STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a pre-determined full annual recertification and state licensure survey. This visit included the investigation of complaint #IN00435432. Complaint #IN00435432: Federal and state deficiencies related to the allegation(s) are cited at: W102, W104, W122, W149, W157, W158 and W186. Survey dates: 1/16/25, 1/17/25, 1/21/25, 1/22/25, 1/23/25, 1/24/25, 1/27/25, 1/28/25, 1/29/25 and 1/30/25. Facility Number: 000775 Provider Number: 15G255 AIM Number: 100248960 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/11/25.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C) and 5 additional clients (D, E, F, G and H), the facility failed to meet the Condition of Participation: Governing Body. The facility's governing body failed to exercise general policy, budget, and operating direction over the facility to ensure: 1) former staff #1 did not hit client B as a form of punishment and/or discipline, 2) a pattern of accidents, falls, and/or injuries with clients B and C was addressed, 3) sufficient staffing	W 0102	**W102: The governing body must ensure that specific governing body and management requirements are met.** **Corrective action:** All staff trained on ANE policy and reporting. **(Attachment A).**	02/23/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amanda D Earl	Quality Assurance Manager	02/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	resources were deployed appropriately to prevent a pattern of accidents, falls, and/or injuries with clients B and C, and 4) the nurse monitored to ensure staff competency in the implementation of clients A, B, D, F, G and H's medication administration programs and maintaining drug security, and implementation of client C's dining plan to reduce his risk of choking and aspiration. Findings include: 1) Please refer to W104. For 3 of 3 sampled clients (A, B and C) and 4 additional clients (D, F, G and H), the governing body failed to exercise general policy, budget, and operating direction over the facility to implement and prevent abuse, neglect, and/or mistreatment to ensure: 1) former staff #1 did not hit client B as a form of punishment and/or discipline, 2) a pattern of accidents, falls, and/or injuries with clients B and C was addressed, 3) sufficient staffing resources were deployed appropriately to prevent a pattern of accidents, falls, and/or injuries with clients B and C, and 4) the nurse monitored to ensure staff competency in the implementation of clients A, B, D, F, G and H's medication administration programs and maintaining drug security, and implementation of client C's dining plan to reduce his risk of choking and aspiration. 2) Please refer to W122. For 3 of 3 sampled clients (A, B and C), the governing body failed to meet the Condition of Participation: Client Protections. The governing body neglected to implement its policy and procedures to ensure their system to prohibit and prevent abuse, neglect, and/or mistreatment was implemented to: 1) ensure former staff #1 did not hit client B as a form of punishment and/or discipline, 2) prevent a pattern of accidents, falls and/or injuries with clients B		Former staff #1 was terminated from employment for substantiated ANE. **(Attachment B)** Quality Assurance investigates all allegations of ANE, the investigation once concluded is reviewed at peer review with ResCare Management. Nurse is at the facility 3 days a week to complete oversight of the health needs of all clients in the facility for no less than 3 months and sends a detailed update to the IDT and administrative team. **(Attachment C)** Nurse will complete one complete medication pass with all new hires in the facility. **(Attachment W)** Program Director created management observation checklist for use during management observations. **(Attachment CC)** ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and C, 3) immediately report an allegation of an inappropriate staff relationship with client A to the administrator and the Bureau of Disabilities Services (BDS) within 24 hours, 4) thoroughly investigate an allegation of an inappropriate staff relationship with client A to rule out any potential abuse, neglect and/or exploitation, and 5) implement corrective measures to prevent a pattern of accidents, falls and/or injuries with clients B and C. 3) Please refer to W158. For 3 of 3 sampled clients (A, B and C) and 4 additional clients (D, F, G and H), the governing body failed to meet the Condition of Participation: Facility Staffing. The governing body failed to provide sufficient staffing to prevent: 1) a pattern of accidents, falls and/or injuries with clients B and C and 2) ensure staff competency with the administration of clients A, B, D, F, G and H's medication administration programs. 4) Please refer to W318. For 3 of 3 sampled clients (A, B and C) and 5 additional clients (D, E, F, G and H), the governing body failed to meet the Condition of Participation: Health Care Services. The governing body's healthcare services failed to ensure the nurse: 1) monitored clients A, B, D, F, G and H's medication administration program to prevent a pattern of medication errors, 2) monitored staff competency in the implementation of client C's dining plan to reduce his risk of choking and aspiration, 3) monitored facility staffing to ensure clients A, B, D, F, G and H received their medications according to their physician orders without error and drug security was maintained with clients A, B, C, D, E, F, G and H's medicines. This federal tag relates to complaint #IN00435432.		by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** All staff trained by the Nurse regarding medication administration, Medication storage and security, QuickMar, Medications that go home for visit process, dining plans and demonstrated how to prep food according to the client's diet. **(Attachment E)** All staff were tested by the Nurse on Medication Administration. **(Attachment F)** Program Manager ordered a lockbox for medication that needs destroyed by a Nurse to be stored in and removed from the facility medication storage. **(Attachment G)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP and QuickMar. **(Attachment H)** Nurse obtained clarified order for how client (H) should receive his medications and trained staff on the updated order. **(Attachment I)** Nurse trained all staff on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9-3-1(a)		client (H) dining plan. **(Attachment J)**. Staffing levels at the home were increased to 3 staff during active treatment hours to ensure staff are deployed throughout the home for monitoring and assistance to all clients. Client (B) and (C) are scheduled to see their PCP on 3/12/25 to obtain a referral to Physical therapy to ensure proper adaptive equipment is in place as needed for fall prevention. QIDP initiated a communication plan to ensure we are speaking to family/guardians to discuss any issues or concerns they may have. **(Attachment K).** The Area Supervisor of the facility at the time of survey was replaced by a veteran Area Supervisor, Chasity Drew, who will have the facility ongoing and will be in the facility a minimum of 3 days a week on varied shifts for training and monitoring. The Nurse Manager was directly monitoring the facility at the time of survey, now direct Nursing oversight has been moved to veteran Nurse, Becky Hughes. ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility. ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios. **Monitoring of Corrective Action:** All training sent to the ResCare trainer for filing in staff files. All oversight observations will be reviewed during daily survey update calls held by ResCare Management and filed in the binder at the facility. Site Reviews will be completed monthly by ResCare management and entered into the site review database. Quality Assurance tracks all site review data and submits to management for follow up and review. Nurse Manager will complete medication administration observations and notify management of any concerns. QIDP will ensure all updated	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			plans and assessments are completed annually and as needed based on client needs. Nurse will ensure all client high risk and dining plans are up to date and staff are trained on any new or updated plans and upload them in TMP for monitoring and review. Nurse Manager pulls reports in QuickMar daily and sends out to all Area Supervisors, Program Managers, Program Director, Nurses, and Executive Director for monitoring and to ensure completion. Weekly calls are held with all Area Supervisors, Program Managers and Program Director to discuss each location and their TMP documentation to ensure completion. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. Program Manager manages the staffing schedule for the facility and provides updates to HR for hiring to ensure the home has proper staffing. **Completion Date: 2/23/25**	
W 0104	483.410(a)(1) GOVERNING BODY			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	Based on record review and interview for 3 of 3 sampled clients (A, B and C) and 4 additional clients (D, F, G and H), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure: 1) former staff #1 did not hit client B as a form of punishment and/or discipline, 2) a pattern of accidents, falls, and/or injuries with clients B and C was addressed, 3) sufficient staffing resources were deployed appropriately to prevent a pattern of accidents, falls, and/or injuries with clients B and C, and 4) the nurse monitored to ensure staff competency in the implementation of clients A, B, D, F, G and H's medication administration programs and maintaining drug security, and implementation of client C's dining plan to reduce his risk of choking and aspiration. Findings include: 1) Please refer to W127. For 1 of 3 sampled clients (B), the governing body failed to prevent physical abuse to ensure former staff #1 did not hit client B as a form of punishment and/or discipline. 2) Please refer to W149. For 2 of 3 sampled clients (B and C), the governing body failed to implement the abuse, neglect, exploitation, mistreatment and/or individual's rights policy to prevent: 1) a pattern of accidents/injuries with client B and 2) a pattern of falls with injuries with client C. 3) Please refer to W186. For 2 of 3 sampled clients (B and C), the governing body failed to ensure sufficient staffing resources were deployed appropriately to prevent: 1) a pattern of accidents and/or injuries with client B and 2) a pattern of falls with injuries with client C.	W 0104	**W104: The governing body will exercise general policy, budget, and operating direction over facility.** **Corrective action:** All staff trained on ANE policy and reporting. **(Attachment A).** Former staff #1 was terminated from employment for substantiated ANE. **(Attachment B)** Quality Assurance investigates all allegations of ANE, the investigation once concluded is reviewed at peer review with ResCare Management. Nurse is at the facility 3 days a week to complete oversight of the health needs of all clients in the facility for no less than 3 months and sends a detailed update to the IDT and administrative team. **(Attachment C)** Nurse will complete one complete medication pass with all new hires in the facility. **(Attachment W)** Program Director created management observation checklist for use during management observations. **(Attachment CC)** ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy,	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4) Please refer to W331. For 3 of 3 sampled clients (A, B and C) and 4 additional clients (D, F, G and H), the governing body failed to ensure the nurse: 1) monitored clients A, B, D, F, G and H's medication administration programs to prevent a pattern of medication errors and 2) monitored to ensure staff competency in the implementation of client C's dining plan to reduce his risk of choking and aspiration. This federal tag relates to complaint #IN00435432. 9-3-1(a)		ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** All staff trained by the Nurse regarding medication administration, Medication storage and security, QuickMar, Medications that go home for visit process, dining plans and demonstrated how to prep food according to the client's diet. **(Attachment E)** All staff were tested by the Nurse on Medication Administration. **(Attachment F)** Program Manager ordered a lockbox for medication that needs destroyed by a Nurse to be stored in and removed from the facility medication storage. **(Attachment G)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP and QuickMar. **(Attachment H)** Nurse obtained clarified order for how client (H) should receive his medications and trained staff on the updated order. **(Attachment I)** Nurse trained all staff on client (H) dining plan. **(Attachment J)**. Staffing levels at the home were increased to 3 staff during active treatment hours to ensure staff are deployed throughout the home for monitoring and assistance to all clients. Client (B) and (C) are scheduled to see their PCP on 3/12/25 to obtain a referral to Physical therapy to ensure proper adaptive equipment is in place as needed for fall prevention. QIDP initiated a communication plan to ensure we are speaking to family/guardians to discuss any issues or concerns they may have. **(Attachment K).** The Area Supervisor of the facility at the time of survey was replaced by a veteran Area Supervisor, Chasity Drew, who will have the facility ongoing and will be in the facility a minimum of 3 days a week on varied shifts for training and monitoring. The Nurse Manager was directly monitoring the facility at the time of survey, now direct	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Nursing oversight has been moved to veteran Nurse, Becky Hughes. ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility. ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills and staffing ratios. **Monitoring of Corrective Action:** All training sent to the ResCare trainer for filing in staff files. All oversight observations will be reviewed during daily survey update calls held by ResCare Management and filed in the binder at the facility. Site Reviews will be completed monthly by ResCare management and entered into the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			site review database. Quality Assurance tracks all site review data and submits to management for follow up and review. Nurse Manager will complete medication administration observations and notify management of any concerns. QIDP will ensure all updated plans and assessments are completed annually and as needed based on client needs. Nurse will ensure all client high risk and dining plans are up to date and staff are trained on any new or updated plans and upload them in TMP for monitoring and review. Nurse Manager pulls reports in QuickMar daily and sends out to all Area Supervisors, Program Managers, Program Director, Nurses, and Executive Director for monitoring and to ensure completion. Weekly calls are held with all Area Supervisors, Program Managers and Program Director to discuss each location and their TMP documentation to ensure completion. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. Program Manager manages the staffing schedule for the facility and provides updates to HR for hiring to ensure the home has	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			proper staffing. **Completion Date: 2/23/25**	
W 0122 Bldg. 00	483.420(a) CLIENT PROTECTIONS Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C), the facility failed to meet the Condition of Participation: Client Protections. The facility neglected to implement its policy and procedures to ensure their system to prohibit and prevent abuse, neglect, and/or mistreatment was implemented to: 1) ensure former staff #1 did not hit client B as a form of punishment and/or discipline, 2) prevent a pattern of accidents, falls and/or injuries with clients B and C, 3) immediately report an allegation of an inappropriate staff relationship with client A to the administrator and the Bureau of Disabilities Services (BDS) within 24 hours, 4) thoroughly investigate an allegation of an inappropriate staff relationship with client A to rule out any potential abuse, neglect and/or exploitation, and 5) implement corrective measures to prevent a pattern of accidents, falls and/or injuries with clients B and C. Findings include: 1) Please refer to W127. For 1 of 3 sampled clients (B), the facility failed to prevent physical abuse to ensure former staff #1 did not hit client B as a form of punishment and/or discipline. 2) Please refer to W149. For 2 of 3 sampled clients (B and C), the facility failed to implement the abuse, neglect, exploitation, mistreatment and/or	W 0122	**W122:** The facility must ensure that specific client protections are met. **Corrective Action:** All staff trained on ANE policy and reporting. **(Attachment A).** Former staff #1 was terminated from employment for substantiated ANE. **(Attachment B)** Quality Assurance investigates all allegations of ANE, the investigation once concluded is reviewed at peer review. Nurse is at the facility 3 days a week to complete oversight of the health needs of all clients in the facility for no less than 3 months and sends a detailed update to the IDT and administrative team. **(Attachment C)** ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	individual's rights policy to prevent: 1) a pattern of accidents/injuries with client B and 2) a pattern of falls with injuries with client C. 3) Please refer to W153. For 1 of 3 sampled clients (A), the facility failed to immediately report an allegation of an inappropriate staff relationship with client A to the administrator and the Bureau of Disabilities Services (BDS) within 24 hours. 4) Please refer to W154. For 1 of 3 sampled clients (A), the facility failed to thoroughly investigate an allegation of an inappropriate staff relationship with client A to rule out any potential abuse, neglect and/or exploitation. 5) Please refer to W157. For 2 of 3 sampled clients (B and C), the facility failed to implement corrective measures to prevent: 1) a pattern of accidents/injuries with client B and 2) a pattern of falls with injuries with client C. This federal tag relates to complaint #IN00435432. 9-3-2(a)		and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP and QuickMar. **(Attachment H)** Staffing levels at the home were increased to 3 staff during active treatment hours to ensure staff are deployed throughout the home for monitoring and assistance to all clients. Client (B) and (C) are scheduled to see their PCP on 3/12/25 to obtain a referral to Physical therapy to ensure proper adaptive equipment is in place as needed for fall prevention. QIDP initiated a communication plan to ensure we are speaking to family/guardians	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			to discuss any issues or concerns they may have. **(Attachment K).** ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios. The Area Supervisor of the facility at the time of survey was replaced by a veteran Area Supervisor, Chasity Drew, who will have the facility ongoing and will be in the facility a minimum of 3 days a week on varied shifts for training and monitoring. The Nurse Manager was directly monitoring the facility at the time of survey, now direct Nursing oversight has been moved to veteran Nurse, Becky Hughes. ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Monitoring of Corrective Action: All training sent to the ResCare trainer for filing in staff files. All oversight observations will be reviewed during daily survey update calls held by ResCare Management and filed in the binder at the facility. Site Reviews will be completed monthly by ResCare management and entered into the site review database. Quality Assurance tracks all site review data and submits to management for follow up and review. Nurse Manager will complete medication administration observations and notify management of any concerns. QIDP will ensure all updated plans and assessments are completed annually and as needed based on client needs. Nurse will ensure all client high risk and dining plans are up to date and staff are trained on any new or updated plans and upload them in TMP for monitoring and review. Nurse Manager pulls reports in QuickMar daily and sends out to all Area Supervisors, Program Managers, Program Director, Nurses, and Executive Director for monitoring and to ensure completion. Weekly calls are held with all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Area Supervisors, Program Managers and Program Director to discuss each location and their TMP documentation to ensure completion. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. Program Manager manages the staffing schedule for the facility and provides updates to HR for hiring to ensure the home has proper staffing. **Completion Date: 2/23/25**	
W 0127 Bldg. 00	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS Based on record review and interview for 1 of 3 sampled clients (B), the facility failed to prevent physical abuse to ensure former staff #1 did not hit client B as a form of punishment and/or discipline. Findings include: On 1/21/25 at 12:27 PM, a review of the facility's Bureau of Disabilities Services (BDS) incident reports and accompanying investigation summaries was conducted. The review indicated the following affecting client B: BDS incident report dated 7/22/24 indicated, "Staff report that [client B] stated another staff (former staff #1) spanks him. [Former staff #1] has been	W 0127	**W127:** The facility must ensure that specific client protections are met**.** **Corrective Action:** All staff trained on ANE policy and reporting. **(Attachment A).** Former staff #1 was terminated from employment for substantiated ANE. **(Attachment B)** Quality Assurance investigates all allegations of ANE, the investigation once concluded is reviewed at peer review with	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	suspended pending results of investigation". Investigation Summary dated 7/26/24 indicated, "Scope:... Did anyone see [former staff #1] spank [client B]... Summary of Interviews:... [Former staff #2] stated [client B] told her on Thursday 7/18/24 that [former staff #1] spanked him. [Former staff #2] stated, she, [client B], [client A] and [former staff #3] were sitting on the porch talking about who was coming in that evening. [Former staff #2] stated they were saying [former staff #1] was coming into work. [Former staff #2] stated [client B] gets 'fired up' when you talk about [former staff #1]. [Former staff #2] stated then [client B] said [former staff #1] was mean to him. [Former staff #2] stated she asked him how she was mean, and [client B said 'I'm going to call the cops on her'. [Former staff #2] stated [client B] waved his in the air and said that's how. [Former staff #2] stated [client A] was sitting there and she asked him about it. [Former staff #2] stated [client A] said 'she spanks him on the butt'... [Former staff #3] stated on either 7/21/24 or 7/22/24 she, [former staff #2], [client B], [client D] and [client A] were all sitting on the porch. [Former staff #3] stated [client B] was talking about [former staff #1] coming into work and [client B] said '[former staff #1] whips my butt'. [Former staff #3] stated they asked [client B] what he meant, and he just kept saying, 'yeah, whips my butt'. [Former staff #3] stated [client A] had gotten up. [Former staff #3] stated [former staff #2 went inside and got [client A]. [Former staff #3] stated [client A] said he saw [former staff #1] whip [client B]. [Former staff #3] stated she didn't report it because she knew it had already been reported. [Former staff #3] stated she did not know [client		ResCare Management. QIDP initiated a communication plan to ensure we are speaking to family/guardians to discuss any issues or concerns they may have. **(Attachment K).** Program Director created management observation checklist for use during management observations. **(Attachment CC)** ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	B] had a bruise on his hip and didn't know how he got the bruise... [Client B] stated he did not like [former staff #1] because she 'says go to your room'. [Client B] then stated, 'hits me in the face'. [Client B] stated it happened 'Friday weekend'. [Client B] then stated, 'whipped my butt'. [Client B] stated [former staff #1] whipped his butt with a belt. [Client B] took his hand and smacked his butt 3 times. [Client B] stated it happened in the kitchen at night... [Client B] stated it has happened more than once. Investigator looked at [client B's] bottom. He did have a small 1-inch round bruise on the side of his hip... [Client A] stated he saw [former staff #1] hit [client B] on his butt a couple days ago. [Client A] stated [client B] wasn't following directions. [Client A] stated [former staff #1] was sitting at the dining room table. [Client A] stated [former staff #1] was telling [client B] he was walking too fast, and he didn't have his walker. [Client A] stated [client B] walked past her and she hit his butt one time (with her hand) and said 'now go get your walker and start using it'. [Client A] stated [client B] got his walker. [Client A] stated the hit was hard and that was all he knew... [Client G] stated he didn't like [former staff #1] because she gets upset 'when we don't do what she wants'. [Client G] stated [former staff #1] will say 'she's going to write us up'. [Client G] stated he has not seen [former staff #1] spank [client B]. [Client G] stated she raises her voice... Factual Findings:... Review of witness statements: 2 witnesses state [client B] reported [former staff #1] 'whips his butt' and 'hits him'. These two witnesses did not witness [former staff #1]		and QuickMar. **(Attachment H)** ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios. Staffing levels at the home were increased to 3 staff during active treatment hours to ensure staff are deployed throughout the home for monitoring and assistance to all clients. ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility. **Monitoring of Corrective Action:** Daily calls are conducted during the condition period with ResCare Management.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	whipping or hitting [client B]. All other staff deny [client B] telling them [former staff #1] spanks or hits him and deny witnessing [former staff #1] spanking or hitting [client B]. [Client A] stated he saw [former staff #1] hit [client B] on his butt a couple days ago. [Former staff #1] denies hitting or spanking [client B]... Client A is not assessed as telling non-truths... Conclusion: The allegation of physical abuse has been substantiated... Recommendations: 1. Retraining to [former staff #2] on ANE (abuse, neglect and exploitation) reporting policy. 2. Term (termination) of employment for [former staff #1] for substantiated ANE". On 1/23/25 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP/Investigator was asked about the incident reporting and investigation for client B being hit by former staff #1. The QIDP stated, "Yes, we substantiated it. We had two clients say it. [Client A] described it. He said she was sitting at the end of the table and grabbed his arm and did this (hand motion hitting client B) and says she spanked him". The QIDP was asked what had been substantiated. The QIDP stated, "Physical abuse, yes that is what we substantiated". On 1/30/25 at 11:50 AM, the Program Director (PD) was interviewed. The PD was asked about the incident reporting and investigation for client B being hit by former staff #1. The PD indicated the investigation substantiated physical abuse by former staff #1 had occurred due to staff hitting client B. The PD indicated physical abuse is prohibited.		Observation forms are reviewed during daily calls for monitoring, follow up and to ensure completion. Quality Assurance tracks all site review data and submits to management for follow up and review. All oversight observations will be reviewed during daily survey update calls held by ResCare Management and filed in the binder at the facility. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. **Completion Date: 2/23/25**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0130 Bldg. 00	9-3-2(a) 483.420(a)(7) PROTECTION OF CLIENTS RIGHTS Based on observation, record review and interview for 1 of 3 sampled clients (C), the facility failed to ensure client C's privacy was ensured while using the bathroom. Findings include: Observations were conducted on 1/16/25 from 2:51 PM to 6:03 PM and on 1/17/25 from 5:58 AM to 8:16 AM. During these observations client C was assisted by staff in the bathroom with personal care and toileting activities. The bathroom doors remained open during client C's personal care and/or toileting. At 3:03 PM, client C was in the bathroom adjacent to the medication administration room. Client C was in the bathroom toileting. At 3:04 PM, the Area Supervisor (AS) assisted client C with pulling up his pants. At this time, client B used his walker to enter the medication administration room to ask the AS a question. The bathroom door was open and client B could see client C and the AS. At 7:51 AM, staff #7 placed gloves on his hands and assisted client C to the bathroom adjacent to the foyer and client bedrooms in the hallway. Staff #7 assisted client C with a transfer from his wheelchair to the toilet. As staff #7 left client C in the bathroom, staff #7 stated, "When I'm here alone, he'll (client C) yell for me when he is ready". The bathroom door remained open while client C used the restroom. On 1/22/25 at 1:09 PM, a review of client C's record	W 0130	**W130:** The facility must ensure that specific client protections are met. **Corrective Action:** QIDP discussed with IDT team that we will ensure a staff always remain in the bathroom with client © to ensure his safety and to prevent falls/injuries. QIDP completed an addendum to client © Individual support plan to include the addition of staff always staying in the bathroom with client ©. **(Attachment L)** QIDP obtained Human Rights Committee approval for staff to remain in the bathroom with client © for prevention of falls/injuries. **(Attachment M)** ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios. ResCare Management will complete observations 7 days a week which includes medication administration observations,	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was conducted. The review indicated the following: Individual Support Plan (ISP) dated 3/15/24 indicated, "Individual Profile:... He (client C) needs verbal prompts and assistance to complete all ADL (adult daily living) skills and would not complete without direct supervision and guidance...". On 1/23/25 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) and Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDP and QIDPD were asked if the bathroom door be left open when client C used the restroom. The QIDP stated, "No". The QIDPD stated, "I agree". The QIDP and QIDPD were asked how client C's privacy should be ensured. The QIDP stated, "The door should be closed. If somebody needs in, we knock and say can I come in. If they need assistance, knock and ask. You always knock". The QIDP was asked if the bathroom door should be left open while toileting and/or assisting with personal care. The QIDP stated, "No, that should not have happened". 9-3-2(a)		mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP and QuickMar. **(Attachment H)** ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Management is held on Thursday each week to discuss any issues/concerns in the facility. ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios. **Monitoring of Corrective Action:** All oversight observations will be reviewed during daily survey update calls held by ResCare Management and filed in the binder at the facility. Site Reviews will be completed monthly by ResCare management and entered into the site review database. Quality Assurance tracks all site review data and submits to management for follow up and review. Daily calls are conducted during the condition period with ResCare Management. Observation forms are reviewed during daily calls for monitoring, follow up and to ensure completion. Quality Assurance tracks all site review data and submits to management for follow up and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			review. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. QIDP will complete/update all client plans annually and as needed and ensure all staff are trained. **Completion Date: 2/23/25**	
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS Based on observation, record review and interview for 2 of 3 sampled clients (B and C), the facility failed to implement the abuse, neglect, exploitation, mistreatment and/or individual's rights policy to prevent: 1) a pattern of accidents/injuries with client B and 2) a pattern of falls with injuries with client C. Findings include: On 1/21/25 at 12:27 PM, a review of the facility's Bureau of Disabilities Services (BDS) incident reports and accompanying investigation summaries was conducted. The review indicated the following affecting clients B and C: 1) BDS incident report dated 1/14/24 indicated, "On 1/12/24 staff noticed bruising on [client B's] foot along the side of the foot... 3 inches long and 1 inch wide. [Client B] stated he fell in his bedroom. Today the staff noticed his foot was swollen... At the clinic an x-ray of his foot was taken. The x-ray results showed a fracture. He was	W 0149	**W149:** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client. **Corrective Action:** All staff trained on ANE policy and reporting. **(Attachment A).** Former staff #1 was terminated from employment for substantiated ANE. **(Attachment B)** Quality Assurance investigates all allegations of ANE, the investigation once concluded is reviewed at peer review with ResCare Management. QIDP discussed with IDT team that we will ensure a staff always remain in the bathroom	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	given a walking shoe, ordered to elevate and ice his foot 3 times per day and was referred to Ortho (Orthopedic Surgeon)...". Investigation summary dated 1/19/24 indicated "On 1/12/24 [client B] showed staff a bruise on his foot and told staff he fell in his bedroom that morning... The bruise is appropriately (sic) 3 inches long and 1 inch wide... The x-rays showed a fracture. He was given a walking shoe and ordered to elevate and ice his foot 3 times per day and was referred to Ortho... Conclusion: The allegation bruising/swelling to [client B's] right foot/ankle is substantiated. The follow up with the Ortho x-ray showed no fracture. All staff deny witness of what happened to [client B's] foot/ankle. Observation of [client B's] bedroom and interview with [client B] found the room to be messy and [client B] said he fell out of bed... Investigation concludes [client B] likely fell in his bedroom injuring his foot/ankle... Recommendations: 1. Ensure bedroom remains trip/fall hazard free - staff assist [client B] each evening to clean room. 2. Ensure shower chair stays in bathroom. 3. Ensure 15 min (minute) checks when [client B] is in his bedroom. 4. When released from Ortho, get PT (physical therapy) eval (evaluation) to find best walker for [client B]. 5. Training to staff to redirect any client attempting to intervene in a behavior on staff's behalf. 6. Training with [client A] to ensure he does not intervene when clients are having a behavioral issue - staff intervene. 7. Staff training to call nurse for any bruising/injury...". 2) BDS incident report dated 4/21/24 indicated, "[Client B] was reminded and prompted several times throughout the shift to use his walker.		with client © to ensure his safety and to prevent falls/injuries. QIDP completed an addendum to client © Individual support plan to include the addition of staff always staying in the bathroom with client ©. **(Attachment L)** QIDP obtained Human Rights Committee approval for staff to remain in the bathroom with client © for prevention of falls/injuries. **(Attachment M)** QIDP implemented 15-minute safety checks for client (B) when he is in his room during active treatment times. **(Attachment DD)** ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios. Client (B) and (C) are scheduled to see their PCP on 3/12/25 to obtain a referral to Physical therapy to ensure proper adaptive equipment is in place as needed for fall prevention. ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[Client B] continued to walk around without his walker, ignoring prompts and redirection. He was walking out of his bedroom, not using his walker. He fell in the bedroom doorway. He fell on his bottom mostly on the right side. He also struck his right side against the doorframe. No injuries...". Investigation summary dated 4/26/24 indicated, "On 4/21/24 at 1:46 PM, [client B] fell walking out of his bedroom. [Client B] was reminded and prompted several times throughout the shift to use his walker, but continued to walk around without his walker... He fell in the bedroom doorway, on his bottom, mostly on the right side. He also struck his right side against the doorframe... Factual Findings:... 5. [Client B] does have a history of falls. Fall plan reads... Interventions: Staff will encourage [client B] to wear non-skin (sic) socks at home if not wearing his shoes, encourage him to hold his head up during ambulation, and use rollator walker during all ambulation. The fall plan in the red book in the home is outdated 11/14/22 but the current plan is uploaded to TMP (electronic record). A copy of the updated fall plan (dated 4/4/24) introducing a gait belt has been delivered to the home but still needs to be trained to all staff. The gait belt is not yet in the home to complete this training and implement the new plan... 8. Observation of the walker finds the brakes are not working. The handles are loose and taped to help support them from moving. Further observation the walker appears to be too short for [client B's] height... Conclusion: The allegation of a fall on 4/21/24 is substantiated. It is substantiated that [client B]		team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP and QuickMar. **(Attachment H)** Staffing levels at the home were increased to 3 staff during active treatment hours to ensure staff are deployed throughout the home for monitoring and assistance to all clients. Client (B) and (C) are scheduled to see their PCP on 3/12/25 to obtain a referral to Physical therapy to ensure proper adaptive equipment is in place as needed for fall prevention. ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	has a fall plan in place and that staff were following the plan as written. The investigation has determined no updates are necessary to the fall plan at this time as the issue appears to be non-compliance on [client B's] part for (not) following the plan as written. The investigation has determined the current walker does not appear to be suitable for [client B's] ambulation needs... Recommendations: 1. Ensure gait belt is delivered to the home and all staff are trained on fall plan updated 4/4/24... 4. Ensure walker is added to adaptive equipment issues spreadsheet and an evaluation for a new walker is scheduled...". 