CENTERS FO	R MEDICARE & MEDIO	CAID SERVICES			0	OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIP A. BUILDIN B. WING	le construction ig <u>00</u>	COM	te survey ipleted 2 3/2024
NAMEOEI	PROVIDER OR SUPPLIE		STR	EET ADDRESS, CITY, STATE, ZIP	COD	
	RE SOUTHEAST II			609 SIMA GRAY RD NRYVILLE, IN 47126		
(X4) ID		STATEMENT OF DEFICIENCIE	ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREF	IX PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAC		AFFROFRIATE	DATE
N 0000						
Bldg. 00						
ыйд. 00	This visit was for t	the pre-determined full	W 0000			
		state licensure survey. This	W 0000			
		nvestigation of complaints				
	#IN00429146 and	e .				
	-	29146: Federal and state				
		d to the allegation(s) are cited at				
	W102, W104, W12	22, W149, W154 and W157.				
	Complaint #IN004	28423: Federal and state				
	-	d to the allegation(s) are cited				
		W122, W149, W154, W157 and				
	W289.					
		5/14/24, 5/15/24, 5/16/14, 5/17/24,				
	5/21/24, 5/22/24 at	nd 5/23/24.				
	Facility Number: ()11664				
	Provider Number:					
	AIMS Number: 20					
	These deficiencies	also reflect state findings in				
	accordance with 4					
	Quality Review of	this report completed by #15068				
	on 6/4/24.					
N 0102	483.410					
		DDY AND MANAGEMENT				
Bldg. 00	The facility must	ensure that specific				
	governing body a	-				
	requirements are					
		ion, record review and	W 0102	Unannounced r	•	06/14/202
		2 sampled clients (A and B), plus		observations began a		
		s (C and D), the governing body		on 6/6/2024 to ensure	-	
		general policy, budget and		being implemented by		
		n over the facility to ensure ogate to assist him to make		Weekday daily observe		
	Chem A had a surr	ogate to assist mini to make	1	remain in effect for 60	Juays. Aller	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE Tracy Callahan **Program Manager** 06/16/2024 Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin

other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 06/26/2024 FORM ADDOVED

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DATE	E SURVEY
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	DING	00	COMPLETE	
		15G746	B. WING			05/23/2024	
JAME OF	PROVIDER OR SUPPLIE	P	<u> </u>	STREET .	ADDRESS, CITY, STATE, ZIP COD	•	
					SIMA GRAY RD		
RES CA	S CARE SOUTHEAST INDIANA			HENRY	YVILLE, IN 47126		
X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
REFIX		NCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		DR LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	-	g informed consent, the facility			60 days monthly, administrat		
	-	buse, neglect, exploitation,			observations will be conducte		
		or violation of individual's rights			The management team		
		e effective implementation of			began daily update meetings		
		behavior plans to prevent			6/6/2024, to ensure complian		
		prevent client to client ng clients A, B, C and D, to			and implement changes need	nea	
		tion of client A and B's formal			developing a plan and implementation of those char		
		documented and to ensure			Meetings will continue until	iges.	
		ral Support Plan (BSP) included			conditions are lifted.		
		behavioral interventions, the			Members of the		
	-	-to-72-hour safety protocol for			administrative team, including	r	
		items within his bedroom, the			managers from Quality, Nurs	-	
		bes, and the use of 911 for			and Programming, will condu	-	
	emergency interve				daily observations on weekda		
					Any issues will be immediate	-	
	The governing bo	dy failed to ensure the facility			reported to the Facility Team	-	
		of Participation: Client			The Facility Maintenand		
		of 2 sampled clients (A and B),			Manger will inspect the site o		
	plus 2 additional c				weekly at a minimum to ident		
					environmental issue that may	-	
	Findings include:				arise.		
					Facility Staff will monito	r	
	1. The governing	body failed to exercise general			home activities and client		
	policy, budget and	l operating direction over the			interactions daily to ensure th	nere	
	facility to ensure of	elient A had a surrogate to assist			is plans are followed if an iss		
	him to make decis	ions regarding informed			noted the appropriate		
		y implemented the abuse,			administrative personnel i.e.	Area	
		on, mistreatment and/or			Supervisor, Program Manage		
		dual's rights policy to ensure the			Nurse, QIDP or AED immedia	ately	
	-	ntation of clients B and C's			and correction will be made.		
		prevent elopement and to			The Behavior Consulta	nt,	
	·	lient aggression regarding			Program Manager, Area		
		d D, to ensure documentation of			Supervisor, Facility Nurse an		
		ormal goal attempts was			QIDP will proactively monitor		
		o ensure client B's Behavioral			clients to ensure plan		
		P) included effective positive			implementation.		
		ntions, the restriction of a			The facility will ensure t		
	24-to-72-hour safe	ety protocol for the removal of all			client A will have someone to	1	

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Event ID: U3OY11 Facility ID: 011664

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2024	
	PROVIDER OR SUPPLIE		16609	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD YVILLE, IN 47126	OD	
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE (X5)	
	shoes, and the use interventions. Plea 2. The governing b met the Condition Protections for 2 o plus 2 additional c W122.	of 911 for emergency use see W104. body failed to ensure the facility of Participation: Client of 2 sampled clients (A and B), lients (C and D). Please see lates to complaints #IN00429146		regarding informed consent. 6, 2024 a Health Representat agreed to be client A's HRC. The facility will ensure to staff are retrained on the ANE policy and the effective implementation of the policy to prevent elopement and client client aggression between client A, B, C, and D. The Program Manager Area Supervisor retrained stat ANE (Abuse, Neglect, and Exploitation) Policy disciplina action will be taken if the policy not followed. Area Supervisor will ensure that Policy is follow and corrective measures are implemented. Monitoring of w done by The Program Manager Area Supervisor, and DSL to ensure all compliance. Staff will complete daily perimeter checks to include window, door, security system check, and gate operations. System checks will be verified Area Supervisor, any deficient will be reported the Program Manager and ResCare Maintenance Manager. The IDT will meet to dis positive reinforcements being added to the BSP's. The BC update clients A, B, C and D's BSP's to reflect those changer and the staff will be trained on those changes. The facility will ensure to the staff are retrained on program	June tive hat E to ents and iff on, ry cy is r and wed, rill be ler, n d by ncies cuss will s s n hat	

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	x3) date survey completed 05/23/2024
	ROVIDER OR SUPPLIE		16609 \$	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD	
RES CAR	E SOUTHEAST I	NDIANA	HENRY	YVILLE, IN 47126	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	(X5) COMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	documenting of the all the clier goals and how to complete the documentation on when a clier goal is not met or completed. The facility will ensure tha the BC updates the BSP's to include or not to include the us 911 for emergency intervention shoes being kept in the office of to elopement issues and the 7 day, 24/72 hour safety protocol the removal of items from their rooms. The Facility will ensure the the QIDP is retrained on thoroughly completing investigations on elopements. QIDP will also ensure follow-up IDT's to ensure the clients plan being implemented to prevent potential neglect. The Area Supervisor will ensure that the staff are retrain on proper documenting of the a the client's goals and how to complete the documentation or when a client's goal is not met completed. The QIDP will ensure that the QIDP is retrained on thoroughly completing investigations on elopements. QIDP will also ensure follow-up IDT's to ensure the clients plan being implemented to prevent the QIDP is retrained on thoroughly completing investigations on elopements. QIDP will also ensure follow-up IDT's to ensure the clients plan being implemented to prevent	DATE DATE
				Persons Responsible: Execut Director, AED, Program Manag	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	r í	ULTIPLE CO JILDING	onstruction 00	COM	(X3) DATE SURVEY COMPLETED 05/23/2024	
		15G746	B. W	ING		05/2		
	PROVIDER OR SUPPLIE		•	16609	address, city, state, zip co SIMA GRAY RD YVILLE, IN 47126	D		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
					Maintenance Manager, G Assurance, Quality Assu Manager, QIDPM, Direc Nursing, Nurse, Area Su QIDP, DSL, and DSP. DATE OF COMPLETION 6/14/2024	irance tor of ipervisor,		
W 0104 Bldg. 00		DDY ody must exercise general od operating direction over						
	interview for 2 of 2 2 additional clients failed to exercise g operating direction client A had a surr decisions regarding implemented the a mistreatment and/o policy to ensure th clients B and C's b elopement and to p aggression regarding ensure documentat goal attempts was client B's Behavion effective positive b restriction of a 24- the removal of all removal of his sho emergency interve Findings include: 1. The governing b had a surrogate to	on, record review and 2 sampled clients (A and B), plus 2 (C and D), the governing body eneral policy, budget and over the facility to ensure ogate to assist him to make g informed consent, the facility puse, neglect, exploitation, or violation of individual's rights e effective implementation of ehavior plans to prevent revent client to client ng clients A, B, C and D, to ion of client A and B's formal documented and to ensure al Support Plan (BSP) included behavioral interventions, the to-72-hour safety protocol for tems within his bedroom, the es, and the use of 911 for ntions.)104	Unannounced rand observations began at th on 6/6/2024 to ensure pi being implemented by si Weekday daily observat remain in effect for 60 da 60 days monthly, admini observations will be con The management began daily update mee 6/6/2024, to ensure com and implement changes developing a plan and implementation of those Meetings will continue u conditions are lifted. Members of the administrative team, incl managers from Quality, and Programming, will c daily observations on we Any issues will be imme reported to the Facility T The Facility Mainte Manger will inspect the si weekly at a minimum to environmental issue that	ne Facility lans are taff. ions will ays. After istrative ducted. team tings on pliance needed changes. ntil uding Nursing onduct eekdays. diately eam. enance site once identify	06/14/2024	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/23/2024 15G746 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16609 SIMA GRAY RD HENRYVILLE, IN 47126 **RES CARE SOUTHEAST INDIANA** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE arise. 2. The governing body failed to implement the Facility Staff will monitor abuse, neglect, exploitation, mistreatment and/or home activities and client violation of individual's rights policy to ensure the interactions daily to ensure there effective implementation of clients B and C's is plans are followed if an issue is behavior plans to prevent elopement and to noted the appropriate prevent client to client aggression regarding administrative personnel i.e. Area clients A, B, C and D. Please see W149. Supervisor, Program Manager, Nurse, QIDP or AED immediately 3. The governing body failed to thoroughly and correction will be made. investigate incidents of elopement to rule out The Behavior Consultant. potential neglect for the implementation of client Program Manager, Area B's program plans. Please see W154. Supervisor, Facility Nurse and QIDP will proactively monitor 4. The governing body failed to develop and clients to ensure plan implement effective corrective measures to implementation. prevent recurrence of clients B and C's elopement The facility will ensure that and peer to peer aggression behaviors. Please see client A will have someone to W157. assist him in making decisions regarding informed consent. June 5. The governing body failed to ensure 6, 2024 a Health Representative documentation of client A and B's formal goal agreed to be client A's HRC. attempts was documented. Please see W252. The facility will ensure that staff are retrained on the ANE 6. The governing body failed to ensure client B's policy and the effective Behavioral Support Plan (BSP) included effective implementation of the policy to positive behavioral interventions, the restriction prevent elopement and client to of a 24-to-72-hour safety protocol for the removal client aggression between clients of all items within his bedroom, the removal of his A, B, C, and D. shoes, and the use of 911 for emergency The Program Manager and interventions. Please see W289. Area Supervisor retrained staff on, ANE (Abuse, Neglect, and This federal tag relates to complaints #IN00429146 Exploitation) Policy disciplinary and #IN00428423. action will be taken if the policy is not followed. Area Supervisor and 9-3-1(a) will ensure that Policy is followed, and corrective measures are implemented. Monitoring of will be done by The Program Manager, Area Supervisor, and DSL to

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

Event ID:

U3OY11 Facility II

Facility ID: 011664

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FORM APPROVED

OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PI	ROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD	
	E SOUTHEAST I	ΝΟΙΔΝΙΔ		SIMA GRAY RD YVILLE, IN 47126	
RES CAN	E SOUTHEAST I	NDIANA			<u>.</u>
(X4) ID		Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLET
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG		DATE
				ensure all compliance.	
				Staff will complete daily perimeter checks to include	
				window, door, security system	
				check, and gate operations.	
				System checks will be verified	by
				Area Supervisor, any deficience	-
				will be reported the Program	
				Manager and ResCare	
				Maintenance Manager.	
				The IDT will meet to disc	uss
				positive reinforcements being	
				added to the BSP's. The BC w	
				update clients A, B, C and D's	
				BSP's to reflect those changes	
				and the staff will be trained on those changes.	
				The facility will ensure th	at
				the staff are retrained on prope	
				documenting of the all the clien	
				goals and how to complete the	
				documentation on when a clier	nťs
				goal is not met or completed.	
				The facility will ensure th	at
				the BC updates the BSP's to	
				include or not to include the us	
				911 for emergency intervention	
				shoes being kept in the office of	
				to elopement issues and the 7 day, 24/72 hour safety protoco	
				the removal of items from their	
				rooms.	
				The Facility will ensure the	nat
				the QIDP is retrained on	
				thoroughly completing	
				investigations on elopements.	The
				QIDP will also ensure follow-u	
				IDT's to ensure the clients plan	n is
				being implemented to prevent	
				potential neglect.	

