Post Certification Revisit e-determined full annual nd state licensure survey and the complaints #IN00409199, nd #IN00419787 conducted on	W 0000			
Complaint #IN(0409199: Not corrected.				
Complaint #IN(0418483: Not corrected.				
Complaint #IN(0419787: Not corrected.				
	a conjunction with the complaints #IN00426039 and				
Survey dates: 2, 2/23/24.	20/24, 2/21/24, 2/22/24 and				
Facility Numbe Provider Numb AIM Number: 1	er: 15G247				
accordance with	of this report completed by #15068				
W 0104 483.410(a)(1) GOVERNING	BODY				
Bldg. 00 The governing policy, budget, the facility.	body must exercise general and operating direction over				
sampled clients	vation and interview for 3 of 3 (A, B and C) and 5 additional G and H), the facility's governing	W 0104	1 The Program manager contacted Boggs Pest Control treat area for insect, and	to	
LABORATORY DIRECTOR'S OR	PROVIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	

Mark Slaughter

AED

03/18/2024

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

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPI	LETED
		15G247	B. WING		02/23	/2024
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
RES CA	RE COMMUNITY A	LTERNATIVES SE IN		CORNWELL DR ERSONVILLE, IN 47130		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROWIDERIC DI AN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF	N BE	COMPLET
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	RIATE	DATE
	body failed to exer	cise operating direction over		contractor sealed area of e	ntry to	
	the facility to ensur	e the group home was free		prevent future pest entry we	ork	
	from numerous dea	d insects scattered throughout		complete.		
	the basement on an	d around the emergency food		2 Program Manager co	ntacted	
	supply and comple	ted the process of sorting		contractor to clean baseme	nt area	
	and/or removal of e	expired food items and water.		work was complete, and ins	stalled	
				an additional barrier to sepa	arate	
	Findings include:			the crawlspace that allowed	l for	
				proper ventilation.		
		s conducted on 2/20/24 from		3 The Program Manage		
		M. At 5:26 PM, the basement		oversaw the cleaning of the	;	
		l winged insects scattered		basement and verified the		
	throughout the floor, shelves and emergency food			satisfactory cleanup of dead	-	
		jugs of the emergency water		that resulted from additiona	l work	
		ritten on their caps indicating		in the basement area.		
		8 PM, the Qualified Intellectual		4 The Program Manage		
		sional (QIDP) was asked about		verified the replacement of		
		the floor, shelving and around		water and verified all emerg	gency	
		d supply and the 2022 dates on		food supply is in date.		
		igs. The QIDP stated, "We		5 A member of the		
	-	and make sure no expired		administrative team will con		
		indicated at the time of the $(11/20/22)$ a post		monthly site reviews for all		
		on (11/20/23), a pest isited the home and stated, "I		in facility and the administra		
		d the day after you left".		hold a weekly ICF meeting discuss issues that arise in		
	Kilow it got sprayed	the day after you left .		facility.	uie	
	At 5:29 PM, the At	ea Supervisor (AS) was asked		i comey:		
		exts and dates for expired		Persons Responsible: AED		
		pply. The AS stated, "The		Quality Assurance Manage		
		s been down here and pulling		Coordinator/QIDP Manager		
		nore dead bugs are falling from		Program Manager, Area	-	
		ng to do work down here when		Supervisor, QIDP, Direct St	upport	
		le. I'll try to go through it".		Lead, and DSP.		
	On 2/21/24 at 3.20	PM, the QIDP was interviewed.				
		d more work had been				
		ing the dead insects and				
		pply. The QIDP stated, "Last				
		as swept and now gone				
	(expired food). The	r	1	1		1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID:

KMB612 Facility ID: 000769

0769 If cont

If continuation sheet

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FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247		A. BUILDING B. WING	00	 X3) DATE SURVEY COMPLETED 02/23/2024
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	2401	T ADDRESS, CITY, STATE, ZIP COD CORNWELL DR ERSONVILLE, IN 47130	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0125 Bldg. 00	 basement to illustiand organized. This and organized. This jugs of water with indicated the expiripurposes such as conneed of water (emposes such as conneed of water (emposes) and the subscription of the subscription	as cited on 11/20/23. The facility nt a systemic plan of correction	W 0125	The facility will ensure the rights of all clients allowing and encourage individual clients to exercise their rights as clients o the facility, and as citizens of the United States, including the right to file complaints, and the right due process. An IDT comprised of paraprofessionals was conducte and determined Client B's need a Health Care Representative (HCR). The QIDP obtained a Heal Care Representative (HCR) for Client B. A review of all clients in the	f e ht to ed for Ith