3) BDS incident report dated 5/1/24 indicated, "This morning when the nurse was at the home, [client B] told her he fell getting out of bed this morning. He has a small area above his left eye appropriately (sic) ¼ inch blood under the skin, skin not broken. He also has a skinned left knee appropriately (sic) the size of a half dollar. First-aid applied...". Investigation summary dated 5/7/24 indicated, "Introduction:... [Client B] told her (nurse) he fell getting out of bed that morning. He has a small area above his left eye approximately ¼ inch with blood under the skin... He also has a skinned left knee appropriately (sic) size of a half dollar... Conclusion: The allegation of a fall on 5/1/24 is substantiated. It is substantiated that [client B] has a fall plan in place. Due to lack of completed daily documentation on 5/1/24, and no witnesses to the fall, it cannot be determined if staff were following the fall plan as written during the incident. It is substantiated the fall plan needs to be updated to include the use of an audio monitor with staff carrying monitor as they complete tasks		concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility. ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios. **Monitoring of Corrective Action:** All training sent to the ResCare trainer for filing in staff files. All oversight observations will be reviewed during daily survey update calls held by ResCare Management and filed in the binder at the facility. QIDP will ensure all updated plans and assessments are completed annually and as needed based on client needs. Nurse will ensure all client high risk and dining plans are up to date and staff are trained on any new or updated plans and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	throughout the house... Recommendations: 1. Training to staff to carry the audio monitor with them as they complete tasks throughout the home. 2. In-service to all home staff that any missing SDL's (daily documentation) discovered moving forward will result in corrective action for staff...". 4) BDS incident report dated 5/23/24 indicated, "[Client B] was attending day program. He was standing in the art room with his walker. He 'dramatically' fell to his knees. His walker spun around and hit him while he was on the floor. Staff checked him for injuries, he has slight redness on his head from the walker...". Investigation summary dated 5/29/24 indicated, "Introduction:... He (client B) 'dramatically' fell to his knees. His walker spun and hit him while he was on the floor. Staff checked him for injuries and found slight redness on his head from the walker... Conclusion: The allegation of a fall on 5/23/24 is substantiated. However, it is unable to be determined if the fall was accidental or behavioral. [Client B] does have a fall plan to include the use of a rotator walker. [Client B] did purposely leave his walker and try and squeeze around a crowded table. [Client B] does have a BSP (behavior support plan) for non-compliance and staff stated in interview [client B] would not listen to direction... Recommendations: 1. Schedule reeval (re-evaluation) for new walker. 2. Retraining to staff per [client B's] BSP. 3. Corrective action for [staff #6] for failure to complete daily documentation...".		upload them in TMP for monitoring and review. Nurse Manager pulls reports in QuickMar daily and sends out to all Area Supervisors, Program Managers, Program Director, Nurses, and Executive Director for monitoring and to ensure completion. Weekly calls are held with all Area Supervisors, Program Managers and Program Director to discuss each location and their TMP documentation to ensure completion. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. Program Manager manages the staffing schedule for the facility and provides updates to HR for hiring to ensure the home has proper staffing. Site Reviews will be completed monthly by ResCare management and entered into the site review database. Quality Assurance tracks all site review data and submits to management for follow up and review. Nurse Manager will complete medication administration observations and notify management of any concerns.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	5) BDS incident report dated 8/25/24 indicated, "[Client B] was standing in front of the door and fell. Staff report he intentionally fell. He has a skinned/scraped knee and a 1 inch scrape on his left wrist...". Investigation summary dated 8/28/24 indicated, "On 8/24/24 at 3:30 PM, [client B] was standing in front of the door and fell. Staff report he intentionally fell. He has a skinned/scraped knee and a 1 inch scrape on his left wrist... Summary of Interviews:... [Staff #5] stated when [client B] fell, he was in the living room folding laundry, [staff #1] was in the office doing TMP (electronic documentation), and [staff #4] was gone running errands. [Staff #5] stated [client B] was using his walker, he was not wearing his gait belt, and he was wearing his slip-on sneakers. [Staff #5] stated [client B] was in his bedroom cleaning, walked out of his bedroom carrying a sheet toward the laundry room, got halfway past the front door, and tripped over the sheet. [Staff #5] stated the sheet got under the wheels of the walker, [client B] stumbled, the walker went sideways, and [client B] fell... [Staff #4] stated he was running errands and not at the home when [client B] fell. [Staff #4] stated he knew [client B] scraped his wrist and knee but did not see the fall... [Staff #1] stated he thought [staff #4] was running an errand and [staff #5] was all over the house cleaning. [Staff #1] wrote the (electronic documentation) but stated he was in the kitchen when [client B] fell and did not see the fall... Conclusion: The allegation of a fall on 8/24/24 is		**Completion Date: 2/23/25**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	substantiated... Recommendations: 1. PT (physical therapy) appt (appointment) today... Will get guidelines for PT exercises and medical consult history. Will address orders for use of walker/gait belt. Will update plans accordingly...". 6A) BDS incident report dated 9/11/24 indicated, "Staff report [client B] purposely threw himself on the floor when there was a visitor at the group home. Staff report [client B] threw himself to the floor to gain attention of the visitor. [Client B's] left knee was skinned and bleeding. First-aid applied...". 6B) BDS incident report dated 9/11/24 indicated, "During the course of a fall investigation staff stated [client B] had been behavioral not listening to redirection. Staff stated in addition to the fall reported... [client B] was mad/upset when staff was redirecting him to another area of the house and he shoved his walker into the staff and purposely dropped to the floor. Another staff stated later that same day, [client B] had gotten a soda and started running through the living room to take the soda to his bedroom and fell as he entered the foyer of the house...". Investigation summary dated 9/13/24 indicated, "Scope of Investigation: 1. Did [client B] fall... 3. Were staff following the fall plan as written? 4. Do any updates need to be made to the existing fall plan to prevent future falls?... Summary of Interviews: [Former staff #3] stated she was working with [staff #6] and [staff #1]. [Former staff #3] stated [staff #6] was in the office and [staff #1] was in the kitchen. [Former staff #3] stated her mom had come to the group home and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[former staff #3] walked outside to her car to feed her baby. [Former staff #3] stated [client B] came out of the front door 'flying down the ramp' with his walker, walked over in front of her mom, and fell to his knees. [Former staff #3] stated she helped him up and took him in the house. [Former staff #3] stated later that day while the maintenance men were working, [client B] kept trying to go in his bedroom while they were working on the window. [Former staff #3] stated she was with [client B], directing him he had to stay out of the bedroom while they worked. [Former staff #3] stated [client B] got mad, shoved his walker into her, and 'dramatically' went to his knees. [Former staff #3] stated [client B] acts in this matter (sic) 'all the time, normal for him, nonstop, continuous'... [Staff #1] stated he was working with [former staff #3]. [Staff #1] stated he was sitting at the dining room table, near the living room, and that [former staff #3] was in the office. [Staff #1] stated [client B] had opened a can of pop and started running through the house. [Staff #1] stated he tried to direct him to slow down and use his walker, but he kept running. [Staff #1] stated when [client B] got to the entry way of the house, he fell to his knees. [Staff #1] stated he would not use his walker as directed... [Staff #1] stated he did not see or know that [client B] had fallen outside or in the hallway that day. [Staff #1] stated [client B] will not listen to staff directives and that he hurries and falls 'all the time'... [Staff #6] stated she worked with [former staff #3] and [staff #1]. [Staff #6] stated she did not see [client B] fall at anytime on 9/10/24... Conclusion: The allegation of fall(s) on 9/10/24 is substantiated. Review of behavior tracking for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	attention seeking behavior indicates [client B] falls when asked not to do something that is inappropriate or disrespectful. It is substantiated that [client B] has a fall plan in place and the existing fall plan and BSP both need updates to ensure appropriate interventions to avoid falls are clearly indicated for staff... Recommendations: 1. Will discuss increased behaviors causing falls with psych (psychiatrist) at appt 10/10/24... 3. Will ensure service delivery log is completed. 4. Will seek new PT eval for use of walker. Will add tennis balls once nursing gets physician orders...". 7) BDS incident report dated 9/14/24 indicated, "[Client B] is assessed as a fall risk and has a fall plan. [Client B] was running with his walker and staff asked him to slow down. [Client B] went around the corner and fell to his buttocks. Staff helped him up and checked for injuries. No visual injuries...". Investigation summary dated 9/18/24 indicated, "On 9/14/24 at 4:00 PM, [client B] was running with his walker and staff asked him to slow down. [Client B] went around a corner and fell to his buttocks... Summary of Interviews: [Former staff #4] stated she worked with [Program Manager] from 2:30 PM until 5:00 PM and had been working when [client B] fell. [Former staff #4] stated [Program Manager] has stepped outside to take a break and that [former staff #4] was folding clothes. [Former staff #4] had put the folded clothes on the kitchen table and walked into the living room to begin cleaning and picking up. [Former staff #4] stated [client B] was using his walker and had walked over to the kitchen table, picked up a pile of folded clothes,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	said they were [client C's], and he (client B) was going to put them away. [Former staff #4] stated [client B] started out walking but then started to run. [Former staff #4] stated she didn't see [client B] fall but heard him yelling out her name for help. [Former staff #4] stated when she walked into the office, [client B] was sitting on his buttocks in [client C's] doorway. [Former staff #4] stated she helped him up, checked for injuries, and found no visual signs of injury. [Former staff #4] stated she wasn't sure what the fall plan says about avoiding falls... [Former staff #4] stated she had not been trained on working with [client B]... [Program Manager] stated she was working with [former staff #4] when [client B] fell. [Program Manager] stated she did not witness the fall as she had just stepped outside to take break when the fall occurred... Conclusion: The allegation of a fall on 9/14/24 is substantiated. [Client B] stated he fell because he 'was running'. [Former staff #4] stated [client B] had his walker at the time of his fall and was a result of him running. Staff documented 2 counts of attention seeking behavior and 4 counts of non-compliance on 9/14/24. It is substantiated that [client B] as a fall plan in place and that staff were following the plan as written. Investigation has determined (that) a psychiatric review would be beneficial to review current behavioral concerns. Need to ensure appropriate interventions and adaptive equipment is appropriate for his needs to avoid falls... Recommendations: 1. Psych review of medications has been scheduled. 2. Seeking OT/PT (Occupational Therapy / Physical Therapy) evaluations. 3. Will ensure all CST's (client specific training) are completed prior to working			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with clients...". 8) BDS incident report dated 10/24/24 indicated, "This morning after getting ready to leave for the day program he (client B) was walking down the hallway wearing another client's shoes and fell to his knees. Staff checked him for injuries. The scab on his left knee broke open, the area is about 1 inch...". Investigation summary dated 10/29/24 indicated, "Scope of Investigation:.. 3. Were staff following the fall plan as written?... Summary of Interviews: [Nurse] stated she was at the house when [client B] fell. [Nurse] stated the staff at the home was [staff #6]. [Nurse] stated [client B] came walking down the hallway with his walker. [Nurse] stated he had on a pair of clogs that looked too big for him. [Nurse] stated she told [client B] he shouldn't be wearing shoes like that and asked him to change his shoes. [Nurse] stated [client B] walked to his bedroom. [Nurse] stated [client B] did appear to be groggy that morning. [Nurse] stated she heard him fall and went to his bedroom... [Nurse] stated she helped him up and took care of the bleeding scab on his knee... [Staff #6] stated she was the only staff working at the time of [client B's] fall... [Staff #6] stated she could see [client B] walking down the hallway. [Staff #6] stated he was walking to his bedroom to change out of his clogs. [Staff #6] stated [client B] was very close to the wall, tried to turn into his bedroom and tripped over the leg of the walker. [Staff #6] stated [client B] 'busted open' the scab on his left knee. [Staff #6] stated that has been on his knee forever and does not heal. [Staff #6] stated his clogs are too long and too thick for him			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to walk... Conclusion: The allegation of a fall on 10/24/24 is substantiated... It is substantiated that [client B] has a fall plan and that staff were following the plan as written. Investigation has determined need to ensure appropriate interventions and adaptive equipment is appropriate for his needs to avoid falls... Recommendations: 1. Regarding the staff ratio, the night shift staff had just left prior to the day shift staff getting clients on the van to leave for the day program. 2) Will follow up on gait belt walker orders...". 9) BDS incident report dated 10/30/24 indicated, "[Client B] arrived to day program around 10:20 AM. As [client B] was exiting the van to enter day program he fell to his knees and hit his head on his walker. Staff assisted him up. [Client B] then entered the day program and walked up the hallway towards the kitchen and fell again in the hall, landing on a water dish. Staff heard him fall and went to assist... 2 inch scratch on the left side of his upper back, a cluster of 3 scratches to his left arm... He was taken to [name of urgent clinic] for evaluation... and diagnosed with a severe UTI (urinary tract infection)...". Investigation summary dated 11/4/24 indicated, "Scope of Investigation:... 3. Were staff following the fall plan as written?... Summary of Interviews: [Staff #6] stated she and [staff #7] were on the van when they arrived at the day program on 10/29/24. [Staff #6] stated [client B] fell 3 times at day program before going to urgent care. [Staff #6] stated she did not see [client B] fall getting off the van, as she was in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	back of the van helping [client C]. [Staff #6] stated she heard [client B] holler. [Staff #6] stated she walked around the van and [client B] was on the ground... [Staff #6] stated [staff #7] and [Day Service Staff / DSS #1] helped him up... [Staff #6] stated she was headed toward the board game room and told [client B] to come into the board game room, but he went the opposite way. [Staff #6] stated [Day Service Team Leader / DSTL] came to the board game room and said [client B] had fallen in the water bowl. [Staff #6] stated [Area Supervisor / AS] was called to get [client B] and take him to urgent care. [Staff #6] stated she and [DSS #1] took [client B] to the bathroom before he left and he again went down in the hallway. [Staff #6] said she had ahold of him but couldn't hold onto him as he fell. [Staff #6] stated [AS] got to the day program and took him to urgent care... [AS] stated [DSTL] called her, but she was already on her way to pick up [client B]. [AS] stated [staff #4] had called and said [client B] was acting funny, so she was going to pick up [client B] to take him to urgent care. [AS] stated [client B] was acting like he couldn't stay awake, and he was trying to fall down... [DSTL] stated she was in her office with the doors open and she heard a big bang and went to the hallway. [DSTL] stated [client B] was sitting on his butt and there was water everywhere... [DSTL] stated she checked him for injuries and [DSS #2] helped her get him up. [DSTL] stated [DSS #2] cleaned up the water and [DSS #2] took [client B] to the bathroom and looked for injuries. [DSTL] stated she found scratches on his arm and a scratch on his back. [DSTL] stated [staff #6] walked in the bathroom and [DSTL] asked her why she let him walk in by himself and [staff #6]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	shrugged her shoulders... [DSS #1] stated she had just walked outside when the... van started unloading. [DSS #1] stated she watched [client B] get off the van. [DSS #1] stated he didn't fall getting out of the van, he staggered and staff (heavy set guy) had ahold of his pants. [Client B] grabbed his walker, took a few steps 'and his walker went one way and his body the other way'. [DSS #1] stated his head smacked off the walker. [DSS #1] stated staff got him back up. [DSS #1] stated staff walked him in and sat him down. [DSS #1] stated [client B] couldn't stand on his own. [DSS #1] stated she was told he fell by the dog and cat food bowl but [DSS #1] didn't see that fall. [DSS #1] stated later she and [staff #6] walked him to the bathroom 'he went down on the walker, and we helped him up'. [DSS #1] stated [staff #6] got a gait belt on him and that helped a lot to get him up. [DSS #1] stated [staff #6] stayed with him after that fall... [Staff #7] stated he and [staff #6] were on the van the morning of 10/29/24, [Staff #7] stated there was a day program staff outside helping to get the guys off the van but he didn't know her name. [Staff #7] stated [client B] was acting like he was 'not all the way there'. [Staff #7] stated [client B] was stumbling for a couple of days before those falls. [Staff #7] stated he helped [client B] off the van and handed [client B] his walker. [Staff #7] stated he went to grab his gait belt but couldn't grab it quick enough and [client B] stumbled over falling on the walker. [Staff #7] stated he helped [client B] up, [client B] went in the building with [staff #6] and the other staff and [staff #7] left... Conclusion: The allegation of a fall on 11/4/24 (sic) is substantiated. Investigation determined that [client B] fell 3 times - once getting off of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	van (being assisted by [staff #7], once while walking down the hallway (not witnessed, unassisted), and while walking to the bathroom ([staff #6] and [DSS #1]) assisting. Nurse stated the falls were more than likely a result of the diagnosis of UTI. It is substantiated that [client B] has a fall plan. During the last fall investigation discussions included seeking a physician's order to remove the gait belt during waking hours as a part of programming. Staff indicated they believed it had been removed and that they were following the current plan. Review of current plan shows no changes have occurred yet, therefore, staff did not follow the plan as written. It is substantiated updates / revisions to the fall plan need to ensure appropriate interventions and adaptive equipment is appropriate for his needs to avoid falls... Recommendations: 1. Nurse will update fall plan reflecting physician's order to d/c (discontinue) the gait belt. 2. Updated fall plan will be trained to home and day program staff. 3. Nurse will obtain MD (medical doctor) order for PT eval...". 10) BDS incident report dated 1/20/25 indicated, "He (client B) is assessed as a fall risk and has a fall plan. Today, he was hurrying down the outside ramp to get on the van and fell. Staff assisted him up and checked for injuries. He has a scrape on his forehead about ½ inch and reopened a scab on his knee. Staff applied first-aid...". Investigation in process. 11) BDS incident report dated 4/9/24 indicated, "[Client C] was in the bathroom, fell and struck his face and jaw. He had bruising to his jaw developing appropriately (sic) 2 inches in size with two red lines on his jaw. He has a small skin			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

mark on his neck and two lines about 8 inches and 12 inches on his shoulder and chest. He was taken to the ER (emergency room) an x-ray on his jaw and clavicle showed no fracture. He was diagnosed with contusion/bruising...".

Investigation summary dated 4/14/24 indicated, "On 4/8/24 at 10:00 AM, [client C] fell in the bathroom and struck his face and jaw. He had bruising to his jaw developing appropriately (sic) 2 inches in size with two red lines on his jaw. He has a small skin mark on his neck and two lines about 8 inches and 12 inches on his shoulder and chest...

Summary of Interviews:... [Former staff #5] stated she and [former staff #6] were called over to [group home] to help out while [staff #6] ran an appointment. [Former staff #6] stated she had taken one of the [group home] clients to an appointment once, but this was the first time she ever worked at [group home]. [Former staff #5] stated she was in the kitchen looking at the client's dining plans when she heard [client C] fall. [Former staff #5] stated [client C] was in the small bathroom nearest the front door. [Former staff #5] stated [client C] screamed and she and [former staff #6] went to [client C]...

[Former staff #6] said he was standing next to the front door when he heard [client C] fall and scream from the bathroom ... [Former staff #6] stated [client C's] walker had gotten caught up in the standing toilet paper holder causing him to fall. [Former staff #6] stated staff called the nurse. [Former staff #6] stated he had never worked at the [group home] before...

Conclusion: The allegation of a fall on 4/8/24 is substantiated. [Client C] had walked to the small

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bathroom in the hallway using his walker when it caught on the standing toilet paper holder causing [client C] to fall. Staff were following the fall plan as written. It has been determined that no updates to the plan are necessary at this time... Recommendations: 1. Will remove the free-standing toilet paper holder and ensure one is attached to the wall. 2. Ensure all staff have received CST (client specific training) prior to working a shift in the home. 3. Ensure service delivery logs are completed by staff every shift worked in the home. 4. Ensure all pain scale assessments documentation is completed every shift in the home...". 12A) BDS incident report dated 5/24/24 indicated, "[Client C] was taken to [hospital] ER for evaluation of his left arm. [Client C] had engaged in behaviors on Tuesday 5/21/24... He dropped himself to the floor several times to avoid walking out to leave the house and landed on his walker when throwing himself to the floor. Yesterday, his left arm appeared swollen and bruising developing on his arm/shoulder and bruising to his right side of his face. [Client C] was complaining of pain. He was taken to the ER for evaluation. At the ER he was diagnosed with left arm humerus fracture (upper arm bone)...". 12B) BDS incident report dated 5/28/24 indicated, "[Client C] was seen at [hospital] due to crying with complaints of pain. On 5/23/24 [BDS incident report] reported [client C] had been engaged in a behavioral episode and threw himself to the floor. At the ER he was diagnosed with fracture of humerus left arm. At the ER he was again diagnosed with fracture of humerus, proximal, left closed ...			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Investigation summary dated 5/20/24 indicated, "Scope of Investigation: 1. Did the fracture occur during the behavioral episode on 5/21/24? 2. Does [client C] have a fall plan? 3. Does [client C] have a BSP to address throwing himself to the floor? 4. Are there any needed programming revisions?... Summary of interviews: ... [Staff #1] stated he has not seen any recent incidents that could have caused the fracture to his arm. [Staff #1] stated he worked Sunday 5/26/24 and [client C] was not complaining of any pain. [Staff #1] stated he was not wearing the sling because it could not be located... [Staff #4] stated his first day to work at [group home] was Friday 5/24/24. [Staff #4] stated he was completing his OJT (on-the job training). [Staff #4] stated [client C] was in a sling and his hand looked fine. [Staff #4] stated when he returned Monday 5/27/24 at 3:00 PM, he did not have the sling on, and his arm was discolored and swollen. [Staff #4] stated staff took him to the ER because he was crying in pain... [Former staff #7] stated his first day to work at [group home] was Friday 5/24/24. [Former staff #7] stated he was completing his OJT training. [Former staff #7] stated [client C] was in a sling and his hand looked fine. [Former staff #7] stated when returned Monday 5/27/24 at 3:00 PM, he did not have the sling on his arm and his arm was purple and swollen. [Former staff #7] stated he was taken to the ER for evaluation... [Former staff #3] stated she has not seen [client C] do anything in the past 7 days that could cause a fracture to his arm... [Staff #7] stated he worked the day [client C] was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mad and threw himself to the floor but arrived after the incident was over. [Staff #7] said he was going to take [client C] to urgent care that day but [client C] refused. [Staff #7] stated [client C] kept dropping himself to the floor while [staff #7] attempted to get [client C] to leave the house. [Staff #7] stated about 1 or 2 days per week [client C] 'throws a fit' and doesn't want to go to the day program. [Staff #7] stated he hasn't seen anything else happen to cause the fracture to his arm... [Staff #6] stated she did not work on 5/21/24 but it was [former staff #1] who told her about the incident... [Staff #6] stated she has not seen anything else happen that could have caused the fracture... [Program Manager] stated all she knew about the incident was what [former staff #1] wrote in the [electronic record]. [Program Manager] stated [client C] will sometimes slide out of chairs, slide off the seat on his walker, slide out of his bed, and slide down your leg to the floor as you are assisting him with tasks... [Former staff #1] stated [client C] will throw himself down in the mornings when he doesn't want to attend day program. [Former staff #1] stated the morning of 5/21/24, [client C] got up, got dressed, and ate breakfast. [Former staff #1] stated she was giving morning meds (medications) to the clients and [client C] went back in his bedroom and laid down. [Former staff #1] stated she called for [client C], telling him he needed to get back up because they would be leaving for the day program. [Former staff #1] stated [client C] was in his bedroom screaming and cussing saying, 'No! Stay home'! [Former staff #1] stated he got back up and continued to scream and cuss and threw himself to the floor 3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	times while in his bedroom. [Former staff #1] stated when he came to his doorway he was screaming, 'stay home' and again, threw himself on the floor. [Former staff #1] stated that time he hit his arm on the rectangle metal part of the brake of his walker. [Former staff #1] stated he then started yelling, 'I hurt my arm! I hurt my arm'! [Former staff #1] stated she did first-aid to his arm by cleaning the area. [Former staff #1] stated she then called [Program Manager]. [Former staff #1] stated [Program Manager] was running another appointment and she had directed [staff #7] to come in to take [client C] to urgent care... [Former Nurse / FN] stated staff sent her a picture of [client C's] arm on the morning of 5/21/24 and his arm was scraped up. She stated staff said he had thrown himself to the floor but di d not mention anything about him being in pain. [FN] stated [Program Manager] called her and said they were going to take [client C] to urgent care and then told her later that day [client C] had refused to go to urgent care. [FN] stated [client C's] arm was not swollen until several days later, and that's when they took him to the emergency room...Conclusion: The allegation [client C] has a fracture of humerus, proximal left, closed is substantiated. It is further substantiated the injury occurred during the behavioral episode on 5/21/24. [Client C] does have a history of becoming upset and throwing himself to the ground. After review of the BSP, [electronic record], and staff interviews, the strategy when he throws himself to the floor does not appear to meet			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the intensity of the behavior and needs revisions. Staff failed to follow the physician's orders with regards to applying ice to his arm...Recommendations: 1. Develop an HRP (health risk plan) for care of the fracture and train staff to follow HRP and all physician orders. 2. IDT (interdisciplinary team) meeting to discuss revisions to BSP. 3. Retraining to staff to complete all daily documentation...". 13) BDS incident report dated 7/2/24 indicated, "Staff was assisting [client C] to bed. [Client C] was refusing. Staff were assisting using gait belt. [Client C] began screaming and threw himself to the floor. Staff attempted to raise [client C] up but he would curl his legs up and would not stand. After several attempts staff called non-emergency 911 for assistance with a lift. When EMS (emergency medical services) arrived [client C] continued to refuse assistance to get up. 3 EMS (staff) lifted [client C] into the bed. [Client C] fell asleep without further issues. Plan to Resolve: [Client C] has a BSP (behavior support plan) for throwing himself on the floor and refusing. Team will review his BSP to determine If any further revision to the plan is needed...".14) BDS incident report dated 9/6/24 indicated, "[Client C] had went (sic) into the bathroom. Staff heard a noise and [client C] yell out for staff. When staff entered the bathroom [client C] was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	laying on the floor on his left side. Staff stated there was urine on the floor in front of the toilet that [client C] had slipped on. Staff further reported a client had left his clothes on the floor and [client C] fell onto the clothes. Staff checked for injuries. A bruise measuring appropriately (sic) 1 inch on the left side of his forehead developed within 20 minutes of the fall. [Client C] was taken to [hospital] for evaluation. At ER a head CT scan (medical imaging) was completed with no findings... orders to apply ice to forehead...Investigation summary dated 9/11/24 indicated, "Scope of Investigation:... 3. Were staff following the fall plan as written...Summary of Interviews: [Staff #1] stated [staff #4] was working alone when [client C] fell. [Staff #1] stated he had not yet arrived to work when the fall occurred... [Staff #4] stated he was working alone when [client C] fell. [Staff #4] stated he had been in the office ordering pizza and heard the fall...Conclusion: The allegation of a fall on 9/6/24 is substantiated. Investigation concludes the fall was likely the result of slipping in the urine or pile of clothes left on the bathroom floor... It is substantiated staff failed to initiate head-injury monitoring per protocol, the nurse failed to update the date during last revision of fall plan, staff documentation was incomplete, and staff ratio was not sufficient to meet the needs of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the home...Recommendations: 1. Seek PT (physical therapy) eval (evaluation) to clarify orders for use of adaptive equipment to meet client needs. Will update plans accordingly... 2. Staff training to ensure appropriate staff at all times and that floor remains free of clutter through periodic checks...".15) BDS incident report dated 9/13/24 indicated, "[Client C] was attending day program. [Client C] had finished his lunch and left the lunchroom after being asked to wait for his peers to finish lunch. [Client C] walked outside through the side door into the fenced yard. A client yelled that [client C] needed help. Staff started through the hallway and could see [client C] laying on the sidewalk ... He was bleeding from appeared to be his mouth nd (sic) nose... Staff called 911 and he was transported to [hospital] for evaluation ... He was diagnosed with a facial abrasion, acute head injury...".Investigation summary dated 9/17/24 indicated, "Scope of the Investigation:... 3. Were staff following the fall plan as written?...Conclusion: The allegation of a fall on 9/13/24 is substantiated. The fall was not witnessed by staff. The investigation concludes the fall was likely the result of the uneven surface of the threshold of the door and [client C's] inability to maneuver the walker and the door. It is substantiated that [client C] has a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	fall a plan in place, however, it is outdated (2/2/23). Witness statements also suggest staff are not adequately trained on the specifics of [client C's] fall plan. It is substantiated staff did not follow the plan as written by failing (to) assist as needed with ambulation on uneven ground. It is substantiated that [client C's] fall plan needs updated to reflect a current date and clarification needs to be added for staff to determine when [client C] should be using the wheelchair and/or the walker...Recommendations: 1. PT eval sch (scheduled) 9/25/24 at 3:30 PM. 2. DP (day program) will ensure as group changes are made, relieving staff will review clients plans. 3. Nursing to update fall plan...".16) BDS incident report dated 9/14/24 indicated, "[Client C] is assessed as a fall risk and has a fall plan. [Client C] had been sitting in his wheelchair and went outside using the wheelchair to sit on the porch. While transferring from the wheelchair he ... fell to the sidewalk on his left back side. Staff assisted [client C] back to his feet and checked for any signs of injury. He had a red area on his left back side. Staff monitored for injuries, and he has small scrapes on his right elbow...".Investigation summary dated 9/18/24 indicated, "Scope of Investigation:... 3. Were staff following the fall plan as written?...Conclusion: The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	allegation of a fall on 9/14/24 is substantiated. The fall was not witnessed by staff. The staffing ratio was insufficient to meet the needs of the client care plans at the time of the incident due to a call-off. Investigation concludes when [client C] attempted to transfer himself from the wheelchair to another chair on an uneven surface without staff assistance. It is substantiated that [client C] has a fall plan in place, however, it is outdated (2/2/23). It is substantiated staff failed to follow the fall plan as written by assisting [client C[on uneven surfaces. Single staff on duty was in the restroom when the incident occurred. It is substantiated that [client C's] fall plan needs to reflect a current date and clarification needs to be added for staff to determine when [client C] should be using the wheelchair and/or the walker...Recommendations: 1. Staff assistance was on the way to the home for staffing ratio and the fall occurred prior to her arrival. 2. Seek PT eval for clarification on adaptive equipment to meet his needs. Will update plans accordingly. 3. Ensure staff complete and document PT exercises and pain scale documentation...".17) BDS incident report dated 9/18/24 indicated, "[Client C] was sitting quietly on the couch. He began to yell at staff to take him to the hospital. [Client C] continued to yell and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	scooted himself towards the end of the couch making himself fall of the couch. Staff assisted him back on the couch, checked him for injuries finding no visual injuries from this fall...".Investigation summary dated 9/21/24 indicated, "Scope of Investigation:... 3. Were staff following the fall plan and/or BSP as written?...Summary of Interviews:... [Former staff #3] stated she and [staff #6] were working at the time of the incident. [Former staff #3] stated they were both sitting on the back deck with a few clients while [client C] was sitting on the couch. [Former staff #3] stated the environment was quiet and the clients in the living room were watching TV (television). [Former staff #3] stated [client C] was sitting on the couch softly 'whining'. [Former staff #3] stated she and [staff #6] both started to come in the back door and [client C] and [client C's] 'whining' got louder as soon as he saw them. [Former staff #3] stated [client C] was saying, 'I want to go to the hospital' and scooted forward to the edge of the couch and slid down onto the floor. [Former staff #3] stated she and [staff #6] got on each side of him with their arms under his arm pits and sat him back onto the couch...[Staff #6] stated she and [former staff #3] were working at the time of the incident. [Staff #6] stated [former staff #3] was outside on the porch and she was in the laundry room.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[Staff #6] stated she heard hollering, [client C] yelling. [Staff #6] stated [client C] was on the couch and had fallen over to his side. [Staff #6] stated [client A] was sitting on the couch and was trying to help [client C] sit back up...Conclusion: The allegation of a fall on 9/17/24 is unsubstantiated. The incident was witnessed by [staff #6] and [former staff #3], who stated [client C] was behavioral and intentionally dropped off the couch... It is substantiated [client C] has a BSP in place that addresses a targeted behavior of flopping/throwing self on floor. It is substantiated that staff followed [client C's] BSP as written during the incident. As described, there was not sufficient time for staff to intervene with a pillow prior to execution of the behavior...Recommendations: 1. IDT meeting to discuss necessary updates to BSP...".18) BDS incident report dated 11/23/24 indicated, "[Client C] is a [age] year old male. Today he had went (sic) to the bathroom to use the restroom. Staff heard him crying and yelling, went to check on him and he had fallen off the toilet. Staff assisted him up and checked for injuries. On the right side of his forehead above his eye he had a laceration appropriately (sic) one inch long... and took him to [hospital] ER for evaluation. At the ER he was diagnosed with a 2 cm (centimeter) forehead laceration...			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wound was closed with steri-strips and given a tetanus shot...".Investigation summary dated 11/26/24 indicated, "Scope of Investigation:... 4. Were staff following the fall plan and/or BSP as written? 