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPI A. BUILDIN B. WING	le construction IG <u>00</u>	(X3) DATE SURVEY COMPLETED 05/23/2024	
	PROVIDER OR SUPPLIE		166	EET ADDRESS, CITY, STATE, ZIP CC 609 SIMA GRAY RD	D	
(X4) ID	RE SOUTHEAST II	STATEMENT OF DEFICIENCIE		NRYVILLE, IN 47126 PROVIDER'S PLAN OF CORR	ECTION	(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFI	IX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	DULD BE PPROPRIATE	COMPLETION DATE
				The Area Supervi ensure that the staff are on proper documenting the client's goals and he complete the document when a client's goal is r completed. The QIPM will en- the QIDP is retrained of thoroughly completing investigations on eloper QIDP will also ensure fe IDT's to ensure the clie being implemented to p potential neglect. Persons Responsible: Director, AED, Program Maintenance Manager, Assurance, Quality Ass Manager, QIDPM, Dire Nursing, Nurse, Area S QIDP, DSL, and DSP. DATE OF COMPLETIC 6/14/2024	e retrained of the all ow to ation on not met or sure that ments. The ollow-up nts plan is revent Executive n Manager, Quality urance ctor of upervisor,	
W 0122 Bldg. 00	clients. Therefor Based on record re failed to meet the 0 Protections for 2 o plus 2 additional c The facility failed surrogate to assist regarding informed	ensure the rights of all e the facility must view and interview the facility Condition of Participation: Client f 2 sampled clients (A and B),	W 0122	Unannounced ran observations began at 1 on 6/6/2024 to ensure p being implemented by s Weekday daily observa remain in effect for 60 o 60 days monthly, admir observations will be con The management	he Facility blans are staff. tions will lays. After histrative nducted.	06/14/2024

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 05/23/2024 15G746 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16609 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE violation of individual's rights policy to ensure the began daily update meetings on effective implementation of clients B and C's 6/6/2024, to ensure compliance behavior plans to prevent elopement and to and implement changes needed prevent client to client aggression regarding developing a plan and clients A, B, C and D, to thoroughly investigate implementation of those changes. incidents of elopement to rule out potential Meetings will continue until neglect for the implementation of client B's conditions are lifted. program plans and to develop and implement Members of the effective corrective measures to prevent administrative team, including recurrence of clients B and C's elopement and peer managers from Quality, Nursing to peer aggression behaviors. and Programming, will conduct daily observations on weekdays. Findings include: Any issues will be immediately reported to the Facility Team. 1. The facility failed to ensure client A had a The Facility Maintenance surrogate to assist him to make decisions Manger will inspect the site once regarding informed consent. Please see W125. weekly at a minimum to identify environmental issue that may 2. The facility failed to implement the abuse, arise. neglect, exploitation, mistreatment and/or Facility Staff will monitor violation of individual's rights (ANE) policy to home activities and client ensure the effective implementation of clients B interactions daily to ensure there and C's behavior plans to prevent elopement and is plans are followed if an issue is to prevent client to client aggression regarding noted the appropriate clients A, B, C and D. Please see W149. administrative personnel i.e. Area Supervisor, Program Manager, 3. The facility failed to thoroughly investigate Nurse, QIDP or AED immediately incidents of elopement to rule out potential and correction will be made. The Behavior Consultant, neglect for the implementation of client B's program plans. Please see W154. Program Manager, Area Supervisor, Facility Nurse and 4. The facility failed to develop and implement QIDP will proactively monitor effective corrective measures to prevent clients to ensure plan recurrence of clients B and C's elopement and peer implementation. to peer aggression behaviors. Please see W157. The facility will ensure that client A will have someone to This federal tag relates to complaints #IN00429146 assist him in making decisions and #IN00428423. regarding informed consent. June 6, 2024 a Health Representative 9-3-2(a) agreed to be client A's HRC. U30Y11 Facility ID: 011664

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	F OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF PH	ROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP COD	
RES CAR	RES CARE SOUTHEAST INDIANA			SIMA GRAY RD YVILLE, IN 47126	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
				The facility will ensure the	at
				staff are retrained on the ANE	
				policy and the effective implementation of the policy to	
				prevent elopement and client to	
				client aggression between clien	
				A, B, C, and D.	
				The Program Manager a	nd
				Area Supervisor retrained staff	on,
				ANE (Abuse, Neglect, and	
				Exploitation) Policy disciplinary	
				action will be taken if the policy	
				not followed. Area Supervisor a will ensure that Policy is follow	
				and corrective measures are	eu,
				implemented. Monitoring of wil	lbe
				done by The Program Manage	
				Area Supervisor, and DSL to	
				ensure all compliance.	
				Staff will complete daily	
				perimeter checks to include	
				window, door, security system check, and gate operations.	
				System checks will be verified	by
				Area Supervisor, any deficienc	-
				will be reported the Program	
				Manager and ResCare	
				Maintenance Manager.	
				The IDT will meet to disc	uss
				positive reinforcements being	
				added to the BSP's. The BC w	/11
				update clients A, B, C and D's BSP's to reflect those changes	
				and the staff will be trained on	' I
				those changes.	
				The facility will ensure the	at
				the staff are retrained on prope	
				documenting of the all the clier	าť's
				goals and how to complete the	
				documentation on when a clier	nťs

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER 15G746	A. BUILDING B. WING	<u>00</u>	completed 05/23/2024
		100110			00/20/2021
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
RES CAF	RE SOUTHEAST II	NDIANA		SIMA GRAY RD YVILLE, IN 47126	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLET
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
				goal is not met or completed.	
				The facility will ensure that	at
				the BC updates the BSP's to	
				include or not to include the use	e of
				911 for emergency intervention	
				shoes being kept in the office d	
				to elopement issues and the 7	
				day, 24/72 hour safety protocol	for
				the removal of items from their	
				rooms.	
				The Facility will ensure th	at
				the QIDP is retrained on	
				thoroughly completing	
				investigations on elopements.	
				QIDP will also ensure follow-up	
				IDT's to ensure the clients plan	IS
				being implemented to prevent potential neglect.	
				The Area Supervisor will	
				ensure that the staff are retrain	ed
				on proper documenting of the a	
				the client's goals and how to	
				complete the documentation or	n
				when a client's goal is not met	
				completed.	
				The QIPM will ensure that	at
				the QIDP is retrained on	
				thoroughly completing	
				investigations on elopements.	
				QIDP will also ensure follow-up	
				IDT's to ensure the clients plan	is
				being implemented to prevent	
				potential neglect.	
				Persons Responsible: Executi	ve
				Director, AED, Program Manag	er,
				Maintenance Manager, Quality	
				Assurance, Quality Assurance	
				Manager, QIDPM, Director of	

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í		ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/23/2024	
AND PLAN	OF CORRECTION	identification number 15G746	A. BU B. WI	JILDING NG	00		
NAME OF I	PROVIDER OR SUPPLIE	R	_		ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD		
RES CAI	RE SOUTHEAST I	NDIANA			VILLE, IN 47126		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORREC	ſION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COPRIATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG			DATE
					Nursing, Nurse, Area Sup QIDP, DSL, and DSP. DATE OF COMPLETION 6/14/2024		
W 0125	483.420(a)(3) PROTECTION C	F CLIENTS RIGHTS					
Bldg. 00	The facility must clients. Therefor encourage individ rights as clients of citizens of the Ur	ensure the rights of all e, the facility must allow and dual clients to exercise their of the facility, and as ited States, including the aints, and the right to due					
	sampled clients (A client A had a surr	view and interview for 1 of 2), the facility failed to ensure ogate to assist him to make g informed consent.	W (0125	Unannounced rando observations began at the on 6/6/2024 to ensure pla being implemented by sta Weekday daily observatio remain in effect for 60 day 60 days monthly, adminis	e Facility ns are ff. ns will /s. After	06/14/2024
	AM. Client A's Int	vas reviewed on 5/15/24 at 10:33 erdisciplinary Diagnostic and (IDEC) Analysis form dated e following:			observations will be cond The management te began daily update meeti 6/6/2024, to ensure comp and implement changes r	eam ngs on liance	
		support in the home, [client A] supportive friendships or	ome, [client A] developing a plan and dships or implementation of tho Meetings will continued	developing a plan and implementation of those of Meetings will continue un conditions are lifted.	-		
		ust be supervised because he is al, social and financial			Members of the administrative team, inclu managers from Quality, N and Programming, will co	ursing	
	assistance for un his actions, proble	verbal prompting to physical iderstanding consequences of n solving and exercising good ting for himself"			daily observations on wee Any issues will be immed reported to the Facility Te The Facility Mainter	ekdays. ately am.	
		made to establish contact with			Manger will inspect the si weekly at a minimum to id	te once	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2024
NAME OF	PROVIDER OR SUPPLIE RE SOUTHEAST I SUMMARY (EACH DEFICIE REGULATORY C [client A's] adoptiv determine if furthe advocacy." Client A's 4/10/24 indicated client A informed consent in program needs. Client A's ISP (Inc 3/12/24 indicated c or HCR (Health C in making informe QIDP (Qualified I	DER OR SUPPLIER OUTHEAST INDIANA SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION ent A's] adoptive mother and guardian to ermine if further support may be needed for rocacy." ent A's 4/10/24 Informed Consent Assessment icated client A needed assistance in providing prmed consent regarding his medical and		ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD YVILLE, IN 47126 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) environmental issue that may arise. Facility Staff will monitor home activities and client interactions daily to ensure the is plans are followed if an issu noted the appropriate administrative personnel i.e. A Supervisor, Program Manager Nurse, QIDP or AED immedia and correction will be made. The Behavior Consultan Program Manager, Area Supervisor, Facility Nurse and QIDP will proactively monitor	05/23/2024 (X5) COMPLETION DATE ere e is vrea ; tely t,
	· · · · · ·	interviewed on 5/14/24 at 4:30 ed client A did not have a		clients to ensure plan implementation. The facility will ensure the client A will have someone to assist him in making decisions regarding informed consent. J 6, 2024 a Health Representati agreed to be client A's HRC. The facility will ensure the staff are retrained on the ANE policy and the effective implementation of the policy to prevent elopement and client to client aggression between clie A, B, C, and D. The Program Manager at Area Supervisor retrained staff ANE (Abuse, Neglect, and Exploitation) Policy disciplinant action will be taken if the polic not followed. Area Supervisor will ensure that Policy is follow and corrective measures are implemented. Monitoring of wi done by The Program Manager	s une ve nat nat o to o to o to o to o to y y y is and ved, II be

		IDENTIFICATION NUMBER 15G746	A. BUILDING <u>00</u> B. WING STREET ADDRESS, CITY, STATE, ZIP CO		(X3) DATE SURVEY COMPLETED 05/23/2024	
RES CAR	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
RES CAR						
	ES CARE SOUTHEAST INDIANA		HENR	YVILLE, IN 47126		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	ί.	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				Area Supervisor, and DSL to		
				ensure all compliance.		
				Staff will complete daily		
				perimeter checks to include		
				window, door, security system		
				check, and gate operations.	by	
				System checks will be verified Area Supervisor, any deficient	-	
				will be reported the Program	500	
				Manager and ResCare		
				Maintenance Manager.		
				The IDT will meet to disc	cuss	
				positive reinforcements being		
				added to the BSP's. The BC	will	
				update clients A, B, C and D's		
				BSP's to reflect those changes	s	
				and the staff will be trained on		
				those changes.		
				The facility will ensure th		
				the staff are retrained on prop		
				documenting of the all the clie		
				goals and how to complete the		
				documentation on when a clie goal is not met or completed.	nis	
				The facility will ensure th	at	
				the BC updates the BSP's to		
				include or not to include the us	se of	
				911 for emergency interventio		
				shoes being kept in the office		
				to elopement issues and the 7		
				day, 24/72 hour safety protoco	ol for	
				the removal of items from their	r	
				rooms.		
				The Facility will ensure the	hat	
				the QIDP is retrained on		
				thoroughly completing	The	
				investigations on elopements.		
				QIDP will also ensure follow-u		
				IDT's to ensure the clients plat being implemented to prevent		

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD		
RES CA	RE SOUTHEAST I	NDIANA		YVILLE, IN 47126		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE	
				potential neglect. The Area Supervisor will ensure that the staff are retrain on proper documenting of the the client's goals and how to complete the documentation of when a client's goal is not me completed. The QIPM will ensure the the QIDP is retrained on thoroughly completing investigations on elopements QIDP will also ensure follow-u IDT's to ensure the clients plat being implemented to prevent potential neglect. Persons Responsible : Execu Director, AED, Program Mana Maintenance Manager, Quality Assurance, Quality Assurance Manager, QIDPM, Director of Nursing, Nurse, Area Supervi QIDP, DSL, and DSP. DATE OF COMPLETION: 6/14/2024	Il ined all on it or hat . The up an is t t utive ager, ty e	
W 0149 Bldg. 00	The facility must written policies a	ENT OF CLIENTS develop and implement nd procedures that prohibit glect or abuse of the client.				
	Based on record re sampled clients (A clients (C and D), the abuse, neglect, and/or violation of policy to ensure th	view and interview for 2 of 2 and B), plus 2 additional the facility failed to implement exploitation, mistreatment findividual's rights (ANE) e effective implementation of ehavior plans to prevent	W 0149	Unannounced random of observations began at the Fa on 6/6/2024 to ensure plans a being implemented by staff. Weekday daily observations of remain in effect for 60 days. A 60 days monthly, administrati	cility are vill After	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	CAID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 05/23/2024
	PROVIDER OR SUPPLIE		16609	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD YVILLE, IN 47126	
X4) ID PREFIX	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	· · ·	prevent client to client		observations will be conduc	
	aggression regardi	ng clients A, B, C and D.		The management tea	
				began daily update meeting	
	Findings include:			6/6/2024, to ensure complia	
				and implement changes ne	eded
		u of Disabilities Services) report		developing a plan and	
		/20/24 at 9:00 AM. The review		implementation of those ch	-
	indicated the follow	wing:		Meetings will continue until	
				conditions are lifted.	
	-	5/18/24 indicated, "[Client D]		Members of the	
	•	eremony on 5/17/24. [Client D]		administrative team, includ	-
	expressed that he would like for his housemate,			managers from Quality, Nu	•
		with staff, attended the ceremony, and returned to daily observations on w		and Programming, will con	
				-	
	the home around 9pm. Upon their arrival home,			Any issues will be immedia	-
	-	dications and went to their		reported to the Facility Tea	
	-	own. Their housemate, [client		The Facility Maintena	
		and was asking why his		Manger will inspect the site	
		on an outing and he couldn't		weekly at a minimum to ide	-
		ssed with [client C] that he had nunity earlier that day and		environmental issue that m	ay
		shopping for personal items		arise.	itor
		C] attempted to go towards		Facility Staff will mon home activities and client	llor
	-	m, staff used verbal redirection,		interactions daily to ensure	thoro
		nt C] began making threats		is plans are followed if an is	
	-	Staff utilized 2 person YSIS		noted the appropriate	SSUE IS
		afe- physical intervention		administrative personnel i.e	
		C] was able to get out of the		Supervisor, Program Mana	
		t D] in the face. Staff again		Nurse, QIDP or AED imme	-
		YSIS, with [client C], again,		and correction will be made	-
	getting out of the hold, making his way to the kitchen window, pulling on it and breaking it. Staff implemented 2 person YSIS and alerted staff on the other side of the home, who positioned			The Behavior Consul	
				Program Manager, Area	,
				Supervisor, Facility Nurse a	and
				QIDP will proactively monit	
		t of [client B's] bedroom door,		clients to ensure plan	
		C] from entering, as [client C]		implementation.	
		of the YSIS hold staff was		The facility will ensure	e that
		was making threats. Staff		client A will have someone	
		, he pushed staff out of the		assist him in making decisi	ons
		ting [client B]. Staff again		regarding informed consen	

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PRINTED: 06/26/2024 FORM APPROVED