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	R MEDICARE & MEDI					-	1B NO. 0938-039	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	î î	ULTIPLE CO JILDING	DNSTRUCTION 00	r í	E SURVEY	
AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247		A. BU B. WI		00		COMPLETED 02/23/2024	
	138247					02/23	0/2024	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD			
RES CA		ALTERNATIVES SE IN		JEFFEI	RSONVILLE, IN 47130			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	1	(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E RIATE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE	
		0 PM, a review of the facility's			facility was conducted by the			
		ties Services (BDS) reports and			to determine the need for a	Health		
		estigation summaries was			Care Representative.			
	affecting client B:	view indicated the following			A member of the administrative team will con	duct c		
	arreeting chefit D.				monthly site reviews for all c			
	BDS incident repo	rt dated 12/22/23 indicated,			in facility and the administra			
	-	ient B] complained of stomach			hold a weekly ICF meeting t			
		want to eat. ResCare LPN			discuss issues that arise in t			
	-	nurse) was contacted, and			facility.			
	[client B] was tran	sported to Urgent Care. Once at			5			
	Urgent Care, [clien	nt B] was assessed, and he was						
	transported by am	bulance to hospital for further			Persons Responsible: AED),		
		atment. Plan to Resolve: A CT			Quality Assurance Manager	, QA		
		vas completed and showed			Coordinator/QIDP Manager,			
	-	ended gall bladder. [Client B]			Program Manager, Area			
	-	gery is scheduled for 12/24/23 to			Supervisor, QIDP, Direct Su	pport		
	-	ler removed. ResCare will			Lead, and DSP.			
		vith the hospital and plan for						
	discharge".							
	On 2/21/24 at 12.2	24 PM, a review of client B's						
		ted. The review indicated the						
	following:							
	8							
	Individual Support	t Plan (ISP) dated 10/16/2023						
	indicated, "Name:	[Client B] Interdisciplinary						
	Team (IDT) Mem	bers:". Client B's ISP did not						
		Care Representative (HCR) listed						
	as part of his IDT	members.						
		PM, the Qualified Intellectual						
		sional (QIDP) was interviewed.						
		ted about client B's gall bladder						
		ed for a HCR. The QIDP						
		did not have a HCR. The QIDP						
	-	ital did not want to perform the						
	gan bladder surger	ry without ensuring client B						

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could provide consent for the surgery and stated, "I don't recall how we got them to agree. They're

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Facility ID: 000769

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/23/2024 15G247 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2401 CORNWELL DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE particular about that". The QIDP was asked if client B required a HCR. The QIDP stated, "I will see if he has the paperwork. At first, they (hospital) were not going to, due to consent. I called them, me and two of the nurses from the hospital with [client B] on the phone, asked if he had the ability to make decisions". The QIDP indicated questions such as, who is your brother, were asked of client B to answer before the hospital would agree to perform his gall bladder surgery. On 2/21/24 at 3:37 PM, the QIDP provided more follow up and a form titled "Appointment of a Health Care Representative" dated 4/12/2010 for review. Client B's HCR form listed two names of people identified as his HCRs and indicated, "I [client B], voluntarily appoint [HCR names], whose telephone number and address are: [HCR contact information] respectively, as my health care representatives who is (sic) authorized to act for me in all matters of health care ... ". The OIDP indicated further follow up was needed and stated, "I need to follow up. I've never seen this paper before". On 2/22/24 at 2:10 PM, the QIDP was interviewed. The QIDP stated, "I called the people on the form. They said they do want to be his health care rep (representatives). It's a [family member] that wants to do that. I've never heard from them before. No holidays or anything". The QIDP was asked if client B had a HCR in place at the time of the gall bladder surgery. The QIDP stated, "Yes". The QIDP was asked if client B's HCR should have been notified of his need for a gall bladder surgery. The QIDP stated, "Yes. I should have told them about it". The QIDP indicated she was going to send a new HCR form to update client B's record and stated, "They want me to call when I Event ID: KMB612 Facility ID: 000769 Page 5 of 23 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/23/2024 15G247 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2401 CORNWELL DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE send the new letter". The QIDP indicated she was going to discuss his recent gall bladder surgery and provide an update on client B's health status with his HCR when she made this phone call. On 2/22/24 at 2:23 PM, the Nurse was interviewed. The Nurse was asked about client B's health care representative and their interest in continuing to be client B's representative. The Nurse stated, "I had no idea he (client B) had a health care rep (representative). They (hospital) asked me, and I couldn't, a conflict of interest. I was not aware [QIDP] had reached out". The Nurse was asked if client B's HCRs should have been notified at the time of client B's gall bladder surgery. The Nurse stated, "Yeah". On 2/23/24 at 10:13 AM, the Quality Assurance Manger (QAM) was interviewed. The QAM was asked about client B's gall bladder surgery, if his health care representative should have been notified, and client B's need for a health care representative. The QAM stated, "In a normal situation I would say yes. I don't know where this information got dropped. Plus, [QIDP] and [Nurse] were not here in 2010 and there was no contact from them. This is something we'll have [QIDP] explore it more. I don't know about the contact from that point (2010). I'll make sure we're following up and consulting with [client B] as well". 9-3-2(a) W 0140 483.420(b)(1)(i) CLIENT FINANCES Bldg. 00 The facility must establish and maintain a system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB	NO.	0938-039