5. Do any updates need to be made to the existing fall plan and/or BSP to prevent future falls?...Summary of Interviews: [Area Supervisor /AS] stated she and [staff #1] were working at the time of [client C's] fall. [AS] stated she had run up to [restaurant] to pick [client G] up while [staff #1] was passing meds. [AS] stated she was walking up the ramp to the front door, [client A] was walking out the door saying [client C] fell... [Staff #1] stated he and [AS] were working when [client C] fell. [Staff #1] stated he was in the office passing meds and [AS] was outside. [Staff #1] stated he heard [client C] yelling and crying so he locked the meds back up and then went to see what was going on with [client C]. [Staff #1] stated [client C] was in the middle bathroom laying on his left side, with his back towards the door. [Staff #1] stated [AS] arrived seconds after he did to see what had happened...Conclusion: The allegation of a fall on 11/23/24 is substantiated. The incident was not witnessed. There is no evidence the fall was behavioral. It is likely [client C] attempted to transfer to the toilet and the wheelchair moved, causing his fall ...			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	It is substantiated that staff followed the fall plan as written... It is substantiated that [client C's] fall plan needs updated for clarification to determine when [client C] should be using the wheelchair verses (sic) the walker. Clarification is also necessary regarding use of the gait belt for transfers. Also, wearing socks/shoes inside is not addressed in the current fall plan...Recommendations: 1. IDT meeting to review and discuss all programming and any necessary revisions...". An observation was conducted on 1/16/25 from 2:51 PM to 6:03 PM. At 3:14 PM, client B used his walker to go from his bedroom to the medication administration room. Client B was using his walker and carrying a plastic container with his art supplies. Client B was not wearing a belt. Upon returning from the medication administration room toward the dining room table, client B dropped a pencil and bent over to pick it up. Client B's pants were low on his hips exposing his undergarment. At 3:16 PM, client B ambulated around the dining room table without the use of his walker. Client B stumbled into his walker. The Area Supervisor (AS) stated, "Slow down, be careful". At 3:17 PM, client B used his walker to ambulate while holding a shirt in his hand and went to his bedroom. Client B stumbled in the hallway. The Team Leader			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(TL) stated, "Slow down, you're making me nervous". At 3:30 PM, client B stood from the dining room table and emptied his pencil sharpener into the trash. As client B bent over toward the trash can, his pants hung low on his hips. Client B was not wearing a belt. At 4:22 PM, the TL used a verbal prompt with client B to clean his spot at the dining room table. Client B walked toward the dining room table and the TL stated, "Walker, walker, walker". Client B returned to his walker in the living room and used it to go back toward the dining room table. As client B went over the threshold between the living room and dining room, the legs of his walker became stuck hitting a piece of wood trim. Client B lifted his walker up and over the wooden trim and continued toward his spot at the dining room table. At 4:35 PM, the AS gathered clean bedding from the sofa and went down the hallway toward the client bedrooms. At 4:37 PM, client B joined the AS in his bedroom. At 4:39 PM, client B and the AS were organizing client B's bedroom. A piece of plywood was attached to the wall and client B was asked what had happened. Client B stated, "I fell down". A white adaptive device was observed in client B's bedroom window. Client B was asked what the adaptive device in his window was for. Client B stated, "For when I get up". At 4:44 PM, client B pushed buttons on the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	white adaptive device and said it was a "bed alarm". The AS stated to client B, "How does it work? Let me see if there is another piece in the office". At 4:46 PM, the AS used her phone to send a text message to the Program Manager to identify the purpose of the white adaptive device in client B's bedroom. During this time, the TL was asked if the white adaptive device in client B's bedroom was a bed alarm or monitor. The TL stated, "Yeah. That has always sat beside his bed". At 4:48 PM, the TL used her phone to text someone while she continued preparing the evening meal. At 4:49 PM, the AS searched the office area for the second piece to client B's white adaptive device. The AS used her phone and called the Qualified Intellectual Disabilities Professional Designee (QIDPD) and stated, "It's an audio monitor". The AS was unable to locate the second piece of client B's audio monitor in the office and continued searching for it. At 4:52 PM, the TL referred to her phone reading a message and stated, "Hey [Surveyor]. It's a baby monitor, it's so you can hear him at night. The other piece is in the office". At 4:57 PM, the AS found the second piece to the monitoring device and stated, "I don't know if this is it. I'll have to plug it in". The AS went to client B's bedroom and spoke to see if the TL could hear an audible sound			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	through the monitor and stated, "Can you hear me"? The TL confirmed with the surveyor she could hear the AS and stated, "Yes, I can hear you. I don't think she can hear me. I think it's one way". Client B's monitor remained on throughout the remainder of the observation period.An observation was conducted on 1/17/25 from 5:58 AM to 8:16 AM. Client C was in his bedroom upon arrival to the group home. Staff #4 and staff #7 were present on the shift. At 6:08 AM, staff #4 physically assisted client C in his wheelchair from his bedroom to the bathroom. At 6:17 AM, staff #4 physically assisted client C in his wheelchair from the bathroom to the living room. Client C proceeded to transfer himself from his wheelchair to a couch in the living room. At 6:18 AM, staff #7 was asked about client C's incident history of falls with a fracture to his arm. Staff #7 stated, "Yeah, he's had two. One broke one arm and it healed and then he fell and broke the other arm. The wheelchair has helped to prevent him from falling". Staff #7 was asked about the timeline for the two incidents he described for client C's fractures to both of his arms. Staff #7 stated, "It's been a while. At least 6 months". At 7:51 AM, staff #7 placed gloves on his hands and assisted client C in the hallway into the bathroom. Staff #7 assisted client C with a transfer			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	from his wheelchair to the toilet. The bathroom door was left open. As staff #7 returned from the bathroom he stated, "When I'm here alone, he'll yell for me when he is ready". Client C was left alone sitting on the toilet in the bathroom while the bathroom door was left open. On 1/22/25 at 1:09 PM, a review of client B's record was conducted. The review indicated the following:Fall Risk Plan dated 11/12/24 indicated, "Actions: Ensure Safety First... 1. Staff will provide an environment free of clutter.2. Staff will provide assistance with ambulation and toileting as needed.3. Staff will encourage [client B] to wear nonskid socks at home when not wearing shoes.4. Staff will encourage [client B] to maintain straight posture and hold head up while ambulating.5. Staff will encourage [client B] to utilize 2 wheel walker w (with) tennis balls on back legs during ambulation. 6. Staff will ensure that [client B] uses a shower chair for all showers.7. Ensure ¼ Bed Rails utilized.8. Staff will use audio monitor when [client B] in his bedroom and have the receiving end of audio monitor within hearing range.9. Staff to encourage [client B] to pay attention and provide prompts/reminders in areas, such as crossing the street, around cars, stairs, curbs, uneven surface, etc.10. Staff to provide hands-on assistance if [client B] is in danger of falling from non-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	compliance to prevent injury.11. Should fall occur perform assessment, refer to Triggers to notify the Nurse, document fall, and any injury noted after medical care is given.12. Staff will report any changes in mobility to the nurse immediately. 13. Staff will notify physician for further recommendations.14. Nursing will assess at visits and document assessment in the medical record.15. Will attend all medical appointments with PCP (primary care physician) and any specialists as indicated.16. Will have labs and other testing completed as ordered...".On 1/22/25 at 1:09 PM, client C's record was reviewed. The review indicated the following:Fall Risk Plan dated 12/5/24 indicated, "Planning and Implementation:1. Interventions:a. Staff will take [client C] to all medical appointments.b. Utilize wheelchair footrest for long distance/footrests off when in home.c. Ensure gait belt is attached to wheelchair to be utilized if client has fallen.d. Will use a wheelchair for ambulation and long distances until seen by Rheumatology for evaluation of arthritis and gout.e. Will utilize rollator walker when completing Home Exercise program.f. [Client C] will use a shower chair for all showers.2. Monitoringa. Staff will monitor for change in increased weakness, unsteady gait and uneven ground.3. Documentationa. Staff will document in the progress notes and internal incident report if			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a fall occurs.4. Notificationa. Staff will notify the Nurse of any issues noted and of any falls with or without injury.5. Traininga. Annually or as neededb. All training is kept in the home, in the training binder, and in training file at office6. What do you do when out of home?All ResCare staff will follow same protocol as listed. All providers are given copy of all high risk plans...".On 1/23/25 at 10:12 AM, the Nurse was interviewed. The Nurse was asked about a pattern of clients B and C's accidents, falls and injuries. The Nurse indicated clients B and C had a pattern of injuries from the incident history. The Nurse was asked if staff should implement the client care plans as written? The Nurse stated, "Yes, they need to be following their plans". The Nurse was asked if appropriate levels of support and supervision should be provided to prevent accidents and/or injuries? The Nurse stated, "Yes".The Nurse was asked what patterns existed in these types of accidents and/or injuries for clients B and C. The Nurse stated, "A lot of unwitnessed. The bathroom, staffing ratios". The Nurse was asked about the lack of staff deployment to prevent accidents and injuries? The Nurse stated, "Right".The Nurse was asked if client C should be left unattended while using the restroom with the door left open. The Nurse stated, "We (interdisciplinary team)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	discussed them (staff) taking him to the larger bathroom since he has the wheelchair. I know he will take himself to the small bathroom. They should encourage him to use the larger bathroom. It would be helpful with more staff". The Nurse was asked about client B's intervention strategies for the use of his monitor to prevent accidents and/or injuries. The Nurse stated, "It's written basically when he is in his room staff should have it on so they can hear... It should be left on at all times, they are supposed to be able to hear it. I know he is all over the house. I think it was when he was in his room alone". The Nurse was asked if client B's monitor should be used during waking hours or non-waking hours. The Nurse stated, "It does not specify. I would leave it on all the time". The Nurse was asked about the implementation of the abuse, neglect, exploitation, mistreatment, and/or violation of individuals rights (ANE) policy. The Nurse indicated all staff should implement the ANE policy as written. The Nurse was asked if the ANE policy should be implemented at all times. The Nurse stated, "Correct".On 1/23/25 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) and the Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDP and the QIDPD were asked about a pattern of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	clients B and C's accidents, falls and injuries. The QIDP and QIDPD indicated clients B and C had a pattern of injuries from incident history. The QIDP and QIDPD were asked if staff should implement clients B and C's fall risk plans as written. The QIDPD stated, "They (staff) should know them (fall risk plan) and follow them". The QIDP stated, "Yes". The QIDP and QIDPD were asked if appropriate levels of staffing should be provided to ensure implementation of clients B and C's health risk plans were being implemented. The QIDP stated, "Staffing ratios should be followed. They should be deployed where the need is for the clients". The QIDP and QIDPD were asked about client B's use of his monitor to prevent accidents and/or injuries. The QIDPD stated, "We added that after a fall from his bed. We implemented a quarter bed rail and a monitor to be able to hear him". The QIDP stated, "The monitor should be used when he's in his room daytime or nighttime". The QIDP was asked if the monitor should be used during all waking hours. The QIDP stated, "Yes, waking hours". The QIDP and QIDPD were asked their knowledge of the monitor being placed in a drawer in the office. The QIDPD stated, "No, not until it was after". The QIDP stated, "I had not noticed it either". The QIDP was asked if client B's fall risk plan for the implementation			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and use of the monitor was being used appropriately during the observation. The QIDP stated, "No, it was not".The QIDP and QIDPD were asked about a pattern from the incident history for client C's falls and/or injuries. The QIDP stated, "Well with [client C] there is a pattern in the bathroom, transfer in general and different surfaces or terrain. Head injuries and significant injuries like broken arms. The deployment and reaction of staff". The QIDPD stated, "Going with [QIDP's] last statement, unwitnessed incidents". The QIDP and QIDPD were asked if client C should be left unattended while toileting and the bathroom door open in the event he needed to holler for help. The QIDP stated, "Well, the door should be shut for privacy. I know we're talking about the middle bathroom. We should encourage him to use the larger bathroom due to his wheelchair". The QIDPD stated, "Recognizing the trend we need to do an IDT and discuss this. There is the privacy, and transfers (preventing accidents)". The QIDP and QIDPD were asked how the abuse, neglect, exploitation, mistreatment and/or violation of an individual's rights (ANE) policy should be implemented. The QIDP stated, "It should be followed at all times". On 1/28/25 at 11:33 AM, a review of the Reporting and Investigating Abuse, Neglect, Exploitation,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Mistreatment, or a Violation of Individual's Rights (ANE) policy dated 1/17/25 was conducted. The ANE policy indicated, "ResCare staff actively advocate for the rights and safety of all individuals... ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights...".On 1/30/25 at 11:50 AM, the Program Director (PD) was interviewed. The PD was asked about implementation of the ANE policy. The PD indicated the ANE policy should be implemented as written. The PD was asked if the ANE policy should be implemented at all times. The PD stated, "Yes".This federal tag relates to complaint #IN00435432.9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to immediately report an allegation of an inappropriate staff relationship with client A to the administrator and the Bureau of Disabilities Services (BDS) within 24 hours. Findings include: On 1/21/25 at 10:42 AM, an advocate for client A was interviewed. The advocate indicated former staff #8 was transferred due to concerns of an inappropriate relationship with client A. Client A's advocate indicated former staff #8 would take client A out on trips but would do other things with him than what was planned. Client A's advocate indicated former staff #8 lived in a hotel	W 0153	**W153:** Staff Treatment of Clients **Corrective Action:** Quality Assurance conducted an investigation regarding an allegation of inappropriate relations with a former staff and client (A) that was reported to the surveyor. **(Attachment N)** All staff trained on the ANE policy. **(Attachment A)** Quality Assurance Manager and Quality Assurance Coordinator were trained by the ResCare Operation Support Specialist regarding the process upon completing an investigation	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for a period of time and had taken client A to her home. Client A's advocate indicated client A had developed a relationship with former staff #8 and would know of her personal issues. Client A's advocate indicated due to these concerns, former staff #8 had been reassigned to work in a different location. On 1/21/25 at 12:27 PM, a review of the facility's Bureau of Disabilities Services (BDS) incident reports and accompanying investigation summaries was conducted. No incident report for an inappropriate staff relationship with client A was available for review. On 1/21/25 at 3:36 PM, the Program Director (PD) was interviewed. The PD was asked about an inappropriate relationship between former staff #8 and client A. The PD indicated she was aware client A's advocate had sent text messages to the Qualified Intellectual Disabilities Professional Designee (QIDPD) and stated, "It was not alleged inappropriate, just too close. Nothing was alleged inappropriate". The PD was asked about former staff #8 taking client A to her home, which was a hotel at the time. The PD stated, "No, [restaurant] and staying up watching movies and getting out of routine". The PD was asked if there were staff living in a hotel that could take client A to where they were living. The PD used a phone and called the Program Manager (PM). At 3:44 PM, the PM indicated through the phone call that former staff #8 had been living in a hotel. The PM indicated she did not have knowledge of an allegation of former staff #8 taking client A to a hotel. The PD stated, "We talked about the concerns his [advocate] had. One of the texts (messages) was taking him to [restaurant] and he knows too much about her personal life like the ex-boyfriend". The PD indicated no BDS incident report had been		and documenting on the updated peer review form. **(Attachment O)** ResCare Management will peer review all investigations to ensure they are thorough.**(Attachment P)** ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Boling, Senior Director of Quality Supports, ResCare Operation Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility. QIDP initiated a communication plan to ensure we are speaking to family/guardians to discuss any issues or concerns they may have. **(Attachment K)** ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	completed or was available for review. On 1/23/25 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) and Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDP and QIDPD were asked about their knowledge of an alleged inappropriate relationship between former staff #8 and client A. The QIDP stated, "I have no knowledge of an inappropriate relationship". The QIDP was asked about reported concerns of an inappropriate relationship. The QIDP stated, "No". The QIDPD stated, "[Advocate] sent me a text and asked why is [former staff #8] offering [client A] her [smoking device]". The QIDP stated, "I do know about that". The QIDP and QIDPD were asked if former staff #8 had been reassigned in regard to client A's advocate's concerns. The QIDP stated, "Yes, she was reassigned to [city]". The QIDPD stated, "I was told he (client A) takes things wrong and too literal. I do think there was a night they stayed up and watched movies. I do know [former staff #8] was transferred out, but I don't know why. She (client A's advocate) did text me about the [smoking device]. I think it was, do you know why [former staff #8] would offer or give [client A] her [smoking device]". The QIDP and QIDPD were asked about their knowledge of former staff #8 living in hotel and allegedly taking client A to her home. The QIDPD stated, "No concerns". The QIDP stated, "No, I do not". The QIDPD stated, "No. In her text she implied they stayed up watching movies. It did not say where. I reported it to [Program Manager]". The QIDP was asked about incident reporting for those concerns and an investigation to rule out potential abuse, neglect and/or exploitation. The QIDP stated, "No, I do not have anything. We don't have an incident		shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP and QuickMar. **(Attachment H)** ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility. ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	report or an investigation". The QIDP and QIDPD indicated more follow up with client A's advocate would occur. On 1/24/25 at 4:42 PM, the QIDP indicated through an email further follow up had been conducted with client A's advocate. The QIDP indicated an incident report was submitted for concerns discussed and an investigation had been initiated. On 1/24/25 at 5:15 PM, a review of the BDS incident report dated 1/24/25 was conducted. The incident report indicated, "On 1/23/25 during an annual facility survey, ISDH Surveyor [name] indicated [advocate] of [age] year old [client A] recently expressed concerns to him. Contact was made with [client A's] [advocate], and she reported [client A] is missing a full-sized bed frame with mattress and box springs, 7 blow-up yard Christmas decorations, 3 strands of lights, and 3 extension cords. She also states a former staff took [client A] to a motel to watch movies for 6 hours, date unknown". 9-3-2(a)		dignity, privacy, documentation, drills, and staffing ratios. **Monitoring of Corrective Action:** All investigations of ANE will be peer reviewed by the Program Manager, Human Resource Manager, Quality Assurance Manager, Program Director, and Executive Director. After the investigation is reviewed by the internal peer review the investigation will then be sent to the Regional Director and Corporate Human Resources for further review to ensure the investigation is thorough and complete. Daily Calls are tracked by the Quality Assurance Manager and include discussion of any allegations of ANE and the investigation into those allegations. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. **Completion Date: 2/23/25**	
W 0154	483.420(d)(3) STAFF TREATMENT OF CLIENTS			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Bldg. 00	Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to thoroughly investigate an allegation of an inappropriate staff relationship with client A to rule out any potential abuse, neglect and/or exploitation. Findings include: On 1/21/25 at 10:42 AM, an advocate for client A was interviewed. The advocate indicated former staff #8 was transferred due to concerns of an inappropriate relationship with client A. Client A's advocate indicated former staff #8 would take client A out on trips but would do other things with him than what was planned. Client A's advocate indicated former staff #8 lived in a hotel for a period of time and had taken client A to her home. Client A's advocate indicated client A had developed a relationship with former staff #8 and would know of her personal issues. Client A's advocate indicated due to these concerns, former staff #8 had been reassigned to work in a different location. On 1/21/25 at 12:27 PM, a review of the facility's Bureau of Disabilities Services (BDS) incident reports and accompanying investigation summaries was conducted. No incident report for an inappropriate staff relationship with client A was available for review. On 1/21/25 at 3:36 PM, the Program Director (PD) was interviewed. The PD was asked about an inappropriate relationship between former staff #8 and client A. The PD indicated she was aware client A's advocate had sent text messages to the Qualified Intellectual Disabilities Professional Designee (QIDPD) and stated, "It was not alleged	W 0154	**W154:** Staff Treatment of Clients **Corrective Action:** Quality Assurance conducted an investigation regarding an allegation of inappropriate relations with a former staff and client (A) that was reported to the surveyor. **(Attachment N)** All staff trained on the ANE policy. **(Attachment A)** Quality Assurance Manager and Quality Assurance Coordinator were trained by the ResCare Operation Support Specialist regarding the process upon completing an investigation and documenting on the updated peer review form. **(Attachment O)** ResCare Management will peer review all investigations to ensure they are thorough.**(Attachment P)** ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility.	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	inappropriate, just too close. Nothing was alleged inappropriate". The PD was asked about former staff #8 taking client A to her home, which was a hotel at the time. The PD stated, "No, [restaurant] and staying up watching movies and getting out of routine". The PD was asked if there were staff living in a hotel that could take client A to where they were living. The PD used a phone and called the Program Manager (PM). At 3:44 PM, the PM indicated through the phone call that former staff #8 had been living in a hotel. The PM indicated she did not have knowledge of an allegation of former staff #8 taking client A to a hotel. The PD stated, "We talked about the concerns his [advocate] had. One of the texts (messages) was taking him to [restaurant] and he knows too much about her personal life like the ex-boyfriend". The PD indicated no BDS incident report had been completed or was available for review. On 1/23/25 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) and Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDP and QIDPD were asked about their knowledge of an alleged inappropriate relationship between former staff #8 and client A. The QIDP stated, "I have no knowledge of an inappropriate relationship". The QIDP was asked about reported concerns of an inappropriate relationship. The QIDP stated, "No". The QIDPD stated, "[Advocate] sent me a text and asked why is [former staff #8] offering [client A] her [smoking device]". The QIDP stated, "I do know about that". The QIDP and QIDPD were asked if former staff #8 had been reassigned in regard to client A's advocate's concerns. The QIDP stated, "Yes, she was reassigned to [city]". The QIDPD stated, "I was told he (client A) takes things wrong and too		QIDP initiated a communication plan to ensure we are speaking to family/guardians to discuss any issues or concerns they may have. **(Attachment K)** ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP and QuickMar. **(Attachment H)** **Monitoring of Corrective**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	literal. I do think there was a night they stayed up and watched movies. I do know [former staff #8] was transferred out, but I don't know why. She (client A's advocate) did text me about the [smoking device]. I think it was, do you know why [former staff #8] would offer or give [client A] her [smoking device]". The QIDP and QIDPD were asked about their knowledge of former staff #8 living in hotel and allegedly taking client A to her home. The QIDPD stated, "No concerns". The QIDP stated, "No, I do not". The QIDPD stated, "No. In her text she implied they stayed up watching movies. It did not say where. I reported it to [Program Manager]". The QIDP was asked about incident reporting for those concerns and an investigation to rule out potential abuse, neglect and/or exploitation. The QIDP stated, "No, I do not have anything. We don't have an incident report or an investigation". The QIDP and QIDPD indicated more follow up with client A's advocate would occur. On 1/24/25 at 4:42 PM, the QIDP indicated through an email further follow up had been conducted with client A's advocate. The QIDP indicated an incident report was submitted for concerns discussed and an investigation had been initiated. On 1/24/25 at 5:15 PM, a review of the BDS incident report dated 1/24/25 was conducted. The incident report indicated, "On 1/23/25 during an annual facility survey, ISDH Surveyor [name] indicated [advocate] of [age] year old [client A] recently expressed concerns to him. Contact was made with [client A's] [advocate], and she reported [client A] is missing a full-sized bed frame with mattress and box springs, 7 blow-up yard Christmas decorations, 3 strands of lights, and 3 extension cords. She also states a former		**Action:** All investigations of ANE will be peer reviewed by the Program Manager, Human Resource Manager, Quality Assurance Manager, Program Director, and Executive Director. After the investigation is reviewed by the internal peer review the investigation will then be sent to the Regional Director and Corporate Human Resources for further review to ensure the investigation is thorough and complete. Daily Calls are tracked by the Quality Assurance Manager and include discussion of any allegations of ANE and the investigation into those allegations. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. **Completion Date: 2/23/25**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	staff took [client A] to a motel to watch movies for 6 hours, date unknown". The investigation was in process. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS Based on observation, record review and interview for 2 of 3 sampled clients (B and C), the facility failed to implement corrective measures to prevent: 1) a pattern of accidents/injuries with client B and 2) a pattern of falls with injuries with client C. Findings include: On 1/21/25 at 12:27 PM, a review of the facility's Bureau of Disabilities Services (BDS) incident reports and accompanying investigation summaries was conducted. The review indicated the following affecting clients B and C: 1) BDS incident report dated 1/14/24 indicated, "On 1/12/24 staff noticed bruising on [client B's] foot along the side of the foot... 3 inches long and 1 inch wide. [Client B] stated he fell in his bedroom. Today the staff noticed his foot was swollen... At the clinic an x-ray of his foot was taken. The x-ray results showed a fracture. He was given a walking shoe, ordered to elevate and ice his foot 3 times per day and was referred to Ortho (Orthopedic Surgeon)...". Investigation summary dated 1/19/24 indicated "On 1/12/24 [client B] showed staff a bruise on his foot and told staff he fell in his bedroom that morning... The bruise is appropriately (sic) 3	W 0157	**W157: Staff treatment of clients.** **Corrective Action:** ·All staff trained on ANE policy and reporting. **(Attachment A).** ·Former staff #1 was terminated from employment for substantiated ANE. **(Attachment B)** ·Quality Assurance investigates all allegations of ANE, the investigation once concluded is reviewed at peer review with ResCare Management. ·ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	inches long and 1 inch wide... The x-rays showed a fracture. He was given a walking shoe and ordered to elevate and ice his foot 3 times per day and was referred to Ortho... Conclusion: The allegation bruising/swelling to [client B's] right foot/ankle is substantiated. The follow up with the Ortho x-ray showed no fracture. All staff deny witness of what happened to [client B's] foot/ankle. Observation of [client B's] bedroom and interview with [client B] found the room to be messy and [client B] said he fell out of bed... Investigation concludes [client B] likely fell in his bedroom injuring his foot/ankle... Recommendations: 1. Ensure bedroom remains trip/fall hazard free - staff assist [client B] each evening to clean room. 2. Ensure shower chair stays in bathroom. 3. Ensure 15 min (minute) checks when [client B] is in his bedroom. 4. When released from Ortho, get PT (physical therapy) eval (evaluation) to find best walker for [client B]. 5. Training to staff to redirect any client attempting to intervene in a behavior on staff's behalf. 6. Training with [client A] to ensure he does not intervene when clients are having a behavioral issue - staff intervene. 7. Staff training to call nurse for any bruising/injury...". 2) BDS incident report dated 4/21/24 indicated, "[Client B] was reminded and prompted several times throughout the shift to use his walker. [Client B] continued to walk around without his walker, ignoring prompts and redirection. He was walking out of his bedroom, not using his walker. He fell in the bedroom doorway. He fell on his bottom mostly on the right side. He also struck his right side against the doorframe. No injuries...". Investigation summary dated 4/26/24 indicated,		QIDP for continued monitoring and training. **(Attachment D)** ·Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP and QuickMar. **(Attachment H)** ·Staffing levels at the home were increased to 3 staff during active treatment hours to ensure staff are deployed throughout the home for monitoring and assistance to all clients. ·Client (B) and (C) are scheduled to see their PCP on 3/12/25 to obtain a referral to Physical therapy to ensure proper adaptive equipment is in place as needed for fall prevention. ·ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. ·A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"On 4/21/24 at 1:46 PM, [client B] fell walking out of his bedroom. [Client B] was reminded and prompted several times throughout the shift to use his walker, but continued to walk around without his walker... He fell in the bedroom doorway, on his bottom, mostly on the right side. He also struck his right side against the doorframe... Factual Findings:... 5. [Client B] does have a history of falls. Fall plan reads... Interventions: Staff will encourage [client B] to wear non-skin (sic) socks at home if not wearing his shoes, encourage him to hold his head up during ambulation, and use rollator walker during all ambulation. The fall plan in the red book in the home is outdated 11/14/22 but the current plan is uploaded to TMP (electronic record). A copy of the updated fall plan (dated 4/4/24) introducing a gait belt has been delivered to the home but still needs to be trained to all staff. The gait belt is not yet in the home to complete this training and implement the new plan... 8. Observation of the walker finds the brakes are not working. The handles are loose and taped to help support them from moving. Further observation the walker appears to be too short for [client B's] height... Conclusion: The allegation of a fall on 4/21/24 is substantiated. It is substantiated that [client B] has a fall plan in place and that staff were following the plan as written. The investigation has determined no updates are necessary to the fall plan at this time as the issue appears to be non-compliance on [client B's] part for (not) following the plan as written. The investigation has determined the current walker does not appear to be suitable for [client B's] ambulation needs...		Management is held on Thursday each week to discuss any issues/concerns in the facility. ·ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios. **Monitoring of Corrective Action:** ·The Abuse and Neglect Policy will be trained annually and reviewed monthly at house meetings. ·IDT meets quarterly and as needed to discuss and update plans annually and as needed. ·QIDP will update all client plans annually and as needed. ·All investigations are reviewed by ResCare management within 5 business days and the peer review signed for documentation. ·All investigations of ANE will be peer reviewed by the Program Manager, Human Resource Manager, Quality Assurance Manager, Program Director, and Executive Director. ·After the investigation is reviewed by the internal peer review the investigation will then be sent to the Regional Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Recommendations: 1. Ensure gait belt is delivered to the home and all staff are trained on fall plan updated 4/4/24... 4. Ensure walker is added to adaptive equipment issues spreadsheet and an evaluation for a new walker is scheduled...". 3) BDS incident report dated 5/1/24 indicated, "This morning when the nurse was at the home, [client B] told her he fell getting out of bed this morning. He has a small area above his left eye appropriately (sic) ¼ inch blood under the skin, skin not broken. He also has a skinned left knee appropriately (sic) the size of a half dollar. First-aid applied...". Investigation summary dated 5/7/24 indicated, "Introduction:... [Client B] told her (nurse) he fell getting out of bed that morning. He has a small area above his left eye approximately ¼ inch with blood under the skin... He also has a skinned left knee appropriately (sic) size of a half dollar... Conclusion: The allegation of a fall on 5/1/24 is substantiated. It is substantiated that [client B] has a fall plan in place. Due to lack of completed daily documentation on 5/1/24, and no witnesses to the fall, it cannot be determined if staff were following the fall plan as written during the incident. It is substantiated the fall plan needs to be updated to include the use of an audio monitor with staff carrying monitor as they complete tasks throughout the house... Recommendations: 1. Training to staff to carry the audio monitor with them as they complete tasks throughout the home. 2. In-service to all home staff that any missing SDL's (daily documentation) discovered moving forward will result in corrective action for staff...".		and Corporate Human Resources for further review to ensure the investigation is thorough and complete. ·Daily Calls are tracked by the Quality Assurance Manager and include discussion of any allegations of ANE and the investigation into those allegations. **Completion Date: 2/23/25**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4) BDS incident report dated 5/23/24 indicated, "[Client B] was attending day program. He was standing in the art room with his walker. He 'dramatically' fell to his knees. His walker spun around and hit him while he was on the floor. Staff checked him for injuries, he has slight redness on his head from the walker...". Investigation summary dated 5/29/24 indicated, "Introduction:... He (client B) 'dramatically' fell to his knees. His walker spun and hit him while he was on the floor. Staff checked him for injuries and found slight redness on his head from the walker... Conclusion: The allegation of a fall on 5/23/24 is substantiated. However, it is unable to be determined if the fall was accidental or behavioral. [Client B] does have a fall plan to include the use of a rotator walker. [Client B] did purposely leave his walker and try and squeeze around a crowded table. [Client B] does have a BSP (behavior support plan) for non-compliance and staff stated in interview [client B] would not listen to direction... Recommendations: 1. Schedule reeval (re-evaluation) for new walker. 2. Retraining to staff per [client B's] BSP. 3. Corrective action for [staff #6] for failure to complete daily documentation...". 5) BDS incident report dated 8/25/24 indicated, "[Client B] was standing in front of the door and fell. Staff report he intentionally fell. He has a skinned/scraped knee and a 1 inch scrape on his left wrist...". Investigation summary dated 8/28/24 indicated,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"On 8/24/24 at 3:30 PM, [client B] was standing in front of the door and fell. Staff report he intentionally fell. He has a skinned/scraped knee and a 1 inch scrape on his left wrist... Summary of Interviews:... [Staff #5] stated when [client B] fell, he was in the living room folding laundry, [staff #1] was in the office doing TMP (electronic documentation), and [staff #4] was gone running errands. [Staff #5] stated [client B] was using his walker, he was not wearing his gait belt, and he was wearing his slip-on sneakers. [Staff #5] stated [client B] was in his bedroom cleaning, walked out of his bedroom carrying a sheet toward the laundry room, got halfway past the front door, and tripped over the sheet. [Staff #5] stated the sheet got under the wheels of the walker, [client B] stumbled, the walker went sideways, and [client B] fell... [Staff #4] stated he was running errands and not at the home when [client B] fell. [Staff #4] stated he knew [client B] scraped his wrist and knee but did not see the fall... [Staff #1] stated he thought [staff #4] was running an errand and [staff #5] was all over the house cleaning. [Staff #1] wrote the (electronic documentation) but stated he was in the kitchen when [client B] fell and did not see the fall... Conclusion: The allegation of a fall on 8/24/24 is substantiated... Recommendations: 1. PT (physical therapy) appt (appointment) today... Will get guidelines for PT exercises and medical consult history. Will address orders for use of walker/gait belt. Will update plans accordingly...".