Event ID: U3OY11 Facility ID: 011664

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	R MEDICARE & MEDI NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2024
	PROVIDER OR SUPPLIE		16609 \$	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD (VILLE, IN 47126	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION
	implemented 2 per hold, and exited th water sewer, near never losing sight. property, but not be assistance. Police home." And, "ResCare manager was sent for psych evaluated then tran and city] for treatr to the ER (Emerge sustained a nosebl noted, he was eval with orders to foll Physician), no new D] was evaluated abrasion and nose home with orders findings noted a cl contusion. Head tr individuals, staff r symptoms of cone nurse. The BC (Be (Qualified Intellec AS (Area Supervi- met at the site on 2 incident, review p as well as holding (meeting) to discu grievance (policy) individuals. A rev initiated. ResCare hospital and plan f C] has a BSP (Bel	ment was contacted, [client C] interviewed with both end on signs and ussion and when to contact charined on signs and user reviewed with both iew of the incident has been will maintain contact with for [client C's] discharge. [Client navior Support Plan) in place to YSIS and behaviors		6, 2024 a Health Represent agreed to be client A's HRC The facility will ensure staff are retrained on the All policy and the effective implementation of the policy prevent elopement and client client aggression between of A, B, C, and D. The Program Manage Area Supervisor retrained s ANE (Abuse, Neglect, and Exploitation) Policy disciplin action will be taken if the por not followed. Area Superviss will ensure that Policy is foll and corrective measures an implemented. Monitoring of done by The Program Mana Area Supervisor, and DSL t ensure all compliance. Staff will complete dai perimeter checks to include window, door, security syste check, and gate operations. System checks will be verifi Area Supervisor, any deficie will be reported the Program Manager and ResCare Maintenance Manager. The IDT will meet to d positive reinforcements bein added to the BSP's. The B update clients A, B, C and D BSP's to reflect those chang and the staff will be trained those changes. The facility will ensure the staff are retrained on pri documenting of the all the completed and the staff are retrained on pri documenting of the all the completed and the staff are retrained on pri documenting of the all the completed and the staff are retrained on pri documenting of the all the completed and the staff are retrained on pri documenting of the all the completed and the staff are retrained on pri documenting of the all the completed and the staff are retrained on pri documenting of the all the completed and the staff are retrained on pri documenting of the all the completed and the staff are retrained on pri documenting of the all the completed and the staff are retrained on pri documenting of the all the completed and the staff are retrained on pri documenting of the all the completed and the staff are retrained on pri documenting of the all the completed and the staff are retrained on pri documenting of the all the completed and the staff are retrained on pri documenting and the staff are retrained on pri documenting and the staff	tative 2. • that NE y to nt to clients er and taff on, hary plicy is for and lowed, re will be ager, to ily em fed by encies n liscuss n liscuss n liscuss n e that oper

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

Event ID: U3OY11 Facility ID: 011664

If continuation sheet Page 17 of 77

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CC	DNSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	DING	00	COMPL	ETED.
		15G746	B. WIN	G		05/23/2024	
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
BEO 0 4							
RES CA	RE SOUTHEAST I	NDIANA		HENRY	VILLE, IN 47126		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETI
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					goals and how to complete the	е	
		QAM (Quality Assurance Manager) provided additional documentation of client D's medical			documentation on when a clie	nťs	
				goal is not met or completed.			
	evaluations and cli			The facility will ensure the	nat		
	5/20/24 at 11:03 A			the BC updates the BSP's to			
		dated 5/18/24 was reviewed on			include or not to include the u		
		1. Client D's Medical			911 for emergency interventio		
		indicated he was seen at the			shoes being kept in the office		
		nent with the reason for the			to elopement issues and the 7		
		ult". The 5/18/24 Medical			day, 24/72 hour safety protoco		
		indicated client D sustained a			the removal of items from thei	r	
	closed head injur	y" and "chest contusion".			rooms.	hat	
	Client C's 5/18/24	IDT indicated the following:			The Facility will ensure t the QIDP is retrained on	nat	
	Chefit C \$ 5/16/24	ID I indicated the following.			thoroughly completing		
	-"Team Discussion	n: IDT team discussed			investigations on elopements.	The	
		ent for [client B] and [client D].			QIDP will also ensure follow-u		
		noted but head tracking to			IDT's to ensure the clients pla	•	
		reviewing Bill of Rights with			being implemented to prevent		
		ardian. Team discussed issues			potential neglect.		
	-	was discussed if he might be			The Area Supervisor wil	I	
		s and how to address that. [PM]			ensure that the staff are retrai		
	en-servicing (sic)	staff on doing checks on mouth			on proper documenting of the	all	
	following med's an	nd ensuring 8 ounces of water			the client's goals and how to		
	was provided at tin	ne of med pass to ensure			complete the documentation of	on	
	Ũ	ned's. Team discussed outings			when a client's goal is not me	t or	
	-	lient C] was not invited by			completed.		
		graduation. However, he had			The QIPM will ensure the	nat	
		ing that morning shopping			the QIDP is retrained on		
		sed how the use of YSIS was			thoroughly completing		
		ing this incident. [Client C] was			investigations on elopements.		
		and pushed staff to get past			QIDP will also ensure follow-u	-	
		t of two YSIS holds. It was			IDT's to ensure the clients pla		
		ent C] was reacting to the other			being implemented to prevent		
	-	attention from staff and he was			potential neglect.		
		ent D] but [client B]was. [Client					
	_	revious placement] along with			Demons Desmans little Fr	tive	
		C] had not completed the			Persons Responsible: Execu		
		t graduating. [Client C] had e arrival of other clients back to			Director, AED, Program Mana	-	
	been cann until the	anival of other chemis back to			Maintenance Manager, Qualit	у	

	R MEDICARE & MEDIC	I	-				MB NO. 0938-0	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	È É		ONSTRUCTION		(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		BUILDING	00		PLETED	
		15G746	В.	WING			3/2024	
NAME OF	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP C	COD		
	RE SOUTHEAST IN				SIMA GRAY RD /VILLE, IN 47126			
	1							
X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR		(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE		COMPLET	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	the home. [Client C			Assurance, Quality As				
	[highway] to sewer			Manager, QIDPM, Dire				
	house two (other ag			Nursing, Nurse, Area	Supervisor,			
	home) with staff for			QIDP, DSL, and DSP.				
	[Client D] and [clie			DATE OF COMPLETI	ON:			
		ations of injuries. [Client C]			6/14/2024			
	was transported to [
	to the police that he	wanted to kill himself."						
	1b. An initial review	w of the facility's BDS reports						
		was completed on $5/14/24$ at						
	•	w indicated the following:						
	-BDS report dated 3	3/15/24 indicated, "[Client C]						
	was upset because l	nis therapy session was						
		to his room, packed a bag then						
	ran out of the home							
	with staff following	g. [Client C] went to the creek,						
		of the group home. While in						
		fell, and sustained a ½ inch						
		[Client C] returned home, and						
	-	esulting in swelling to his						
	-	LPN (not specified) was						
		nt C] was transported to the						
	ER for evaluation o							
	And,							
	-"[Client C] was as	sessed, there were no broken						
		Client C] was discharged to					1	
		P in place to address the						
	behaviors."							
	10 BDS report date	ed 3/14/24 indicated, "[Client C]						
	-	playing catch when the ball hit						
		B] acted as if he was going to hit						
							1	
] then ran after [client B],					1	
		hrough staff and hit [client B]						
		s. Staff redirected both						
	individuals to calmi	ing areas."						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SUI COMPLET 05/23/20	ED	
	PROVIDER OR SUPPLI		STREET ADDRESS, CITY, STATE, ZIP COD 16609 SIMA GRAY RD				
RES CA	RES CARE SOUTHEAST INDIANA			/VILLE, IN 47126			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) OMPLETIO DATE	
	And,						
	,						
	"BSPs are in place	e to address the behaviors.					
	[Client B] sustaine	ed a ½ inch red mark on his back					
	and 1-inch red ma	rk on the back of his left arm. No					
	further injuries we	ere reported to have developed."					
	-The review did n	ot indicate documentation of an					
	investigation of th	e incident.					
	1d. BDS report da	ted 3/9/24 indicated, "Staff					
	reported [client C]] attempted to take something					
	that belonged to [client B]. [Client B] ran outside					
	and [client C] foll	owed him, along with staff.					
	[Client C] tackled	[client B] to the grass,					
	attempting to chol	ke him. Staff separated both					
	individuals. There	were no physical injuries					
	present, however,	[client B] was transported to					
	the ER for evaluat	tion to the aggression."					
	And,						
	"[Client B] was as	ssessed in the ER, with no					
	Ũ	discharged to home. [Client C]					
	-	e to address aggression. Staff					
		onitor and follow plans in place.					
		letermine if any changes are					
	needed."						
		ot indicate documentation of an					
	investigation of th	e incident.					
	-	ted 3/2/24 indicated, "Staff					
] was attempting to 'redirect'					
		ted as if he was going to hit					
		A] responded by hitting [client					
		d both individuals, [client C]					
	_	ran outside, to the highway,					
	then came back in	side where he began trying to					

TERS FO			-			OMB NO. 0938-03		
		X1) PROVIDER/SUPPLIER/CLIA			NSTRUCTION	· · ·	(X3) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	_	APLETED	
		15G746	B. WI	NG		05/	23/2024	
	PROVIDER OR SUPPLIEF		-	STREET A	ADDRESS, CITY, STATE, ZIP C	COD		
					SIMA GRAY RD			
RES CA	RE SOUTHEAST IN	IDIANA		HENRY	VILLE, IN 47126			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	COMPLET	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	-	ed the wall and office door.						
		was, again, used and [client C]						
	calmed and spoke v	vith staff."						
	And,							
	[Client C] sustaine	ed a 1/2-inch scratch on his						
	hand. [Client A] die	l not have any injuries. No						
		e observed. Both individuals						
		to address the behaviors.						
	Staff will continue	to follow plans in place."						
	-The review did not	indicate documentation of an						
	investigation of the							
		v of the facility's BDS reports						
	-	vas completed on 5/14/24 at						
	1:30 PM. The revie	w indicated the following:						
	-BDS report dated	3/18/24 indicated, "Staff						
	-	was prompted to complete his						
		gan yelling at staff, then ran						
		ved, [client B] made it to the						
	highway and contin	ued to walk, then began						
	throwing rocks at c	ars. Staff contacted police for						
	assistance with gett	ing [client B] home."						
	And,							
	"[Client B] returned	home with staff. [Client B] has						
	-	ldress the behaviors. Staff will						
	continue to follow j	olans."						
	2b. BDS report date	ed 3/8/24 indicated, "[Client B]						
	-	his housemate was going to						
		sn't. [Client B] left the home,						
		g. [Client B] returned to the site						
	without further repo	orted incidents."						
	And,							

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/23/2024 15G746 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16609 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE "[Client B] has a BSP in place to address the behavior. He was not out of line of sight of staff. There were no injuries as a result of this incident." 2c. BDS report dated 3/5/24 indicated, "It was reported [client B] became upset when he thought staff was talking about him and ran out the door going to [other agency home] with staff following. [Client B] was walked back to his house by staff and the [BC (Behavior Consultant)]. When [client B] returned, he began beating on the walls and door resulting the door breaking and chipping paint and dry wall from throwing a chair. Staff verbally redirected [client B] to his safe space for calming time. The nurse was notified." And, "Staff assessed [client B] for injuries with none being noted and notified administration of the property damage. Staff will continue to monitor [client B], following his plans in place, and notify his team of any changes. No further incidents have been reported."2d.) On 5/16/24 at 10:42 AM, a review of the facility's Bureau of Disabilities Services (BDS) reports and accompanying investigation summaries was conducted. The review indicated the following affecting clients B and C: BDS incident report dated 2/9/24 indicated, "It was reported [client B] eloped from the house and was immediately followed by staff. [Client B] crossed [highway] multiple times dodging in and out of traffic. Police were called to assist due to [client B] nearly getting hit by vehicles and refusing redirection from staff. Police arrived and [client B] returned to the home with staff and the officers left. [Client B] then began attempting to Event ID: U30Y11 Facility ID: 011664 Page 22 of 77 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G746 05/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16609 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE strangle himself using a cord and hitting and kicking at staff. Staff implemented 2-person YSIS (You're Safe, I'm Safe) hold for 30 seconds two times. [Client B] then opened his bedroom window and exited the home. Staff followed and maintained line of sight. Staff were able to implement 2- person YSIS and escort [client B] home. The police arrived again due to the window alarm being triggered when [client B] eloped. The nurse was notified. Plan to Resolve: [Client B] did not receive any signs of injury. Staff will continue to monitor [client B], following his plans in place which include 1:1 supervision and YSIS in his HRC (Human Rights Committee) approved behavior plan. Staff will notify [client B's] team of any changes. No further incidents have been reported ... ". No investigation was available for review. 2e.) BDS incident report dated 2/15/24 indicated, "It was reported [client B] eloped from his house and went to another site. Staff was able to gain control of [client B] and escort him back to his site. [Client B] then ran from staff onto [highway]. BC (Behavior Consultant) followed in her car and [client B] then ran in front of traffic. BC explained to [client B] he needed to get in the car or she would have to call the police. [Client B] got in the car and staff placed [client B] in a 2-person YSIS hold to his home and [client B] went into his room. Approximately 10 minutes later, [client B] eloped again from his house to another site. Staff were able to place [client B] in a 2-person YSIS hold and [client B] began fighting staff and dropped to the ground and started crawling around. Staff again placed [client B] in a 2-person YSIS hold and got [client B] in the van. [Client B] ran to the back of the van, grabbed a tire iron and began swinging it at staff. Staff were able to deflect U30Y11 Facility ID: 011664 Page 23 of 77 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULT A. BUILE B. WING		NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	PROVIDER OR SUPPLIE	ER			DDRESS, CITY, STATE, ZIP COD		
RES CA	RE SOUTHEAST I	NDIANA			IMA GRAY RD /ILLE, IN 47126		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO) BE	COMPLETIC
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	Т	AG	DEFICIENCY)		DATE
	[client B] and plac	e him in a 2-person YSIS seated					
	hold and transport	ed him back to his site. Once					
	[client B] arrived a	at his site, EMS was called and					
	transported [client	B] to the ER (emergency room)					
	for an evaluation.	Plan to Resolve: [Client B] was					
		R and admitted to [behavioral					
		for further treatment. ResCare					
		act with the hospital and plan for					
	discharge ".						
	No investigation v	vas available for review.					
	2f.) BDS incident	report dated 2/22/24 indicated,					
		atching TV (television) in the					
		his housemate [client A] stood					
	-	ient C] on the chin. [Client C]					
		out the side door to the patio					
		ng. [Client C] came back in with					
		his calming area. [Client C] was					
		e previous incident and began					
	_	suicide and went out the side					
	-	aff following and ran toward the					
	-	ne wanted to be hit by a car. The					
		to assist with traffic. EMS					
	-	orted [client C] to the ER for					
	evaluation. The nu	arse was notified. Plan to					
	Resolve: [client C] was evaluated in the ER and					
	admitted to [behav	vioral health facility #2] for					
	further evaluation	and treatment. ResCare will					
	maintain contact v	vith the hospital and plan for					
		A] did not show any signs of					
		comfort. Staff will continue to					
		the nurse of any changes".					
	Investigation sum	mary dated 3/19/24 indicated,					
	-	2/20/24, [client C] was watching					
		bom when his housemate [client					
	-	apped [client C] on the chin.					
		et, walked out the side door to					
		f following. [Client C] came back					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/23/2024			
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 16609 SIMA GRAY RD					
RES CA	RE SOUTHEAST I	INDIANA		VILLE, IN 47126				
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF	LD BE	(X5) COMPLETIC		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
	in with staff and w C] was still upset is began making three side door again wit toward the highwa by a car. The police traffic Summary of Interv Professional/DSP and was watching saw [client C] sit r him to move. He co reached up and hit C] got really mad followed and he w have a moment an go to his room and Then he got mad a going to be at [groo the rules. He was g going to hit him. T again. I followed I Lead/DSL]. We tr he was going to ru to [Behavioral Hez and [DSL] called I out in the middle co of it. The police ca road and he told th	rent to his calming area. [Client from the previous incident and aats of suicide and went out the th staff following and ran by voicing he wanted to be hit are were called to assist with views: [Direct Support #1] stated, 'I was in the kitchen over [client C] and [client A]. I ight next to [client A]. I asked lidn't listen. Then [client A] just [client C] on the chin. [Client and stomped out of the door. I as cursing and yelling. I let him d then I asked if he wanted to I calm. He went to his room. Igain and was saying he wasn't up home]. That he didn't like going to hurt anyone that was Chen he walked out of the house him and so did [Direct Support ied to talk to him. He was saying n into traffic and wanted to go alth Facility #1]. I followed him BC and cops due to him being of the road and not coming out ume to help get him out of the nem he was going to kill himself it to be inpatient at [Behavioral						
	Health Facility #1 police. The police to do. [DSL] told to the phone. Police to called EMS (emer transport to the ho to anything I said. [client B] ran and	J. He was screaming at the asked us what we wanted them hem she had the behaviorist on talked to behaviorist, and we gency medical services) for spital. He just wasn't listening It was almost like that day said he wanted to go to the ent to [Behavioral Health						