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G247	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		completed 02/23/2024
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	2401 (ADDRESS, CITY, STATE, ZIP COD CORNWELL DR ERSONVILLE, IN 47130	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
		view and interview for 3 of 3	W 0140	The facility will establish	03/17/2024
	sampled clients (A,	B and C) and 5 additional		and maintain a system that	00/1//202
		and H), the facility failed to		assures a full and complete	
		mplete accounting of clients		accounting of clients' personal	
		and H's personal funds		funds.	
	entrusted to the fac			The Facility will retrain sta	aff
		5		on the standard of maintaining t	
	Findings include:			system of accounting for client's	
	6			funds entrusted to the facility. A	
	Confidential Interv	iew (CI #1) indicated concerns		receipts for the purchases must	
		hopping and purchasing of		be returned to the facility and	
		ems. CI #1 indicated the safe at		identify which client funds were	
		left unlocked and money had		spent on. The DSL will conduct	
		l stated, "A client got into the		weekly reviews of the Client	
	-	her clients' money. I guess the		Financial Record's to ensure all	
	-	ked and that's how I don't		transactions have been recorde	
		y (staff) were spending their		and account is balanced. The	4
		the P-card was in the (safe).		Program Manager will in-service	2
		\$100.00 and no documentation		the Area Supervisor, and Direct	
		e or had been". CI #1 was		Support Lead on the use of clien	
		noney had been in cash or a		finance book.	
		1 stated, "I don't know. It was		All employees will be	
		ion of it being there or spent".		trained on the revised standard	
				and disciplinary action will be	
	On 2/20/24 at 12:30) PM, a review of the facility's		given if the standard is not	
		ies Services (BDS) reports and		followed.	
		estigation summaries was		The Facility will ensure th	at
		iew indicated the following		the abuse neglect and exploitati	
		B, C, D, E, F, G and H:		policy is followed.	
	-			A member of the	
	1) BDS incident rep	port dated 2/5/24 indicated,		Administrative team will conduc	ta
	"During a financial	audit it was discovered, [client		monthly site reviews for all clien	
	B] has \$1.00 in mis	sing funds, [client C] had \$13.00		in facility and the administrator	
		nd [client A] had \$23.00 in		hold a weekly ICF meeting to	
	-	to Resolve: Staff will be		discuss issues that arise in the	
		ancial audit policy and		facility.	
		saction logs. Bill of Rights and			
		completed with [client B], [client			
		ResCare will reimburse [client B]		Persons Responsible: AED,	
		3.00, and [client A] \$7.24".		Quality Assurance Manager, QA	A