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6A) BDS incident report dated 9/11/24 indicated, "Staff report [client B] purposely threw himself on the floor when there was a visitor at the group home. Staff report [client B] threw himself to the floor to gain attention of the visitor. [Client B's] left knee was skinned and bleeding. First-aid applied...". 6B) BDS incident report dated 9/11/24 indicated, "During the course of a fall investigation staff stated [client B] had been behavioral not listening to redirection. Staff stated in addition to the fall reported... [client B] was mad/upset when staff was redirecting him to another area of the house and he shoved his walker into the staff and purposely dropped to the floor. Another staff stated later that same day, [client B] had gotten a soda and started running through the living room to take the soda to his bedroom and fell as he entered the foyer of the house...". Investigation summary dated 9/13/24 indicated, "Scope of Investigation: 1. Did [client B] fall... 3. Were staff following the fall plan as written? 4. Do any updates need to be made to the existing fall plan to prevent future falls?... Summary of Interviews: [Former staff #3] stated she was working with [staff #6] and [staff #1]. [Former staff #3] stated [staff #6] was in the office and [staff #1] was in the kitchen. [Former staff #3] stated her mom had come to the group home and [former staff #3] walked outside to her car to feed her baby. [Former staff #3] stated [client B] came out of the front door 'flying down the ramp' with his walker, walked over in front of her mom, and fell to his knees. [Former staff #3] stated she helped him up and took him in the house. [Former staff #3] stated later that day while the maintenance men were working, [client B] kept			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	trying to go in his bedroom while they were working on the window. [Former staff #3] stated she was with [client B], directing him he had to stay out of the bedroom while they worked. [Former staff #3] stated [client B] got mad, shoved his walker into her, and 'dramatically' went to his knees. [Former staff #3] stated [client B] acts in this matter (sic) 'all the time, normal for him, nonstop, continuous'... [Staff #1] stated he was working with [former staff #3]. [Staff #1] stated he was sitting at the dining room table, near the living room, and that [former staff #3] was in the office. [Staff #1] stated [client B] had opened a can of pop and started running through the house. [Staff #1] stated he tried to direct him to slow down and use his walker, but he kept running. [Staff #1] stated when [client B] got to the entry way of the house, he fell to his knees. [Staff #1] stated he would not use his walker as directed... [Staff #1] stated he did not see or know that [client B] had fallen outside or in the hallway that day. [Staff #1] stated [client B] will not listen to staff directives and that he hurries and falls 'all the time'... [Staff #6] stated she worked with [former staff #3] and [staff #1]. [Staff #6] stated she did not see [client B] fall at anytime on 9/10/24... Conclusion: The allegation of fall(s) on 9/10/24 is substantiated. Review of behavior tracking for attention seeking behavior indicates [client B] falls when asked not to do something that is inappropriate or disrespectful. It is substantiated that [client B] has a fall plan in place and the existing fall plan and BSP both need updates to ensure appropriate interventions to avoid falls are clearly indicated for staff...			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Recommendations: 1. Will discuss increased behaviors causing falls with psych (psychiatrist) at appt 10/10/24... 3. Will ensure service delivery log is completed. 4. Will seek new PT eval for use of walker. Will add tennis balls once nursing gets physician orders...". 7) BDS incident report dated 9/14/24 indicated, "[Client B] is assessed as a fall risk and has a fall plan. [Client B] was running with his walker and staff asked him to slow down. [Client B] went around the corner and fell to his buttocks. Staff helped him up and checked for injuries. No visual injuries...". Investigation summary dated 9/18/24 indicated, "On 9/14/24 at 4:00 PM, [client B] was running with his walker and staff asked him to slow down. [Client B] went around a corner and fell to his buttocks... Summary of Interviews: [Former staff #4] stated she worked with [Program Manager] from 2:30 PM until 5:00 PM and had been working when [client B] fell. [Former staff #4] stated [Program Manager] has stepped outside to take a break and that [former staff #4] was folding clothes. [Former staff #4] had put the folded clothes on the kitchen table and walked into the living room to begin cleaning and picking up. [Former staff #4] stated [client B] was using his walker and had walked over to the kitchen table, picked up a pile of folded clothes, said they were [client C's], and he (client B) was going to put them away. [Former staff #4] stated [client B] started out walking but then started to run. [Former staff #4] stated she didn't see [client B] fall but heard him yelling out her name for help. [Former staff #4] stated when she walked into the office, [client B] was sitting on his buttocks in [client C's] doorway. [Former staff #4] stated she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	helped him up, checked for injuries, and found no visual signs of injury. [Former staff #4] stated she wasn't sure what the fall plan says about avoiding falls... [Former staff #4] stated she had not been trained on working with [client B]... [Program Manager] stated she was working with [former staff #4] when [client B] fell. [Program Manager] stated she did not witness the fall as she had just stepped outside to take break when the fall occurred... Conclusion: The allegation of a fall on 9/14/24 is substantiated. [Client B] stated he fell because he 'was running'. [Former staff #4] stated [client B] had his walker at the time of his fall and was a result of him running. Staff documented 2 counts of attention seeking behavior and 4 counts of non-compliance on 9/14/24. It is substantiated that [client B] as a fall plan in place and that staff were following the plan as written. Investigation has determined (that) a psychiatric review would be beneficial to review current behavioral concerns. Need to ensure appropriate interventions and adaptive equipment is appropriate for his needs to avoid falls... Recommendations: 1. Psych review of medications has been scheduled. 2. Seeking OT/PT (Occupational Therapy / Physical Therapy) evaluations. 3. Will ensure all CST's (client specific training) are completed prior to working with clients...". 8) BDS incident report dated 10/24/24 indicated, "This morning after getting ready to leave for the day program he (client B) was walking down the hallway wearing another client's shoes and fell to his knees. Staff checked him for injuries. The scab on his left knee broke open, the area is about 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	inch...". Investigation summary dated 10/29/24 indicated, "Scope of Investigation:.. 3. Were staff following the fall plan as written?... Summary of Interviews: [Nurse] stated she was at the house when [client B] fell. [Nurse] stated the staff at the home was [staff #6]. [Nurse] stated [client B] came walking down the hallway with his walker. [Nurse] stated he had on a pair of clogs that looked too big for him. [Nurse] stated she told [client B] he shouldn't be wearing shoes like that and asked him to change his shoes. [Nurse] stated [client B] walked to his bedroom. [Nurse] stated [client B] did appear to be groggy that morning. [Nurse] stated she heard him fall and went to his bedroom... [Nurse] stated she helped him up and took care of the bleeding scab on his knee... [Staff #6] stated she was the only staff working at the time of [client B's] fall... [Staff #6] stated she could see [client B] walking down the hallway. [Staff #6] stated he was walking to his bedroom to change out of his clogs. [Staff #6] stated [client B] was very close to the wall, tried to turn into his bedroom and tripped over the leg of the walker. [Staff #6] stated [client B] 'busted open' the scab on his left knee. [Staff #6] stated that has been on his knee forever and does not heal. [Staff #6] stated his clogs are too long and too thick for him to walk... Conclusion: The allegation of a fall on 10/24/24 is substantiated... It is substantiated that [client B] has a fall plan and that staff were following the plan as written. Investigation has determined need to ensure appropriate interventions and adaptive equipment is appropriate for his needs to avoid			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	falls... Recommendations: 1. Regarding the staff ratio, the night shift staff had just left prior to the day shift staff getting clients on the van to leave for the day program. 2) Will follow up on gait belt walker orders...". 9) BDS incident report dated 10/30/24 indicated, "[Client B] arrived to day program around 10:20 AM. As [client B] was exiting the van to enter day program he fell to his knees and hit his head on his walker. Staff assisted him up. [Client B] then entered the day program and walked up the hallway towards the kitchen and fell again in the hall, landing on a water dish. Staff heard him fall and went to assist... 2 inch scratch on the left side of his upper back, a cluster of 3 scratches to his left arm... He was taken to [name of urgent clinic] for evaluation... and diagnosed with a severe UTI (urinary tract infection)...". Investigation summary dated 11/4/24 indicated, "Scope of Investigation:... 3. Were staff following the fall plan as written?... Summary of Interviews: [Staff #6] stated she and [staff #7] were on the van when they arrived at the day program on 10/29/24. [Staff #6] stated [client B] fell 3 times at day program before going to urgent care. [Staff #6] stated she did not see [client B] fall getting off the van, as she was in the back of the van helping [client C]. [Staff #6] stated she heard [client B] holler. [Staff #6] stated she walked around the van and [client B] was on the ground... [Staff #6] stated [staff #7] and [Day Service Staff / DSS #1] helped him up... [Staff #6] stated she was headed toward the board game room and told [client B] to come into the board game room, but he went the opposite way. [Staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#6] stated [Day Service Team Leader / DSTL] came to the board game room and said [client B] had fallen in the water bowl. [Staff #6] stated [Area Supervisor / AS] was called to get [client B] and take him to urgent care. [Staff #6] stated she and [DSS #1] took [client B] to the bathroom before he left and he again went down in the hallway. [Staff #6] said she had ahold of him but couldn't hold onto him as he fell. [Staff #6] stated [AS] got to the day program and took him to urgent care... [AS] stated [DSTL] called her, but she was already on her way to pick up [client B]. [AS] stated [staff #4] had called and said [client B] was acting funny, so she was going to pick up [client B] to take him to urgent care. [AS] stated [client B] was acting like he couldn't stay awake, and he was trying to fall down... [DSTL] stated she was in her office with the doors open and she heard a big bang and went to the hallway. [DSTL] stated [client B] was sitting on his butt and there was water everywhere... [DSTL] stated she checked him for injuries and [DSS #2] helped her get him up. [DSTL] stated [DSS #2] cleaned up the water and [DSS #2] took [client B] to the bathroom and looked for injuries. [DSTL] stated she found scratches on his arm and a scratch on his back. [DSTL] stated [staff #6] walked in the bathroom and [DSTL] asked her why she let him walk in by himself and [staff #6] shrugged her shoulders... [DSS #1] stated she had just walked outside when the... van started unloading. [DSS #1] stated she watched [client B] get off the van. [DSS #1] stated he didn't fall getting out of the van, he staggered and staff (heavy set guy) had ahold of his pants. [Client B] grabbed his walker, took a few steps			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	'and his walker went one way and his body the other way'. [DSS #1] stated his head smacked off the walker. [DSS #1] stated staff got him back up. [DSS #1] stated staff walked him in and sat him down. [DSS #1] stated [client B] couldn't stand on his own. [DSS #1] stated she was told he fell by the dog and cat food bowl but [DSS #1] didn't see that fall. [DSS #1] stated later she and [staff #6] walked him to the bathroom 'he went down on the walker, and we helped him up'. [DSS #1] stated [staff #6] got a gait belt on him and that helped a lot to get him up. [DSS #1] stated [staff #6] stayed with him after that fall... [Staff #7] stated he and [staff #6] were on the van the morning of 10/29/24, [Staff #7] stated there was a day program staff outside helping to get the guys off the van but he didn't know her name. [Staff #7] stated [client B] was acting like he was 'not all the way there'. [Staff #7] stated [client B] was stumbling for a couple of days before those falls. [Staff #7] stated he helped [client B] off the van and handed [client B] his walker. [Staff #7] stated he went to grab his gait belt but couldn't grab it quick enough and [client B] stumbled over falling on the walker. [Staff #7] stated he helped [client B] up, [client B] went in the building with [staff #6] and the other staff and [staff #7] left... Conclusion: The allegation of a fall on 11/4/24 (sic) is substantiated. Investigation determined that [client B] fell 3 times - once getting off of the van (being assisted by [staff #7], once while walking down the hallway (not witnessed, unassisted), and while walking to the bathroom ([staff #6] and [DSS #1]) assisting. Nurse stated the falls were more than likely a result of the diagnosis of UTI. It is substantiated that [client B] has a fall plan. During the last fall investigation discussions included seeking a physician's order			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to remove the gait belt during waking hours as a part of programming. Staff indicated they believed it had been removed and that they were following the current plan. Review of current plan shows no changes have occurred yet, therefore, staff did not follow the plan as written. It is substantiated updates / revisions to the fall plan need to ensure appropriate interventions and adaptive equipment is appropriate for his needs to avoid falls... Recommendations: 1. Nurse will update fall plan reflecting physician's order to d/c (discontinue) the gait belt. 2. Updated fall plan will be trained to home and day program staff. 3. Nurse will obtain MD (medical doctor) order for PT eval...". 10) BDS incident report dated 1/20/25 indicated, "He (client B) is assessed as a fall risk and has a fall plan. Today, he was hurrying down the outside ramp to get on the van and fell. Staff assisted him up and checked for injuries. He has a scrape on his forehead about ½ inch and reopened a scab on his knee. Staff applied first-aid...". Investigation in process. 11) BDS incident report dated 4/9/24 indicated, "[Client C] was in the bathroom, fell and struck his face and jaw. He had bruising to his jaw developing appropriately (sic) 2 inches in size with two red lines on his jaw. He has a small skin mark on his neck and two lines about 8 inches and 12 inches on his shoulder and chest. He was taken to the ER (emergency room) an x-ray on his jaw and clavicle showed no fracture. He was diagnosed with contusion/bruising...". Investigation summary dated 4/14/24 indicated, "On 4/8/24 at 10:00 AM, [client C] fell in the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bathroom and struck his face and jaw. He had bruising to his jaw developing appropriately (sic) 2 inches in size with two red lines on his jaw. He has a small skin mark on his neck and two lines about 8 inches and 12 inches on his shoulder and chest... Summary of Interviews:... [Former staff #5] stated she and [former staff #6] were called over to [group home] to help out while [staff #6] ran an appointment. [Former staff #6] stated she had taken one of the [group home] clients to an appointment once, but this was the first time she ever worked at [group home]. [Former staff #5] stated she was in the kitchen looking at the client's dining plans when she heard [client C] fall. [Former staff #5] stated [client C] was in the small bathroom nearest the front door. [Former staff #5] stated [client C] screamed and she and [former staff #6] went to [client C]... [Former staff #6] said he was standing next to the front door when he heard [client C] fall and scream from the bathroom ... [Former staff #6] stated [client C's] walker had gotten caught up in the standing toilet paper holder causing him to fall. [Former staff #6] stated staff called the nurse. [Former staff #6] stated he had never worked at the [group home] before... Conclusion: The allegation of a fall on 4/8/24 is substantiated. [Client C] had walked to the small bathroom in the hallway using his walker when it caught on the standing toilet paper holder causing [client C] to fall. Staff were following the fall plan as written. It has been determined that no updates to the plan are necessary at this time... Recommendations: 1. Will remove the free-standing toilet paper holder and ensure one is			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	attached to the wall. 2. Ensure all staff have received CST (client specific training) prior to working a shift in the home. 3. Ensure service delivery logs are completed by staff every shift worked in the home. 4. Ensure all pain scale assessments documentation is completed every shift in the home...". 12A) BDS incident report dated 5/24/24 indicated, "[Client C] was taken to [hospital] ER for evaluation of his left arm. [Client C] had engaged in behaviors on Tuesday 5/21/24... He dropped himself to the floor several times to avoid walking out to leave the house and landed on his walker when throwing himself to the floor. Yesterday, his left arm appeared swollen and bruising developing on his arm/shoulder and bruising to his right side of his face. [Client C] was complaining of pain. He was taken to the ER for evaluation. At the ER he was diagnosed with left arm humerus fracture (upper arm bone)...". 12B) BDS incident report dated 5/28/24 indicated, "[Client C] was seen at [hospital] due to crying with complaints of pain. On 5/23/24 [BDS incident report] reported [client C] had been engaged in a behavioral episode and threw himself to the floor. At the ER he was diagnosed with fracture of humerus left arm. At the ER he was again diagnosed with fracture of humerus, proximal, left closed ... Investigation summary dated 5/20/24 indicated, "Scope of Investigation: 1. Did the fracture occur during the behavioral episode on 5/21/24? 2. Does [client C] have a fall plan? 3. Does [client C] have a BSP to address throwing himself to the floor? 4. Are there any needed programming revisions?... Summary of interviews: ... [Staff #1] stated he has			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not seen any recent incidents that could have caused the fracture to his arm. [Staff #1] stated he worked Sunday 5/26/24 and [client C] was not complaining of any pain. [Staff #1] stated he was not wearing the sling because it could not be located... [Staff #4] stated his first day to work at [group home] was Friday 5/24/24. [Staff #4] stated he was completing his OJT (on-the job training). [Staff #4] stated [client C] was in a sling and his hand looked fine. [Staff #4] stated when he returned Monday 5/27/24 at 3:00 PM, he did not have the sling on, and his arm was discolored and swollen. [Staff #4] stated staff took him to the ER because he was crying in pain... [Former staff #7] stated his first day to work at [group home] was Friday 5/24/24. [Former staff #7] stated he was completing his OJT training. [Former staff #7] stated [client C] was in a sling and his hand looked fine. [Former staff #7] stated when returned Monday 5/27/24 at 3:00 PM, he did not have the sling on his arm and his arm was purple and swollen. [Former staff #7] stated he was taken to the ER for evaluation... [Former staff #3] stated she has not seen [client C] do anything in the past 7 days that could cause a fracture to his arm... [Staff #7] stated he worked the day [client C] was mad and threw himself to the floor but arrived after the incident was over. [Staff #7] said he was going to take [client C] to urgent care that day but [client C] refused. [Staff #7] stated [client C] kept dropping himself to the floor while [staff #7] attempted to get [client C] to leave the house. [Staff #7] stated about 1 or 2 days per week [client C] 'throws a fit' and doesn't want to go to the day			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	program. [Staff #7] stated he hasn't seen anything else happen to cause the fracture to his arm... [Staff #6] stated she did not work on 5/21/24 but it was [former staff #1] who told her about the incident... [Staff #6] stated she has not seen anything else happen that could have caused the fracture... [Program Manager] stated all she knew about the incident was what [former staff #1] wrote in the [electronic record]. [Program Manager] stated [client C] will sometimes slide out of chairs, slide off the seat on his walker, slide out of his bed, and slide down your leg to the floor as you are assisting him with tasks... [Former staff #1] stated [client C] will throw himself down in the mornings when he doesn't want to attend day program. [Former staff #1] stated the morning of 5/21/24, [client C] got up, got dressed, and ate breakfast. [Former staff #1] stated she was giving morning meds (medications) to the clients and [client C] went back in his bedroom and laid down. [Former staff #1] stated she called for [client C], telling him he needed to get back up because they would be leaving for the day program. [Former staff #1] stated [client C] was in his bedroom screaming and cussing saying, 'No! Stay home'! [Former staff #1] stated he got back up and continued to scream and cuss and threw himself to the floor 3 times while in his bedroom. [Former staff #1] stated when he came to his doorway he was screaming, 'stay home' and again, threw himself on the floor. [Former staff #1] stated that time he hit his arm on the rectangle metal part of the brake of his walker. [Former staff #1] stated he then started yelling, 'I hurt my arm! I hurt my arm'! [Former staff #1] stated she did first-aid to his arm by cleaning			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the area. [Former staff #1] stated she then called [Program Manager]. [Former staff #1] stated [Program Manager] was running another appointment and she had directed [staff #7] to come in to take [client C] to urgent care... [Former Nurse / FN] stated staff sent her a picture of [client C's] arm on the morning of 5/21/24 and his arm was scraped up. She stated staff said he had thrown himself to the floor but did not mention anything about him being in pain. [FN] stated [Program Manager] called her and said they were going to take [client C] to urgent care and then told her later that day [client C] had refused to go to urgent care. [FN] stated [client C's] arm was not swollen until several days later, and that's when they took him to the emergency room...Conclusion: The allegation [client C] has a fracture of humerus, proximal left, closed is substantiated. It is further substantiated the injury occurred during the behavioral episode on 5/21/24. [Client C] does have a history of becoming upset and throwing himself to the ground. After review of the BSP, [electronic record], and staff interviews, the strategy when he throws himself to the floor does not appear to meet the intensity of the behavior and needs revisions. Staff failed to follow the physician's orders with regards to applying ice to his arm...Recommendations: 1. Develop an HRP (health risk plan) for care			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of the fracture and train staff to follow HRP and all physician orders. 2. IDT (interdisciplinary team) meeting to discuss revisions to BSP. 3. Retraining to staff to complete all daily documentation...". 13) BDS incident report dated 7/2/24 indicated, "Staff was assisting [client C] to bed. [Client C] was refusing. Staff were assisting using gait belt. [Client C] began screaming and threw himself to the floor. Staff attempted to raise [client C] up but he would curl his legs up and would not stand. After several attempts staff called non-emergency 911 for assistance with a lift. When EMS (emergency medical services) arrived [client C] continued to refuse assistance to get up. 3 EMS (staff) lifted [client C] into the bed. [Client C] fell asleep without further issues. Plan to Resolve: [Client C] has a BSP (behavior support plan) for throwing himself on the floor and refusing. Team will review his BSP to determine If any further revision to the plan is needed...".14) BDS incident report dated 9/6/24 indicated, "[Client C] had went (sic) into the bathroom. Staff heard a noise and [client C] yell out for staff. When staff entered the bathroom [client C] was laying on the floor on his left side. Staff stated there was urine on the floor in front of the toilet that [client C] had slipped on. Staff further reported a client had left his clothes on the floor and [client C] fell onto the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	clothes. Staff checked for injuries. A bruise measuring appropriately (sic) 1 inch on the left side of his forehead developed within 20 minutes of the fall. [Client C] was taken to [hospital] for evaluation. At ER a head CT scan (medical imaging) was completed with no findings... orders to apply ice to forehead...Investigation summary dated 9/11/24 indicated, "Scope of Investigation:... 3. Were staff following the fall plan as written...Summary of Interviews: [Staff #1] stated [staff #4] was working alone when [client C] fell. [Staff #1] stated he had not yet arrived to work when the fall occurred... [Staff #4] stated he was working alone when [client C] fell. [Staff #4] stated he had been in the office ordering pizza and heard the fall...Conclusion: The allegation of a fall on 9/6/24 is substantiated. Investigation concludes the fall was likely the result of slipping in the urine or pile of clothes left on the bathroom floor... It is substantiated staff failed to initiate head-injury monitoring per protocol, the nurse failed to update the date during last revision of fall plan, staff documentation was incomplete, and staff ratio was not sufficient to meet the needs of the home...Recommendations: 1. Seek PT (physical therapy) eval (evaluation) to clarify orders for use of adaptive equipment to meet client needs. Will update plans accordingly... 2. Staff training to ensure			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	appropriate staff at all times and that floor remains free of clutter through periodic checks...".15) BDS incident report dated 9/13/24 indicated, "[Client C] was attending day program. [Client C] had finished his lunch and left the lunchroom after being asked to wait for his peers to finish lunch. [Client C] walked outside through the side door into the fenced yard. A client yelled that [client C] needed help. Staff started through the hallway and could see [client C] laying on the sidewalk ... He was bleeding from appeared to be his mouth nd (sic) nose... Staff called 911 and he was transported to [hospital] for evaluation ... He was diagnosed with a facial abrasion, acute head injury...".Investigation summary dated 9/17/24 indicated, "Scope of the Investigation:... 3. Were staff following the fall plan as written?...Conclusion: The allegation of a fall on 9/13/24 is substantiated. The fall was not witnessed by staff. The investigation concludes the fall was likely the result of the uneven surface of the threshold of the door and [client C's] inability to maneuver the walker and the door. It is substantiated that [client C] has a fall a plan in place, however, it is outdated (2/2/23). Witness statements also suggest staff are not adequately trained on the specifics of [client C's] fall plan. It is substantiated staff did not follow the plan as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	written by failing (to) assist as needed with ambulation on uneven ground. It is substantiated that [client C's] fall plan needs updated to reflect a current date and clarification needs to be added for staff to determine when [client C] should be using the wheelchair and/or the walker...Recommendations: 1. PT eval sch (scheduled) 9/25/24 at 3:30 PM. 2. DP (day program) will ensure as group changes are made, relieving staff will review clients plans. 3. Nursing to update fall plan...".16) BDS incident report dated 9/14/24 indicated, "[Client C] is assessed as a fall risk and has a fall plan. [Client C] had been sitting in his wheelchair and went outside using the wheelchair to sit on the porch. While transferring from the wheelchair he ... fell to the sidewalk on his left back side. Staff assisted [client C] back to his feet and checked for any signs of injury. He had a red area on his left back side. Staff monitored for injuries, and he has small scrapes on his right elbow...".Investigation summary dated 9/18/24 indicated, "Scope of Investigation:... 3. Were staff following the fall plan as written?...Conclusion: The allegation of a fall on 9/14/24 is substantiated. The fall was not witnessed by staff. The staffing ratio was insufficient to meet the needs of the client care plans at the time of the incident due to a call-off.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Investigation concludes when [client C] attempted to transfer himself from the wheelchair to another chair on an uneven surface without staff assistance. It is substantiated that [client C] has a fall plan in place, however, it is outdated (2/2/23). It is substantiated staff failed to follow the fall plan as written by assisting [client C[on uneven surfaces. Single staff on duty was in the restroom when the incident occurred. It is substantiated that [client C's] fall plan needs to reflect a current date and clarification needs to be added for staff to determine when [client C] should be using the wheelchair and/or the walker...Recommendations: 1. Staff assistance was on the way to the home for staffing ratio and the fall occurred prior to her arrival. 2. Seek PT eval for clarification on adaptive equipment to meet his needs. Will update plans accordingly. 3. Ensure staff complete and document PT exercises and pain scale documentation...".17) BDS incident report dated 9/18/24 indicated, "[Client C] was sitting quietly on the couch. He began to yell at staff to take him to the hospital. [Client C] continued to yell and scooted himself towards the end of the couch making himself fall of the couch. Staff assisted him back on the couch, checked him for injuries finding no visual injuries from this fall...".Investigation summary dated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	9/21/24 indicated, "Scope of Investigation:... 3. Were staff following the fall plan and/or BSP as written?...Summary of Interviews:... [Former staff #3] stated she and [staff #6] were working at the time of the incident. [Former staff #3] stated they were both sitting on the back deck with a few clients while [client C] was sitting on the couch. [Former staff #3] stated the environment was quiet and the clients in the living room were watching TV (television). [Former staff #3] stated [client C] was sitting on the couch softly 'whining'. [Former staff #3] stated she and [staff #6] both started to come in the back door and [client C] and [client C's] 'whining' got louder as soon as he saw them. [Former staff #3] stated [client C] was saying, 'I want to go to the hospital' and scooted forward to the edge of the couch and slid down onto the floor. [Former staff #3] stated she and [staff #6] got on each side of him with their arms under his arm pits and sat him back onto the couch...[Staff #6] stated she and [former staff #3] were working at the time of the incident. [Staff #6] stated [former staff #3] was outside on the porch and she was in the laundry room. [Staff #6] stated she heard hollering, [client C] yelling. [Staff #6] stated [client C] was on the couch and had fallen over to his side. [Staff #6] stated [client A] was sitting on the couch and was trying to help [client C] sit			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	back up...Conclusion: The allegation of a fall on 9/17/24 is unsubstantiated. The incident was witnessed by [staff #6] and [former staff #3], who state [client C] was behavioral and intentionally dropped off the couch... It is substantiated [client C] has a BSP in place that addresses a targeted behavior of flopping/throwing self on floor. It is substantiated that staff followed [client C's] BSP as written during the incident. As described, there was not sufficient time for staff to intervene with a pillow prior to execution of the behavior...Recommendations: 1. IDT meeting to discuss necessary updates to BSP...".18) BDS incident report dated 11/23/24 indicated, "[Client C] is a [age] year old male. Today he had went (sic) to the bathroom to use the restroom. Staff heard him crying and yelling, went to check on him and he had fallen off the toilet. Staff assisted him up and checked for injuries. On the right side of his forehead above his eye he had a laceration appropriately (sic) one inch long... and going to him to [hospital] ER for evaluation. At the ER he was diagnosed with a 2 cm (centimeter) forehead laceration... wound was closed with steri-strips and given a tetanus shot...".Investigation summary dated 11/26/24 indicated, "Scope of Investigation:... 4. Were staff following the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	fall plan and/or BSP as written? 5. Do any updates need to be made to the existing fall plan and/or BSP to prevent future falls?...Summary of Interviews: [Area Supervisor /AS] stated she and [staff #1] were working at the time of [client C's] fall. [AS] stated she had run up to [restaurant] to pick [client G] up while [staff #1] was passing meds. [AS] stated she was walking up the ramp to the front door, [client A] was walking out the door saying [client C] fell... [Staff #1] stated he and [AS] were working when [client C] fell. [Staff #1] stated he was in the office passing meds and [AS] was outside. [Staff #1] stated he heard [client C] yelling and crying so he locked the meds back up and then went to see what was going on with [client C]. [Staff #1] stated [client C] was in the middle bathroom laying on his left side, with his back towards the door. [Staff #1] stated [AS] arrived seconds after he did to see what had happened...Conclusion: The allegation of a fall on 11/23/24 is substantiated. The incident was not witnessed. There is no evidence the fall was behavioral. It is likely [client C] attempted to transfer to the toilet and the wheelchair moved, causing his fall ... It is substantiated that staff followed the fall plan as written... It is substantiated that [client C's] fall plan needs updated for clarification to determine when [client C]			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	should be using the wheelchair verses (sic) the walker. Clarification is also necessary regarding use of the gait belt for transfers. Also, wearing socks/shoes inside is not addressed in the current fall plan...Recommendations: 1. IDT meeting to review and discuss all programming and any necessary revisions...". An observation was conducted on 1/16/25 from 2:51 PM to 6:03 PM. At 3:14 PM, client B used his walker to go from his bedroom to the medication administration room. Client B was using his walker and carrying a plastic container with his art supplies. Client B was not wearing a belt. Upon returning from the medication administration room toward the dining room table, client B dropped a pencil and bent over to pick it up. Client B's pants were low on his hips exposing his undergarment. At 3:16 PM, client B ambulated around the dining room table without the use of his walker. Client B stumbled into his walker. The Area Supervisor (AS) stated, "Slow down, be careful". At 3:17 PM, client B used his walker to ambulate while holding a shirt in his hand and went to his bedroom. Client B stumbled in the hallway. The Team Leader (TL) stated, "Slow down, you're making me nervous". At 3:30 PM, client B stood from the dining room table and emptied his pencil sharpener into the trash. As client B bent			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	over toward the trash can, his pants hung low on his hips. Client B was not wearing a belt. At 4:22 PM, the TL used a verbal prompt with client B to clean his spot at the dining room table. Client B walked toward the dining room table and the TL stated, "Walker, walker, walker". Client B returned to his walker in the living room and used it to go back toward the dining room table. As client B went over the threshold between the living room and dining room, the legs of his walker became stuck hitting a piece of wood trim. Client B lifted his walker up and over the wooden trim and continued toward his spot at the dining room table. At 4:35 PM, the AS gathered clean bedding from the sofa and went down the hallway toward the client bedrooms. At 4:37 PM, client B joined the AS in his bedroom. At 4:39 PM, client B and the AS were organizing client B's bedroom. A piece of plywood was attached to the wall and client B was asked what had happened. Client B stated, "I fell down". A white adaptive device was observed in client B's bedroom window. Client B was asked what the adaptive device in his window was for. Client B stated, "For when I get up". At 4:44 PM, client B pushed buttons on the white adaptive device and said it was a "bed alarm". The AS stated to client B, "How does it work? Let me see if there is another piece in the office". At 4:46 PM, the AS			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	used her phone to send a text message to the Program Manager to identify the purpose of the white adaptive device in client B's bedroom. During this time, the TL was asked if the white adaptive device in client B's bedroom was a bed alarm or monitor. The TL stated, "Yeah. That has always sat beside his bed". At 4:48 PM, the TL used her phone to text someone while she continued preparing the evening meal. At 4:49 PM, the AS searched the office area for the second piece to client B's white adaptive device. The AS used her phone and called the Qualified Intellectual Disabilities Professional Designee (QIDPD) and stated, "It's an audio monitor". The AS was unable to locate the second piece of client B's audio monitor in the office and continued searching for it. At 4:52 PM, the TL referred to her phone reading a message and stated, "Hey [Surveyor]. It's a baby monitor, it's so you can hear him at night. The other piece is in the office". At 4:57 PM, the AS found the second piece to the monitoring device and stated, "I don't know if this is it. I'll have to plug it in". The AS went to client B's bedroom and spoke to see if the TL could hear an audible sound through the monitor and stated, "Can you hear me"? The TL confirmed with the surveyor she could hear the AS and stated, "Yes, I can hear you. I don't think she can			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hear me. I think it's one way". Client B's monitor remained on throughout the remainder of the observation period.An observation was conducted on 1/17/25 from 5:58 AM to 8:16 AM. Client C was in his bedroom upon arrival to the group home. Staff #4 and staff #7 were present on the shift. At 6:08 AM, staff #4 physically assisted client C in his wheelchair from his bedroom to the bathroom. At 6:17 AM, staff #4 physically assisted client C in his wheelchair from the bathroom to the living room. Client C proceeded to transfer himself from his wheelchair to a couch in the living room. At 6:18 AM, staff #7 was asked about client C's incident history of falls with a fracture to his arm. Staff #7 stated, "Yeah, he's had two. One broke one arm and healed and then he fell and broke the other arm. The wheelchair has helped to prevent him from falling. Staff #7 was asked about the timeline for the two incidents he described for client C's fractures to both of his arms. Staff #7 stated, "It's been a while. At least 6 months". At 7:51 AM, staff #7 placed gloves on his hands and assisted client C in the hallway into the bathroom. Staff #7 assisted client C with a transfer from his wheelchair to the toilet. The bathroom door was left open. As staff #7 returned from the bathroom he stated, "When I'm here alone, he'll yell for me when			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	he is ready". Client C was left alone sitting on the toilet in the bathroom while the bathroom door was left open. On 1/22/25 at 1:09 PM, a review of client B's record was conducted. The review indicated the following:Fall Risk Plan dated 11/12/24 indicated, "Actions: Ensure Safety First... 