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 05/23/2024			
	PROVIDER OR SUPPLIE		16609	STREET ADDRESS, CITY, STATE, ZIP COD 16609 SIMA GRAY RD HENRYVILLE, IN 47126				
(X4) ID PREFIX		/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF	DULD BE	(X5) COMPLETIO		
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE		
	Facility #1]. I rem outside when all th	ember [client C] was standing nat happened'						
	got hit by [client A followed him out of in. [DSP #3] was of [DSP #1] talked to wanted to talk to [she would talk to H come right now. H door and headed fd stayed back, [DSP in my car to follow yelling. He was sa think he said he way mentioned [Behav the Area supervised the Hwy (highway by a car. I called th wasn't coming out The cops came and at them. I got on th what was happenin everyone he wante Facility #1]. He to himself. They call down and then we (evaluation). Not s he seems to want the Conclusion: It is s strategies were add (client A and clien Plans) and were in Recommendations	ubstantiated all behavior dressed in each individual's tt C's) BSPs (Behavior Support nplemented appropriately s: Staff will continue to work coping strategies to implement						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15G746 B. WING 05/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16609 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE On 5/16/24 at 11:34 AM, a focused review of client B's record was conducted. The review indicated the following: Behavior Support Plan (BSP) dated 11/30/23 indicated, "Target Behaviors:... Elopement; 0 occurrences each month for 3 months. Measured/Data Collection: Leaving the area with the intent to escape staff supervision at home or in community ... Client Specific Restrictions:... Limited Phone Use; Due to an increase in behaviors, including elopement, [client B] will be limited to speaking with his family ... twice per week at a scheduled date and time ... Supervision; Due to decrease in elopement, [client B] will be removed from 1:1 and placed on line of sight during waking hours. This is defined as staff being able to see him at all times, but they do not need to be in the same room ... Door and Window Alarms; Alarms are placed on bedroom windows, exterior doors and the kitchen door due to client risk of elopements and theft. These alarms notify staff of door or window opening and do not limit opening or other use... Reactive Procedures:... Elopement; -Verbally redirect him back to his side of the house. -Engage him in preferred activity with the staff in his area. -If he is attempting to leave an area, request that he go for a walk with staff and/or go to an area away from the source of what may be frustrating/bothering him. If he continues to attempt to leave or does leave, immediately follow Event ID: U30Y11 Facility ID: 011664 Page 27 of 77 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	x1) provider/supplier/clia identification number 15G746	(X2) MULTIPLE CC A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2024		
NAME OF PROVIDER OR SUPPLI		STREET ADDRESS, CITY, STATE, ZIP COD 16609 SIMA GRAY RD				
RES CARE SOUTHEAST	INDIANA	HENRY	/VILLE, IN 47126			
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPR(DEFICIENCY)) BE	(X5) COMPLETIC DATE	
 assigned area or a solve with him. -If he complies priving with him on what -If he does not coordinate (Area Supervisor) of the incident. -If while at the hord is walking in the priving with the one-persent of the behavior priving driveway, staff will block him of the behavior priving the staff will block him of the behavior priving the staff will block him of the behavior present behavior persents behavior persents behavior persents behavior persent physical with the one-persent behavior persent physical interdisciplinary of 12/6/23 indicated agitated due to hor ran out the back of group home with returned to his grow were reported Plan of Action: Stin place [Behavior Consult Disabilities Profemother [Client (with staff monitor idea and would lii conversations with a week, currently 	Team Meeting (IDT) dated , "On 12/4/23, [client B] became pusemate's behaviors. [Client B] loor and went to the neighboring staff following. [Client B] pup home with staff. No injuries taff will continue to follow plans tant] and [Qualified Intellectual ssional] have met w/ (with) his B] currently talks with mom daily pring) but not sure that is a good ke to limit his phone h his family and restrict to twice calls daily at 8 AM. [Client B] o go on home visit for the					

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/23/2024 15G746 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16609 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE dates/times and parameters if she does not answer and implement a phone log ... Believed he possibly has schizoaffective ([Director of Nursing] suggested getting gene testing to determine at next appt (appointment) and possibly having a medication adverse effect with the Halo (Haldol/ schizophrenia) injection monthly. Increase in behaviors as it gets closer to next dose, supposed to receive every 14 days. [Program Director] suggested a PRN (as needed) medication ". Interdisciplinary Team Meeting (IDT) dated 3/4/24 indicated, "Behavioral: Client's BSP addresses elopement with reactive strategies. Staff are often right next to client and he will move to go to his room and turn and run. Team has worked to monitor client at all times. However, it has been demonstrated that the more attention [client B] gets, the more he acts out ... Include any IDT Recommendations: ... [Client B] did not leave the property. [Client B] was never out of sight of staff. [Client B] was never in danger of harm to self or others. Staff were following his plan. Team moved [client B] to office side of home to provide added supervision and attention ... Team Discussion: Team reviewed a pattern of increased elopements on [client B's] part. Team has continued to meet to address these changes. We admitted a new client to the home and as of 3/1/24 (when) we transitioned a client out of [group home] and admitted another new client. This is an extreme amount of change for [client B] to deal with. We moved him on 3/1/24 from his old room to one on the side of the office. Team agrees that this will let him have the attention of the staff on that side of the home and separate him from Event ID: U30Y11 Facility ID: 011664 Page 29 of 77 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(\mathbf{x}_2)	MULTIPLE CO	ONSTRUCTION	(X3) DA	TE SURVEY
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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		BUILDING	00	_	
		15G746	В.	WING		05/	23/2024
NAME OF	PROVIDER OR SUPPLIE	2		STREET	ADDRESS, CITY, STATE, ZIP (COD	
					SIMA GRAY RD		
RES CA	RE SOUTHEAST IN	NDIANA		HENRY	YVILLE, IN 47126		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO	RECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE	COMPLETI
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ere they are on one-to-one					
	staffing and can't ad	ddress his issues as quickly".					
	On 5/16/24 at 1:40	PM, a focused review of client					
		ducted. The review indicated					
	the following:						
	Behavior Support F	Plan (BSP) dated 3/15/24					
		Behaviors: Elopement; 0					
	occurrences each m	-					
	Measured/Data Col	llection: Leaving the area with					
		staff supervision at home or					
	in community						
	Client Specific Res	trictions:					
	Alarms; Due to exc	essive elopement/leaving					
		e home, alarms will be placed					
	on all windows, kit	chen, pantry, office, bedroom					
	and exterior doors.	The restriction will be reviewed					
	quarterly						
	Reactive Procedure	es: Elopement;					
	-Verbally redirect h	nim back to his side of the					
	house.						
		ferred activity with the staff in					
	his area.						
		to leave an area, request that					
		th staff and/or go to an area					
	away from the sour	-					
	-	g him. If he continues to					
	_	does leave, immediately follow					
		o redirect him back to the					
	assigned area or an solve with him.	area where you can problem					
		vide abundant praise and work					
	with him on what is	-					
		ply, immediately notify the AS					
		and BC (Behavior Consultant)					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		COM	(X3) DATE SURVEY COMPLETED 05/23/2024	
	PROVIDER OR SUPPLIE		16609	ADDRESS, CITY, STATE, ZIP SIMA GRAY RD YVILLE, IN 47126	COD		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	is walking in the n staff will block hir -If the behavior pe driveway, staff will I'm Safe/Physical I with the one-perso behavior persists s two-person physic On 5/17/24 at 10:1 Director (PD) were were asked about t indication of an ad client B as a contri behavior such as e she was not a part stated, "I don't kno AM, the Nurse rev "I'm not aware of t (genetic testing)". had not experience Haldol and stated, inpatient stays". A was not there, but him from monthly act like that all the The Nurse was ask testing. The Nurse indication of client diagnosis or being "I think suspected. sometimes note thi	ne, he is attempting to leave and eighborhood or toward the road in from going that direction. rsists and he gets to the end of Il implement YSIS (You're Safe, Behavioral Intervention) starting in physical redirection. If the taff will implement the al redirection". 2 AM, the Nurse and Program e interviewed. The Nurse and PD the IDT meeting minutes verse reaction to medication for ibuting factor for increased lopement. The Nurse indicated of this team meeting and ow what that's about". At 10:17 riewed the IDT note and stated, this. [Client B] has not had Geno The Nurse indicated client B ed any adverse reaction to "Not to my knowledge, even t 10:21 AM, the PD stated, "I do remember saying switching to weekly (dosage). He does not time, maybe PRN (as needed)". ted if client B had the genetic stated, "No, I would have hiatrist) if I would have hiatrist) if I would have e was asked about the IDT's t B being schizoaffective as a speculative. The Nurse stated, [Behavior Clinician] will ings". The Nurse was asked if zoaffective disorder for client B d with client B's psychiatrist.					
		"Not that I know of. I did not out it. Let me look, maybe they					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		COM	(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP C	COD		
RES CA	RE SOUTHEAST I	NDIANA		YVILLE, IN 47126			
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	did. I'll have to loo	ok". At 10:27 AM, the PD was					
	asked about tracki	ng for the use of Haldol with					
	client B to gather	data concerning the suspected					
	increase in behavi	oral incidents. The PD indicated					
	the only tracking b	being completed was the usual					
		g and stated, "We just talked					
		t be increasing when he comes	1				
	-	AM, the Nurse stated, "That					
		o [behavioral health facility #1]					
	-	es Day $(2/14/24)$. He went out to					
		and staff was able to get him					
		The police came. He was					
		eatbelt. I felt he needed an eval					
	-	rent from the ER (emergency					
		ral health facility #1]. Going					
		from [behavioral health facility					
		attention seeking behaviors".					
	-	were asked if the IDT met to					
	review the dischar	for the modifications to client					
		The Nurse shook her head no					
	and the PD stated,	"No".					
	On 5/17/24 at 11:1	3 AM, the Behavior Consultant					
	(BC) was interview	wed. The BC was asked about	1				
	the implementation	n of clients B and C's positive	1				
	replacement strate	gies and staff implementation of	1				
	_	edures to prevent them from	1				
	elopement. The B	C stated, "Yeah, yep it's client					
		placement strategies). It's					
		t B) busy". The BC was asked					
		g out of bounds versus					
		w staff should interact when a	1				
	•	g redirection. The BC stated, "If	1				
		y can start the YSIS (You're	1				
		th him (client B), usually there					
		on, he would be redirectable					
		C was asked the definition	1				
		unds versus elopement. The BC	1				
	stated, "The differ	ence is off property. Intent to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		x1) provider/supplier/clia identification number 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		COM	X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	PROVIDER OR SUPPLIE	R		i address, city, state, zip SIMA GRAY RD	COD		
RES CA	RE SOUTHEAST I	NDIANA	HENR	YVILLE, IN 47126			
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIC	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	referring to client I "Both really. [Clie The BC was asked implementation of intervention YSIS BC stated, "The er will try to implement once less restrictive attempted should as the elopement of c "Yes. Sometimes t just put them into a many people woul client C during phy stated, "For him, h someone is in contr person is enough". were incidents whe implement the YS from elopement. T On 5/20/24 at 10:4 Manager (QAM) w asked about clients neglect. The QAM asked about staff in behavioral intervent the driveway to pri- stated, "I would sa written I would area is different the QAM was asked h picture for the num	BC was asked if she was B or client C. The BC stated, nt B] prefers to go to house #2". to define when staff the physical behavioral should be initiated by staff. The do of the driveway is where they ent YSIS". The BC was asked e interventions had been taff implement YSIS to prevent lients B and C. The BC stated, here is a need for a break, not a hold". The BC was asked how d be needed to safely support ysical intervention. The BC e tends to calm down when rol. My experience is one The BC was asked if there ere staff were unable to IS to prevent clients B and C he BC stated, "Yes sir". 6 AM, the Quality Assurance vas interviewed. The QAM was s being free from abuse and t stated, "Yes". The QAM was mplementation of the physical ntion using YSIS at the end of event elopement. The QAM y yes, if that's how the plan is say leaving to go to another an going to the highway". The er knowledge of an overall ober of times client B had eloped					
	across or near the years. The QAM in provide more feed abuse, neglect, exp	acing himself in danger on, highway for the past 3 to 4 ndicated she would review and back. The QAM indicated the ploitation, mistreatment and/or dual's rights (ANE) policy					

AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP COD		
				SIMA GRAY RD /VILLE, IN 47126		
RES CA	RE SOUTHEAST I	NDIANA		VILLE, IN 47 120		
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORREC		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	LD BE ROPRIATE	COMPLETIO
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	should be implement	ented at all times.				
	0 5/20/24 + 1.02					
		3 PM, the QAM indicated				
	-	nt B's elopement history which				
	-	vay as: 2021 - 5 elopements, f sight of him, 2022 - 3				1
		staff in line of sight of him, and				
	-	its, with staff in line of sight of				1
	-	of line of sight for 10 seconds.				
	min, i ne was out	of fine of sight for to seconds.				
	On 5/20/24 at 12:2	26 PM, a review of the undated				
		Support Needs (ESN)				
		uideline was conducted. The				
		"Consumers in an extensive				
		ill receive intensive assistance				
		natic behavior(s) and continued				
	-	o that they may ultimately live a				
		integrated life with the fewest				
	possible supports.	Individuals living in				
	residences under t	his category must be				
	supervised at all ti	mes and the staffing pattern at				
	full capacity shoul	d be a minimum of: three (3)				
	staff on the day sh	ift; three (3) staff on the				
	evening shift; and	two (2) staff on the night shift".				
	On 5/20/24 at 1:08	3 PM, the Assistant Executive				
		as interviewed. The AED was				
		ttern of elopement incidents				
	between clients B	and C and the indication from				
	interviews where	implementation of YSIS physical				
	behavioral interve	ntions to prevent clients B and				
		to the highway may not always				
		ED indicated communication				
		orcement had occurred and was				
		ortive to assist during				
	-	ts. The AED stated, "Nothing				
		ve talked about different ideas.				
		ase in elopement since March				1
		stments to meds (medications).				
	Maybe adding a fe	ence. They talked about [name				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/23/2024	
	PROVIDER OR SUPPLIE		16609	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD YVILLE, IN 47126		
	1					(10)
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETIO
IAU		DR LSC IDENTIFYING INFORMATION We don't have the capability to	IAG			DATE
	lock our doors. It's	s my understanding ESN can't . I may be wrong on that. One				
	onsiderations is	elopement for [name of				
	locked facility]	". The AED was asked if he				
	felt the level of	support needed for clients B				
	and C was a mo	ore secured and/or locked				
	facility to keep	them from eloping to the				
	highway. The A	ED stated, "I think it could				
		rial and error with the alarm				
	system. That's t	o keep people out". The				
	-	more follow up to review				
		's level of support and the				
		of the positive behavioral				
	-	vent elopements placing				
		dangerous situation on				
		highway was needed. The				
		the ANE policy should be				
		all times.On 5/20/24 at 3:24				
	-	f the 11/10/23 ANE policy				
		The review indicated the				
		Care staff actively advocate				
	-	id safety of all individuals				
	-	prohibits abuse, neglect,				
	-	istreatment, or violation of an				
	-	nts".This federal tag relates				
	-	IN00429146 and				
	#IN00428423.9					
/ 0154	483.420(d)(3)	(")				
		IENT OF CLIENTS				
Bldg. 00	-	have evidence that all				
		s are thoroughly investigated. eview and interview for 1 of 2	W 0154	Unannounced rando	om daily	06/14/202

DEPARTMENT OF HEALTH AND HUMAN SERVICES

NTERS FOI	R MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 05/23/2024
	PROVIDER OR SUPPLIE RE SOUTHEAST I		16609 S	ddress, city, state, zip cod SIMA GRAY RD VILLE, IN 47126	
(X4) ID	SUMMARY	Y STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	sampled clients (B	B), plus 1 additional client (C),		observations began at the Fa	acility
	the facility failed t	to thoroughly investigate		on 6/6/2024 to ensure plans	are
	incidents of eloper	ment to rule out potential		being implemented by staff.	
	neglect for the imp	plementation of client B's		Weekday daily observations	will
	program plans.			remain in effect for 60 days.	
				60 days monthly, administrat	
	Findings include:			observations will be conducted	
				The management team	
	1a. An review of t	he facility's BDS (Bureau of		began daily update meetings	
		es) reports and investigations		6/6/2024, to ensure compliar	
	was completed on	5/14/24 at 1:30 PM. The review		and implement changes need	
	indicated the follo	wing:		developing a plan and	
		0		implementation of those char	nges.
	-BDS report dated	3/9/24 indicated, "Staff reported		Meetings will continue until	0
	[client C] attempte	ed to take something that		conditions are lifted.	
	belonged to [client	t B]. [Client B] ran outside and		Members of the	
	[client C] followed	d him, along with staff. [Client C]		administrative team, including	q
	tackled [client B]	to the grass, attempting to choke		managers from Quality, Nurs	-
	him. Staff separate	ed both individuals. There were		and Programming, will condu	-
	no physical injurie	es present, however, [client B]		daily observations on weekda	
	was transported to	the ER (Emergency Room) for		Any issues will be immediate	-
	evaluation to the a			reported to the Facility Team	-
				The Facility Maintenan	ce
	And,			Manger will inspect the site of	
				weekly at a minimum to iden	
	"[Client B] was as	sessed in the ER, with no		environmental issue that may	-
	findings and was d	discharged to home. [Client C]		arise.	
	has a BSP in place	e to address aggression. Staff		Facility Staff will monito	or
	will continue to m	onitor and follow plans in place.		home activities and client	
	IDT will meet to d	letermine if any changes are		interactions daily to ensure the	nere
	needed."			is plans are followed if an iss	ue is
				noted the appropriate	
		ot indicate documentation of an		administrative personnel i.e.	Area
	investigation of the	e incident.		Supervisor, Program Manage	er,
				Nurse, QIDP or AED immedi	ately
	-	ted 3/2/24 indicated, "Staff		and correction will be made.	
		was attempting to 'redirect'		The Behavior Consulta	nt,
	[client A], then act	ted as if he was going to hit		Program Manager, Area	
	[client A]. [Client	A] responded by hitting [client		Supervisor, Facility Nurse an	d
	C]. Staff redirected	d both individuals, [client C]		QIDP will proactively monitor	.

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Event ID: U3OY11 Facility ID: 011664

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

EPARIMENT OF HEALTH AND HUMAN SERVICES						APPROVED 10. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SU	RVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLET	ED
		15G746	B. WING		05/23/20	24
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
				SIMA GRAY RD		
RES CA	RE SOUTHEAST II	NDIANA	HENR	YVILLE, IN 47126		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE C	OMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	-	ran outside, to the highway,		clients to ensure plan		
	then came back ins	side where he began trying to		implementation.		
	hit staff and punch	ed the wall and office door.		The facility will ensure	e that	
	Verbal redirection	was, again, used and [client C]		client A will have someone	to	
	calmed and spoke	with staff."		assist him in making decision	ons	
				regarding informed consent		
	And,			6, 2024 a Health Represent		
				agreed to be client A's HRC		
	"[Client C] sustain	ed a 1/2-inch scratch on his		The facility will ensure		
		id not have any injuries. No		staff are retrained on the Al		
		re observed. Both individuals		policy and the effective		
	-	e to address the behaviors.		implementation of the policy	/ to	
	· ·	to follow plans in place."		prevent elopement and clie		
		1 1		client aggression between o		
	-The review did no	ot indicate documentation of an		A, B, C, and D.		
	investigation of the			The Program Manage	er and	
	-	10:42 AM, a review of the		Area Supervisor retrained s		
		f Disabilities Services (BDS)		ANE (Abuse, Neglect, and	dan on,	
	-	panying investigation		Exploitation) Policy disciplin	an/	
		nducted. The review indicated		action will be taken if the po	-	
		cting clients B and C:		not followed. Area Supervis	-	
	the following affect	thing chemis D and C.		will ensure that Policy is fol		
	BDS incident ron	ort dated 2/9/24 indicated, "It		· · · ·		
	-	at B] eloped from the house and		and corrective measures an		
		followed by staff. [Client B]		implemented. Monitoring of		
	-			done by The Program Man	-	
		multiple times dodging in and		Area Supervisor, and DSL	.0	
		were called to assist due to		ensure all compliance.		
		etting hit by vehicles and		Staff will complete dat	-	
	-	n from staff. Police arrived and		perimeter checks to include		
		to the home with staff and the		window, door, security syst		
		nt B] then began attempting to		check, and gate operations		
		sing a cord and hitting and		System checks will be verif	-	
	-	aff implemented 2-person YSIS		Area Supervisor, any defici		
		Safe) hold for 30 seconds two		will be reported the Program	n	
		nen opened his bedroom window		Manager and ResCare		
		ne. Staff followed and		Maintenance Manager.		
		sight. Staff were able to		The IDT will meet to c		
		on YSIS and escort [client B]		positive reinforcements bein	ng	
	-	arrived again due to the window		added to the BSP's. The B	C will	
	1 1 1 1 4 4		1		- · · · · · · · · · · · · · · · · · · ·	

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alarm being triggered when [client B] eloped. The

Event ID:

U30Y11

Facility ID: 011664

If continuation sheet

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update clients A, B, C and D's

DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTEDS FOD MEDICADE & MEDICAID SEDVICES	

TOF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED
PROVIDER OR SUPPLIER			00	COMPLETED
	15G746	B. WING		
				05/23/2024
		STREET	ADDRESS, CITY, STATE, ZIP COD	
		16609	SIMA GRAY RD	
RE SOUTHEAST IN	IDIANA	HENR	YVILLE, IN 47126	
SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
nurse was notified.	Plan to Resolve: [Client B] did		BSP's to reflect those change	s
			and the staff will be trained or	n l
to monitor [client B], following his plans in place		those changes.	
which include 1:1 s	upervision and YSIS in his		The facility will ensure the	nat
HRC (Human Righ	ts Committee) approved		the staff are retrained on prop	er
behavior plan. Staff	will notify [client B's] team of		documenting of the all the clie	ent's
any changes. No fu	rther incidents have been		goals and how to complete th	e
reported ".			documentation on when a clie	ent's
			goal is not met or completed.	
No investigation wa	as available for review.		The facility will ensure the	nat
			the BC updates the BSP's to	
2b) BDS incident re	eport dated 2/15/24 indicated,		include or not to include the u	se of
"It was reported [cli	ient B] eloped from his house		911 for emergency intervention	ons,
and went to another	site. Staff were able to gain		shoes being kept in the office	due
control of [client B]	and escort him back to his		to elopement issues and the 7	7
site. [Client B] then	ran from staff onto [highway].		day, 24/72 hour safety protoc	ol for
BC (Behavior Cons	ultant) followed in her car and		the removal of items from the	r
[client B] then ran i	n front of traffic. BC explained		rooms.	
to [client B] he need	ded to get in the car, or she		The Facility will ensure t	hat
would have to call t	he police. [Client B] got in the		the QIDP is retrained on	
car and staff placed	[client B] in a 2-person YSIS		thoroughly completing	
hold to his home an	d [client B] went into his room.		investigations on elopements.	The
Approximately 10 r	ninutes later, [client B] eloped		QIDP will also ensure follow-u	ıр
again from his hous	e to another site. Staff were		IDT's to ensure the clients pla	n is
able to place [client	B] in a 2-person YSIS hold		being implemented to prevent	
and [client B] began	n fighting staff and dropped to		potential neglect.	
the ground and start	ted crawling around. Staff		The Area Supervisor wil	I
again placed [client	B] in a 2-person YSIS hold		ensure that the staff are retrai	ned
and got [client B] ir	n the van. [Client B] ran to the		on proper documenting of the	all
back of the van, gra	bbed a tire iron and began		the client's goals and how to	
swinging it at staff.	Staff were able to deflect		complete the documentation of	on
[client B] and place	him in a 2-person YSIS seated		when a client's goal is not me	t or
hold and transported	d him back to his site. Once		completed.	
[client B] arrived at	his site, EMS was called and		The QIPM will ensure the	nat
transported [client H	3] to the ER (emergency room)		the QIDP is retrained on	
for an evaluation. P	lan to Resolve: [Client B] was		thoroughly completing	
evaluated in the ER	and admitted to [behavioral			The
health facility #1] for	or further treatment. ResCare			
will maintain contact	ct with the hospital and plan for		IDT's to ensure the clients pla	n is
discharge ".			-	
	(EACH DEFICIEN REGULATORY OF nurse was notified. not receive any sign to monitor [client B which include 1:1 s HRC (Human Righ behavior plan. Staff any changes. No fur reported". No investigation wa 2b) BDS incident ra "It was reported [client B] site. [Client B] then BC (Behavior Cons [client B] then ran i to [client B] he need would have to call the car and staff placed hold to his home an Approximately 10 r again from his house able to place [client and [client B] began the ground and starf again placed [client and [client B] and placed hold and transported [client B] arrived att transported [client I] for an evaluation. P evaluated in the ER health facility #1] fo will maintain contait	No investigation was available for review. 2b) BDS incident report dated 2/15/24 indicated, "It was reported [client B] eloped from his house and went to another site. Staff were able to gain control of [client B] and escort him back to his site. [Client B] then ran from staff onto [highway]. BC (Behavior Consultant) followed in her car and [client B] then ran in front of traffic. BC explained to [client B] he needed to get in the car, or she would have to call the police. [Client B] got in the car and staff placed [client B] in a 2-person YSIS hold to his home and [client B] went into his room. Approximately 10 minutes later, [client B] eloped again from his house to another site. Staff were able to place [client B] in a 2-person YSIS hold and [client B] began fighting staff and dropped to the ground and started crawling around. Staff again placed [client B] in the van. [Client B] ran to the back of the van, grabbed a tire iron and began swinging it at staff. Staff were able to deflect [client B] and place him in a 2-person YSIS seated hold and transported him back to his site. Once [client B] and place him in a 2-person YSIS seated hold and transported him back to his site. Once [client B] arrived at his site, EMS was called and transported [client B] to the ER (emergency room) for an evaluation. Plan to Resolve: [Client B] was evaluated in the ER and admitted to [behavioral health facility #1] for further treatment. ResCare will maintain contact with the hospital and plan for discharge".	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATIONPREFIX TAGnurse was notified. Plan to Resolve: [Client B] did not receive any signs of injury. Staff will continue to monitor [client B], following his plans in place which include 1:1 supervision and YSIS in his HRC (Human Rights Committee) approved behavior plan. Staff will notify [client B's] team of any changes. No further incidents have been reported".No investigation was available for review.2b) BDS incident report dated 2/15/24 indicated, "It was reported [client B] eloped from his house and went to another site. Staff were able to gain control of [client B] and escort him back to his site. [Client B] then ran from staff onto [highway]. BC (Behavior Consultant) followed in her car and [client B] then ran in front of traffic. BC explained to [client B] hen call the police. [Client B] got in the car and staff placed [client B] in a 2-person YSIS hold to his home and [client B] went into his room. Approximately 10 minutes later, [client B] eloped again from his house to another site. Staff were able to place [client B] in a 2-person YSIS hold and [client B] in a 2-person YSIS hold and got [client B] in the van. [Client B] ran to the back of the van, grabbed a tire iron and began swinging it at staff. Staff were able to deflect [client B] and place him in a 2-person YSIS seated hold and transported him back to his site. Conce [client B] and place him in a 2-person YSIS seated hold and transported him back to his site. EMS was called and transported [client B] to the ER (emergency room) for an evaluation. Plan to Resolve: [Client B] was evaluated in the ER and admitted to [behavioral 	(EACH DEFICENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATIONPREFIX TAGCHRONE RADA OF CONSERVENCES OF THE APPROPRING TO THE APPROPRING THE APPROPRING TO THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE APPROPRING THE AP