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COM	(X3) DATE SURVEY COMPLETED 02/23/2024	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 2401 CORNWELL DR JEFFERSONVILLE, IN 47130				
							(17)
(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 CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE
TAG	Investigation Sum 2/5/24 with an and "Introduction: On Department receiv [client B], [client C] and [client A] each books that may be investigation was in determine what hat Conclusion: It is su unaccounted for has \$13.00 unacco [client E] had \$31. was found in an en- in the safe It is su \$23.00 unaccounted what happened to the 2) No BDS inciden review. Investigation Sum 8/31/23 indicated, (sic/exploitation) if it was reported dur for [client B], [clien D], [client G], [clion balance with cash Factual Findings: has receipts totalinn hand leaving \$43.7 [Client C] with tot	mary dated 1/29/24 through endment date of 2/9/24 indicated, 1/27/24, the Quality Assurance ed an incident report indicating C], [client E], [client F], [client G], a had funds from their finance unaccounted for. An nitiated in an attempt to ppened to funds abstantiated [client B] has \$1.00 It is substantiated [client C] unted for It is unsubstantiated 00 unaccounted for; the money weloped marked with his name abstantiated [client A] has ed for It cannot be determined the funds". ht report was available for mary dated 8/24/23 through "An exploration nvestigation was initiated when ring a financial audit, finances ent E], [client H], [client F], [client ent A] and [client C's] did not		TAG	DEFICIENCY Coordinator/QIDP Man Program Manager, Are Supervisor, QIDP, Dire Lead, and DSP.	ager, a	DATE
	[Client E] with tota	al of \$100.00 has receipts					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMEI AND PLAN	PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 15G247 B. WING				00	(X3) DATE SURVEY COMPLETED 02/23/2024	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		2401 C	ADDRESS, CITY, STATE, ZIP COE ORNWELL DR RSONVILLE, IN 47130)	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
	totaling \$97.46 wi \$2.54 unaccounted	th \$0.00 cash on hand leaving I for					
		al of \$100.00 has receipts th \$0.27 cash on hand leaving 1 for					
		al of \$100.00 has receipts th \$10.94 cash on hand leaving ed for					
		al of \$100.00 has receipts th \$2.00 cash on hand leaving ed for					
		al of \$50.00 has receipts totaling cash on hand leaving \$21.97					
		al of \$100.00 has receipts th \$20.57 cash on hand leaving					
	June 2023 shows:.	aventories updated from 2022 to Due to inability to locate wn how much the items cost urchased or how					
	clients pocket mor they needed it. [Fo witnessed a forme a client from a diff [Former staff #1] i	stated she witnessed staff give ney to take to day program when ormer staff #1] stated she r site supervisor give money to ferent client's money envelope. s unaware if any money given to r was deducted from the l) ledger					
	show staff did not	s, including ledgers and receipts properly document ey should have, not accounting					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	EMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 15G247 B. WING				(X3) DATE SURVEY COMPLETED 02/23/2024		
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN		2401 C	ADDRESS, CITY, STATE, ZII ORNWELL DR RSONVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
	Staff responsible f through 4/28/23 w received are no lor Conclusion: It has has \$43.73 unacco H] \$6.81, [client F G] \$21.97, and [cl over his amount Recommendations staff on client fina audits by DSL (dir audits by DSL (dir audit by AS (Area On 2/20/24 at 4:35 finances was comp clients A, B, C, D, to be dated Januar on hand financial review. On 2/21/24 at 4:03 Manager and Qual Professional (QID and QIDP were as for a lack of accou funds and the revi- financial ledgers f accounting had oc QAM indicated a p incident report) ha QAM was asked if entrusted to the far accurately and acc	or cash to go to day program. For client finances from 9/1/22 hen the last receipt was ager employed with ResCare been determined that: [Client B] unted for, [client E] \$2.54, [client] \$10.03, [client D] \$18.50, [client ient C] \$5.31. [Client A] has \$7.02 E: Reimburse all clients. Retrain nces and accounting. Weekly rect support lead). Biweekly Supervisor)". FPM, a review of the clients' beted. The review indicated E, F, G and H's financial ledgers y 2023. No February 2024 cash ledgers were available for FPM, the Quality Assurance ified Intellectual Disabilities P) were interviewed. The QAM ked about the incident history ming for the clients' personal ew of the cash on hand or all the clients indicating no curred since January 2024. The recent financial audit (2/5/24 d found accounting issues. The f the clients' personal funds cility should be maintained ounted for. The QAM stated, on the ledger". The QIDP stated,					
	"Site leads do it w would make sense	on the ledger". The QIDP stated, eekly". The QAM stated, "It that [Area Supervisor] should the ledger". The QAM indicated					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/23/2024 15G247 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2401 CORNWELL DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE she had spoken with the Area Supervisor about documenting her financial audits and indicated more follow up was needed to ensure all accounting, audits, and transactions were being properly documented to ensure all client personal funds entrusted to the facility were accurate and accounted for. On 2/23/24 at 10:13 AM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the incident history for missing money indicated in the 8/24/23 investigation. The QAM indicated a BDS incident report was not available for review and stated, "We looked at it as missing money and not exploitation. A financial audit found it (missing money) and we initiated the investigation. The QAM indicated the 2/5/24 incident was also a situation where a financial audit found missing money, was reported and an investigation initiated. The QAM indicated investigations into both incidents did not indicate exploitation had occurred, but a lack of accounting for the clients' personal funds. The QAM was asked how the clients' personal funds should be maintained and accounted for. The QAM stated, "At all times". 9-3-2(a) W 0149 483.420(d)(1) STAFF TREATMENT OF CLIENTS Bldg. 00 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 3 W 0149 The Facility will retrain staff 03/17/2024 sampled clients (A, B and C) and 5 additional at the site on the Abuse, Neglect clients (D, E, F, G and H), the facility failed to and Exploitation Policy and implement the Abuse, Neglect, Exploitation, disciplinary action will be given if Mistreatment and/or Violation of Individual's the policy is not followed. Area Rights (ANE) policy to ensure: 1) allegations of Supervisor and Direct Support Event ID: KMB612 Facility ID: 000769 Page 11 of 23 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

03/26/2024

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	03/26/2024
FORM API	PROVED
OMB NO.)938-039