1. Staff will provide an environment free of clutter.2. Staff will provide assistance with ambulation and toileting as needed.3. Staff will encourage [client B] to wear nonskid socks at home when not wearing shoes.4. Staff will encourage [client B] to maintain straight posture and hold head up while ambulating.5. Staff will encourage [client B] to utilize 2 wheel walker w (with) tennis balls on back legs during ambulation. 6. Staff will ensure that [client B] uses a shower chair for all showers.7. Ensure ¼ Bed Rails utilized.8. Staff will use audio monitor when [client B] in his bedroom and have the receiving end of audio monitor within hearing range.9. Staff to encourage [client B] to pay attention and provide prompts/reminders in areas, such as crossing the street, around cars, stairs, curbs, uneven surface, etc.10. Staff to provide hands-on assistance if [client B] is in danger of falling from non-compliance to prevent injury.11. Should fall occur perform assessment, refer to Triggers to notify the Nurse, document fall, and any injury noted after medical care is given.12.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Staff will report any changes in mobility to the nurse immediately. 13. Staff will notify physician for further recommendations.14. Nursing will assess at visits and document assessment in the medical record.15. Will attend all medical appointments with PCP (primary care physician) and any specialists as indicated.16. Will have labs and other testing completed as ordered...".On 1/22/25 at 1:09 PM, client C's record was reviewed. The review indicated the following:Fall Risk Plan dated 12/5/24 indicated, "Planning and Implementation:1. Interventions:a. Staff will take [client C] to all medical appointments.b. Utilize wheelchair footrest for long distance/footrests off when in home.c. Ensure gait belt is attached to wheelchair to be utilized if client has fallen.d. Will use a wheelchair for ambulation and long distances until seen by Rheumatology for evaluation of arthritis and gout.e. Will utilize rollator walker when completing Home Exercise program.f. [Client C] will use a shower chair for all showers.2. Monitoringa. Staff will monitor for change in increased weakness, unsteady gait and uneven ground.3. Documentationa. Staff will document in the progress notes and internal incident report if a fall occurs.4. Notificationa. Staff will notify the Nurse of any issues noted and of any falls with or without injury.5. Traininga. Annually or as neededb. All training is kept			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	in the home, in the training binder, and in training file at office6. What do you do when out of home?All ResCare staff will follow same protocol as listed. All providers are given copy of all high risk plans ...".On 1/23/25 at 10:12 AM, the Nurse was interviewed. The Nurse was asked about a pattern of clients B and C's accidents, falls and injuries. The Nurse indicated clients B and C had a pattern of injuries from the incident history. The Nurse was asked if staff should implement the client care plans as written? The Nurse stated, "Yes, they need to be following their plans". The Nurse was asked if appropriate levels of support and supervision should be provided to prevent accidents and/or injuries. The Nurse stated, "Yes".The Nurse was asked what patterns existed in these types of accidents and/or injuries for clients B and C. The Nurse stated, "A lot of unwitnessed. The bathroom, staffing ratios". The Nurse was asked about the lack of staff deployment to prevent accidents and injuries. The Nurse stated, "Right".The Nurse was asked if client C should be left unattended while using the restroom with the door left open. The Nurse stated, "We (interdisciplinary team) discussed them (staff) taking him to the larger bathroom since he has the wheelchair. I know he will take himself to the small bathroom. They should encourage him to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	use the larger bathroom. It would be helpful with more staff". The Nurse was asked about client B's intervention strategies for the use of his monitor to prevent accidents and/or injuries. The Nurse stated, "It's written basically when he is in his room staff should have it on so they can hear... It should be left on at all times, they are supposed to be able to hear it. I know he is all over the house. I think it was when he was in his room alone". The Nurse was asked if client B's monitor should be used during waking hours or non-waking hours. The Nurse stated, "It does not specify. I would leave it on all the time". On 1/23/25 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) and the Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDP and the QIDPD were asked about a pattern of clients B and C's accidents, falls and injuries. The QIDP and QIDPD indicated clients B and C had a pattern of injuries from incident history. The QIDP and QIDPD were asked if staff should implement clients B and C's fall risk plans as written. The QIDPD stated, "They (staff) should know them (fall risk plan) and follow them". The QIDP stated, "Yes". The QIDP and QIDPD were asked if appropriate levels of staffing should be provided to ensure implementation of clients B and C's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	health risk plans. The QIDP stated, "Staffing ratios should be followed. They should be deployed where the need is for the clients". The QIDP and QIDPD were asked about client B's use of his monitor to prevent accidents and/or injuries. The QIDPD stated, "We added that after a fall from his bed. We implemented a quarter bed rail and a monitor to be able to hear him". The QIDP stated, "The monitor should be used when he's in his room daytime or nighttime". The QIDP was asked if the monitor should be used during all waking hours. The QIDP stated, "Yes, waking hours". The QIDP and QIDPD were asked their knowledge of the monitor being placed in a drawer in the office. The QIDPD stated, "No, not until it was after". The QIDP stated, "I had not noticed it either". The QIDP was asked if client B's fall risk plan for the implementation and use of the monitor was being used appropriately during the observation. The QIDP stated, "No, it was not".The QIDP and QIDPD were asked about a pattern from the incident history for client C's falls and/or injuries. The QIDP stated, "Well with [client C] there is a pattern in the bathroom, transfer in general and different surfaces or terrain. Head injuries and significant injuries like broken arms. The deployment and reaction of staff". The QIDPD stated, "Going with [QIDP's] last statement,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unwitnessed incidents". The QIDP and QIDPD were asked if client C should be left unattended while toileting and the bathroom door open in the event he needed to holler for help. The QIDP stated, "Well, the door should be shut for privacy. I know we're talking about the middle bathroom. We should encourage him to use the larger bathroom due to his wheelchair". The QIDPD stated, "Recognizing the trend we need to do an IDT and discuss this. There is the privacy, and transfers (preventing accidents)". On 1/30/25 at 11:50 AM, the Program Director (PD) was interviewed. The PD was asked about corrective measures to prevent a pattern of accident, falls, and/or injuries for clients B and C. The PD indicated the need to ensure previous recommendations from past investigations be discussed to ensure implementation. The PD stated during the review process as incidents occur, have the previous recommendations been "implemented and affective. Are we doing what we're supposed to be doing". The PD indicated increased staffing supports had been added with additional monitoring with management staffing at the group home. This federal tag relates to complaint #IN00435432.9-3-2(a)			
W 0158 Bldg. 00	483.430 FACILITY STAFFING Based on observation, record review and	W 0158	**W158: Facility Staffing**	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interview for 3 of 3 sampled clients (A, B and C) and 4 additional clients (D, F, G and H), the facility failed to meet the Condition of Participation: Facility Staffing. The facility failed to deploy sufficient staffing to prevent: 1) a pattern of accidents and/or injuries with client B and 2) a pattern of falls with injuries with client C, and 3) staff competency with the administration of clients A, B, D, F, G and H's medication administration programs. Findings include: 1) Please refer to W186. For 2 of 3 sampled clients (B and C), the facility failed to ensure sufficient staffing resources were deployed appropriately to prevent: 1) a pattern of accidents and/or injuries with client B and 2) a pattern of falls with injuries with client C. 2) Please refer to W192. For 2 of 3 sampled clients (A and B) and 4 additional clients (D, F, G and H), the facility failed to ensure staff competency with the administration of clients A, B, D, F, G and H's medication administration programs. This federal tag relates to complaint #IN00435432. 9-3-3(a)		**Corrective Action:** Nurse is at the facility 3 days a week to complete oversight of the health needs of all clients in the facility for no less than 3 months and sends a detailed update to the IDT and administrative team. **(Attachment C)** The Area Supervisor of the facility at the time of survey was replaced by a veteran Area Supervisor, Chasity Drew, who will have the facility ongoing and will be in the facility a minimum of 3 days a week on varied shifts for training, monitoring and to ensure staff are deployed appropriately. ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** All staff trained by the Nurse regarding medication administration, Medication storage	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			and security, QuickMar, Medications that go home for visit process, dining plans and demonstrated how to prep food according to the client's diet. **(Attachment E)** All staff were tested on Medication Administration competency tests by the Nurse. **(Attachment F)** Program Manager ordered a lockbox for medication that needs destroyed by a Nurse to be stored in and removed from the facility medication storage. **(Attachment G)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP and QuickMar. **(Attachment H)** Nurse obtained clarified order for how client (H) should receive his medications and trained staff on the updated order. **(Attachment I)** Staffing levels at the home were increased to a minimum of 3 staff during active treatment hours to ensure staff are deployed throughout the home for monitoring and assistance to all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			clients. Client (B) and (C) are scheduled to see their PCP on 3/12/25 to obtain a referral to Physical therapy to ensure proper adaptive equipment is in place as needed for fall prevention. ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility. ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios. **Monitoring of Corrective Action:** All oversight observations will be reviewed during daily survey update calls held by ResCare Management and filed in the binder at the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Nurse will complete medication administration observations to ensure staff competency and notify management of any concerns. QIDP will ensure all updated plans and assessments are completed annually and as needed based on client needs. Nurse will ensure all client high risk and dining plans are up to date and staff are trained on any new or updated plans and upload them in TMP for monitoring and review. Nurse Manager pulls reports in QuickMar daily that show if all medications were passed as scheduled and sends out the report to all Area Supervisors, Program Managers, Program Director, Nurses, and Executive Director for monitoring and to ensure completion. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. Program Manager manages the staffing schedule for the facility and provides updates to HR for hiring to ensure the home has proper staffing. **Completion Date: 2/23/25**	
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF Based on observation, record review and	W 0186	**W186:** The facility must provide	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interview for 2 of 3 sampled clients (B and C), the facility failed to ensure sufficient staffing resources were deployed appropriately to prevent: 1) a pattern of accidents and/or injuries with client B and 2) a pattern of falls with injuries with client C. Findings include: On 1/21/25 at 12:27 PM, a review of the facility's Bureau of Disabilities Services (BDS) incident reports and accompanying investigation summaries was conducted. The review indicated the following affecting clients B and C: 1) BDS incident report dated 1/14/24 indicated, "On 1/12/24 staff noticed bruising on [client B's] foot along the side of the foot... 3 inches long and 1 inch wide. [Client B] stated he fell in his bedroom. Today the staff noticed his foot was swollen... At the clinic an x-ray of his foot was taken. The x-ray results showed a fracture. He was given a walking shoe, ordered to elevate and ice his foot 3 times per day and was referred to Ortho (Orthopedic Surgeon)...". Investigation summary dated 1/19/24 indicated "On 1/12/24 [client B] showed staff a bruise on his foot and told staff he fell in his bedroom that morning... The bruise is appropriately (sic) 3 inches long and 1 inch wide... The x-rays showed a fracture. He was given a walking shoe and ordered to elevate and ice his foot 3 times per day and was referred to Ortho... Conclusion: The allegation bruising/swelling to [client B's] right foot/ankle is substantiated. The follow up with the Ortho x-ray showed no fracture. All staff deny witness of what happened to [client B's] foot/ankle. Observation of [client B's]		sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. **Corrective action:** The Area Supervisor of the facility at the time of survey was replaced by a veteran Area Supervisor, Chasity Drew, who will have the facility ongoing and will be in the facility a minimum of 3 days a week on varied shifts for training, monitoring and to ensure staff are deployed appropriately. ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bedroom and interview with [client B] found the room to be messy and [client B] said he fell out of bed... Investigation concludes [client B] likely fell in his bedroom injuring his foot/ankle... Recommendations: 1. Ensure bedroom remains trip/fall hazard free - staff assist [client B] each evening to clean room. 2. Ensure shower chair stays in bathroom. 3. Ensure 15 min (minute) checks when [client B] is in his bedroom ... 7. Staff training to call nurse for any bruising/injury...". 2) BDS incident report dated 5/1/24 indicated, "This morning when the nurse was at the home, [client B] told her he fell getting out of bed this morning. He has a small area above his left eye appropriately (sic) ¼ inch blood under the skin, skin not broken. He also has a skinned left knee appropriately (sic) the size of a half dollar. First-aid applied...". Investigation summary dated 5/7/24 indicated, "Introduction:... [Client B] told her (nurse) he fell getting out of bed that morning. He has a small area above his left eye approximately ¼ inch with blood under the skin... He also has a skinned left knee appropriately (sic) size of a half dollar... Conclusion: The allegation of a fall on 5/1/24 is substantiated. It is substantiated that [client B] has a fall plan in place. Due to lack of completed daily documentation on 5/1/24, and no witnesses to the fall, it cannot be determined if staff were following the fall plan as written during the incident. It is substantiated the fall plan needs to be updated to include the use of an audio monitor with staff carrying monitor as they complete tasks throughout the house... Recommendations: 1. Training to staff to carry the		staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP and QuickMar. **(Attachment H)** Staffing levels at the home were increased to a minimum of 3 staff during active treatment hours to ensure staff are deployed throughout the home for monitoring and assistance to all clients. ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility. ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	audio monitor with them as they complete tasks throughout the home. 2. In-service to all home staff that any missing SDL's (daily documentation) discovered moving forward will result in corrective action for staff...". 3) BDS incident report dated 8/25/24 indicated, "[Client B] was standing in front of the door and fell. Staff report he intentionally fell. He has a skinned/scraped knee and a 1 inch scrape on his left wrist...". Investigation summary dated 8/28/24 indicated, "On 8/24/24 at 3:30 PM, [client B] was standing in front of the door and fell. Staff report he intentionally fell. He has a skinned/scraped knee and a 1 inch scrape on his left wrist... Summary of Interviews:... [Staff #5] stated when [client B] fell, he was in the living room folding laundry, [staff #1] was in the office doing TMP (electronic documentation), and [staff #4] was gone running errands. [Staff #5] stated [client B] was using his walker, he was not wearing his gait belt, and he was wearing his slip-on sneakers. [Staff #5] stated [client B] was in his bedroom cleaning, walked out of his bedroom carrying a sheet toward the laundry room, got halfway past the front door, and tripped over the sheet. [Staff #5] stated the sheet got under the wheels of the walker, [client B] stumbled, the walker went sideways, and [client B] fell... [Staff #4] stated he was running errands and not at the home when [client B] fell. [Staff #4] stated he knew [client B] scraped his wrist and knee but did not see the fall... [Staff #1] stated he thought [staff #4] was running an errand and [staff #5] was all over the house		**Monitoring of Corrective Action**: All oversight observations will be reviewed during daily survey update calls held by ResCare Management and filed in the binder at the facility. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. Program Manager manages the staffing schedule for the facility and provides updates to HR for hiring to ensure the home has proper staffing. Site Reviews will be completed monthly by ResCare management and entered into the site review database. Quality Assurance tracks all site review data and submits to management for follow up and review. **Completion Date: 2/23/25**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cleaning. [Staff #1] wrote the (electronic documentation) but stated he was in the kitchen when [client B] fell and did not see the fall... Conclusion: The allegation of a fall on 8/24/24 is substantiated... 4A) BDS incident report dated 9/11/24 indicated, "Staff report [client B] purposely threw himself on the floor when there was a visitor at the group home. Staff report [client B] threw himself to the floor to gain attention of the visitor. [Client B's] left knee was skinned and bleeding. First-aid applied...". 4B) BDS incident report dated 9/11/24 indicated, "During the course of a fall investigation staff stated [client B] had been behavioral not listening to redirection. Staff stated in addition to the fall reported... [client B] was mad/upset when staff was redirecting him to another area of the house and he shoved his walker into the staff and purposely dropped to the floor. Another staff stated later that same day, [client B] had gotten a soda and started running through the living room to take the soda to his bedroom and fell as he entered the foyer of the house...". Investigation summary dated 9/13/24 indicated, "Scope of Investigation: 1. Did [client B] fall... 3. Were staff following the fall plan as written?... Summary of Interviews: [Former staff #3] stated she was working with [staff #6] and [staff #1]. [Former staff #3] stated [staff #6] was in the office and [staff #1] was in the kitchen. [Former staff #3] stated her mom had come to the group home and [former staff #3] walked outside to her car to feed her baby. [Former staff #3] stated [client B] came out of the front door 'flying down the ramp' with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	his walker, walked over in front of her mom, and fell to his knees. [Former staff #3] stated she helped him up and took him in the house. [Former staff #3] stated later that day while the maintenance men were working, [client B] kept trying to go in his bedroom while they were working on the window. [Former staff #3] stated she was with [client B], directing him he had to stay out of the bedroom while they worked. [Former staff #3] stated [client B] got mad, shoved his walker into her, and 'dramatically' went to his knees. [Former staff #3] stated [client B] acts in this matter (sic) 'all the time, normal for him, nonstop, continuous'... [Staff #1] stated he was working with [former staff #3]. [Staff #1] stated he was sitting at the dining room table, near the living room, and that [former staff #3] was in the office. [Staff #1] stated [client B] had opened a can of pop and started running through the house. [Staff #1] stated he tried to direct him to slow down and use his walker, but he kept running. [Staff #1] stated when [client B] got to the entry way of the house, he fell to his knees. [Staff #1] stated he would not use his walker as directed... [Staff #1] stated he did not see or know that [client B] had fallen outside or in the hallway that day. [Staff #1] stated [client B] will not listen to staff directives and that he hurries and falls 'all the time'... [Staff #6] stated she worked with [former staff #3] and [staff #1]. [Staff #6] stated she did not see [client B] fall at anytime on 9/10/24... Conclusion: The allegation of fall(s) on 9/10/24 is substantiated...". 5) BDS incident report dated 9/14/24 indicated, "[Client B] is assessed as a fall risk and has a fall			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	plan. [Client B] was running with his walker and staff asked him to slow down. [Client B] went around the corner and fell to his buttocks. Staff helped him up and checked for injuries. No visual injuries...". Investigation summary dated 9/18/24 indicated, "On 9/14/24 at 4:00 PM, [client B] was running with his walker and staff asked him to slow down. [Client B] went around a corner and fell to his buttocks... Summary of Interviews: [Former staff #4] stated she worked with [Program Manager] from 2:30 PM until 5:00 PM and had been working when [client B] fell. [Former staff #4] stated [Program Manager] had stepped outside to take a break and that [former staff #4] was folding clothes. [Former staff #4] had put the folded clothes on the kitchen table and walked into the living room to begin cleaning and picking up. [Former staff #4] stated [client B] was using his walker and had walked over to the kitchen table, picked up a pile of folded clothes, said they were [client C's], and he (client B) was going to put them away. [Former staff #4] stated [client B] started out walking but then started to run. [Former staff #4] stated she didn't see [client B] fall but heard him yelling out her name for help. [Former staff #4] stated when she walked into the office, [client B] was sitting on his buttocks in [client C's] doorway. [Former staff #4] stated she helped him up, checked for injuries, and found no visual signs of injury. [Former staff #4] stated she wasn't sure what the fall plan says about avoiding falls... [Former staff #4] stated she had not been trained on working with [client B]... [Program Manager] stated she was working with [former staff #4] when [client B] fell. [Program Manager] stated she did not witness the fall as			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	she had just stepped outside to take break when the fall occurred... Conclusion: The allegation of a fall on 9/14/24 is substantiated...". 6) BDS incident report dated 10/24/24 indicated, "This morning after getting ready to leave for the day program he (client B) was walking down the hallway wearing another client's shoes and fell to his knees. Staff checked him for injuries. The scab on his left knee broke open, the area is about 1 inch...". Investigation summary dated 10/29/24 indicated, "Scope of Investigation:.. 3. Were staff following the fall plan as written?... Summary of Interviews: [Nurse] stated she was at the house when [client B] fell. [Nurse] stated the staff at the home was [staff #6]. [Nurse] stated [client B] came walking down the hallway with his walker. [Nurse] stated he had on a pair of clogs that looked too big for him. [Nurse] stated she told [client B] he shouldn't be wearing shoes like that and asked him to change his shoes. [Nurse] stated [client B] walked to his bedroom. [Nurse] stated [client B] did appear to be groggy that morning. [Nurse] stated she heard him fall and went to his bedroom... [Nurse] stated she helped him up and took care of the bleeding scab on his knee... [Staff #6] stated she was the only staff working at the time of [client B's] fall... [Staff #6] stated she could see [client B] walking down the hallway. [Staff #6] stated he was walking to his bedroom to change out of his clogs. [Staff #6] stated [client B] was very close to the wall, tried to turn into his bedroom and tripped over the leg of the walker.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[Staff #6] stated [client B] 'busted open' the scab on his left knee. [Staff #6] stated that has been on his knee forever and does not heal. [Staff #6] stated his clogs are too long and too thick for him to walk... Conclusion: The allegation of a fall on 10/24/24 is substantiated... Recommendations: 1. Regarding the staff ratio, the night shift staff had just left prior to the day shift staff getting clients on the van to leave for the day program ...". 7) BDS incident report dated 10/30/24 indicated, "[Client B] arrived to day program around 10:20 AM. As [client B] was exiting the van to enter day program he fell to his knees and hit his head on his walker. Staff assisted him up. [Client B] then entered the day program and walked up the hallway towards the kitchen and fell again in the hall, landing on a water dish. Staff heard him fall and went to assist... 2 inch scratch on the left side of his upper back, a cluster of 3 scratches to his left arm... He was taken to [name of urgent clinic] for evaluation... and diagnosed with a severe UTI (urinary tract infection)...". Investigation summary dated 11/4/24 indicated, "Scope of Investigation:... 3. Were staff following the fall plan as written?... Summary of Interviews: [Staff #6] stated she and [staff #7] were on the van when they arrived at the day program on 10/29/24. [Staff #6] stated [client B] fell 3 times at day program before going to urgent care. [Staff #6] stated she did not see [client B] fall getting off the van, as she was in the back of the van helping [client C]. [Staff #6] stated she heard [client B] holler. [Staff #6] stated she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	walked around the van and [client B] was on the ground... [Staff #6] stated [staff #7] and [Day Service Staff / DSS #1] helped him up... [Staff #6] stated she was headed toward the board game room and told [client B] to come into the board game room, but he went the opposite way. [Staff #6] stated [Day Service Team Leader / DSTL] came to the board game room and said [client B] had fallen in the water bowl. [Staff #6] stated [Area Supervisor / AS] was called to get [client B] and take him to urgent care. [Staff #6] stated she and [DSS #1] took [client B] to the bathroom before he left and he again went down in the hallway. [Staff #6] said she had ahold of him but couldn't hold onto him as he fell. [Staff #6] stated [AS] got to the day program and took him to urgent care... [AS] stated [DSTL] called her, but she was already on her way to pick up [client B]. [AS] stated [staff #4] had called and said [client B] was acting funny, so she was going to pick up [client B] to take him to urgent care. [AS] stated [client B] was acting like he couldn't stay awake, and he was trying to fall down... [DSTL] stated she was in her office with the doors open and she heard a big bang and went to the hallway. [DSTL] stated [client B] was sitting on his butt and there was water everywhere... [DSTL] stated she checked him for injuries and [DSS #2] helped her get him up. [DSTL] stated [DSS #2] cleaned up the water and [DSS #2] took [client B] to the bathroom and looked for injuries. [DSTL] stated she found scratches on his arm and a scratch on his back. [DSTL] stated [staff #6] walked in the bathroom and [DSTL] asked her why she let him walk in by himself and [staff #6] shrugged her shoulders...			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[DSS #1] stated she had just walked outside when the... van started unloading. [DSS #1] stated she watched [client B] get off the van. [DSS #1] stated he didn't fall getting out of the van, he staggered and staff (heavy set guy) had ahold of his pants. [Client B] grabbed his walker, took a few steps 'and his walker went one way and his body the other way'. [DSS #1] stated his head smacked off the walker. [DSS #1] stated staff got him back up. [DSS #1] stated staff walked him in and sat him down. [DSS #1] stated [client B] couldn't stand on his own. [DSS #1] stated she was told he fell by the dog and cat food bowl but [DSS #1] didn't see that fall. [DSS #1] stated later she and [staff #6] walked him to the bathroom 'he went down on the walker, and we helped him up'. [DSS #1] stated [staff #6] got a gait belt on him and that helped a lot to get him up. [DSS #1] stated [staff #6] stayed with him after that fall... [Staff #7] stated he and [staff #6] were on the van the morning of 10/29/24, [Staff #7] stated there was a day program staff outside helping to get the guys off the van but he didn't know her name. [Staff #7] stated [client B] was acting like he was 'not all the way there'. [Staff #7] stated [client B] was stumbling for a couple of days before those falls. [Staff #7] stated he helped [client B] off the van and handed [client B] his walker. [Staff #7] stated he went to grab his gait belt but couldn't grab it quick enough and [client B] stumbled over falling on the walker. [Staff #7] stated he helped [client B] up, [client B] went in the building with [staff #6] and the other staff and [staff #7] left... Conclusion: The allegation of a fall on 11/4/24 (sic) is substantiated. Investigation determined that [client B] fell 3 times - once getting off of the van (being assisted by [staff #7], once while walking down the hallway (not witnessed,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unassisted), and while walking to the bathroom ([staff #6] and [DSS #1]) assisting... During the last fall investigation discussions included seeking a physician's order to remove the gait belt during waking hours as a part of programming. Staff indicated they believed it had been removed and that they were following the current plan. Review of current plan shows no changes have occurred yet, therefore, staff did not follow the plan as written. It is substantiated updates / revisions to the fall plan need to ensure appropriate interventions and adaptive equipment is appropriate for his needs to avoid falls...". 8) BDS incident report dated 4/9/24 indicated, "[Client C] was in the bathroom, fell and struck his face and jaw. He had bruising to his jaw developing appropriately (sic) 2 inches in size with two red lines on his jaw. He has a small skin mark on his neck and two lines about 8 inches and 12 inches on his shoulder and chest. He was taken to the ER (emergency room) an x-ray on his jaw and clavicle showed no fracture. He was diagnosed with contusion/bruising...". Investigation summary dated 4/14/24 indicated, "On 4/8/24 at 10:00 AM, [client C] fell in the bathroom and struck his face and jaw. He had bruising to his jaw developing appropriately (sic) 2 inches in size with two red lines on his jaw. He has a small skin mark on his neck and two lines about 8 inches and 12 inches on his shoulder and chest... Summary of Interviews:... [Former staff #5] stated she and [former staff #6] were called over to [group home] to help out while [staff #6] ran an appointment. [Former staff #6] stated she had taken one of the [group home] clients to an appointment once, but this was the first time she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ever worked at [group home]. [Former staff #5] stated she was in the kitchen looking at the client's dining plans when she heard [client C] fall. [Former staff #5] stated [client C] was in the small bathroom nearest the front door. [Former staff #5] stated [client C] screamed and she and [former staff #6] went to [client C]... [Former staff #6] said he was standing next to the front door when he heard [client C] fall and scream from the bathroom... [Former staff #6] stated [client C's] walker had gotten caught up in the standing toilet paper holder causing him to fall. [Former staff #6] stated staff called the nurse. [Former staff #6] stated he had never worked at the [group home] before... Conclusion: The allegation of a fall on 4/8/24 is substantiated ... Recommendations: ... 2. Ensure all staff have received CST (client specific training) prior to working a shift in the home ...". 9A) BDS incident report dated 5/24/24 indicated, "[Client C] was taken to [hospital] ER for evaluation of his left arm. [Client C] had engaged in behaviors on Tuesday 5/21/24... He dropped himself to the floor several times to avoid walking out to leave the house and landed on his walker when throwing himself to the floor. Yesterday, his left arm appeared swollen and bruising developing on his arm/shoulder and bruising to his right side of his face. [Client C] was complaining of pain. He was taken to the ER for evaluation. At the ER he was diagnosed with left arm humerus fracture (upper arm bone)...". 9B) BDS incident report dated 5/28/24 indicated, "[Client C] was seen at [hospital] due to crying			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	with complaints of pain. On 5/23/24 [BDS incident report] reported [client C] had been engaged in a behavioral episode and threw himself to the floor. At the ER he was diagnosed with fracture of humerus left arm. At the ER he was again diagnosed with fracture of humerus, proximal, left closed... Investigation summary dated 5/20/24 indicated, "Scope of Investigation: 1. Did the fracture occur during the behavioral episode on 5/21/24? 2. Does [client C] have a fall plan? 3. Does [client C] have a BSP to address throwing himself to the floor? 4. Are there any needed programming revisions?... Summary of interviews: ... [Staff #1] stated he has not seen any recent incidents that could have caused the fracture to his arm. [Staff #1] stated he worked Sunday 5/26/24 and [client C] was not complaining of any pain. [Staff #1] stated he was not wearing the sling because it could not be located... [Staff #4] stated his first day to work at [group home] was Friday 5/24/24. [Staff #4] stated he was completing his OJT (on-the job training). [Staff #4] stated [client C] was in a sling and his hand looked fine. [Staff #4] stated when he returned Monday 5/27/24 at 3:00 PM, he did not have the sling on, and his arm was discolored and swollen. [Staff #4] stated staff took him to the ER because he was crying in pain... [Former staff #7] stated his first day to work at [group home] was Friday 5/24/24. [Former staff #7] stated he was completing his OJT training. [Former staff #7] stated [client C] was in a sling and his hand looked fine. [Former staff #7] stated when returned Monday 5/27/24 at 3:00 PM, he did not have the sling on his arm and his arm was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	purple and swollen. [Former staff #7] stated he was taken to the ER for evaluation... [Former staff #3] stated she has not seen [client C] do anything in the past 7 days that could cause a fracture to his arm... [Staff #7] stated he worked the day [client C] was mad and threw himself to the floor but arrived after the incident was over. [Staff #7] said he was going to take [client C] to urgent care that day but [client C] refused. [Staff #7] stated [client C] kept dropping himself to the floor while [staff #7] attempted to get [client C] to leave the house. [Staff #7] stated about 1 or 2 days per week [client C] 'throws a fit' and doesn't want to go to the day program. [Staff #7] stated he hasn't seen anything else happen to cause the fracture to his arm... [Staff #6] stated she did not work on 5/21/24 but it was [former staff #1] who told her about the incident... [Staff #6] stated she has not seen anything else happen that could have caused the fracture... [Program Manager] stated all she knew about the incident was what [former staff #1] wrote in the [electronic record]. [Program Manager] stated [client C] will sometimes slide out of chairs, slide off the seat on his walker, slide out of his bed, and slide down your leg to the floor as you are assisting him with tasks... [Former staff #1] stated [client C] will throw himself down in the mornings when he doesn't want to attend day program. [Former staff #1] stated the morning of 5/21/24, [client C] got up, got dressed, and ate breakfast. [Former staff #1] stated she was giving morning meds (medications) to the clients and [client C] went			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	back in his bedroom and laid down. [Former staff #1] stated she called for [client C], telling him he needed to get back up because they would be leaving for the day program. [Former staff #1] stated [client C] was in his bedroom screaming and cussing saying, 'No! Stay home'! [Former staff #1] stated he got back up and continued to scream and cuss and threw himself to the floor 3 times while in his bedroom. [Former staff #1] stated when he came to his doorway he was screaming, 'stay home' and again, threw himself on the floor. [Former staff #1] stated that time he hit his arm on the rectangle metal part of the brake of his walker. [Former staff #1] stated he then started yelling, 'I hurt my arm! I hurt my arm'! [Former staff #1] stated she did first-aid to his arm by cleaning the area. [Former staff #1] stated she then called [Program Manager]. [Former staff #1] stated [Program Manager] was running another appointment and she had directed [staff #7] to come in to take [client C] to urgent care... [Former Nurse / FN] stated staff sent her a picture of [client C's] arm on the morning of 5/21/24 and his arm was scraped up. She stated staff said he had thrown himself to the floor but did not mention anything about him being in pain. [FN] stated [Program Manager] called her and said they were going to take [client C] to urgent care and then told her later that day [client C] had refused to go to urgent care. [FN] stated [client C's] arm was not swollen until several days later, and that's when they took him to the emergency room... Conclusion: The allegation [client C] has a fracture of humerus, proximal left, closed is substantiated ... Staff failed to follow the physician's orders with regards to applying ice to his arm...".