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

Event ID: U3OY11 Facility ID: 011664

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	15G746			05/23/2024
NAME OF	PROVIDER OR SUPPLIE	R .		ADDRESS, CITY, STATE, ZIP COD	
RES CA	RE SOUTHEAST I	NDIANA		SIMA GRAY RD YVILLE, IN 47126	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE
	No investigation w	vas available for review.		potential neglect.	
	On 5/17/24 at 12:5	58 PM, a request for the		Persons Responsible: Execu	tive
		client B's elopement incident		Director, AED, Program Mana	
	-	made with the Program Director		Maintenance Manager, Qualit	-
		cated investigations for the		Assurance, Quality Assurance	
	-	ncident were not available for		Manager, QIDPM, Director of	
	review, but more f	ollow up would be provided.		Nursing, Nurse, Area Supervis QIDP, DSL, and DSP.	sor,
		31 AM, the Quality Assurance		DATE OF COMPLETION:	
		vas interviewed. The QAM was		6/14/2024	
		vestigations for the above			
		r client B. The QAM indicated a			
		n with the PD had occurred and			
	-	s for client B's elopement had			
	-	ce. The QAM was asked if			
	-	nt incidents above would			
		on to rule out any potential ure to implement client B's			
	-	e QAM stated, "We would			
		nent)". The QAM indicated she			
		o determine if investigations			
	-	provide for review. No			
	-	client B's incidents of			
	-	provided for review.			
	This federal tag re and #IN00428423	lates to complaints #IN00429146			
	9-3-2(a)				
W 0157	483.420(d)(4)				
D 11 65		ENT OF CLIENTS			
Bldg. 00	corrective action				
		eview and interview for 2 of 2	W 0157	Unannounced random d	
		and B), plus 2 additional		observations began at the Fac	-
		the facility failed to develop and		on 6/6/2024 to ensure plans a	re
	implement effectiv	e corrective measures to		being implemented by staff.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CO A. BUILDING B. WING	DISTRUCTION <u>00</u>	x3) date survey completed 05/23/2024
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA		16609 5	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD VILLE, IN 47126		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	prevent recurrence and peer to peer ag Findings include: 1a. A BDS (Burea was reviewed on 5 indicated the follo -BDS report dated had a graduation of expressed that he [client B] to attende with staff, attended the home around 9 they took their me bedrooms to lay de C], became upset, housemates were of attend. Staff discu accessed the comr spent the morning with staff. [Client [client D's] bedrood at which time [client towards [client D] (You're Safe I'm S technique), [client hold, and hit [client attempted 2 person getting out of the I kitchen window, p implemented 2 per the other side of th themselves in from to prevent [client C] was able to get ou implementing and followed [client C]	e of clients B and C's elopement ggression behaviors. u of Disabilities Services) report 5/20/24 at 9:00 AM. The review		Weekday daily observations will remain in effect for 60 days. Af 60 days monthly, administrative observations will be conducted The management team began daily update meetings of 6/6/2024, to ensure compliance and implement changes needed developing a plan and implementation of those chang Meetings will continue until conditions are lifted. Members of the administrative team, including managers from Quality, Nursin and Programming, will conduct daily observations on weekday Any issues will be immediately reported to the Facility Team. The Facility Maintenance Manger will inspect the site on weekly at a minimum to identify environmental issue that may arise. Facility Staff will monitor home activities and client interactions daily to ensure the is plans are followed if an issue noted the appropriate administrative personnel i.e. Af Supervisor, Program Manager, Nurse, QIDP or AED immediate and correction will be made. The Behavior Consultant Program Manager, Area Supervisor, Facility Nurse and QIDP will proactively monitor clients to ensure plan implementation. The facility will ensure the	II ter e . n e . g . g . g . g . g . g . g . g . g . g . g . g . . g . . g .

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

Event ID:

U3OY11 Facility ID: 011664

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PRINTED: 06/26/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	R MEDICARE & MEDIO NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 05/23/2024
	PROVIDER OR SUPPLIE		16609	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD YVILLE, IN 47126	-
X4) ID PREFIX	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	implemented 2 per hold, and exited th water sewer, near never losing sight. property, but not b assistance. Police a home." And, "ResCare manager was sent for psych evaluated then tran and city] for treatm to the ER (Emerge sustained a nosebl noted, he was eval with orders to folle Physician), no new D] was evaluated i abrasion and nosel home with orders a findings noted a cl contusion. Head tr individuals, staff r symptoms of conc nurse. The BC (Be (Qualified Intellec AS (Area Supervis met at the site on 2 incident, review pl as well as holding (meeting) to discu grievance (policy) individuals. A revi initiated. ResCare hospital and plan f C] has a BSP (Ber	R LSC IDENTIFYING INFORMATION rson YSIS, [client C] broke the he home. [Client C] walked to the [highway], with staff following, [Client C] returned to the herefore staff contacted police for arrived and [client C] returned ment was contacted, [client C] iatric evaluation, [client C] was hsferred to [psychiatric facility ment. [Client B] was transported ency Room) for evaluation, he eed with no further injuries uated and discharged to home ow up with PCP (Primary Care w diagnosis was given. [Client in the ER, he sustained a ½ inch bleed. He was discharged to to follow up with PCP, hospital osed head injury and chest acking was initiated for both etrained on signs and ussion and when to contact chavior Consultant), QIDP tual Disabilities Professional), sor) and PM (Program Manager) 5/18 (2024) to discuss the lans, and complete staff training an IDT (Interdisciplinary Team) ss the incident. Bill of rights and were reviewed with both iew of the incident has been will maintain contact with for [client C's] discharge. [Client navior Support Plan) in place to YSIS and behaviors	TAG	client A will have someone to assist him in making decisions regarding informed consent. J 6, 2024 a Health Representat agreed to be client A's HRC. The facility will ensure th staff are retrained on the ANE policy and the effective implementation of the policy to prevent elopement and client client aggression between clie A, B, C, and D. The Program Manager a Area Supervisor retrained stat ANE (Abuse, Neglect, and Exploitation) Policy disciplinar action will be taken if the polic not followed. Area Supervisor will ensure that Policy is follow and corrective measures are implemented. Monitoring of w done by The Program Manage Area Supervisor, and DSL to ensure all compliance. Staff will complete daily perimeter checks to include window, door, security system check, and gate operations. System checks will be verified Area Supervisor, any deficien will be reported the Program Manager and ResCare Maintenance Manager. The IDT will meet to disc positive reinforcements being added to the BSP's. The BC update clients A, B, C and D's BSP's to reflect those change and the staff will be trained on those changes.	June ive hat ive o to ents and ff on, y y y y y y is and ved, ill be er, n d by cies cuss will s s

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

Event ID:

U3OY11 Facility ID: 011664

If continuation sheet Page 41 of 77

TATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	CIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION			
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G746	A. BUILDING B. WING	00	COMPLETED 05/23/2024	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
AME OF	PROVIDER OR SUPPLIE	K	16609 \$	SIMA GRAY RD		
RES CA	RE SOUTHEAST II	NDIANA	HENRY	/VILLE, IN 47126		
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
REFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				The facility will ensure t		
		surance Manager) provided		the staff are retrained on pro		
		ntation of client D's medical		documenting of the all the cli		
		ent C's 5/18/24 IDT via email on		goals and how to complete th	ne	
		M. Client D's Medical		documentation on when a cli		
		dated 5/18/24 was reviewed on		goal is not met or completed.		
		I. Client D's Medical		The facility will ensure t	hat	
	Consultation form	indicated he was seen at the		the BC updates the BSP's to		
	emergency departm	nent with the reason for the		include or not to include the u	use of	
	visit listed as "assa	ult". The 5/18/24 Medical		911 for emergency intervention	ons,	
	Consultation form	indicated client D sustained a		shoes being kept in the office	due	
	"closed head injury	" and "chest contusion".		to elopement issues and the	7	
				day, 24/72 hour safety protoc	col for	
	Client C's 5/18/24	IDT indicated the following:		the removal of items from the	eir	
				rooms.		
	-"Team Discussion	: IDT team discussed		The Facility will ensure	that	
	outcomes of incide	ent for [client B] and [client D].		the QIDP is retrained on		
	No further issues n	oted but head tracking to		thoroughly completing		
	continue. [QIDP] r	eviewing Bill of Rights with		investigations on elopements	. The	
	both clients and gu	ardian. Team discussed issues		QIDP will also ensure follow-		
	with [client C]. It	was discussed if he might be		IDT's to ensure the clients pla	-	
	cheeking his med's	and how to address that. [PM]		being implemented to preven		
	en-servicing (sic) s	taff on doing checks on mouth		potential neglect.		
		d ensuring 8 ounces of water		The Area Supervisor w	ill	
		ne of med pass to ensure		ensure that the staff are retra		
	-	ned's. Team discussed outings		on proper documenting of the	e all	
	÷	lient C] was not invited by		the client's goals and how to		
	-	graduation. However, he had		complete the documentation	on	
		ing that morning shopping		when a client's goal is not me		
		sed how the use of YSIS was		completed.		
		ng this incident. [Client C] was		The QIPM will ensure t	hat	
		and pushed staff to get past		the QIDP is retrained on		
		t of two YSIS holds. It was		thoroughly completing		
		ent C] was reacting to the other		investigations on elopements	. The	
		attention from staff and he was		QIDP will also ensure follow-		
		nt D] but [client B]was. [Client		IDT's to ensure the clients pla		
		revious placement] along with		being implemented to preven		
	_	C] had not completed the		potential neglect.		
		t graduating. [Client C] had				
		e arrival of other clients back to				
		anity of other energies back to	1	1		

STATEMENT OF DEFICIENCE	ES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 00	· ,	ATE SURVEY OMPLETED	
AND FLAN OF CORRECTION	15G746	A. BOILDING 00 B. WING		05/23/2024		
NAME OF PROVIDER OR SUI	PLIER		ADDRESS, CITY, STATE, ZIP	P COD		
RES CARE SOUTHEA	ST INDIANA		SIMA GRAY RD YVILLE, IN 47126			
(X4) ID SUMM	IARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF C		(X5)	
	ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)		COMPLETIC DATE	
 [highway] to shouse two (oth home) with st. [Client D] and [hospital] for was transported to the police the police	ent C] left the home and ran across ewer plant and headed toward her agency owned operated group off following. Police were called. [client B] were transported to evaluations of injuries. [Client C] d to [hospital] due to having stated hat he wanted to kill himself." review of the facility's BDS reports tons was completed on 5/14/24 at review indicated the following: ated 3/15/24 indicated, "[Client C] ause his therapy session was vent to his room, packed a bag then home, with staff following. [Client creek, behind the property of the While in the creek, [client C] fell, and inch abrasion on his leg. [Client C] , and punched the wall, resulting in the R for evaluation of his as assessed, there were no broken ngs. [Client C] was discharged to a BSP in place to address the t dated 3/14/24 indicated, "[Client C] were playing catch when the ball hit ent B] acted as if he was going to hit ent C] then ran after [client B], way through staff and hit [client B] d arms. Staff redirected both		Persons Responsible Director, AED, Progra Maintenance Manage Assurance, Quality A Manager, QIDPM, Di Nursing, Nurse, Area QIDP, DSL, and DSF DATE OF COMPLET 6/14/2024	am Manager, er, Quality ssurance irector of a Supervisor, P.		

TERS FO	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-03			
	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G746	î î	JILDING	nstruction 00	СОМ	(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	PROVIDER OR SUPPLIEF	ł	_		ADDRESS, CITY, STATE, ZIP C SIMA GRAY RD	COD		
RES CA	RE SOUTHEAST IN	IDIANA			VILLE, IN 47126			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COF	RECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	HOULD BE APPROPRIATE	COMPLETI	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	And,							
	"BSPs are in place	to address the behaviors.						
		l a $\frac{1}{2}$ inch red mark on his back						
		t on the back of his left arm. No						
		e reported to have developed."						
	1d BDS report date	ed 3/9/24 indicated, "Staff						
	-	attempted to take something						
		ient B]. [Client B] ran outside						
		wed him, along with staff.						
		client B] to the grass,						
		him. Staff separated both						
		vere no physical injuries						
		client B] was transported to						
		on to the aggression."						
	And,							
	"[Client B] was ass	essed in the ER, with no						
	-	scharged to home. [Client C]						
	-	to address aggression. Staff						
		nitor and follow plans in place.						
		termine if any changes are						
	needed."							
	-	ed 3/2/24 indicated, "Staff						
		was attempting to 'redirect'						
		ed as if he was going to hit						
		A] responded by hitting [client						
		both individuals, [client C]						
	-	an outside, to the highway,						
		de where he began trying to						
		the wall and office door.						
	calmed and spoke v	vas, again, used and [client C] vith staff."						
	And,							

NTERS FO	R MEDICARE & MEDIC	(OMB NO. 0938-03					
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			COM	(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	PROVIDER OR SUPPLIER	-	STREET ADDRESS, CITY, STATE, ZIP COD			COD		
	RE SOUTHEAST IN				SIMA GRAY RD WILLE, IN 47126			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED(S DI AN OF CO	OBDECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETIC	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
		ed a 1/2-inch scratch on his						
		l not have any injuries. No						
		e observed. Both individuals						
	-	to address the behaviors.						
	Staff will continue	to follow plans in place."						
		v of the facility's BDS reports						
	-	was completed on 5/14/24 at w indicated the following:						
	reported [client B]	8/18/24 indicated, "Staff was prompted to complete his						
	outside. Staff follow	gan yelling at staff, then ran ved, [client B] made it to the ued to walk, then began						
	throwing rocks at ca	ars. Staff contacted police for ing [client B] home."						
	And,							
		l home with staff. [Client B] has ldress the behaviors. Staff will blans."						
	was upset because h the store, and he wa	ed 3/8/24 indicated, "[Client B] his housemate was going to asn't. [Client B] left the home, g. [Client B] returned to the site ported incidents."						
	And,							
	behavior. He was no	SP in place to address the ot out of line of sight of staff. ies as a result of this incident."						
	reported [client B] l staff was talking ab	ed 3/5/24 indicated, "It was became upset when he thought out him and ran out the door hey home] with staff following.						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/23/2024 15G746 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16609 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE [Client B] was walked back to his house by staff and the [BC (Behavior Consultant)]. When [client B] returned, he began beating on the walls and door resulting the door breaking and chipping paint and dry wall from throwing a chair. Staff verbally redirected [client B] to his safe space for calming time. The nurse was notified." And, "Staff assessed [client B] for injuries with none being noted and notified administration of the property damage. Staff will continue to monitor [client B], following his plans in place, and notify his team of any changes. No further incidents have been reported."On 5/16/24 at 10:42 AM, a review of the facility's Bureau of Disabilities Services (BDS) reports and accompanying investigation summaries was conducted. The review indicated the following affecting clients B and C: 2d.) BDS incident report dated 2/9/24 indicated, "It was reported [client B] eloped from the house and was immediately followed by staff. [Client B] crossed [highway] multiple times dodging in and out of traffic. Police were called to assist due to [client B] nearly getting hit by vehicles and refusing redirection from staff. Police arrived and [client B] returned to the home with staff and the officers left. [Client B] then began attempting to strangle himself using a cord and hitting and kicking at staff. Staff implemented 2-person YSIS (You're Safe, I'm Safe) hold for 30 seconds two times. [Client B] then opened his bedroom window and exited the home. Staff followed and maintained line of sight. Staff were able to implement 2- person YSIS and escort [client B] home. The police arrived again due to the window alarm being triggered when [client B] eloped. The Event ID: U30Y11 Facility ID: 011664 Page 46 of 77 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