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD		(X3) DATE SURVEY COMPLETED 02/23/2024	
NAME OF I							
(X4) ID PREFIX		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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	staff sleeping were	immediately reported, 2) to			Lead will ensure that the Abuse,		
	prevent staff verbal	abuse directed toward client			Neglect and Exploitation Policy i	s	
	D, and 3) allegation	s of clients A, B, C, D, E, F, G			followed. Monitoring of ANE will		
	and H's missing per	sonal funds were immediately			done by The Program Manager,		
	reported.				Area Supervisor and Direct		
					Support Lead to ensure all		
	Findings include:				incidents of possible abuse,		
	-				neglect and exploitation are		
	On 2/20/24 at 12:30	PM, a review of the facility's			reported to the QA department.		
	Bureau of Disabilit	ies Services (BDS) reports and			The Program Manager will		
	accompanying inve	stigation summaries was			ensure the Area Supervisor will		
		iew indicated the following			retrain staff on the Abuse, Negle	ect	
	affecting clients C a				and Exploitation Policy and		
	6				disciplinary action will be given it	f	
	1) BDS incident rep	port dated 2/2/24 indicated, "On			the policy is not followed.		
		d when she arrived at the			Area Supervisor and		
	-	eep and snoring in the office			Program Manager will ensure th	at	
		sitting in the living (room). It			the Abuse, Neglect and		
		hat on $1/25$ (2024), when staff			Exploitation Policy is followed		
	-	site after dropping clients off,			through random monitoring.		
		leep then as well and [client			The area supervisor in		
		e living room. Plan to Resolve:			serviced facility staff on ResCare	2	
		ced on leave pending the			anonymous compliance line		
	-	estigation. Staff will continue			allowing an additional resource f	or	
		and provide all necessary			staff to report outside the		
	supports".] F			Administrative chain, and on		
	11				ResCare's non-retaliation and Z	ero	
	Investigation Sumn	nary dated 2/2/24 through			Violence policy.		
	-	On $2/1/24$, the Quality			Monitoring of Corrective		
		ent received an incident report			Action: The Program Manager,		
	-	ff arrived at the house, staff			Area Supervisor and Residential		
	-	ep and snoring in the office			Manager will ensure all incidents		
		s sitting in the living room. Staff			of possible abuse, neglect and		
		25/24, staff [staff #12] was			exploitation are reported to the C	A	
		while [client C] sat in the living			department.		
	room	L _]					
	Summary of Intervi	ews: [Staff #9] reported when			Persons Responsible: AED,		
		[name of group home] staff			Quality Assurance Manager, QA		
		ep and snoring in the office			Coordinator/QIDP Manager,		
		-r shoring in the office					