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10) BDS incident report dated 7/2/24 indicated, "Staff was assisting [client C] to bed. [Client C] was refusing. Staff were assisting using gait belt. [Client C] began screaming and threw himself to the floor. Staff attempted to raise [client C] up but he would curl his legs up and would not stand. After several attempts staff called non-emergency 911 for assistance with a lift. When EMS (emergency medical services) arrived [client C] continued to refuse assistance to get up. 3 EMS (staff) lifted [client C] into the bed. [Client C] fell asleep without further issues. Plan to Resolve: [Client C] has a BSP (behavior support plan) for throwing himself on the floor and refusing. Team will review his BSP to determine If any further revision to the plan is needed...". 11) BDS incident report dated 9/6/24 indicated, "[Client C] had went (sic) into the bathroom. Staff heard a noise and [client C] yell out for staff. When staff entered the bathroom [client C] was laying on the floor on his left side. Staff stated there was urine on the floor in front of the toilet that [client C] had slipped on. Staff further reported a client had left his clothes on the floor and [client C] fell onto the clothes. Staff checked for injuries. A bruise measuring appropriately (sic) 1 inch on the left side of his forehead developed within 20 minutes of the fall. [Client C] was taken to [hospital] for evaluation. At ER a head CT scan (medical imaging) was completed with no findings... orders to apply ice to forehead... Investigation summary dated 9/11/24 indicated, "Scope of Investigation:... 3. Were staff following the fall plan as written... Summary of Interviews: [Staff #1] stated [staff #4] was working alone when [client C] fell. [Staff #1] stated he had not yet arrived to work when the fall			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	occurred... [Staff #4] stated he was working alone when [client C] fell. [Staff #4] stated he had been in the office ordering pizza and heard the fall... Conclusion: The allegation of a fall on 9/6/24 is substantiated. Investigation concludes the fall was likely the result of slipping in the urine or pile of clothes left on the bathroom floor... It is substantiated staff failed to initiate head-injury monitoring per protocol, the nurse failed to update the date during last revision of fall plan, staff documentation was incomplete, and staff ratio was not sufficient to meet the needs of the home... Recommendations:... 2. Staff training to ensure appropriate staff at all times and that floor remains free of clutter through periodic checks...". 12) BDS incident report dated 9/13/24 indicated, "[Client C] was attending day program. [Client C] had finished his lunch and left the lunchroom after being asked to wait for his peers to finish lunch. [Client C] walked outside through the side door into the fenced yard. A client yelled that [client C] needed help. Staff started through the hallway and could see [client C] laying on the sidewalk... He was bleeding from appeared to be his mouth nd (sic) nose... Staff called 911 and he was transported to [hospital] for evaluation... He was diagnosed with a facial abrasion, acute head injury...". Investigation summary dated 9/17/24 indicated, "Scope of the Investigation:... 3. Were staff following the fall plan as written?... Conclusion: The allegation of a fall on 9/13/24 is substantiated. The fall was not witnessed by staff. The investigation concludes the fall was likely the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	result of the uneven surface of the threshold of the door and [client C's] inability to maneuver the walker and the door ... Witness statements also suggest staff are not adequately trained on the specifics of [client C's] fall plan. It is substantiated staff did not follow the plan as written by failing (to) assist as needed with ambulation on uneven ground ...". Recommendations: 1. PT eval sch (scheduled) 9/25/24 at 3:30 PM. 2. DP (day program) will ensure as group changes are made, relieving staff will review clients plans. 3. Nursing to update fall plan...". 13) BDS incident report dated 9/14/24 indicated, "[Client C] is assessed as a fall risk and has a fall plan. [Client C] had been sitting in his wheelchair and went outside using the wheelchair to sit on the porch. While transferring from the wheelchair he... fell to the sidewalk on his left back side. Staff assisted [client C] back to his feet and checked for any signs of injury. He had a red area on his left back side. Staff monitored for injuries, and he has small scrapes on his right elbow...". Investigation summary dated 9/18/24 indicated, "Scope of Investigation:... 3. Were staff following the fall plan as written?... Conclusion: The allegation of a fall on 9/14/24 is substantiated. The fall was not witnessed by staff. The staffing ratio was insufficient to meet the needs of the client care plans at the time of the incident due to a call-off. Investigation concludes when [client C] attempted to transfer himself from the wheelchair to another chair on an uneven surface without staff assistance ... It is substantiated staff failed to follow the fall plan as written by assisting [client C[on uneven surfaces.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Single staff on duty was in the restroom when the incident occurred. It is substantiated that [client C's] fall plan needs to reflect a current date and clarification needs to be added for staff to determine when [client C] should be using the wheelchair and/or the walker... Recommendations: 1. Staff assistance was on the way to the home for staffing ratio and the fall occurred prior to her arrival ...". 14) BDS incident report dated 9/18/24 indicated, "[Client C] was sitting quietly on the couch. He began to yell at staff to take him to the hospital. [Client C] continued to yell and scooted himself towards the end of the couch making himself fall of the couch. Staff assisted him back on the couch, checked him for injuries finding no visual injuries from this fall...". Investigation summary dated 9/21/24 indicated, "Scope of Investigation:... 3. Were staff following the fall plan and/or BSP as written?... Summary of Interviews:... [Former staff #3] stated she and [staff #6] were working at the time of the incident. [Former staff #3] stated they were both sitting on the back deck with a few clients while [client C] was sitting on the couch ... [Staff #6] stated she and [former staff #3] were working at the time of the incident. [Staff #6] stated [former staff #3] was outside on the porch and she was in the laundry room ... [Staff #6] stated [client A] was sitting on the couch and was trying to help [client C] sit back up ...". 15) BDS incident report dated 11/23/24 indicated, "[Client C] is a [age] year old male. Today he had went (sic) to the bathroom to use the restroom.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Staff heard him crying and yelling, went to check on him and he had fallen off the toilet. Staff assisted him up and checked for injuries. On the right side of his forehead above his eye he had a laceration appropriately (sic) one inch long... and going to take him to [hospital] ER for evaluation. At the ER he was diagnosed with a 2 cm (centimeter) forehead laceration... wound was closed with steri-strips and given a tetanus shot...".Investigation summary dated 11/26/24 indicated, "Scope of Investigation:... 4. Were staff following the fall plan and/or BSP as written?...Summary of Interviews: [Area Supervisor /AS] stated she and [staff #1] were working at the time of [client C's] fall. [AS] stated she had run up to [restaurant] to pick [client G] up while [staff #1] was passing meds. [AS] stated she was walking up the ramp to the front door, [client A] was walking out the door saying [client C] fell...[Staff #1] stated he and [AS] were working when [client C] fell. [Staff #1] stated he was in the office passing meds and [AS] was outside. [Staff #1] stated he heard [client C] yelling and crying so he locked the meds back up and then went to see what was going on with [client C]. [Staff #1] stated [client C] was in the middle bathroom laying on his left side, with his back towards the door. [Staff #1] stated [AS] arrived seconds after he did to see what had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	happened...Conclusion: The allegation of a fall on 11/23/24 is substantiated. The incident was not witnessed. There is no evidence the fall was behavioral. It is likely [client C] attempted to transfer to the toilet and the wheelchair moved, causing his fall...".An observation was conducted on 1/16/25 from 2:51 PM to 6:03 PM. At 3:14 PM, client B used his walker to go from his bedroom to the medication administration room. Client B was using his walker and carrying a plastic container with his art supplies. Client B was not wearing a belt. Upon returning from the medication administration room toward the dining room table, client B dropped a pencil and bent over to pick it up. Client B's pants were low on his hips exposing his undergarment. At 3:16 PM, client B ambulated around the dining room table without the use of his walker. Client B stumbled into his walker. The Area Supervisor (AS) stated, "Slow down, be careful". At 3:17 PM, client B used his walker to ambulate while holding a shirt in his hand and went to his bedroom. Client B stumbled in the hallway. The Team Leader (TL) stated, "Slow down, you're making me nervous". At 3:30 PM, client B stood from the dining room table and emptied his pencil sharpener into the trash. As client B bent over toward the trash can, his pants hung low on his hips. Client B was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not wearing a belt. At 4:22 PM, the TL used a verbal prompt with client B to clean his spot at the dining room table. Client B walked toward the dining room table and the TL stated, "Walker, walker, walker". Client B returned to his walker in the living room and used it to go back toward the dining room table. As client B went over the threshold between the living room and dining room, the legs of his walker became stuck hitting a piece of wood trim. Client B lifted his walker up and over the wooden trim and continued toward his spot at the dining room table. At 4:35 PM, the AS gathered clean bedding from the sofa and went down the hallway toward the client bedrooms. At 4:37 PM, client B joined the AS in his bedroom. At 4:39 PM, client B and the AS were organizing client B's bedroom. A piece of plywood was attached to the wall and client B was asked what had happened. Client B stated, "I fell down". A white adaptive device was observed in client B's bedroom window. Client B was asked what the adaptive device in his window was for. Client B stated, "For when I get up". At 4:44 PM, client B pushed buttons on the white adaptive device and said it was a "bed alarm". The AS stated to client B, "How does it work? Let me see if there is another piece in the office". At 4:46 PM, the AS used her phone to send a text message to			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the Program Manager to identify the purpose of the white adaptive device in client B's bedroom. During this time, the TL was asked if the white adaptive device in client B's bedroom was a bed alarm or monitor. The TL stated, "Yeah. That has always sat beside his bed". At 4:48 PM, the TL used her phone to text someone while she continued preparing the evening meal. At 4:49 PM, the AS searched the office area for the second piece to client B's white adaptive device. The AS used her phone and called the Qualified Intellectual Disabilities Professional Designee (QIDPD) and stated, "It's an audio monitor". The AS was unable to locate the second piece of client B's audio monitor in the office and continued searching for it. At 4:52 PM, the TL referred to her phone reading a message and stated, "Hey [Surveyor]. It's a baby monitor, it's so you can hear him at night. The other piece is in the office". At 4:57 PM, the AS found the second piece to the monitoring device and stated, "I don't know if this is it. I'll have to plug it in". The AS went to client B's bedroom and spoke to see if the TL could hear an audible sound through the monitor and stated, "Can you hear me"? The TL confirmed with the surveyor she could hear the AS and stated, "Yes, I can hear you. I don't think she can hear me. I think it's one way". Client B's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	monitor remained on throughout the remainder of the observation period.An observation was conducted on 1/17/25 from 5:58 AM to 8:16 AM. Client C was in his bedroom upon arrival to the group home. Staff #4 and staff #7 were present on the shift. At 6:08 AM, staff #4 physically assisted client C in his wheelchair from his bedroom to the bathroom. At 6:17 AM, staff #4 physically assisted client C in his wheelchair from the bathroom to the living room. Client C proceeded to transfer himself from his wheelchair to a couch in the living room. At 6:18 AM, staff #7 was asked about client C's incident history of falls with a fracture to his arm. Staff #7 stated, "Yeah, he's had two. One broke one arm and healed and then he fell and broke the other arm. The wheelchair has helped to prevent him from falling. Staff #7 was asked about the timeline for the two incidents he described for client C's fractures to both of his arms. Staff #7 stated, "It's been a while. At least 6 months". At 7:25 AM, staff #4 began assisting client C with his morning medication routine. At 7:51 AM, staff #4 placed gloves on his hands and assisted client C in the hallway into the bathroom. Staff #7 assisted client C with a transfer from his wheelchair to the toilet. The bathroom door was left open. As staff #7 returned from the bathroom he stated,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"When I'm here alone, he'll yell for me when he is ready". Client C was left alone sitting on the toilet in the bathroom while the bathroom door was left open. On 1/22/25 at 1:09 PM, a review of client B's record was conducted. The review indicated the following:Fall Risk Plan dated 11/12/24 indicated, "Actions: Ensure Safety First... 1. Staff will provide an environment free of clutter.2. Staff will provide assistance with ambulation and toileting as needed.3. Staff will encourage [client B] to wear nonskid socks at home when not wearing shoes.4. Staff will encourage [client B] to maintain straight posture and hold head up while ambulating.5. Staff will encourage [client B] to utilize 2 wheel walker w (with) tennis balls on back legs during ambulation. 6. Staff will ensure that [client B] uses a shower chair for all showers.7. Ensure ¼ Bed Rails utilized.8. Staff will use audio monitor when [client B] in his bedroom and have the receiving end of audio monitor within hearing range.9. Staff to encourage [client B] to pay attention and provide prompts/reminders in areas, such as crossing the street, around cars, stairs, curbs, uneven surface, etc.10. Staff to provide hands-on assistance if [client B] is in danger of falling from non-compliance to prevent injury.11. Should fall occur perform assessment, refer to Triggers to notify the Nurse, document fall, and any			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	injury noted after medical care is given.12. Staff will report any changes in mobility to the nurse immediately. 13. Staff will notify physician for further recommendations.14. Nursing will assess at visits and document assessment in the medical record.15. Will attend all medical appointments with PCP (primary care physician) and any specialists as indicated.16. Will have labs and other testing completed as ordered...".On 1/22/25 at 1:09 PM, client C's record was reviewed. The review indicated the following:Fall Risk Plan dated 12/5/24 indicated, "Planning and Implementation:1. Interventions:a. Staff will take [client C] to all medical appointments.b. Utilize wheelchair footrest for long distance/footrests off when in home.c. Ensure gait belt is attached to wheelchair to be utilized if client has fallen.d. Will use a wheelchair for ambulation and long distances until seen by Rheumatology for evaluation of arthritis and gout.e. Will utilize rollator walker when completing Home Exercise program.f. [Client C] will use a shower chair for all showers.2. Monitoringa. Staff will monitor for change in increased weakness, unsteady gait and uneven ground.3. Documentationa. Staff will document in the progress notes and internal incident report if a fall occurs.4. Notificationa. Staff will notify the Nurse of any issues noted and of any falls with or without injury.5. Traininga.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Annually or as neededb. All training is kept in the home, in the training binder, and in training file at office6. What do you do when out of home?All ResCare staff will follow same protocol as listed. All providers are given copy of all high risk plans ...".On 1/23/25 at 10:12 AM, the Nurse was interviewed. The Nurse was asked about a pattern of clients B and C's accidents, falls and injuries. The Nurse indicated clients B and C had a pattern of injuries from the incident history. The Nurse was asked if appropriate levels of support and supervision should be provided to prevent accidents and/or injuries. The Nurse stated, "Yes".The Nurse was asked what patterns existed in these types of accidents and/or injuries for clients B and C. The Nurse stated, "A lot of unwitnessed. The bathroom, staffing ratios". The Nurse was asked about the lack of staff deployment to prevent accidents and injuries. The Nurse stated, "Right".The Nurse was asked if client C should be left unattended while using the restroom with the door left open. The Nurse stated, "We (interdisciplinary team) discussed them (staff) taking him to the larger bathroom since he has the wheelchair. I know he will take himself to the small bathroom. They should encourage him to use the larger bathroom. It would be helpful with more staff". The Nurse was asked			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	about client B's intervention strategies for the use of his monitor to prevent accidents and/or injuries. The Nurse stated, "It's written basically when he is in his room staff should have it on so they can hear... It should be left on at all times, they are supposed to be able to hear it. I know he is all over the house. I think it was when he was in his room alone". The Nurse was asked if client B's monitor should be used during waking hours or non-waking hours. The Nurse stated, "It does not specify. I would leave it on all the time". On 1/23/25 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) and the Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDP and the QIDPD were asked about a pattern of clients B and C's accidents, falls and injuries. The QIDP and QIDPD indicated clients B and C had a pattern of injuries from incident history. The QIDP and QIDPD were asked if appropriate levels of staffing should be provided to ensure the implementation of clients B and C's health risk plans to prevent accidents and/or injuries. The QIDP stated, "Staffing ratios should be followed. They should be deployed where the need is for the clients". The QIDP and QIDPD were asked about staff's implementation for the use of client B's monitor to prevent accidents and/or injuries.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The QIDP stated, "No, it was not".The QIDP and QIDPD were asked about a pattern from the incident history for client C's falls and/or injuries. The QIDP stated, "Well with [client C] there is a pattern in the bathroom, transfer in general and different surfaces or terrain. Head injuries and significant injuries like broken arms. The deployment and reaction of staff". The QIDPD stated, "Going with [QIDP's] last statement, unwitnessed incidents". On 1/30/25 at 11:50 AM, the Program Director (PD) was interviewed. The PD was asked about corrective measures to prevent a pattern of accident, falls, and/or injuries for clients B and C. The PD indicated the need to ensure previous recommendations from past investigations be discussed to ensure implementation. The PD stated during the review process as incidents occur, have the previous recommendations been "implemented and affective. Are we doing what we're supposed to be doing". The PD indicated increased staffing supports had been added with additional monitoring with management staffing at the group home. This federal tag relates to complaint #IN00435432.9-3-3(a)			
W 0192 Bldg. 00	483.430(e)(2) STAFF TRAINING PROGRAM Based on observation, record review and interview for 2 of 3 sampled clients (A and B) and	W 0192	**W192:** Staff Training Program	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4 additional clients (D, F, G and H), the facility failed to ensure staff competency with the administration of clients A, B, D, F, G and H's medication administration programs. Findings include: On 1/21/25 at 10:42 AM, an interview was conducted with an advocate of client A. Client A's advocate indicated there was a lack of consistency for client A medication administration program. Client A's advocate stated, "Send me all of his (client A) medications, all of his PRN's (as needed). They (staff) crossed out daytime and said make it nighttime". Client A's advocate indicated she believed this was client A's cholesterol medication. Client A's advocate indicated all of client A's medications were sent with him for family visits and stated, "No sheet, not signing, the whole bubble pack". Client A's advocate indicated no instructions were provided when all of client A's medications were sent home for family visits. Client A's advocate indicated instances where morning medication would be sent, and the family was told to write the time of the afternoon and evening administrations on the packing of the morning medication. Client A's advocate indicated a lack of consistency for medication administration supports. An observation was conducted on 1/17/25 from 5:58 AM to 8:16 AM. At 6:50 AM, staff #4 used a verbal prompt with client H to come to the medication administration room and to wash his hands. At 6:52 AM, staff #4 placed gloves on his hands and began preparing client H's morning medications. At 6:56 AM, staff #4 popped out 3 tablets of Thioridazine (psychotic/depressive disorders) 25 mg (milligrams) and handed the surveyor the package of the medication. The		**Corrective Action:** Nurse is at the facility 3 days a week to complete oversight of the health needs of all clients in the facility for no less than 3 months and sends a detailed update to the IDT and administrative team. **(Attachment C)** ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** Nurse will complete one complete medication pass with all new hires in the facility. **(Attachment W)** All staff trained by the Nurse regarding medication administration, Medication storage and security, QuickMar, Medications that go home for visit process, dining plans and demonstrated how to prep food according to the client's diet.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	prescription label indicated client H should only receive 2 tablets of the medication. The surveyor handed staff #4 the packaging back and asked what the prescription label indicated for administration in comparison to the electronic medication administration record (MAR). Staff #4 read the prescription label followed by the electronic MAR. Staff #4 stated, "My mistake" and removed one of three tablets of Thioridazine 25 mg and placed it back in the bubble pack with tape over the backside. At 7:11 AM, staff #4 placed client H's medication tablets into a plastic bag and began crushing client H's medications. As staff #4 crushed client H's medication, a portion of client H's chewable multivitamin that did not crush was removed from the plastic bag by staff #4 and placed on the desk. Staff #4 proceeded to pour the crushed powder medication into a plastic spoon while hovering the spoon over a container of apple sauce. At 7:14 AM, client H was administered his crushed medication on the spoon followed by a bite of apple sauce. The portion of client H's multivitamin placed on the desk was omitted from the administration of other crushed medications. At 7:23 AM, client H drank his morning boost concluding his morning medication routine. At 7:24 AM, the portion of client H's multivitamin not crushed remained on the desk. At 7:35 AM, staff #4 washed his hands and began preparing for the client C's morning medication routine. At 7:37 AM, staff #4 assisted client C from the medication administration room to the dining room table. The medication cabinet was unlocked and open, the medication administration room was unlocked and left open, and no staff was in the medication room. Client H's portion of the multivitamin that was not crushed previously on the desk was no longer on the desk. Throughout the remainder of staff #4's morning medication routine with the clients, staff		**(Attachment E)** All staff were tested by the Nurse on Medication Administration. **(Attachment F)** Program Manager ordered a lockbox for medication that needs destroyed by a Nurse to be stored in and removed from the facility medication storage. **(Attachment G)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP and QuickMar. **(Attachment H)** Nurse obtained clarified order for how client (H) should receive his medications and trained staff on the updated order. **(Attachment I)** ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	#4 would leave the medication room to verbally prompt clients to come to the medication room leaving the medication unlocked and unsecured with no staff present. At 7:39 AM, staff #4 used a verbal prompt asking client E to come to the medication room. Staff #4 left client E sitting in a chair in the medication administration room while he went into the adjacent bathroom shutting the door. Client E was left unattended in the medication administration room with the medication cabinet open and unlocked and unsecured. At 7:40 AM, staff #4 opened the bathroom door and returned to the medication administration room with client E. At 8:01 AM staff #4 came out of the medication administration room to verbally prompt client D in the living room to say that it was his turn for morning medicines. The door to the medication administration room was left open, and the medication cabinet was open with clients A, B, C, D, E, F, G and H's medicines left unattended and unsecured. At 8:11 AM, client D returned to the living room with staff #4 following him. Staff #4 used a verbal prompt with client A in the living room to say that it was his turn for morning medicines. The door to the medication administration room was left open, and the medication cabinet was open with clients A, B, C, D, E, F, G and H's medicines left unattended and unsecured. On 1/22/25 at 1:52 PM, a focused review of client H's record was conducted. The review indicated the following: Physician's Order dated 12/1/24 indicated, "Diet: Pureed foods with pre-thickened honey thick fluids medication in pureed foods... Animal Shaped Chew Tab (tablet) - give one tablet by mouth once daily for vitamin supplement... Thioridazine Tab 25 mg - Give three (3) tablets (75		of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility. ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios. **Monitoring of Corrective Action:** All oversight observations will be reviewed during daily survey update calls held by ResCare Management and filed in the binder at the facility. Nurse will complete medication administration observations to ensure staff competency and notify management of any concerns. QIDP will ensure all updated plans and assessments are completed annually and as needed based on client needs. Nurse will ensure all client high risk and dining plans are up to date and staff are trained on any new or updated plans and upload them in TMP for monitoring and review. Nurse Manager pulls reports in QuickMar daily that show if all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mg) by mouth at 4 PM and at bedtime for impulse control disorder... Thioridazine Tab 25 mg - Give two (2) tablets (50 mg) by mouth every morning for impulse control disorder...". Dining Plan dated 9/23/24 indicated, "Medications: [Client H] takes his medications whole in puree food followed by honey thick fluids...". On 1/21/25 at 12:27 PM, a review of the facility's Bureau of Disabilities Services (BDS) incident reports and accompanying investigation summaries was conducted. The review indicated the following affecting clients A, B, D, F and G: 1) BDS incident report dated 5/20/24 indicated, "When staff was completing a med (medication) audit the staff found a med error. [Client D] is ordered the following medications at 7:00 AM - Albuterol Diskett (shortness of breath), Amiodarone (irregular heartbeat)100 mg, Benztropine (muscle control) 0.5 mg, Bicalutamide (prostate cancer) 50 mg, Eliquis (prevent and treat blood clots) 5 mg, Ferrous flutic/salme (shortness of breath) 325 mg, Loratadine (allergy symptoms) 10 mg, Metoprolol (high blood pressure) 100 mg, Montelukast (prevent difficulty breathing) 10 mg, Pantoprazole (stomach acid) 40 mg, Risperidone (schizophrenia/bipolar disorder) 2 mg, and Boost (supplement). On 5/10/24 at 7 AM med pass [client D] did not receive any of the ordered medications for the 7 AM med pass...". 2) BDS incident report dated 5/20/24 indicated, "When staff was completing a med audit staff found a med error. [Client F] is ordered Align (healthy digestive system) 4 mg, Ferrous Sulf (iron deficiency) 325 mg, Healthy eyes (macular		medications were passed as scheduled and sends out the report to all Area Supervisors, Program Managers, Program Director, Nurses, and Executive Director for monitoring and to ensure completion. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. **Completion Date: 2/23/25**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	degeneration), Loperamide (relieve diarrhea) 2 mg, Methscopolam (sic/stomach ulcers) 2 mg, Sertraline (panic attacks/obsessive compulsive disorder) 150 mg, OcuSoft lid scrub (eye cleanser). The med error is on 5/10/24 at 7 AM. [Client F] was given the morning medications twice for an extra dose of each of his morning meds...". 3) BDS incident report dated 5/28/24 indicated, "When staff was completing a med audit staff found a med error. The med error is: [Client A] did not receive his 8 PM meds on 5/27/24. [Client A] should have received Atorvastatin (lower cholesterol) 20 mg, Cetirizine (allergy) 10 mg, Divalproex (seizure) 500 mg, Olopatadine (itching of the eye) 1 % eye drop, Clonidine (high blood pressure) 0.1 mg, Ammonium Lactate (dry skin) lotion...". 4) BDS incident report dated 6/6/24 indicated, "[Client G] is ordered Olanzapine (schizophrenia/bipolar disorder) 5 mg at 7 PM. Review of documentation today found a med error. The med error is [client G] did not receive his Olanzapine 5 mg at 7 PM on 6/3/24, 6/4/24 and 6/5/24. His script (prescription) had expired and doctor did not renew/update script with pharmacy. The script was sent to pharmacy and he received the med today...". 5) BDS incident report dated 6/6/24 indicated, "[Client B] is ordered Lybalvi (bipolar disorder) 20/10 mg once daily at 5 PM. Review of documentation found a med error. The med error is [client B] did not receive his Lybalvi 20/10 mg from 5/30/24 through 6/6/24. The Lybalvi script had expired and not been renewed/updated at the pharmacy. The script has been sent to the pharmacy...".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	6) BDS incident report dated 9/21/24 indicated, "This morning at the 7 AM me pass [client B] received a housemates medication. The housemate also has the first name [name]. Medications [client B] received in error: Thioridazine HCL 25 mg (psychotic/depressive disorders), Risperidone (schizophrenia/bipolar disorder) 3 mg, Healthy eyes (macular degeneration), Multi Vitamin Chew 1 tab (tablet), Loperamide (relieve diarrhea) Cap 2 mg, Propranolol HCL (slow heart rate/anxiety) 20 mg, Metoclopramide (gastroesophageal reflux disease) 5 mg, Montelukast SOD (asthma) 10 mg. He did not receive his ordered 7 AM meds... Staff called 911 and he was taken to [hospital] ER (emergency room) for evaluation. At ER vitals were good and released for the ER to monitor...". 7A) BDS incident report dated 10/18/24 indicated, "[Client B] is a [age] year old male. He has a recent medication change. When he arrived at the day program his gait was unsteady, he had slurred speech and was drooling. The nurse contacted the psych (psychiatrist) and was advised to have him evaluated at the ER. He was taken to [hospital] ER for evaluation. At the ER labs (blood work) and UA (urine analysis) were completed. All results were normal. He was released from the ER with a recommendation to decrease his Alprazolam (anxiety/panic disorder) from 1 mg bid (twice a day) to 0.5 mg bid. The nurse has reached out to the psych to discuss the ER recommendations...". 7B) BDS incident report dated 10/28/24 indicated, "[Client B] is ordered Alprazolam 1 mg at 8:00 PM. His order was Alprazolam 1 mg at 8:00 AM and 1 mg at 8:00 PM until 10/24/24 when the 8:00 AM dose was discontinued. This morning when [client B] got to the day program he appeared lethargic.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The nurse was at the (group) home and checked his medications and finding (sic) he was given the Alprazolam 1 mg at 8:00 AM discontinued dose in error. [Client B] did appear lethargic but more alert throughout the day...". On 1/23/25 at 10:12 AM, the Nurse was interviewed. The Nurse was asked about client H's medication administration for whole or crushed medicines. The Nurse stated, "His diet order does say whole. It needs to be re-worded in quick MAR. It says with foods". The Nurse was asked to confirm client H's medicines should not be crushed. The Nurse stated, "Correct". The Nurse was asked what client H's physician's order indicated for medication administration. The Nurse stated, "At the top of the order it says medication with puree foods. On his dining plan it says whole". The Nurse indicated client H's chewable vitamin should not have been crushed and client H should have been administered the vitamin as a whole tablet. The Nurse stated, "All of these guys (staff) will need to go through core A and B". The Nurse was asked about the medication administration room's door left open during medication administration. The Nurse stated, "Well, I discussed that with [Program Director]. She called that the fire door. Should they have privacy, yes. I guess they should shut it for privacy... The main door, yes you probably should shut that to prevent confusion. If someone was coming out of their room, you would stop the medication pass until they went through... It's an awkward area, I guess that's what they've used... Yes, if they shut the door to the main area and stop the med pass to redirect those coming out of their room. I think keeping the door (main door) shut would cut a lot of it (confusion) down".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Nurse was asked if the medications should be left unlocked and left unsecured. The Nurse stated, "No, they shouldn't". The Nurse was asked what should occur to prompt the next client to come to the medication administration room to ensure medications were secure. The Nurse stated, "Well, they should lock that door, but if there is more than one staff, the other staff could bring them (clients) to them (staff). If they leave the room, it should be locked back up". The Nurse was asked if medications should be secured and not left unattended. The Nurse stated, "Yes". The Nurse was asked about incident history indicating a pattern of medication errors affecting clients A, B, D, F and G. The Nurse indicated she had reviewed the medication error history. The Nurse stated in regard to client B receiving client H's medications in error, "They called 911 because there was only one staff there. No one else could take him (client B) to the hospital". The Nurse stated in regard to clients A, B, D, F and G's medication errors, "Staff did not scan and look at quick MAR (medication administration record) to follow the orders. They're not utilizing the system properly. They're not doing the job properly. Not that they were not trained properly. They pull out the medications and supposed to do three checks, I feel they're pulling out the pill packs and not checking". The Nurse was asked how the clients' medications should be administered. The Nurse stated, "According to agency policy. They are all trained in core A and B. They do initial training and annual training". The Nurse was asked if clients A, B, D, F, G and H's medications should be administered according to their physician orders without error. The Nurse stated, "Yes".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The Nurse was asked about the process of sending and/or receiving client medications for family visits, how instructions for the administration of those medications should be provided to the family, and the concern for all of client A's medications being sent home with him and the inconsistency for instruction to document afternoon and evening medication administration times on his morning medication pill packaging. The Nurse stated, "So, they are to send their daily medication, not all of the PRNs (as needed). They should verify what they are sending and what they are getting back. That way they can verify the meds are given while they're (clients) are gone. I would instruct the family to initial the bubble packs like we do. That's what I would do, so you can ensure the account is correct". The Nurse was asked if there was documentation for the exchange of client medications and/or receipt of any unused medications returning. The Nurse stated, "Yes, there is a form". The Nurse was asked if staff were using the form. The Nurse stated, "That, I do not know". The Nurse was asked about instructing the family to fill out afternoon and evening medication administrations with the times on a morning medication. The Nurse stated, "They should send what is needed. There are times where they can use the morning medication for evenings, or whatever. That is not the rule, instead of having a med error, I'm going to make sure they get their medication. We need a better process for sending the medications home. Maybe we will do training and add it to core A and B. Everyone in the house just had it". The Nurse was asked how the client medication administration programs were being monitored. The Nurse stated, "There has been, in other places not that home specifically". The Nurse was asked if additional monitoring to ensure staff			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	competency with the administration of clients A, B, D, F, G and H's medication administration programs was needed. The Nurse stated, "Yes". 9-3-3(a)			