06/26/2024

PRINTED:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G746		A. BUILDING B. WING	CONSTRUCTION 00	CON	(X3) DATE SURVEY COMPLETED 05/23/2024		
NAME OF PROVIDER OR SUPPLIER RES CARE SOUTHEAST INDIANA			STREET ADDRESS, CITY, STATE, ZIP COD 16609 SIMA GRAY RD HENRYVILLE, IN 47126				
(X4) ID PREFIX		' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE	(X5) COMPLETIO	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY		DATE	
	not receive any sig to monitor [client] which include 1:1 HRC (Human Rig behavior plan. Stat any changes. No fir reported". No investigation w 2e.) BDS incident "It was reported [client B] the site. [Client B] the Sc (Behavior Corr [client B] then ran to [client B] then ran to [client B] hen rea would have to call car and staff place hold to his home a Approximately 10 again from his hou able to place [clier and [client B] begat the ground and stat again placed [clier and got [client B] back of the van, gr swinging it at staff [client B] arrived a transported [client for an evaluation.] evaluated in the E] health facility #1]	. Plan to Resolve: [Client B] did gns of injury. Staff will continue B], following his plans in place supervision and YSIS in his hts Committee) approved ff will notify [client B's] team of arther incidents have been vas available for review. report dated 2/15/24 indicated, lient B] eloped from his house er site. Staff was able to gain B] and escort him back to his n ran from staff onto [highway]. Isultant) followed in her car and in front of traffic. BC explained eded to get in the car or she the police. [Client B] got in the d [client B] in a 2-person YSIS nd [client B] went into his room. minutes later, [client B] eloped use to another site. Staff were at B] in a 2-person YSIS hold an fighting staff and dropped to rted crawling around. Staff at B] in a 2-person YSIS hold in the van. [Client B] ran to the abbed a tire iron and began C. Staff were able to deflect e him in a 2-person YSIS seated ed him back to his site. Once at his site, EMS was called and B] to the ER (emergency room) Plan to Resolve: [Client B] was R and admitted to [behavioral for further treatment. ResCare act with the hospital and plan for					

		CDICARE & MEDICAID SERVICES F DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION					OMB NO. 0938-0 (X3) DATE SURVEY	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	ì í					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLETED		
		15G746	B. W	ING		05/	23/2024	
NAME OF	PROVIDER OR SUPPLIEF	-			DDRESS, CITY, STATE, ZIP	COD		
					SIMA GRAY RD			
RES CA	RE SOUTHEAST IN	IDIANA		HENRY	VILLE, IN 47126			
X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CO		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLET	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	No investigation wa	as available for review.						
	2f) BDS incident r	eport dated 2/22/24 indicated,						
		-						
	"[Client C] was watching TV (television) in the living room when his housemate [client A] stood							
	-	ent C] on the chin. [Client C]						
		ut the side door to the patio						
		g. [Client C] came back in with						
		s calming area. [Client C] was						
		previous incident and began						
	-	aicide and went out the side						
	-	ff following and ran toward the						
	-	wanted to be hit by a car. The						
		o assist with traffic. EMS						
	-	rted [client C] to the ER for						
	-	se was notified. Plan to						
		was evaluated in the ER and oral health facility #2] for						
	-	nd treatment. ResCare will						
		th the hospital and plan for						
		A] did not show any signs of omfort. Staff will continue to						
		the nurse of any changes".						
		the nurse of any changes						
	Investigation summ	ary dated 3/19/24 indicated,						
	"Introduction: On 2	/20/24, [client C] was watching						
	TV in the living roo	om when his housemate [client						
	A] stood up and sla	pped [client C] on the chin.						
	[Client C] got upset	, walked out the side door to						
	the patio with staff	following. [Client C] came back						
	_	ent to his calming area. [Client						
		om the previous incident and						
		ts of suicide and went out the						
		n staff following and ran						
		voicing he wanted to be hit						
		were called to assist with						
	traffic							
	Summary of Intervi	ews: [Direct Support						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	СОМ	(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	NAME OF PROVIDER OR SUPPLIER		STREET 16609	OD			
RES CA			HENR	YVILLE, IN 47126			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	COMPLETIC	
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE	
	Professional/DSP	#1] stated, 'I was in the kitchen					
	and was watching	over [client C] and [client A]. I					
	saw [client C] sit r	ight next to [client A]. I asked					
	him to move. He d	lidn't listen. Then [client A] just					
	reached up and hit	[client C] on the chin. [Client					
	-	and stomped out of the door. I	1				
		as cursing and yelling. I let him	1				
		d then I asked if he wanted to	1				
	go to his room and	l calm. He went to his room.					
	-	gain and was saying he wasn't					
	-	up home]. That he didn't like					
		going to hurt anyone that was					
		Then he walked out of the house					
		him and so did [Direct Support					
	-	ied to talk to him. He was saying					
		n into traffic and wanted to go					
		alth Facility #1]. I followed him					
		BC and cops due to him being					
		of the road and not coming out					
		ame to help get him out of the					
	-	hem he was going to kill himself					
		to be inpatient at [Behavioral					
]. He was screaming at the					
		asked us what we wanted them					
		hem she had the behaviorist on					
		alked to behaviorist, and we					
	-	gency medical services) for					
		spital. He just wasn't listening					
	-						
		It was almost like that day					
		said he wanted to go to the					
	-	ent to [Behavioral Health					
		ember [client C] was standing					
	outside when all th	hat happened					
	[DSL] stated 'I wa	as in the office when [client C]					
		A]. He got pretty upset. [DSP #1]					
		on the patio, and he came back					
		on [client C's] side of the home.	1				
		him, but he was mad. He	1				
			1				
	wanted to talk to	BC] she said when he calmed,	1			1	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ICTION	X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	PROVIDER OR SUPPLIE	R			SS, CITY, STATE, ZIP COD		
RES CA	RE SOUTHEAST I	NDIANA			GRAY RD E, IN 47126		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	X (E/	PROVIDER'S PLAN OF CORRECT ACH CORRECTIVE ACTION SHOUL SS-REFERENCED TO THE APPR	D BE	(X5) COMPLETIO
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG		DEFICIENCY)	OTRAL	DATE
	she would talk to l	nim. He said he wanted her to					
	come right now. H	le took off out of the garage					
	door and headed f	or the highway. [DSP #3]					
	stayed back, [DSP	#1] walked with him, and I got					
		v him. He was cursing and					
		ying something to [DSP #1]. I					
		as going to the hospital. He					
		ioral Health Facility #1]. I called					
	_	or and the BC. He went out into					
	· ·) and said he wanted to get hit					
		ne cops for help because he					
		of the Hwy for me or [DSP #1].					
	-	d he started yelling and cursing					
	-	the phone with BC and told her					
	-	ng and that he was telling					
		ed to go to [Behavioral Health					
	-	ld the cops he was going to kill					
		ed for EMS and [client C] calmed					
		nt to the hospital for psych eval					
		sure if he will get admitted but					
	he seems to want t	-					
	Conclusion: It is s	ubstantiated all behavior					
	strategies were add	dressed in each individual's					
	(client A and clien	t C's) BSPs (Behavior Support					
	Plans) and were in	nplemented appropriately					
	Recommendations	: Staff will continue to work					
		coping strategies to implement					
	in place of suicida						
		34 AM, a focused review of client					
	B's record was cor the following:	nducted. The review indicated					
		Plan (BSP) dated 11/30/23					
	-	Behaviors: Elopement; 0					
	occurrences each i	nonth for 3 months.					
	Measured/Data Co	ollection: Leaving the area with					
	the intent to escan	e staff supervision at home or	1				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15G746 B. WING 05/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16609 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE in community... Client Specific Restrictions:... Limited Phone Use; Due to an increase in behaviors, including elopement, [client B] will be limited to speaking with his family ... twice per week at a scheduled date and time ... Supervision; Due to decrease in elopement, [client B] will be removed from 1:1 and placed on line of sight during waking hours. This is defined as staff being able to see him at all times, but they do not need to be in the same room ... Door and Window Alarms; Alarms are placed on bedroom windows, exterior doors and the kitchen door due to client risk of elopements and theft. These alarms notify staff of door or window opening and do not limit opening or other use... Reactive Procedures:... Elopement; -Verbally redirect him back to his side of the house. -Engage him in preferred activity with the staff in his area. -If he is attempting to leave an area, request that he go for a walk with staff and/or go to an area away from the source of what may be frustrating/bothering him. If he continues to attempt to leave or does leave, immediately follow him and continue to redirect him back to the assigned area or an area where you can problem solve with him. -If he complies provide abundant praise and work with him on what is bothering him. -If he does not comply, immediately notify the AS (Area Supervisor) and BC (Behavior Consultant) of the incident. -If while at the home, he is attempting to leave and U30Y11 Event ID: Facility ID: 011664 Page 51 of 77 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

06/26/2024

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/23/2024 15G746 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16609 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE is walking in the neighborhood or toward the road staff will block him from going that direction. -If the behavior persists and he gets to the end of driveway, staff will implement YSIS (You're Safe, I'm Safe/Physical Behavioral Intervention) starting with the one-person physical redirection. If the behavior persists staff will implement the two-person physical redirection ... ". Interdisciplinary Team Meeting (IDT) dated 12/6/23 indicated, "On 12/4/23, [client B] became agitated due to housemate's behaviors. [Client B] ran out the back door and went to the neighboring group home with staff following. [Client B] returned to his group home with staff. No injuries were reported ... Plan of Action: Staff will continue to follow plans in place ... [Behavior Consultant] and [Qualified Intellectual Disabilities Professional] have met w/ (with) his mother ... [Client B] currently talks with mom daily (with staff monitoring) but not sure that is a good idea and would like to limit his phone conversations with his family and restrict to twice a week, currently calls daily at 8 AM. [Client B] will not be able to go on home visit for the holidays due to family issues... Limit calls to Mom to twice a week with specific dates/times and parameters if she does not answer and implement a phone log... Believed he possibly has schizoaffective ([Director of Nursing] suggested getting gene testing to determine at next appt (appointment) and possibly having a medication adverse effect with the Halo (Haldol/ schizophrenia) injection monthly. Increase in behaviors as it gets closer to Event ID: U30Y11 Facility ID: 011664 Page 52 of 77 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

06/26/2024

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING		(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP C SIMA GRAY RD	OD	
RES CA	RE SOUTHEAST I	NDIANA	HENRY	/VILLE, IN 47126		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	(X5) COMPLETIO
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
		ed to receive every 14 days.] suggested a PRN (as needed)				
	indicated, "Behavi	Feam Meeting (IDT) dated 3/4/24 foral: Client's BSP addresses active strategies. Staff are often				
	right next to client room and turn and	and he will move to go to his run. Team has worked to				
		ll times. However, it has been the more attention [client B] acts out				
	did not leave the p out of sight of staf danger of harm to following his plan	tecommendations: [Client B] property. [Client B] was never f. [Client B] was never in self or others. Staff were . Team moved [client B] to office ovide added supervision and				
	increased elopeme has continued to n We admitted a new 3/1/24 (when) we [group home] and This is an extreme to deal with. We n room to one on the that this will let hi on that side of the the new clients wh staffing and can't a On 5/16/24 at 1:40	Team reviewed a pattern of ents on [client B's] part. Team neet to address these changes. w client to the home and as of transitioned a client out of admitted another new client. a mount of change for [client B] noved him on 3/1/24 from his old e side of the office. Team agrees m have the attention of the staff home and separate him from here they are on one-to-one address his issues as quickly".				
	the following: Behavior Support	nducted. The review indicated Plan (BSP) dated 3/15/24 Behaviors: Elopement; 0				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15G746 B. WING 05/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16609 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE occurrences each month for 3 months. Measured/Data Collection: Leaving the area with the intent to escape staff supervision at home or in community... Client Specific Restrictions:... Alarms; Due to excessive elopement/leaving assigned area in the home, alarms will be placed on all windows, kitchen, pantry, office, bedroom and exterior doors. The restriction will be reviewed quarterly... Reactive Procedures:... Elopement; -Verbally redirect him back to his side of the house. -Engage him in preferred activity with the staff in his area. -If he is attempting to leave an area, request that he go for a walk with staff and/or go to an area away from the source of what may be frustrating/bothering him. If he continues to attempt to leave or does leave, immediately follow him and continue to redirect him back to the assigned area or an area where you can problem solve with him. -If he complies provide abundant praise and work with him on what is bothering him. -If he does not comply, immediately notify the AS (Area Supervisor) and BC (Behavior Consultant) of the incident. -If while at the home, he is attempting to leave and is walking in the neighborhood or toward the road staff will block him from going that direction. -If the behavior persists and he gets to the end of driveway, staff will implement YSIS (You're Safe, I'm Safe/Physical Behavioral Intervention) starting with the one-person physical redirection. If the behavior persists staff will implement the two-person physical redirection ... ". U30Y11 Event ID: Facility ID: 011664 Page 54 of 77 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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06/26/2024

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP COD MA GRAY RD		
RES CA	RE SOUTHEAST I	NDIANA			/ILLE, IN 47126		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	П		PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO) BE PRIATE	COMPLETIC
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	T.	AG	DEFICIENCY)		DATE
	On 5/17/24 at 10:1	2 AM, the Nurse and Program					
	Director (PD) wer	e interviewed. The Nurse and PD					
	were asked about	the IDT meeting minutes					
	indication of an ad	lverse reaction to medication for					
	client B as a contr	ibuting factor for increased					
		lopement. The Nurse indicated					
		of this team meeting and					
		ow what that's about". At 10:17					
	AM, the Nurse rev	viewed the IDT note and stated,					
	"I'm not aware of	this. [Client B] has not had Geno					
	(genetic testing)".	The Nurse indicated client B					
	had not experience	ed any adverse reaction to					
	Haldol and stated,	"Not to my knowledge, even					
	inpatient stays". A	t 10:21 AM, the PD stated, "I					
	was not there, but	do remember saying switching					
	him from monthly	to weekly (dosage). He does not					
	act like that all the	time, maybe PRN (as needed)".					
	The Nurse was asl	ted if client B had the genetic					
	testing. The Nurse	stated, "No, I would have					
	asked psych (psyc	hiatrist) if I would have					
	known". The Nurs	e was asked about the IDT's					
	indication of clien	t B being schizoaffective as a					
	diagnosis or being	speculative. The Nurse stated,					
	"I think suspected.	[Behavior Clinician] will					
	sometimes note th	ings". The Nurse was asked if					
	the suspected schi	zoaffective disorder for client B					
	-	d with client B's psychiatrist.					
	The Nurse stated,	"Not that I know of. I did not					
	talk with psych ab	out it. Let me look, maybe they					
		ok". At 10:27 AM, the PD was					
	asked about tracki	ng for the use of Haldol with					
		data concerning the suspected					
	-	oral incidents. The PD indicated					
	the only tracking b	being completed was the usual					
		g and stated, "We just talked					
		t be increasing when he comes					
		AM, the Nurse stated, "That					
		o [behavioral health facility #1]					
	-	es Day $(2/14/24)$. He went out to					