If continuation sheet Page 12 of 23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G247	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	СОМ	(X3) DATE SURVEY COMPLETED 02/23/2024	
	PROVIDER OR SUPPLI		2401 0	ADDRESS, CITY, STATE, ZIP CO)D		
RES CA	RE COMMUNITY /	ALTERNATIVES SE IN	JEFFE	RSONVILLE, IN 47130			
(X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	ECTION DULD BE PROPRIATE	(X5) COMPLETIO	
TAG	 while [client C] w [Staff #9] reported clients off at work house, staff [staff room while [client room. [Staff #9] st 1/25/24 incident u afraid of the staff. Factual Findings:. working at [name transition to a wai worked at the hom reported [staff #11] office when she at This is the second for allegations of [[Staff #9] stated sl After [staff #9] rej sleeping, and (sic) was received, on 2 from [staff #9] (th separately) 6 of witnessing staff sl shift or coming or Conclusion: It can slept while on shift determined if [staff 1/25/24". On 2/21/24 at 1:44 reviewed. The rev Individual Support indicated, "Dischat team recommends supervision while 	as sitting in the living room. I that on 1/25/24, after dropping shop and arriving back to the #12] was asleep in the living t C] was sitting in the living tated she did not report the ntil this date because she was [Staff #9] was temporarily of group home] pending ver location and had only he since 1/24/24 [Staff #9]] was asleep and snoring in the rived at the house on 2/1/24. suspension and investigation [staff #11] sleeping on shift he was afraid of [staff #11] ported the allegations of staff anonymous compliance call 2/1/24, alleging verbal abuse is is being investigated 6 staff interviewed denied eeping when they have been on	TAG	Program Manager, Area Supervisor, QIDP, Direc Lead, and DSP.		DATE	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247			DING	NSTRUCTION 00	CO	te survey Mpleted 2 3/2024
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	2	2401 CC	DDRESS, CITY, STATE, ZIP C DRNWELL DR SONVILLE, IN 47130	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL NR LSC IDENTIFYING INFORMATION	PR	ID EFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE / DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
		To learn IL (independent pend time with staff on eech".					
	"Allegations were abuse (sic) toward	eport dated 1/2/24 indicated, received of staff being verbally s [client D]. The staff member in ed on administrative leave ions".					
	1/8/24 indicated, ' was initiated when [former direct sup and speaks to [clia manner Conclu yells at [client D].	mary dated 1/1/24 through Introduction: An investigation a report was received that staff port lead/DSL] yells at [client D] ent D] in an inappropriate sion: Substantiated [former DSL] Substantiated [former DSL] tte comments to [client D]".					
	concerns with the purchasing of clot indicated the safe unlocked and mor stated, "A client g other clients' mon- unlocked and that' they (staff) were s P-card was in ther \$100.00 and no do there or had been" money had been in stated, "I don't know	terview (CI #1) indicated finances, shopping and hes and food items. CI #1 at the home had been left ey had been missing. CI #1 ot into the safe and got into ey. I guess the safe had been s how I don't understand why pending their money when the e (safe). [Client A] received ocumentation it (money) was . CI #1 was asked if client A's n cash or a debit/gift card. CI #1 ow. It was just no it being there or spent".					
	Bureau of Disabili accompanying inv conducted. The re	30 PM, a review of the facility's ties Services (BDS) reports and estigation summaries was view indicated the following , B, C, D, E, F, G and H:					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 15G247	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/23/2024		
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 2401 CORNWELL DR JEFFERSONVILLE, IN 47130				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID p		PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETIC
TAG	REGULATORY C	PR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	No BDS incident	reports were available for review.					
	8/31/23 indicated,	mary dated 8/24/23 through "An exploration nvestigation was initiated when					
		ring a financial audit, finances					
	-	ent E], [client H], [client F], [client					
	D], [client G], [cli balance with cash	ent A] and [client C's] did not on hand					
	has receipts totalir	[Client B] with total of \$100.00 ng \$38.27 with \$18.00 cash on 73 unaccounted for					
		al of \$50.00 has receipts totaling 2 cash on hand leaving \$5.31					
		al of \$100.00 has receipts th \$0.00 cash on hand leaving 1 for					
		al of \$100.00 has receipts th \$0.27 cash on hand leaving 1 for					
		al of \$100.00 has receipts th \$10.94 cash on hand leaving ed for					
		tal of \$100.00 has receipts th \$2.00 cash on hand leaving ed for					
		tal of \$50.00 has receipts totaling cash on hand leaving \$21.97					
	[Client A] with tot	tal of \$100.00 has receipts					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247		A. BUILDIN B. WING		COI 02/	te survey Mpleted 23/2024
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	240	EET ADDRESS, CITY, STAT 1 CORNWELL DR FERSONVILLE, IN 4		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	AN OF CORRECTION ACTION SHOULD BE D TO THE APPROPRIATE JENCY)	(X5) COMPLETIC DATE
		th \$20.57 cash on hand leaving				
	June 2023 shows:	aventories updated from 2022 to Due to inability to locate wn how much the items cost urchased or how				
	clients pocket mor they needed it. [For witnessed a forme a client from a dif [Former staff #1]	stated she witnessed staff give ney to take to day program when ormer staff #1] stated she r site supervisor give money to ferent client's money envelope. is unaware if any money given to y was deducted from the l) ledger				
	show staff did not expenditures as th for pocket change Staff responsible f through 4/28/23 w	s, including ledgers and receipts properly document ey should have, not accounting or cash to go to day program. For client finances from 9/1/22 hen the last receipt was nger employed with ResCare				
	has \$43.73 unacco H] \$6.81, [client F	been determined that: [Client B] punted for, [client E] \$2.54, [client [] \$10.03, [client D] \$18.50, [client ient C] \$5.31. [Client A] has \$7.02				
	staff on client fina	:: Reimburse all clients. Retrain nces and accounting. Weekly rect support lead). Biweekly Supervisor)".				
	Manager was inter about immediate r	3 AM, the Quality Assurance viewed. The QAM was asked eporting of suspected abuse, on to ensure implementation of				