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN Based on record review and interview for 1 of 3 sampled clients (A), the facility failed to ensure client A's program plan included additional methodology for staffing supports to assist client A with the promotion of good oral health and hygiene. Findings include: On 1/22/25 at 11:02 AM, a review of client A's record was conducted. The review indicated the following: Individual Support Plan (ISP) dated 12/5/24 indicated, "Needs:... Needs to improve oral hygiene... Priority Objectives: 1. Oral hygiene... Formal Goal/Data Collection Sheet: Goal: 1. Oral Hygiene... Objective: [Client A] will brush (his) teeth for 2 minutes with 2 verbal prompts, 80% of opportunities per month for 6 consecutive months by 12/5/25...". Goal progress data indicated the following successful completions and recommendations: December 2024... 100%... Continue... November 2024...77%... Continue... October 2024... 78%... Continue... September 2024... 50%... Continue... August 2024... 59%... Continue... July 2024... 96%... Continue... June 2024... 89%... Continue...	W 0240	**W240:** The individual program plan must describe relevant interventions to support the individual toward independence. **Corrective action:** The QIDP updated client (A) oral hygiene goal by adding to the methodology steps of the goal for staff to better assist client (A) with his oral hygiene. (**Attachment Q)** Staff trained on client (1) updated goal. **(Attachment R)** QIDP trained to ensure client goals are written within the client's ability and ensure the goal is achievable. **(Attachment S)** QIDP will complete monthly summary and submits to the Program Manager for review including all appointments and follow ups. **(Attachment T)** **Monitoring of Corrective Action**: QIDP will update the Individual Support Plan annually and as needed. All trainings are sent to the HR department for tracking. IDT Meetings are held	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	May 2024... 68%... Continue... April 2024... 55%... Continue... March 2024... 100%... Revised 4/1/2024... February 2024... 100%... Continue... January 2024... 97%... Continue...". Dental Consult dated 11/8/23 indicated, "Reason for visit: Dental check-up... Results Findings of Examination: Noted severe wear from grinding. Noted a few cavities, watching for now. Lots of plaque on his teeth and irritated gingiva, recommended regular brushing...". Dental Consult dated 4/5/24 indicated, "Scan completed for occlusal guard fabrication...". Dental Consult dated 4/23/24 indicated, "Delivered occlusal guard, good fit...". Dental Consult dated 11/11/24 indicated, "Results/Findings of Examination: Several areas of decay and broken teeth. Severe wear on all teeth. Fillings needed: #15... 19 crown, 20... 22... 27... 29... 30-crown... Physician / Consult Orders: Return for two more visit for fillings and caps. Return in one year for yearly cleaning and exam...". Dental Consult dated 11/25/24 indicated, "Results / Findings of Examination: Restored #18... #19... #20... #21... #22... Deep decay at #19, may require extraction if patient has pain symptoms... Physician / Consult Orders: Pt (patient) to return for treatment on right side...". Risk Plan dated 12/5/24 indicated, "Gingivitis:... Actions: 1. Encourage and assist [client A] as needed in proper oral care. 2. Medications as ordered. 3. Monitor for triggers to notify nursing and report to the nurse if noted. 4. Nursing will assess as needed. 5. Staff Will notify dentist for		quarterly to discuss any concerns with individuals plans and programming, monthly summaries will be reviewed at this time which includes goal percentages progress. **Completion Date: 2/23/25**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	changes in condition for further recommendations. 6. Will attend all appointments with PCP (primary care physician) and other specialists as indicated. 7. Will be seen by the dentist as recommended. 8. Labs and other tests will be completed as ordered by physician." On 1/23/25 at 10:12 AM, the Nurse was interviewed. The Nurse was asked about client A's dental consults indicating a decline in his oral health and hygiene in comparison to his progress with his oral hygiene goal and level of staffing supports. The Nurse stated, "The first consult said he had cavities and we go back and it says he has severe cavities. I wonder about their documentation, how bad was it. I did put it (brushing teeth) in TMP (electronic treatment record) as a targeted observation. That way it has to be checked off (by staff) as done. Before it was not, this way it makes sure staff are following up to get it done". The Nurse was asked if this change in the electronic record would require retraining of client A's program plan for oral hygiene. The Nurse stated, "It should pop up for them to do. I've told them they need to. It's in his plans, this is my way to make sure it is saying it's done". The Nurse was asked if this change indicated an increased level of staff supports was needed to assist client A in the promotion of his oral hygiene. The Nurse stated, "Yes and I added his nightguard (prevent grinding of teeth) to make sure they're check at night that he's using it". On 1/23/25 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) and Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDP and QIDPD were asked about client A's dental consults indicating a decline in his oral health and hygiene in comparison to his progress with his oral			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	hygiene goal and level of staffing supports. The QIDP stated, "I think we need ask him what he needs, does he like his toothpaste". The QIDPD stated, "I think the goal says verbal prompts and staff may need to ensure he's being assisted. We discussed the goal and making revisions. A review of how the goal is running. We had different staff at the time his goal was going on as well". 9-3-4(a)			
W 0268 Bldg. 00	483.450(a)(1)(i) CONDUCT TOWARD CLIENT Based on observation, record review and interview for 1 of 3 sampled clients (B) and 1 additional client (H), the facility failed to ensure the dignity of clients B and H to ensure appropriately fitting clothing was worn. Findings include: An observation was conducted on 1/16/25 from 2:51 PM to 6:03 PM. At 2:58 PM, client B used his walker to ambulate going toward his bedroom. Client B was not wearing a belt. Client B's pants hung low on his hips and the adult incontinent brief he was wearing exposed. At 3:14 PM, client B used his walker to ambulate while carrying a plastic container from his bedroom toward the medication administration room. Client B was not wearing a belt. Client B's pants hung low on his hips exposing the adult incontinent brief he was wearing underneath his pants. At 4:20 PM, client B stood in the living room and asked the Area Supervisor (AS) about his clean bedding on the sofa. Client B was not wearing a belt and his pants hung low on his hips exposing the adult incontinent brief he was wearing. At 5:08 PM,	W 0268	**W268: Conduct towards clients** **Corrective Action:** Program Manager ordered clients new clothing to ensure proper fit. **(Attachment U)** Program Manager ordered all clients new belts to ensure pants are proper fitting. **(Attachment V)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP and QuickMar. **(Attachment H)** ResCare Management will complete observations 7 days a week which includes medication	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	client B used his walker to go from his bedroom to the dining room and back to his bedroom. Client B was not wearing a belt. Client B's pants hung down low on his hips exposing his adult incontinent brief. At 5:18 PM client B was seated at the dining room table and client H was in the living room seated on the sofa. At 5:25 PM, the AS used a verbal prompt with the group to wash their hands in preparation for their evening meal. At 5:30 PM, client H returned from washing his hands to the dining room. Client H was holding his pants with his hand. When client H let go of his pants, his pants fell around his ankles and exposed his underwear. The Team Leader (TL) stated, "[Client H], pull your pants up". At 5:34 PM, client B and client H were seated at the dining room table with their housemates and began their evening meal. At 5:36 PM, the TL stated to client B, "[Client B] I see something you did not do this morning. You did not put underwear on. You have a brief on, that's only for nighttime". Client B and client H remained seated to finish their meals. On 1/22/25 at 12:16 PM, a review of client B's record was conducted. The review indicated the following: Individual Support Plan (ISP) dated 11/12/24 indicated, "Needs:... To learn to wear appropriate clothing...". On 1/22/25 at 1:52 PM, a focused review of client H's record was conducted. The review indicated the following: Individual Support Plan (ISP) dated 9/23/24 indicated, "Needs: [Client H] is not able to consistently identify or communicate his needs, wants, emotions, and /or medical needs. Staff must be aware of changes in [client H's]		administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility. ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	appearance, physical symptoms, behaviors... Needs to learn to bath independently... Needs guidance shifting focus from one activity to another... Needs to learn to do laundry independently...". On 1/23/25 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) and Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDP and QIDPD were asked about clients B and H's clothing not fitting properly and how their dignity should be ensured. The QIDP stated, "We should ensure proper fitting clothes at all times. If they do wear depends (adult incontinent brief) we need to make sure during the mornings they're assisted to wear appropriate clothing and not the depends". 9-3-5(a)		**Monitoring of Corrective Action:** All oversight observations will be reviewed during daily survey update calls held by ResCare Management and filed in the binder at the facility. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. Site Reviews will be completed monthly by ResCare management and entered into the site review database. **Completion Date: 2/23/25**	
W 0318 Bldg. 00	483.460 HEALTH CARE SERVICES Based on observation, record review, and interview for 3 of 3 sampled clients (A, B and C) and 5 additional clients (D, E, F, G and H), the facility failed to meet the Condition of Participation: Health Care Services. The facility's health care services failed to ensure the nurse: 1) monitored clients A, B, D, F, G and H's medication administration program to prevent a pattern of medication errors, 2) ensured staff competency in the implementation of client C's dining plan to reduce his risk of choking and aspiration, 3) clients A, B, D, F and G received their medications according to their physician orders without error,	W 0318	**W318: The facility must ensure that specific health care services requirements are met.** **Corrective action:** The Nurse Manager was directly monitoring the facility at the time of survey, now direct Nursing oversight has been moved to veteran Nurse, Becky Hughes. Nurse is at the facility 3 days a week to complete oversight of the health needs of all clients in	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4) ensured client H was administered his medications according to his physician orders without error, and 5) ensured staff maintained drug security with clients A, B, C, D, E, F, G and H's medicines. Findings include: 1) Please refer to W331. For 3 of 3 sampled clients (A, B and C) and 4 additional clients (D, F, G and H), the facility's nursing services failed to ensure: 1) clients A, B, D, F, G and H's medication administration programs were implemented to prevent a pattern of medication errors and 2) staff competency in the implementation of client C's dining plan to reduce his risk of choking and aspiration. 2) Please refer to W368. For 2 of 3 sampled clients (A and B) and 3 additional clients (D, F and G), the facility's health care services failed to ensure clients A, B, D, F and G received their medications according to their physician orders without error. 3) Please refer to W369. For 1 additional client (H), the facility's health care services failed to ensure client H was administered his medications according to his physician orders without error. 4) Please refer to W382. For 3 of 3 sampled clients (A, B and C), and 5 additional clients (D, E, F, G and H), the facility's health care services failed to ensure staff maintained drug security with clients A, B, C, D, E, F, G and H's medicines. 9-3-6(a)		the facility for no less than 3 months and sends a detailed update to the IDT and administrative team. **(Attachment C)** Nurse will conduct at a minimum of one medication observation with all new hires in the facility prior to them being released from OJT and being able to pass medications. **(Attachment W)** Nurse checks all Physician orders to ensure accuracy monthly prior to placing them in the facility. ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** All staff trained by the Nurse regarding medication administration, Medication storage and security, QuickMar, Medications that go home for visit process, dining plans and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			demonstrated how to prep food according to the client's diet. **(Attachment E)** All staff were tested by the Nurse on Medication Administration. **(Attachment F)** Program Manager ordered a lockbox for medication that needs destroyed by a Nurse to be stored in and removed from the facility medication storage. **(Attachment G)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP and QuickMar. **(Attachment H)** Nurse obtained clarified order for how client (H) should receive his medications and trained staff on the updated order. **(Attachment I)** Nurse trained all staff on client (H) dining plan. **(Attachment J)**. ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility. ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios. **Monitoring of Corrective Action:** All training sent to the ResCare trainer for filing in staff files. All oversight observations will be sent to the Program Manager for monitoring and to ensure completion. Site Reviews will be completed monthly by ResCare management and entered into the database. Nurse updates High Risk Plans annually and as health needs change.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Nurse Manager will send medication administration observations to the Program Manager for tracking and review. Nurse updates High Risk Plans and trains staff and sends out to the IDT for team review. **Completion Date: 2/23/25**	
W 0331 Bldg. 00	483.460(c) NURSING SERVICES Based on observation, record review and interview for 3 of 3 sampled clients (A, B and C) and 4 additional clients (D, F, G and H), the facility's nurse failed to ensure: 1) clients A, B, D, F, G and H's medication administration programs were implemented without a pattern of medication errors and 2) ensure staff competency in the implementation of client C's dining plan to reduce his risk of choking and aspiration. Findings include: 1) On 1/21/25 at 10:42 AM, an interview was conducted with an advocate of client A. Client A's advocate indicated there was a lack of consistency for client A's medication administration program. Client A's advocate stated, "Send me all of his (client A) medications, all of his PRN's (as needed). They (staff) crossed out daytime and said make it nighttime". Client A's advocate indicated she believed this was client A's cholesterol medication. Client A's advocate indicated all of client A's medications were sent with him for family visits and stated, "No sheet, not signing, the whole bubble pack". Client A's advocate indicated no instructions were provided	W 0331	**W331**: The facility must provide clients with nursing services in accordance with their needs. **Corrective action:** The Nurse Manager was directly monitoring the facility at the time of survey, now direct Nursing oversight has been moved to veteran Nurse, Becky Hughes. Nurse is at the facility 3 days a week to complete oversight of the health needs of all clients in the facility and complete medication observations on varied shifts with varied staff for no less than 3 months and sends a detailed update to the IDT and administrative team. **(Attachment C)** Nurse will conduct at a minimum of one medication observation with all new hires in the facility prior to them being released from OJT and being able	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	when all of client A's medications were sent home for family visits. Client A's advocate indicated instances where morning medication would be sent, and the family was told to write the time of the afternoon and evening medication administrations on the packing of the morning medication. Client A's advocate indicated a lack of consistency for client A's medication administration supports. An observation was conducted on 1/17/25 from 5:58 AM to 8:16 AM. At 6:50 AM, staff #4 used a verbal prompt with client H to come to the medication administration room and to wash his hands. At 6:52 AM, staff #4 placed gloves on his hands and began preparing client H's morning medications. At 6:56 AM, staff #4 popped out 3 tablets of Thioridazine (psychotic/depressive disorders) 25 mg (milligrams) and handed the surveyor the package of the medication. The prescription label indicated client H should only receive 2 tablets of the medication. The surveyor handed staff #4 the packaging back and asked what the prescription label indicated for administration in comparison to the electronic medication administration record (MAR). Staff #4 read the prescription label followed by the electronic MAR. Staff #4 stated, "My mistake" and removed one of three tablets of Thioridazine 25 mg and placed it back in the bubble pack with tape over the backside. At 7:11 AM, staff #4 placed client H's medication tablets into a plastic bag and began crushing client H's medications. As staff #4 crushed client H's medication, a portion of client H's chewable multivitamin that did not crush was removed from the plastic bag by staff #4 and placed on the desk. Staff #4 proceeded to pour the crushed powder medication into a plastic spoon while hovering the spoon over a container of apple sauce. At 7:14 AM,		to pass medications. **(Attachment W)** Nurse checks all Physician orders to ensure accuracy monthly prior to placing them in the facility. ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** All staff trained by the Nurse regarding medication administration, Medication storage and security, QuickMar, Medications that go home for visit process, dining plans and demonstrated how to prep food according to the client's diet. **(Attachment E)** Nurse trained all staff on the checklist for medications to go home with families to ensure they are aware of medications, dosages, confirm the supply is adequate for the scheduled visit length. **(Attachment X)**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	client H was administered his crushed medication on the spoon followed by a bite of apple sauce. The portion of client H's multivitamin placed on the desk was omitted from the administration of other crushed medications. At 7:23 AM, client H drank his morning boost concluding his morning medication routine. At 7:24 AM, the portion of client H's multivitamin not crushed remained on the desk. At 7:35 AM, staff #4 washed his hands and began preparing for the client C's morning medication routine. At 7:37 AM, staff #4 assisted client C from the medication administration room to the dining room table. The medication cabinet was unlocked and open, the medication administration room was unlocked and left open, and no staff was in the medication room. Client H's portion of the multivitamin that was not crushed previously on the desk was no longer on the desk. Throughout the remainder of staff #4's morning medication routine with the clients, staff #4 would leave the medication room to verbally prompt clients to come to the medication room leaving the medication unlocked and unsecured with no staff present. At 7:39 AM, staff #4 used a verbal prompt asking client E to come to the medication room. Staff #4 left client E sitting in a chair in the medication administration room while he went into the adjacent bathroom shutting the door. Client E was left unattended in the medication administration room with the medication cabinet open and unlocked and unsecured. At 7:40 AM, staff #4 opened the bathroom door and returned to the medication administration room with client E. At 8:01 AM staff #4 came out of the medication administration room to verbally prompt client D in the living room to say that it was his turn for morning medicines. The door to the medication administration room was left open, and the medication cabinet was open with clients A, B, C, D, E, F, G and H's		The go home process for medications will be added to the Core A&B training that all new hires receive upon hire. All staff were tested by the Nurse on Medication Administration. **(Attachment F)** Program Manager ordered a lockbox for medication that needs destroyed by a Nurse to be stored in and removed from the facility medication storage. **(Attachment G)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and documentation on paper and TMP and QuickMar. **(Attachment H)** Nurse obtained clarified order for how client (H) should receive his medications and trained staff on the updated order. **(Attachment I)** Nurse trained all staff on client (H) dining plan. **(Attachment J)**. All staff receive medication administration and food preparation training upon hire, annually and as needed. ResCare Management including the ResCare Operation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medicines left unattended and unsecured. At 8:11 AM, client D returned to the living room with staff #4 following him. Staff #4 used a verbal prompt with client A in the living room to say that it was his turn for morning medicines. The door to the medication administration room was left open, and the medication cabinet was open with clients A, B, C, D, E, F, G and H's medicines left unattended and unsecured. On 1/22/25 at 1:52 PM, a focused review of client H's record was conducted. The review indicated the following: Physician's Order dated 12/1/24 indicated, "Diet: Pureed foods with pre-thickened honey thick fluids medication in pureed foods... Animal Shaped Chew Tab (tablet) - give one tablet by mouth once daily for vitamin supplement... Thioridazine Tab 25 mg - Give three (3) tablets (75 mg) by mouth at 4 PM and at bedtime for impulse control disorder... Thioridazine Tab 25 mg - Give two (2) tablets (50 mg) by mouth every morning for impulse control disorder...". Dining Plan dated 9/23/24 indicated, "Medications: [Client H] takes his medications whole in puree food followed by honey thick fluids...". On 1/21/25 at 12:27 PM, a review of the facility's Bureau of Disabilities Services (BDS) incident reports and accompanying investigation summaries was conducted. The review indicated the following affecting clients A, B, D, F and G: 1) BDS incident report dated 5/20/24 indicated, "When staff was completing a med (medication) audit the staff found a med error. [Client D] is		Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility. **Monitoring of Corrective Action:** All training sent to the ResCare trainer for filing in staff files. All oversight observations will be reviewed during daily survey update calls held by ResCare Management and filed in the binder at the facility. Quality Assurance tracks all site review data and submits to management for follow up and review. Nurse Manager will complete medication administration observations and notify management of any concerns. Nurse will ensure all client high risk and dining plans are up to date and staff are trained on any new or updated plans and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	ordered the following medications at 7:00 AM - Albuterol Diskett (shortness of breath), Amiodarone (irregular heartbeat)100 mg, Benztropine (muscle control) 0.5 mg, Bicalutamide (prostate cancer) 50 mg, Eliquis (prevent and treat blood clots) 5 mg, Ferrous flutic/salme (shortness of breath) 325 mg, Loratadine (allergy symptoms) 10 mg, Metoprolol (high blood pressure) 100 mg, Montelukast (prevent difficulty breathing) 10 mg, Pantoprazole (stomach acid) 40 mg, Risperidone (schizophrenia/bipolar disorder) 2 mg, and Boost (supplement). On 5/10/24 at 7 AM med pass [client D] did not receive any of the ordered medications for the 7 AM med pass...". 2) BDS incident report dated 5/20/24 indicated, "When staff was completing a med audit staff found a med error. [Client F] is ordered Align (healthy digestive system) 4 mg, Ferrous Sulf (iron deficiency) 325 mg, Healthy eyes (macular degeneration), Loperamide (relieve diarrhea) 2 mg, Methscopolam (sic/stomach ulcers) 2 mg, Sertraline (panic attacks/obsessive compulsive disorder) 150 mg, OcuSoft lid scrub (eye cleanser). The med error is on 5/10/24 at 7 AM. [Client F] was given the morning medications twice for an extra dose of each of his morning meds...". 3) BDS incident report dated 5/28/24 indicated, "When staff was completing a med audit staff found a med error. The med error is: [Client A] did not receive his 8 PM meds on 5/27/24. [Client A] should have received Atorvastatin (lower cholesterol) 20 mg, Cetirizine (allergy) 10 mg, Divalproex (seizure) 500 mg, Olopatadine (itching of the eye) 1 % eye drop, Clonidine (high blood pressure) 0.1 mg, Ammonium Lactate (dry skin) lotion...". 4) BDS incident report dated 6/6/24 indicated,		upload them in TMP for monitoring and review. All medication checklist for go home medications are reviewed and signed by both staff and the individual the client is leaving the facility with to ensure understanding of medication administration. Nurse Manager pulls reports in QuickMar daily and sends out to all Area Supervisors, Program Managers, Program Director, Nurses, and Executive Director for monitoring and to ensure completion. Weekly calls are held with all Area Supervisors, Program Managers and Program Director to discuss each location and their TMP documentation to ensure completion. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. **Completion Date: 2/23/25**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	"[Client G] is ordered Olanzapine (schizophrenia/bipolar disorder) 5 mg at 7 PM. Review of documentation today found a med error. The med error is [client G] did not receive his Olanzapine 5 mg at 7 PM on 6/3/24, 6/4/24 and 6/5/24. His script (prescription) had expired and doctor did not renew/update script with pharmacy. The script was sent to pharmacy and he received the med today...". 5) BDS incident report dated 6/6/24 indicated, "[Client B] is ordered Lybalvi (bipolar disorder) 20/10 mg once daily at 5 PM. Review of documentation found a med error. The med error is [client B] did not receive his Lybalvi 20/10 mg from 5/30/24 through 6/6/24. The Lybalvi script had expired and not been renewed/updated at the pharmacy. The script has been sent to the pharmacy...". 6) BDS incident report dated 9/21/24 indicated, "This morning at the 7 AM me pass [client B] received a housemates medication. The housemate also has the first name [name]. Medications [client B] received in error: Thioridazine HCL 25 mg (psychotic/depressive disorders), Risperidone (schizophrenia/bipolar disorder) 3 mg, Healthy eyes (macular degeneration), Multi Vitamin Chew 1 tab (tablet), Loperamide (relieve diarrhea) Cap 2 mg, Propranolol HCL (slow heart rate/anxiety) 20 mg, Metoclopramide (gastroesophageal reflux disease) 5 mg, Montelukast SOD (asthma) 10 mg. He did not receive his ordered 7 AM meds... Staff called 911 and he was taken to [hospital] ER (emergency room) for evaluation. At ER vitals were good and released for the ER to monitor...". 7A) BDS incident report dated 10/18/24 indicated, "[Client B] is a [age] year old male. He has a recent			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medication change. When he arrived at the day program his gait was unsteady, he had slurred speech and was drooling. The nurse contacted the psych (psychiatrist) and was advised to have him evaluated at the ER. He was taken to [hospital] ER for evaluation. At the ER labs (blood work) and UA (urine analysis) were completed. All results were normal. He was released from the ER with a recommendation to decrease his Alprazolam (anxiety/panic disorder) from 1 mg bid (twice a day) to 0.5 mg bid. The nurse has reached out to the psych to discuss the ER recommendations...". 7B) BDS incident report dated 10/28/24 indicated, "[Client B] is ordered Alprazolam 1 mg at 8:00 PM. His order was Alprazolam 1 mg at 8:00 AM and 1 mg at 8:00 PM until 10/24/24 when the 8:00 AM dose was discontinued. This morning when [client B] got to the day program he appeared lethargic. The nurse was at the (group) home and checked his medications and finding (sic) he was given the Alprazolam 1 mg at 8:00 AM discontinued dose in error. [Client B] did appear lethargic but more alert throughout the day...". On 1/23/25 at 10:12 AM, the Nurse was interviewed. The Nurse was asked about client H's medication administration for whole or crushed medicines. The Nurse stated, "His diet order does say whole. It needs to be re-worded in quick MAR. It says with foods". The Nurse was asked to confirm client H's medicines should not be crushed. The Nurse stated, "Correct". The Nurse was asked what client H's physician's order indicated for medication administration. The Nurse stated, "At the top of the order it says medication with puree foods. On his dining plan it says whole". The Nurse indicated client H's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	chewable vitamin should not have been crushed and client H should have been administered the vitamin as a whole tablet. The Nurse stated, "All of these guys (staff) will need to go through core A and B". The Nurse was asked about the medication administration room's door left open during medication administration. The Nurse stated, "Well, I discussed that with [Program Director]. She called that the fire door. Should they have privacy, yes. I guess they should shut it for privacy... The main door, yes you probably should shut that to prevent confusion. If someone was coming out of their room, you would stop the medication pass until they went through... It's an awkward area, I guess that's what they've used... Yes, if they shut the door to the main area and stop the med pass to redirect those coming out of their room. I think keeping the door (main door) shut would cut a lot of it (confusion) down". The Nurse was asked if the medications should be left unlocked and left unsecured. The Nurse stated, "No, they shouldn't". The Nurse was asked what should occur to prompt the next client to come to the medication administration room to ensure medications were secure. The Nurse stated, "Well, they should lock that door, but if there is more than one staff, the other staff could bring them (clients) to them (staff). If they leave the room, it should be locked back up". The Nurse was asked if medications should be secured and not left unattended. The Nurse stated, "Yes". The Nurse was asked about incident history indicating a pattern of medication errors affecting clients A, B, D, F and G. The Nurse indicated she had reviewed the medication error history. The Nurse stated in regard to client B receiving client			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	H's medications in error, "They called 911 because there was only one staff there. No one else could take him (client B) to the hospital". The Nurse stated in regard to clients A, B, D, F and G's medication errors, "Staff did not scan and look at quick MAR to follow the orders. They're not utilizing the system properly. They're not doing the job properly. Not that they were not trained properly. They pull out the medications and supposed to do three checks, I feel they're pulling out the pill packs and not checking". The nurse stated in regard to client B receiving his discontinued Alprazolam, "That med error, it's not showing how they could give it. That is a double locked medication. I don't remember that med error". The Nurse was asked how the clients' medications should be administered. The Nurse stated, "According to agency policy. They are all trained in core A and B. They do initial training and annual training". The Nurse was asked if clients A, B, D, F, G and H's medications should be administered according to their physician orders without error. The Nurse stated, "Yes". The Nurse was asked about the process of sending and/or receiving client medications for family visits, how instructions for the administration of those medications should be provided to the family, and the concern for all of client A's medications being sent home with him and the inconsistency for instruction to document afternoon and evening medication administration times on his morning medication pill packaging. The Nurse stated, "So, they are to send their daily medication, not all of the PRNs (as needed). They should verify what they are sending and what they are getting back. That way they can verify the meds are given while they're (clients) are gone.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	I would instruct the family to initial the bubble packs like we do. That's what I would do, so you can ensure the account is correct". The Nurse was asked if there was documentation for the exchange of client medications and/or receipt of any unused medications returning. The Nurse stated, "Yes, there is a form". The Nurse was asked if staff were using the form. The Nurse stated, "That, I do not know". The Nurse was asked about instructing the family to fill out afternoon and evening medication administrations with the times on a morning medication. The Nurse stated, "They should send what is needed. There are times where they can use the morning medication for evenings, or whatever. That is not the rule, instead of having a med error, I'm going to make sure they get their medication. We need a better process for sending the medications home. Maybe we will do training and add it to core A and B. Everyone in the house just had it". The Nurse was asked how the client medication administration programs were being monitored. The Nurse stated, "There has been, in other places not that home specifically". The Nurse was asked if additional monitoring was needed. The Nurse stated, "Yes". 2) Observations were conducted on 1/16/25 from 2:51 PM to 6:03 PM and on 1/17/25 from 5:58 AM to 8:16 AM. During these observations client C was served whole bread during his evening and morning meals. At 5:38 PM, client C was seated in his wheelchair and pulled up to the dining room table for the evening as the Team Leader (TL) and Area Supervisor (AS) finished preparing for the evening meal. At 5:41 PM, client C was served a whole piece of bread. At 5:45 PM, the AS asked client C if he wanted butter on his bread. Client C stated, "Yeah". At 5:46 PM, the AS buttered client C's bread. At 5:48 PM, client C held his partially			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	eaten butter bread in his left hand as he took bites from the whole piece served to him. At 6:30 AM, staff #7 used physical assistance with client C to position him while seated in his wheelchair up to the dining room table for the morning meal. At 6:35 AM, staff #7 used a verbal prompt to indicate to all the clients to pass the toast around the table. Client C was served a whole piece of toast during his morning meal. At 6:39 AM, staff #4 used physical assistance to help client C with lemonade. Client C took bites from the whole piece of toast. Client C was served a whole piece of bread during his morning. On 1/21/25 at 12:27 PM, a review of the facility's Bureau of Disabilities Services (BDS) incident reports and accompanying investigation summaries was conducted. The review indicated the following affecting client C: BDS incident report dated 9/3/24 indicated, "[Client C] was attending day program. [Client C] was in the lunchroom eating lunch. He began to struggle to breath (sic) and was gagging. Staff were beside him and encouraged him to cough. He coughed and spit up food. The Heimlich Maneuver was not required. He was taken to [hospital] ER (emergency room) for evaluation. At the ER a chest x-ray was completed with results of no findings. He was released from the ER with orders to follow up with his PCP (primary care physician)...". Investigation summary dated 9/9/24 indicated, "Introduction:... On 12/31/23 [client C] was hospitalized for pneumonia. He then went to the [name of rehabilitation center] for rehab for strength and ambulation. He was discharged from the [name of rehabilitation center] on 2/15/24 and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	admitted back to the [name] group home... On 9/2/24 at 11:00 AM, [client C] was attending day program. While in the lunchroom eating lunch, he began to struggle to breath (sic) and was gagging. Staff were beside him and encouraged him to cough. He coughed and spat up food. The Heimlich Maneuver was not required. He was taken to [name of hospital] ER for evaluation... Summary of Interviews: [Day Service Staff / DSS #3] stated she was busy in the med (medication) room when she heard [staff #6] yell for her from the lunchroom. [DSS #3] stated when she entered the lunchroom, [client C] had his back to her and he was sitting in the chair squirming around. [DSS #3] stated [staff #6] was telling [client C] to 'spit it out'. [DSS #3] stated she raised [client C's] right arm and patted him on the back. [DSS #3] stated after she patted him on the back, he spit out a piece of the sandwich 'clotted together'... [Staff #6] stated for lunch [client C] had a lunchmeat sandwich... [Staff #6] stated she cut his sandwich into ¼ inch pieces at the table... [Staff #6] stated [client C] took a piece of his sandwich, didn't chew good enough before he tried to swallow, and started coughing ... Conclusion:... [Client C's] diet was chopped into ¼ inch to ½ inch pieces. This is smaller than the physician ordered diet plan guideline, stating it is to be chopped into 1 inch pieces... It is substantiated that [client C] is assessed as at risk for choking and aspiration based on his current dining plan. His diet texture has been downgraded pending a swallow study. Results will determine any necessary updates to [client C's] prior dining plan...			