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/23/2024 15G247 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2401 CORNWELL DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE client C's program plan, to prevent staff verbal abuse directed toward client D, and missing client personal funds. The QAM indicated the staff verbal abuse toward client D had been substantiated. The QAM stated, "I believe the incident date was 8/24/23 (missing money). I don't see a BDS (incident) report filed. We looked at it as an accounting issue, rather than exploitation". The QAM was asked how the ANE policy should be implemented. The QAM stated, "At all times. Staff should report immediately and are trained at time of hire and annually thereafter". On 2/22/24 at 3:27 PM, a review of the Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights (ANE) policy was conducted. The ANE policy indicated, "ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare, local, state and federal guidelines... ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights ... ". This deficiency was cited on 11/20/23. The facility failed to implement a systemic plan of correction to prevent recurrence. This federal tag relates to complaints #IN00409199, #IN00418483 and #IN00419787. 9-3-2(a) W 0153 483.420(d)(2) STAFF TREATMENT OF CLIENTS Event ID: KMB612 Facility ID: 000769 Page 17 of 23 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/23/2024 15G247 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2401 CORNWELL DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE. IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Bldg. 00 The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 3 of 3 W 0153 1 The facility must ensure that 03/17/2024 sampled clients (A, B and C) and 5 additional all allegations of mistreatment, clients (D, E, F, G and H), the facility failed to neglect or abuse, as well as immediately report to the administrator and injuries of unknown source, are Bureau of Disabilities Services (BDS) within 24 reported immediately to the hours, in accordance with state law: 1) clients A, administrator or to other officials in B, C, D, E, F, G and H's missing personal funds accordance with State law through and 2) alleged negligence for the implementation established procedures. of client C's program plan due to staff sleeping 2 The Area Supervisor will while on duty. train all Facility Staff on the BDDS Reporting Standard. Findings include: 3 The Facility will retrain staff at the site on the Abuse, Neglect 1) Confidential Interview (CI #1) indicated and Exploitation Policy and concerns with the finances, shopping and disciplinary action will be given if purchasing of clothes and food items. CI #1 the policy is not followed. Area indicated the safe at the home had been left Supervisor and Direct Support unlocked and money had been missing. CI #1 Lead will ensure that the Abuse, stated, "A client got into the safe and got into Neglect and Exploitation Policy is other clients' money. I guess the safe had been followed. Monitoring of ANE will unlocked and that's how ... I don't understand why done by The Program Manager, they (staff) were spending their money when the Area Supervisor and Direct P-card was in there (safe). [Client A] received Support Lead to ensure all \$100.00 and no documentation it (money) was incidents of possible abuse, there or had been". CI #1 was asked if client A's neglect and exploitation are money had been in cash or a debit/gift card. CI #1 reported to the QA department. stated, "I don't know. It was just no 4 The Program Manager will documentation of it being there or spent". ensure the Area Supervisor will retrain staff on the Abuse, Neglect On 2/20/24 at 12:30 PM, a review of the facility's and Exploitation Policy and Bureau of Disabilities Services (BDS) reports and disciplinary action will be given if accompanying investigation summaries was the policy is not followed. conducted. The review indicated the following 5 Area Supervisor and affecting clients A, B, C, D, E, F, G and H: Program Manager will ensure that

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Event ID:

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Facility ID: 000769

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 15G247	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/23/2024	
	PROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	2401 0	ADDRESS, CITY, STATE, ZIP CO CORNWELL DR ERSONVILLE, IN 47130	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)	ECTION ULD BE PROPRIATE	(X5) COMPLETIC DATE
	No BDS incident r Investigation Sum 8/31/23 indicated, (sic/exploitation) i it was reported dur for [client B], [clie D], [client G], [clie balance with cash Factual Findings: has receipts totalin hand leaving \$43.7 [Client C] with tot \$22.57 with \$22.12 unaccounted for [Client E] with tot totaling \$97.46 wit \$2.54 unaccounted [Client H] with tot totaling \$92.92 wit \$6.81 unaccounted [Client F] with tot totaling \$79.03 wit \$10.03 unaccounted [Client D] with tot totaling \$79.50 wit \$18.50 unaccounted [Client G] with tot	eports were available for review. mary dated 8/24/23 through "An exploration nvestigation was initiated when ing a financial audit, finances nt E], [client H], [client F], [client ent A] and [client C's] did not on hand . [Client B] with total of \$100.00 g \$38.27 with \$18.00 cash on 73 unaccounted for al of \$50.00 has receipts totaling 2 cash on hand leaving \$5.31 al of \$100.00 has receipts th \$0.00 cash on hand leaving 1 for al of \$100.00 has receipts th \$0.27 cash on hand leaving 1 for al of \$100.00 has receipts th \$10.94 cash on hand leaving d for al of \$100.00 has receipts th \$2.00 cash on hand leaving d for al of \$100.00 has receipts th \$10.94 cash on hand leaving d for al of \$100.00 has receipts th \$2.00 cash on hand leaving d for		the Abuse, Neglect and Exploitation Policy is foll through random monitor 6 The area supervise serviced facility staff on anonymous compliance allowing an additional re staff to report outside the Administrative chain, an ResCare's non-retaliation Violence policy 7 A member of the administrative team will monthly site review for a in facility and the admini hold a weekly ICF meeti discuss issues that arise facility. Persons Responsible: A Quality Assurance Mana Coordinator/QIDP Mana Program Manager, Area Supervisor, QIDP, Direc Lead, and DSP.	ing. or in ResCare line source for e d on on and Zero conduct a all clients strator will ng to e in the AED, ager, QA iger,	
	[Client A] with tot	al of \$100.00 has receipts				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 15G247	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 02/23/2024	
	PROVIDER OR SUPPLI	ER ALTERNATIVES SE IN	2401 C	ADDRESS, CITY, STATE, ZIP (ORNWELL DR RSONVILLE, IN 47130	COD	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
	totaling \$86.45 w \$7.02 in excess	ith \$20.57 cash on hand leaving				
	June 2023 shows: receipts, its unkno	nventories updated from 2022 to Due to inability to locate own how much the items cost urchased or how				
	clients pocket mo they needed it. [F witnessed a forme a client from a dif [Former staff #1]	stated she witnessed staff give ney to take to day program when ormer staff #1] stated she rr site supervisor give money to ferent client's money envelope. is unaware if any money given to y was deducted from the 1) ledger				
	show staff did not expenditures as the for pocket change Staff responsible through 4/28/23 w	es, including ledgers and receipts properly document ey should have, not accounting or cash to go to day program. for client finances from 9/1/22 when the last receipt was nger employed with ResCare				
	has \$43.73 unacco H] \$6.81, [client I	been determined that: [Client B] bunted for, [client E] \$2.54, [client F] \$10.03, [client D] \$18.50, [client lient C] \$5.31. [Client A] has \$7.02				
	staff on client fina	s: Reimburse all clients. Retrain ances and accounting. Weekly rect support lead). Biweekly a Supervisor)".				
	2/1/24, staff report house, staff was a	eport dated 2/2/24 indicated, "On ted when she arrived at the sleep and snoring in the office s sitting in the living (room). It				

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/23/2024 15G247 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2401 CORNWELL DR **RES CARE COMMUNITY ALTERNATIVES SE IN** JEFFERSONVILLE, IN 47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE was also reported that on 1/25 (2024), when staff arrived back at the site after dropping clients off, another staff was asleep then as well and [client C] was sitting in the living room. Plan to Resolve: Staff have been placed on leave pending the outcome of the investigation. Staff will continue to monitor [client C] and provide all necessary supports". Investigation Summary dated 2/2/24 through 2/9/24 indicated, "On 2/1/24, the Quality Assurance Department received an incident report indicating when staff arrived at the house, staff [staff #11] was asleep and snoring in the office while [client C] was sitting in the living room. Staff also reported on 1/25/24, staff [staff #12] was asleep then as well while [client C] sat in the living room... Summary of Interviews:... [Staff #9] reported when she arrived back at [name of group home] staff [staff #11] was asleep and snoring in the office while [client C] was sitting in the living room. [Staff #9] reported that on 1/25/24, after dropping clients off at workshop and arriving back to the house, staff [staff #12] was asleep in the living room while [client C] was sitting in the living room. [Staff #9] stated she did not report the 1/25/24 incident until this date because she was afraid of the staff ... Factual Findings:... [Staff #9] was temporarily working at [name of group home] pending transition to a waiver location and had only worked at the home since 1/24/24... [Staff #9] reported [staff #11] was asleep and snoring in the office when she arrived at the house on 2/1/24. This is the second suspension and investigation for allegations of [staff #11] sleeping on shift ... [Staff #9] stated she was afraid of [staff #11]... Event ID: KMB612 Facility ID: 000769 Page 21 of 23 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES

03/26/2024

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		0	(X3) DATE SURVEY COMPLETED 02/23/2024	
	PROVIDER OR SUPPLE	ER ALTERNATIVES SE IN	240	01 CORN	ess, city, state, zip cod WELL DR NVILLE, IN 47130		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREF TAG	CF	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETIC DATE
	sleeping, and (sic, was received, on 2 from [staff #9] (th separately) 6 of witnessing staff sl shift or coming of Conclusion: It car slept while on shi determined if [sta 1/25/24". On 2/21/24 at 1:4 reviewed. The rev Individual Suppor indicated, "Dischat team recommends supervision while activities, as he has skills. He requires activities Needs living) skills. To s developing his sp On 2/23/24 at 10: Manager (QAM) asked about repor and H's missing p suspected neglect C's program plan on shift. The QAM date was 8/24/23 BDS (incident) re accounting issue, QAM indicated th funds and suspect have immediately	 anot be determined if [staff #11] ft on 2/1/24. It cannot be ff #12] slept while on shift on 5 PM, client C's record was iew indicated the following: t Plan (ISP) dated 4/29/23 arge Plan: The interdisciplinary that he (client C) have participating in community as not acquired safe pedestrian a structure for leisure time : To learn IL (independent pend time with staff on 					

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CENTERS FO	R MEDICARE & MEDICA	AID SERVICES			OMB NO. 0938-039	
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G247		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED 02/23/2024	
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	2401 C	ADDRESS, CITY, STATE, ZIP COD CORNWELL DR RSONVILLE, IN 47130		
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	9-3-2(a)	n you on that one .				
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Bldg. 00			W 9999	No response		03/17/2024

KMB612 Facility ID: 000769