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Recommendations: 1. Diet has been downgraded pending results of a swallow study...". On 1/22/25 at 1:09 PM, a review of client C's record was conducted. The review indicated the following: Swallow Study dated 12/9/24 indicated, "Results/Findings of Examination: no aspiration... Physician/Consultant Orders: none...". Dining Plan dated 10/30/24 indicated, "Behavioral Precautions: eats fast and stuffs foods... Food texture: Ground diet...". On 1/23/25 at 10:12 AM, the Nurse was interviewed. The Nurse was asked about client C's choking incident from 9/2/24 and his swallow study to confirm an appropriate diet texture being conducted on 12/9/24. The Nurse stated, "Yes, we had a hard time getting with doctor [name of primary care physician]". The Nurse was asked if client C remained on the downgraded diet order indicated in the investigation for ground food texture since his September 2024 choking incident. The Nurse stated, "Yes". The Nurse was asked what diet texture for food should client C currently be receiving based on the swallow study and follow up with the primary care physician (PCP). The Nurse stated, "He went to ground... He remained on that I do believe. I'm pulling it up to be certain, a ground diet". The Nurse was asked if client C should be served whole pieces of bread during his mealtimes. The Nurse stated, "No". The Nurse was asked what needed to occur to ensure client C was served the appropriate diet texture to prevent choking risks. The Nurse stated, "More training and observation to make sure they're doing it properly". The Nurse			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was asked if she was referring to more monitoring of client C's mealtimes. The Nurse nodded her head and indicated "Yes". On 1/23/25 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) and Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDP and QIDPD were asked about client C's September 2024 choking incident, the investigation indicating a downgraded diet until completion of a swallow study, and the observations of client C being served whole pieces of bread during his evening and morning mealtimes. The QIDP stated, "Yes, he is supposed to be having the ground diet". The QIDP was asked if client C should be served whole pieces of bread. The QIDP stated, "No, ground diet means all pieces of food. The QIDP was asked if staff failed to implement client C's dining plan for food texture to ensure he received a ground diet to reduce the risk of choking. The QIDP stated, "Yes". The QIDPD was asked how staff implement client C's dining plan. The QIDPD stated, "As written for ground diet textures". 9-3-6(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION Based on record review and interview for 2 of 3 sampled clients (A and B) and 3 additional clients (D, F and G), the facility failed to ensure clients A, B, D, F and G received their medications according to their physician orders without error. Findings include: On 1/21/25 at 12:27 PM, a review of the facility's Bureau of Disabilities Services (BDS) incident	W 0368	**W368:** The facility for drug administration must assure that all drugs, including those that are self-administered are administered without error. **Corrective Action:** The Nurse Manager was directly monitoring the facility at	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	reports and accompanying investigation summaries was conducted. The review indicated the following affecting clients A, B, D, F and G: 1) BDS incident report dated 5/20/24 indicated, "When staff was completing a med (medication) audit the staff found a med error. [Client D] is ordered the following medications at 7:00 AM - Albuterol Diskett (shortness of breath), Amiodarone (irregular heartbeat)100 mg, Benztropine (muscle control) 0.5 mg, Bicalutamide (prostate cancer) 50 mg, Eliquis (prevent and treat blood clots) 5 mg, Ferrous flutic/salme (shortness of breath) 325 mg, Loratadine (allergy symptoms) 10 mg, Metoprolol (high blood pressure) 100 mg, Montelukast (prevent difficulty breathing) 10 mg, Pantoprazole (stomach acid) 40 mg, Risperidone (schizophrenia/bipolar disorder) 2 mg, and Boost (supplement). On 5/10/24 at 7 AM med pass [client D] did not receive any of the ordered medications for the 7 AM med pass...". 2) BDS incident report dated 5/20/24 indicated, "When staff was completing a med audit staff found a med error. [Client F] is ordered Align (healthy digestive system) 4 mg, Ferrous Sulf (iron deficiency) 325 mg, Healthy eyes (macular degeneration), Loperamide (relieve diarrhea) 2 mg, Methscopolam (sic/stomach ulcers) 2 mg, Sertraline (panic attacks/obsessive compulsive disorder) 150 mg, OcuSoft lid scrub (eye cleanser). The med error is on 5/10/24 at 7 AM. [Client F] was given the morning medications twice for an extra dose of each of his morning meds...". 3) BDS incident report dated 5/28/24 indicated, "When staff was completing a med audit staff found a med error. The med error is: [Client A] did not receive his 8 PM meds on 5/27/24. [Client A] should have received Atorvastatin (lower bad		the time of survey, now direct Nursing oversight has been moved to veteran Nurse, Becky Hughes. Nurse is at the facility 3 days a week to complete oversight of the health needs of all clients in the facility for no less than 3 months and sends a detailed update to the IDT and administrative team. **(Attachment C)** Nurse will conduct at a minimum of one medication observation with all new hires in the facility prior to them being released from OJT and being able to pass medications. **(Attachment W)** Nurse checks all Physician orders to ensure accuracy monthly prior to placing them in the facility. ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	cholesterol) 20 mg, Cetirizine (allergy) 10 mg, Divalproex (seizure) 500 mg, Olopatadine (itching of the eye) 1 % eye drop, Clonidine (high blood pressure) 0.1 mg, Ammonium Lactate (dry skin) lotion...". 4) BDS incident report dated 6/6/24 indicated, "[Client G] is ordered Olanzapine (schizophrenia/bipolar disorder) 5 mg at 7 PM. Review of documentation today found a med error. The med error is [client G] did not receive his Olanzapine 5 mg at 7 PM on 6/3/24, 6/4/24 and 6/5/24. His script (prescription) had expired and doctor did not renew/update script with pharmacy. The script was sent to pharmacy and he received the med today...". 5) BDS incident report dated 6/6/24 indicated, "[Client B] is ordered Lybalvi (bipolar disorder) 20/10 mg once daily at 5 PM. Review of documentation found a med error. The med error is [client B] did not receive his Lybalvi 20/10 mg from 5/30/24 through 6/6/24. The Lybalvi script had expired and not been renewed/updated at the pharmacy. The script has been sent to the pharmacy...". 6) BDS incident report dated 9/21/24 indicated, "This morning at the 7 AM med pass [client B] received a housemate's medication. The housemate also has the first name [name]. Medications [client B] received in error: Thioridazine HCL 25 mg (psychotic/depressive disorders), Risperidone (schizophrenia/bipolar disorder) 3 mg, Healthy eyes (macular degeneration), Multi Vitamin Chew 1 tab (tablet), Loperamide (relieve diarrhea) Cap 2 mg, Propranolol HCL (slow heart rate/anxiety) 20 mg, Metoclopramide (gastroesophageal reflux disease) 5 mg, Montelukast SOD (asthma) 10 mg. He did		All staff trained by the Nurse regarding medication administration, Medication storage and security, QuickMar, Medications that go home for visit process, dining plans and demonstrated how to prep food according to the client's diet. **(Attachment E)** Nurse trained all staff on the checklist for medications to go home with families to ensure they are aware of medications, dosages, confirm the supply is adequate for the scheduled visit length. **(Attachment X)** The go home process for medications will be added to the Core A&B training that all new hires receive upon hire. All staff were tested by the Nurse on Medication Administration. **(Attachment F)** Program Manager ordered a lockbox for medication that needs destroyed by a Nurse to be stored in and removed from the facility medication storage. **(Attachment G)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	not receive his ordered 7 AM meds... Staff called 911 and he was taken to [hospital] ER (emergency room) for evaluation. At ER vitals were good and released for the ER to monitor...". 7A) BDS incident report dated 10/18/24 indicated, "[Client B] is a [age] year old male. He has a recent medication change. When he arrived at the day program his gait was unsteady, he had slurred speech and was drooling. The nurse contacted the psych (psychiatrist) and was advised to have him evaluated at the ER. He was taken to [hospital] ER for evaluation. At the ER labs (blood work) and UA (urine analysis) were completed. All results were normal. He was released from the ER with a recommendation to decrease his Alprazolam (anxiety/panic disorder) from 1 mg bid (twice a day) to 0.5 mg bid. The nurse has reached out to the psych to discuss the ER recommendations...". 7B) BDS incident report dated 10/28/24 indicated, "[Client B] is ordered Alprazolam 1 mg at 8:00 PM. His order was Alprazolam 1 mg at 8:00 AM and 1 mg at 8:00 PM until 10/24/24 when the 8:00 AM dose was discontinued. This morning when [client B] got to the day program he appeared lethargic. The nurse was at the (group) home and checked his medications and finding he was given the Alprazolam 1 mg at 8:00 AM discontinued dose in error. [Client B] did appear lethargic but more alert throughout the day...". On 1/23/25 at 10:12 AM, the Nurse was interviewed. The Nurse was asked about incident history indicating a pattern of medication errors affecting clients A, B, D, F and G. The Nurse indicated she had reviewed the medication error history. The Nurse stated in regard to client B receiving client H's medications in error, "They		documentation on paper and TMP and QuickMar. **(Attachment H)** Nurse obtained clarified order for how client (H) should receive his medications and trained staff on the updated order. **(Attachment I)** All staff receive medication administration and food preparation training upon hire, annually and as needed. ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility. ResCare Safety committee meets quarterly to discuss trends and patterns for medication errors and prevention. **Monitoring of Corrective Action:** All training sent to the ResCare trainer for filing in staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	called 911 because there was only one staff there. No one else could take him (client B) to the hospital". The Nurse stated in regard to clients A, B, D, F and G's medication errors, "Staff did not scan and look at quick MAR (medication administration records) to follow the orders. They're not utilizing the system properly. They're not doing the job properly. Not that they were not trained properly. They pull out the medications and supposed to do three checks, I feel they're pulling out the pill packs and not checking". The nurse stated in regard to client B receiving his discontinued Alprazolam, "That med error, it's not showing how they could give it. That is a double locked medication. I don't remember that med error". The Nurse was asked how the clients' medications should be administered. The Nurse stated, "According to agency policy. They are all trained in core A and B. They do initial training and annual training". The Nurse was asked if clients A, B, D, F and G's medications should be administered according to their physician orders without error. The Nurse stated, "Yes". On 1/23/25 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) and Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDP and QIDPD were asked about the pattern of medication errors and how clients A, B, D, F and G's medications should be administered. The QIDP stated, "Should be administered according to the doctor orders". The QIDP was asked if clients A, B, D, F and G's medications should be administered according to their physician orders without error. The QIDP stated, "Yes". 9-3-6(a)		files. All oversight observations will be reviewed during daily survey update calls held by ResCare Management and filed in the binder at the facility. Quality Assurance tracks all site review data and submits to management for follow up and review. Nurse Manager will complete medication administration observations and notify management of any concerns. All medication checklist for go home medications are reviewed and signed by both staff and the individual the client is leaving the facility with to ensure understanding of medication administration and to ensure an adequate supply of staffing for the length of the scheduled visit. Nurse Manager pulls reports in QuickMar daily and sends out to all Area Supervisors, Program Managers, Program Director, Nurses, and Executive Director for monitoring and to ensure completion. Weekly calls are held with all Area Supervisors, Program Managers and Program Director to discuss each location and their TMP documentation to ensure completion. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Completion Date: 2/23/25	
W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION Based on observation, record review and interview for 1 additional client (H), the facility failed to ensure client H was administered his medications according to his physician orders without error. Findings include: An observation was conducted on 1/17/25 from 5:58 AM to 8:16 AM. At 6:50 AM, staff #4 used a verbal prompt with client H to come to the medication administration room and to wash his hands. At 6:52 AM, staff #4 placed gloves on his hands and began preparing client H's morning medications. At 6:56 AM, staff #4 popped out 3 tablets of Thioridazine (psychotic/depressive disorders) 25 mg (milligrams) and handed the surveyor the package of the medication. The prescription label indicated client H should only receive 2 tablets of the medication. The surveyor handed staff #4 the packaging back and asked what the prescription label indicated for administration in comparison to the electronic medication administration record (MAR). Staff #4 read the prescription label followed by the electronic MAR. Staff #4 stated, "My mistake" and removed one of three tablets of Thioridazine 25 mg and placed it back in the bubble pack with tape over the backside. At 7:11 AM, staff #4 placed client H's medication tablets into a plastic bag and began crushing client H's medications. As staff #4 crushed client H's medication, a portion of client H's chewable multivitamin that did not crush was removed from the plastic bag	W 0369	**W369:** The facility for drug administration must assure that all drugs, including those that are self-administered are administered without error. **Corrective Action:** Nurse is at the facility 3 days a week to complete oversight of the health needs of all clients in the facility for no less than 3 months and sends a detailed update to the IDT and administrative team. **(Attachment C)** Nurse will conduct at a minimum of one medication observation with all new hires in the facility prior to them being released from OJT and being able to pass medications. **(Attachment W)** Nurse trained all staff on the checklist for medications to go home with families to ensure they are aware of medications, dosages, confirm the supply is adequate for the scheduled visit length. **(Attachment X)** The go home process for medications will be added to the Core A&B training that all new hires receive upon hire.	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	by staff #4 and placed on the desk. Staff #4 proceeded to pour the crushed powder medication into a plastic spoon while hovering the spoon over a container of apple sauce. At 7:14 AM, client H was administered his crushed medication on the spoon followed by a bite of apple sauce. The portion of client H's multivitamin placed on the desk was omitted from the administration of other crushed medications. At 7:23 AM, client H drank his morning boost concluding his morning medication routine. At 7:24 AM, the portion of client H's multivitamin not crushed remained on the desk. On 1/22/24 at 1:52 PM, a focused review of client H's record was conducted. The review indicated the following: Physician's Order dated 12/1/24 indicated, "Diet: Pureed foods with pre-thickened honey thick fluids medication in pureed foods... Animal Shaped Chew Tab (tablet) - give one tablet by mouth once daily for vitamin supplement... Thioridazine Tab 25 mg - Give three (3) tablets (75 mg) by mouth at 4 PM and at bedtime for impulse control disorder... Thioridazine Tab 25 mg - Give two (2) tablets (50 mg) by mouth every morning for impulse control disorder...". Dining Plan dated 9/23/24 indicated, "Medications: [Client H] takes his medications whole in puree food followed by honey thick fluids...". On 1/23/25 at 10:12 AM, the Nurse was interviewed. The Nurse was asked about client H's medication administration for whole or crushed medicines. The Nurse stated, "His diet order does say whole. It needs to be re-worded in quick		Nurse checks all Physician orders to ensure accuracy monthly prior to placing them in the facility each month. Nurse obtained clarified order for how client (H) should receive his medications and trained staff on the updated order. **(Attachment I)** Nurse trained all staff on client (H) clarified order to crush his medications. **(Attachment E)** All staff trained by the Nurse regarding medication administration, Medication storage and security, QuickMar, Medication go home process, dining plans and demonstrated how to food prep food according to the client's diets. **(Attachment E)** All staff were tested by the Nurse on Medication Administration. **(Attachment F)** Program Manager ordered a lockbox for medication that needs destroyed by a Nurse to be stored in and removed from the facility medication storage. **(Attachment G)** Program Director, Program Manager and Area Supervisor conducted a staff meeting at the facility to review Adaptive equipment, Hygiene practices and goals, the cleaning schedule for staff at the facility, Privacy, Dignity, prevention of falls and incidents, monthly drills, Staffing ratios, ANE reporting, Active Treatment, mealtime process and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	MAR. It says with foods". The Nurse was asked to confirm client H's medicines should not be crushed. The Nurse stated, "Correct". The Nurse was asked what client H's physician's order indicated for medication administration. The Nurse stated, "At the top of the order it says medication with puree foods. On his dining plan it says whole". The Nurse indicated client H's chewable vitamin should not have been crushed and client H should have been administered the vitamin as a whole tablet. The Nurse stated, "All of these guys (staff) will need to go through core A and B". The Nurse was asked how the clients' medications should be administered. The Nurse stated, "According to agency policy. They are all trained in core A and B. They do initial training and annual training". The Nurse was asked if clients H's medications should be administered according to the physician order without error. The Nurse stated, "Yes". On 1/23/25 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) and Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDP and QIDPD were asked about client H's medication administration. The QIDP stated, "I actually think it says whole on the dining plan and the physician orders says pureed for food. We have to look at that". The QIDPD stated, "I recall the order being administered whole in apple sauce. I don't recall anytime where his medications were crushed". The QIDP and QIDPD were asked if client H should receive all of his medications. The QIDP stated, "He should yes". The QIDP and QIDPD were asked if staff remove the multivitamin place it on the desk omitting that portion from client H's		documentation on paper and TMP and QuickMar. **(Attachment H)** ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	administration routine. The QIDP stated, "No". The QIDP and QIDPD were asked how client medications should be administered. The QIDP stated, "Should be administered according to the doctor orders". The QIDP was asked if client H's medication should be administered according to his physician orders without error. The QIDP stated, "Yes". 9-3-6(a)		**Monitoring of Corrective Action:** All training sent to the ResCare trainer for filing in staff files. All oversight observations will be reviewed during daily survey update calls held by ResCare Management and filed in the binder at the facility. Quality Assurance tracks all site review data and submits to management for follow up and review. Nurse Manager will complete medication administration observations and notify management of any concerns. All medication checklist for go home medications are reviewed and signed by both staff and the individual the client is leaving the facility with to ensure understanding of medication administration and to ensure an adequate supply of staffing for the length of the scheduled visit. Nurse Manager pulls reports in QuickMar daily and sends out to all Area Supervisors, Program Managers, Program Director, Nurses, and Executive Director for monitoring and to ensure completion. Weekly calls are held with all Area Supervisors, Program Managers and Program Director to discuss each location and their TMP documentation to ensure completion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. **Completion Date: 2/23/25**	
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING Based on observation and interview for 3 of 3 sampled clients (A, B and C), and 5 additional clients (D, E, F, G and H), the facility failed to maintain drug security with clients A, B, C, D, E, F, G and H's medicines. Findings include: An observation was conducted on 1/17/25 from 5:58 AM to 8:16 AM. At 6:50 AM, staff #4 used a verbal prompt with client H to come to the medication administration room and to wash his hands. At 6:52 AM, staff #4 placed gloves on his hands and began preparing client H's morning medications. At 7:11 AM, staff #4 placed client H's medication tablets into a plastic bag and began crushing client H's medications. As staff #4 crushed client H's medication, a portion of client H's chewable multivitamin that did not crush was removed from the plastic bag by staff #4 and placed on the desk. Staff #4 proceeded to pour the crushed powder medication into a plastic spoon while hovering the spoon over a container of apple sauce. At 7:14 AM, client H was administered his crushed medication on the spoon followed by a bite of apple sauce. The portion of client H's multivitamin placed on the desk was omitted from the administration of other crushed medications. At 7:23 AM, client H drank his morning boost concluding his morning medication	W 0382	**W382**: The facility must keep all drugs and biologicals locked except when being prepared for administration. **Corrective action:** Nurse trained all staff on ensuring cabinets containing medication is always locked unless staff are present and administering medications, if they leave the room they must lock the cabinets. If other clients in the facility were to enter the private medication area the med pass must halt and then resume when privacy has been restored. (**Attachment E)** All staff trained by the Nurse regarding medication administration, Medication storage and security, QuickMar, Medication go home process, dining plans and demonstrated how to food prep food according to the client's diets. **(Attachment E)** All staff were tested by the Nurse on Medication Administration. **(Attachment F)**	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	routine. At 7:24 AM, the portion of client H's multivitamin not crushed remained on the desk. At 7:35 AM, staff #4 washed his hands and began preparing for another client's morning medication routine. At 7:37 AM, staff #4 assisted client C from the medication administration room to the dining room table. The medication cabinet was unlocked and open, the medication administration room was unlocked and left open, and no staff was in the medication room. Client H's portion of the multivitamin that was not crushed previously on the desk was no longer on the desk. At 7:39 AM, staff #4 used a verbal prompt asking client E to come to the medication room. Staff #4 left client E sitting in a chair in the medication administration room while he went into the adjacent bathroom shutting the door. Client E was left unattended in the medication administration room with the medication cabinet open and unlocked with clients A, B, C, D, E, F, G and H's medicines unsecured. At 7:40 AM, staff #4 opened the bathroom door and returned to the medication administration room with client E. At 8:01 AM staff #4 came out of the medication administration room to verbally prompt client D in the living room to say that it was his turn for morning medicines. The door to the medication administration room was left open, and the medication cabinet was open with clients A, B, C, D, E, F, G and H's medicines left unattended and unsecured. At 8:11 AM, client D returned to the living room with staff #4 following him. Staff #4 used a verbal prompt with client A in the living room to say that it was his turn for morning medicines. The door to the medication administration room was left open, and the medication cabinet was open with clients A, B, C, D, E, F, G and H's medicines left unattended and unsecured. On 1/23/25 at 10:12 AM, the Nurse was		Program Manager ordered a lockbox for medication that needs destroyed by a Nurse to be stored in and removed from the facility medication storage. **(Attachment G)** Nurse trained all staff on the checklist for medications to go home with families to ensure they are aware of medications, dosages, confirm the supply is adequate for the scheduled visit length. **(Attachment X)** The go home process for medications will be added to the Core A&B training that all new hires receive upon hire. ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios. ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interviewed. The Nurse was asked if the medications should be left unlocked and left unsecured. The Nurse stated, "No, they shouldn't". The Nurse was asked what should occur to prompt the next client to come to the medication administration room to ensure medications were secure. The Nurse stated, "Well, they should lock that door, but if there is more than one staff, the other staff could bring them (clients) to them (staff). If they leave the room, it should be locked back up". The Nurse was asked if medications should be secured and not left unattended. He Nurse stated, "Yes". On 1/23/25 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) and Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDP and QIDPD were asked if clients A, B, C, D, E, F, G and H's medications should be left unattended and unsecured. The QIDP stated, "No. If they have to leave all medication cabinets should be locked". The QIDP and QIDPD were asked what should occur to prompt the next client to come to the medication administration room to ensure medication security. The QIDPD stated, "They should lock any medication left out if they need to leave the room". The QIDP and QIDPD indicated clients A, B, C, D, E, F, G and H's medications should be secured at all times and not left unattended. 9-3-6(a)		**Monitoring of Corrective Action:** Completed monthly site review is sent to the management team as well as entered in the database by Quality Assurance to ensure completion. All training sent to the ResCare trainer for filing in staff files. All oversight observations will be reviewed during daily survey update calls held by ResCare Management and filed in the binder at the facility. Quality Assurance tracks all site review data and submits to management for follow up and review. Nurse Manager will complete medication administration observations and notify management of any concerns. All medication checklist for go home medications are reviewed and signed by both staff and the individual the client is leaving the facility with to ensure understanding of medication administration and to ensure an adequate supply of staffing for the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			length of the scheduled visit. Nurse Manager pulls reports in QuickMar daily and sends out to all Area Supervisors, Program Managers, Program Director, Nurses, and Executive Director for monitoring and to ensure completion. Quality Assurance Manager tracks daily call discussions and sends out to ResCare Management daily. **Completion Date: 2/23/25**	
W 0440 Bldg. 00	483.470(i)(1) EVACUATION DRILLS Based on record review and interview for 3 of 3 sampled clients (A, B and C) and 5 additional clients (D, E, F, G and H), the facility failed to ensure staff conducted quarterly evacuation drills for each shift of personnel. Findings include: On 1/22/25 at 10:20 AM, a review of the group home's evacuation drills was conducted. The review of the evacuation drills indicated the following affecting clients A, B, C, D, E, F, G and H: During the first shift (7:00 AM - 3:00 PM), there were no evacuation drills from 10/1/24 to 12/31/24. During the second shift (3:00 PM - 12:00 AM), there were no evacuation drills from 1/1/24 to	W 0440	**W440: Evacuation Drills** **Corrective Action:** Program Director completed a training with all staff over the drill schedule, proper times to conduct the drills, proper way to conduct drills and the process to enter the drills on TMP. (**Attachment H**) Quality Assurance Manager set an event that will send a reminder automatically to the Area Supervisor of the facility to ensure they notify the home and remind them of the drill scheduled that day and shift and remind them of utilizing varied times throughout the shift that it is completed each	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3/30/24. On 1/22/25 at 10:56 AM, the Qualified Intellectual Disabilities Professional (QIDP) and Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDP and QIDPD were asked about the missing first shift and second shift evaluation drills. The QIDP and QIDPD indicated no further evaluation drills could be provided for review. The QIDP and QIDPD were asked how the evacuation drills should be conducted. The QIDP stated, "There should be a fire drill for each quarter for all of shifts". 9-3-7(a)		month. Area Supervisor will complete a weekly check to ensure drills are conducted as scheduled. **(Attachment AA)** ResCare Management completes site reviews at the facility monthly and that includes monitoring environmental issues, drug security issues, client dignity, privacy, documentation, drills, and staffing ratios. **Monitoring of Corrective Action:** The Area Supervisor and Site Supervisor will send completed weekly checks to the Program Manager for monitoring and to ensure completion. Quality Assurance Manager tracks all drills for the facility to ensure completion. Management Site Reviews will be entered into the database for monitoring and to ensure completion. Weekly calls are held with all Area Supervisors, Program Manager and Program Director to review TMP documentation including the scheduled and completed drills. The Safety Committee will monitor quarterly for completion of scheduled drills.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Completion Date: 2/23/25	
W 0474 Bldg. 00	483.480(b)(2)(iii) MEAL SERVICES Based on observation, record review and interview of 1 of 3 sampled clients (C), the facility failed to ensure staff prepared client C's food texture appropriately for all foods ground and served him whole pieces of bread. Findings include: Observations were conducted on 1/16/25 from 2:51 PM to 6:03 PM and on 1/17/25 from 5:58 AM to 8:16 AM. During these observations client C was served whole bread during his evening and morning meals. At 5:38 PM, client C was seated in his wheelchair and pulled up to the dining room table for the evening as the Team Leader (TL) and Area Supervisor (AS) finished preparing for the evening meal. At 5:41 PM, client C was served a whole piece of bread. At 5:45 PM, the AS asked client C if he wanted butter on his bread. Client C stated, "Yeah". At 5:46 PM, the AS buttered client C's bread. At 5:48 PM, client C held his partially eaten buttered bread in his left hand as he took bites from the whole piece served to him. At 6:30 AM, staff #7 used physical assistance with client C to position him while seated in his wheelchair up to the dining room table for the morning meal. At 6:35 AM, staff #7 used a verbal prompt to indicate to all the clients to pass the toast around the table. Client C was served a whole piece of toast during his morning meal. At 6:39 AM, staff #4 used physical assistance to help client C with lemonade. Client C took bites from the whole piece of toast. Client C was served a	W 0474	**W474:** Food must be served in a form consistent with the developmental level of the client. **Corrective Action:** Nurse trained all staff on dining plans. (**Attachment E**) All staff trained on food preparations upon hire, annually and as needed. Nurse will update all dining and high -risk plans annually and as needed. Nurse completes weekly documentation review in the facility. **(Attachment EE)** QIDP will update Individual Program Plan annually and as needed and will include all adaptive equipment, high risk issues and dining plans. ResCare Management will complete observations 7 days a week which includes medication administration observations, mealtime observations, privacy, ensure staff are deployed properly and a dignity check on all clients in the facility. Daily observations are reviewed with the management team daily to address any issues or concerns. Once conditions are	02/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	whole piece of bread during his morning. On 1/21/25 at 12:27 PM, a review of the facility's Bureau of Disabilities Services (BDS) incident reports and accompanying investigation summaries was conducted. The review indicated the following affecting client C: BDS incident report dated 9/3/24 indicated, "[Client C] was attending day program. [Client C] was in the lunchroom eating lunch. He began to struggle to breath and was gagging. Staff were beside him and encouraged him to cough. He coughed and spit up food. The Heimlich Maneuver was not required. He was taken to [hospital] ER (emergency room) for evaluation. At the ER a chest x-ray was completed with results of no findings. He was released from the ER with orders to follow up with his PCP (primary care physician)...". Investigation summary dated 9/9/24 indicated, "Introduction:... On 12/31/23 [client C] was hospitalized for pneumonia. He then went to the [name of rehabilitation center] for rehab for strength and ambulation. He was discharged from the [name of rehabilitation center] on 2/15/24 and admitted back to the [name] group home... On 9/2/24 at 11:00 AM, [client C] was attending day program. While in the lunchroom eating lunch, he began to struggle to breath and was gagging. Staff were beside him and encouraged him to cough. He coughed and spat up food. The Heimlich Maneuver was not required. He was taken to [name of hospital] ER for evaluation... Summary of Interviews: [Day Service Staff / DSS #3] stated she was busy in the med (medication) room when she heard [staff #6] yell for her from the lunchroom. [DSS #3] stated when she entered		lifted observations will go to 5 days a week on varied days and shifts for a minimum of 60 days and then 3 times weekly thereafter by the Area Supervisor, Nurse and QIDP for continued monitoring and training. **(Attachment D)** ResCare Management including the ResCare Operation Support Specialist and State Director of Nursing conducts daily calls to discuss observations, staffing, medical issues or concerns and day to day concerns/issues within the facility. A weekly call with James Bolling, Senior Director of Quality Supports, ResCare Operation Support Specialist, State Director of Nursing and ResCare Management is held on Thursday each week to discuss any issues/concerns in the facility. **Monitoring of Corrective Action:** Nurse will update all dining and high- risk plans as needed and annually and send to the Nurse Manager for review. Nurse weekly review is sent to all ResCare Management for review and to ensure completion. QIDP will review Individual Program Plans quarterly and update as needed. The QIDP will update the Individual Program Plan as needed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the lunchroom, [client C] had his back to her and he was sitting in the chair squirming around. [DSS #3] stated [staff #6] was telling [client C] to 'spit it out'. [DSS #3] stated she raised [client C's] right arm and patted him on the back. [DSS #3] stated after she patted him on the back, he spit out a piece of the sandwich 'clotted together'... [Staff #6] stated for lunch [client C] had a lunchmeat sandwich... [Staff #6] stated she cut his sandwich into ¼ inch pieces at the table... [Staff #6] stated [client C] took a piece of his sandwich, didn't chew good enough before he tried to swallow, and started coughing ... Conclusion:... [Client C's] diet was chopped into ¼ inch to ½ inch pieces. This is smaller than the physician ordered diet plan guideline, stating it is to be chopped into 1 inch pieces... It is substantiated that [client C] is assessed as at risk for choking and aspiration based on his current dining plan. His diet texture has been downgraded pending a swallow study. Results will determine any necessary updates to [client C's] prior dining plan... Recommendations: 1. Diet has been downgraded pending results of a swallow study...". On 1/22/25 at 1:09 PM, a review of client C's record was conducted. The review indicated the following: Swallow Study dated 12/9/24 indicated, "Results/Findings of Examination: no aspiration... Physician/Consultant Orders: none...". Dining Plan dated 10/30/24 indicated, "Behavioral Precautions: eats fast and stuffs foods... Food texture: Ground diet...". On 1/23/25 at 10:12 AM, the Nurse was		including mealtime adaptive equipment and dining plans. **Completion Date: 2/23/25**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	interviewed. The Nurse was asked about client C's choking incident from 9/2/24 and his swallow study to confirm an appropriate diet texture being conducted on 12/9/24. The Nurse stated, "Yes, we had a hard time getting with doctor [name of primary care physician]". The Nurse was asked if client C remained on the downgraded diet order indicated in the investigation for ground food texture since his September 2024 choking incident. The Nurse stated, "Yes". The Nurse was asked what diet texture for food should client C currently be receiving based on the swallow study and follow up with the primary care physician (PCP). The Nurse stated, "He went to ground... He remained on that I do believe. I'm pulling it up to be certain, a ground diet". The Nurse was asked if client C should be served whole pieces of bread during his mealtimes. The Nurse stated, "No". The Nurse was asked what needed to occur to ensure client C was served the appropriate diet texture to prevent choking risks. The Nurse stated, "More training and observation to make sure they're doing it properly". The Nurse was asked if she was referring to more monitoring of client C's mealtimes. The Nurse nodded her head and indicated "Yes". On 1/23/25 at 12:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) and Qualified Intellectual Disabilities Professional Designee (QIDPD) were interviewed. The QIDP and QIDPD were asked about client C's September 2024 choking incident, the investigation indicating a downgraded diet until completion of a swallow study, and the observations of client C being served whole pieces of bread during his evening and morning mealtimes. The QIDP stated, "Yes, he is supposed to be having the ground diet". The QIDP was asked if client C should be served			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G255	A. BUILDING 00 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	154 CHAD DR VERSAILLES, IN 47042

(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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	whole pieces of bread. The QIDP stated, "No, ground diet means all pieces of food. The QIDP was asked if staff failed to implement client C's dining plan for food texture to ensure he received a ground diet to reduce the risk of choking. The QIDP stated, "Yes". The QIDPD was asked how staff implement client C's dining plan. The QIDPD stated, "As written for ground diet textures". 9-3-8(a)			