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLET		NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MUL A. BUIL B. WINC	DING	ISTRUCTION	(X3) DATE SURVEY COMPLETED 05/23/2024	
RES CARE SOUTHEAST INDIANA HENRYVILLE, IN 47128 (X4) ID SUMMARY STATEMENT OF DEFICIENCE PRETX TAG ID D REPUTE TAG D	NAME OF	NAME OF PROVIDER OR SUPPLIER						
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Taning to work once at the end of the arriveraging								
staff should implement YSIS to prevent the		-	-					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	PROVIDER OR SUPPLIE	R		t address, city, state, zip 9 SIMA GRAY RD	COD	
RES CA	RE SOUTHEAST I	NDIANA		RYVILLE, IN 47126		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	"Yes. Sometimes to just put them into many people woul client C during phy stated, "For him, h someone is in cont person is enough". incidents where sta the YSIS to prever elopement. The BC On 5/20/24 at 10:4 Manager (QAM) v asked about clients neglect. The QAM asked about staff i behavioral interver the driveway to pr stated, "I would sa written I would sa written I would sa is different than gc was asked her kno the number of time involved placing h near the highway ff QAM indicated sh more feedback. On 5/20/24 at 1:03 through email clie involved the highway with staff in line o elopements, with s 2023 - 8 elopement him, 1 he was out	ts B and C. The BC stated, here is a need for a break, not a hold". The BC was asked how d be needed to safely support ysical intervention. The BC e tends to calm down when rol. My experience is one The BC was asked about aff were unable to implement at clients B and C from C stated, "Yes sir". 6 AM, the Quality Assurance vas interviewed. The QAM was being free from abuse and t stated, "Yes". The QAM was mplementation of the physical ation using YSIS at the end of event elopement. The QAM y yes, if that's how the plan is say leaving to go to another area bing to the highway". The QAM weldge of an overall picture for es client B had eloped which imself in danger on, across or for the past 3 to 4 years. The e would review and provide				
	measures based or	to develop effective corrective the pattern of elopement lients B and C to a highway				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP (COD	
RES CA	RE SOUTHEAST I	NDIANA		YVILLE, IN 47126		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETIO
TAG	REGULATORY C	OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	and the lack of eff	ective positive behavioral				
	interventions to pr	event a pattern of elopement				
	-	Indicated through interviews				
		elopement in a manner in which				
	staff would not be	able to progress from least				
		restrictive interventions for the				
	-	YSIS physical behavioral				1
		prevent clients B and client C				
	-	cidents and/or reaching the				1
	highway.					
		3 PM, the Assistant Executive				
	Director (AED) wa	as interviewed. The AED was				
	asked about correc	ctive measure to address the				
	pattern of elopeme	ent incidents between clients B				
	and C and the indi	cation from interviews where				
	-	SIS physical behavioral				
	-	event clients B and C from				
		ighway may not always be				
	-) indicated communication with				
		nent had occurred and was				
		ortive to assist during				
	-	ts. The AED stated, "Nothing				
		ve talked about different ideas.				
		ase in elopement since March				
		stments to meds (medications).				
		ence. They talked about [name				
		We don't have the capability to				
		s my understanding ESN can't				
		. I may be wrong on that. One				1
	-	derations is elopement for [name ". The AED was asked if he felt				1
		t needed for clients B and C				1
		d and/or locked facility to keep				1
		to the highway. The AED				1
		ould be. We've had trial and				1
		m system. That's to keep people				1
		licated more follow up to review				1
		evel of support and the				1
		The positive behavioral				1
	implementation of	the positive behavioral				

PRINTED: 06/26/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G746	A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/23/2024	
	PROVIDER OR SUPPLI		1660	eet address, city, state, zip cod 09 SIMA GRAY RD NRYVILLE, IN 47126		
(X4) ID PREFIX TAG	(EACH DEFICII	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPP DEFICIENCY)	LD BE	(X5) COMPLETION DATE
W 0252 Bldg. 00	themselves in a danear the highway This federal tag #IN00429146 a 483.440(e)(1) PROGRAM DOO Data relative to a criteria specified plan objectives of measurable term Based on record of sampled clients (<i>A</i> ensure documenta goal attempts was Findings include: 1. Client A's reco 10:33 AM. Client dated 3/12/24 ind training objective -"OBJECTIVE: W once a week with opportunities for -"DATA COLLE after [client A] pa and putting it awa -"OBJECTIVE: W purchase (by use one verbal promp months by 03-12- -"DATA COLLE weekends, and am	g relates to complaints and #IN00428423.9-3-2(a) CUMENTATION accomplishment of the l in client individual program must be documented in ns. eview and interview for 2 of 2 A and B), the facility failed to ation of client A and B's formal documented. rd was reviewed on 5/15/24 at A's ISP (Individual Support Plan) icated the following formal s: Will fold and put away his laundry one verbal prompt 95% of the 12 months by 03-12-2025." CTION: One (1) time per week rticipates in folding his laundry ty."	W 0252	Unannounced rando observations began at the on 6/6/2024 to ensure pla being implemented by sta Weekday daily observation remain in effect for 60 day 60 days monthly, administ observations will be cond The management the began daily update meeti 6/6/2024, to ensure comp and implement changes of developing a plan and implementation of those of Meetings will continue un conditions are lifted. Members of the administrative team, incluin managers from Quality, N and Programming, will co daily observations on weat Any issues will be immed reported to the Facility Te The Facility Mainter Manger will inspect the si weekly at a minimum to id environmental issue that arise. Facility Staff will mod	e Facility ins are aff. ons will ys. After trative ucted. eam ngs on bliance needed changes. til ding lursing nduct ekdays. iately eam. nance te once dentify may	06/14/202

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 15G746 B. WING 05/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16609 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE. IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE -"OBJECTIVE: Will read to staff from a book or home activities and client newspaper daily with one verbal prompt 75% of interactions daily to ensure there the opportunities for 12 months by 03-12-2025." is plans are followed if an issue is noted the appropriate -"DATA COLLECTION: One (1) time daily after administrative personnel i.e. Area [client A] correctly reads at least two (2) words Supervisor, Program Manager, during AM or PM shifts." Nurse, QIDP or AED immediately and correction will be made. -"OBJECTIVE: Will wipe off the table and put his The Behavior Consultant, dishes in the sink after dinner with two verbal Program Manager, Area prompts 100% of the opportunities for 12 months Supervisor, Facility Nurse and by 03-12-2024." QIDP will proactively monitor clients to ensure plan -"DATA COLLECTION: Daily During meal time." implementation. The facility will ensure that -"OBJECTIVE: Will get up nightly and use the client A will have someone to bathroom with 2 verbal prompts 90% of the assist him in making decisions opportunities for 12 months by 03-12-2024 (sic)." regarding informed consent. June 6, 2024 a Health Representative -"DATA COLLECTION: PM shift." agreed to be client A's HRC. The facility will ensure that -"OBJECTIVE: Will pour himself a cup of water staff are retrained on the ANE for med's, return cup to kitchen sink after med's policy and the effective with one verbal prompt 100% of the opportunities implementation of the policy to by 03-12-2024 (sic)." prevent elopement and client to client aggression between clients -"DATA COLLECTION: Daily when [client A] A, B, C, and D. applies (sic) his medication properly." The Program Manager and Area Supervisor retrained staff on, -"OBJECTIVE: While in public, [client A] will be ANE (Abuse, Neglect, and introduced to different activities, exercises and Exploitation) Policy disciplinary safe practices in the community with two verbal action will be taken if the policy is prompts 85% of opportunities for 12 months by not followed. Area Supervisor and 03-12-2024 (sic)." will ensure that Policy is followed, and corrective measures are -"DATA COLLECTION: Twice weekly while implemented. Monitoring of will be [client A] is on his outings." done by The Program Manager, Area Supervisor, and DSL to Client A's record did not indicate documentation ensure all compliance. of client A's goal attempts. Staff will complete daily

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

Event ID:

U30Y11

If continuation sheet

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Facility ID: 011664

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	06/26/2024
FORM API	PROVED
OMB NO. (938-039

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	· · · · · · · · · · · · · · · · · · ·	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G746	A. BUILDING B. WING	<u>00</u>	COMPLETED 05/23/2024	
	PROVIDER OR SUPPLIEF		16609	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD YVILLE, IN 47126		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
				perimeter checks to include		
		was reviewed on 5/15/24 at		window, door, security system		
	11:25 AM. Client E	s ISP dated 11/14/23 indicated		check, and gate operations.		
	the following forma	al training objectives:		System checks will be verified b	у	
				Area Supervisor, any deficienci	es	
		ll clean his room daily including		will be reported the Program		
	making his bed with	n no verbal prompts 100% of all		Manager and ResCare		
		s 12 consecutive months by		Maintenance Manager.		
	11/14/2024."			The IDT will meet to discu	ISS	
				positive reinforcements being		
	-"DATA COLLEC"	ΓΙΟΝ: Daily."		added to the BSP's. The BC w	ill	
		-	update clients A, B, C and D's			
				BSP's to reflect those changes		
	-"OBJECTIVE: Client will be able to identify wants versus needs when asking for items to be purchased utilizing cash, p-card, or online with			and the staff will be trained on		
				those changes.		
				The facility will ensure that	t	
	two verbal prompts 85% of the opportunities for	-		the staff are retrained on proper		
	12 months by 11.14			documenting of the all the client		
	12 months by 11.1	.20.		goals and how to complete the		
		TION: Weekly discussion with		documentation on when a client	Pe	
	staff."	TOW. Weekly discussion with		goal is not met or completed.		
	starr.			-	+	
	"ODIECTIVE, W	ll discuss with staff appropriate		The facility will ensure tha		
				the BC updates the BSP's to	f	
		inxiety/anger by practice self-		include or not to include the use		
		with no verbal prompts 90%		911 for emergency intervention		
	of the opportunities	for 12 months by 11/14/2024."		shoes being kept in the office d	ue	
		$\mathbf{FION}_{i} \cap \mathbf{a}_{i} (1) \neq \dots \neq \mathbf{a}_{i} (1) \neq \dots$		to elopement issues and the 7	for	
		TION: One (1) time daily, AM or		day, 24/72 hour safety protocol	IOF	
	PM shifts."			the removal of items from their		
				rooms.		
	-"OBJECTIVE: Will select a chore from			The Facility will ensure the	at	
	list without any verbal prompts 100% of the opportunities for 12 months by 11/14/2024." -"DATA COLLECTION: Daily."			the QIDP is retrained on		
				thoroughly completing		
				investigations on elopements.		
				QIDP will also ensure follow-up		
				IDT's to ensure the clients plan	is	
	-"OBJECTIVE: Will improve hygiene with two			being implemented to prevent		
		% of the opportunities for 12		potential neglect.		
	months by 11/14/20)24."		The Area Supervisor will		
monus by 11/17/2027.			ensure that the staff are retrained	he		

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Event ID:

U3OY11 Facility ID: 011664

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	Г OF HEALTH AND HU R MEDICARE & MEDIO						RM APPROVED IB NO. 0938-039
STATEMEN	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	ì í	JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF I	PROVIDER OR SUPPLIE	R	-		ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD		
RES CA	RE SOUTHEAST II	NDIANA			YVILLE, IN 47126		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION TION: Daily."		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY) on proper documenting of th	RIATE	(X5) COMPLETION DATE
	 -"OBJECTIVE: W medications, the puone verbal prompt opportunities by 11 -"DATA COLLEC -"OBJECTIVE: [C ways to maintain h by being able to co the support of staff months by 11/14/2 -"DATA COLLEC -"OBJECTIVE: W leisure activity of co 90% of opportuniti 11/14/2024." -"DATA COLLEC Client B's record d of client B's goal a QIDP (Qualified In Professional) was i AM. QIDP indicate attempts should be electronic record k clients A and B's g 	 iill learn the names of two urpose, and side effects with 100% accuracy at all 1/14/2024." CTION: Daily." Client B] will be able to identify is own safety out of the home ommunicate dangers of leaving 590% of opportunities for 12 024." CTION: Daily." ill choose and participate in a choice with one verbal prompt ies for 12 months by CTION: Daily." id not indicate documentation 			 bit proper documentating of the client's goals and how to complete the documentation when a client's goal is not m completed. The QIPM will ensure the QIDP is retrained on thoroughly completing investigations on elopements QIDP will also ensure follow-IDT's to ensure the clients plbeing implemented to prever potential neglect. Persons Responsible: Exect Director, AED, Program Mar Maintenance Manager, Quality Assurance Manager, Quality Assurance, Quality Assurance Manager, QIDPM, Director of Nursing, Nurse, Area Superv QIDP, DSL, and DSP. DATE OF COMPLETION: 6/14/2024 	on et or that s. The up an is nt cutive nager, ity ce	

U3OY11 Facility ID: 011664

011664 If

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION <u>00</u>	x3) date survey completed 05/23/2024
	PROVIDER OR SUPPLIE		16609	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD	
RES CA	RE SOUTHEAST I	NDIANA	HENR	YVILLE, IN 47126	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
N 0289 Bldg. 00	BEHAVIOR The use of system	PROPRIATE CLIENT			
	incorporated into program plan, in (4) and (5) of this				
	interview for 1 of 2 failed to ensure cli (BSP) included eff interventions, the r safety protocol for his bedroom, the ruse of 911 for eme Findings include: Observations were on 5/14/24 from 3: 5/15/14 from 6:45 was observed in th observation period while inside of the DSP (Direct Suppo client B's shoes fro medication admini	ion, record review and 2 sampled clients (B), the facility ent B's Behavioral Support Plan Fective positive behavioral restriction of a 24-to-72-hour the removal of all items within emoval of his shoes, and the regency interventions. • conducted at the group home :50 PM through 5:00 PM and on AM through 8:15 AM. Client B is home throughout the is and was not wearing shoes home. On 5/15/24 at 7:36 PM, ort Professional) #3 retrieved om the home's locked stration room and encouraged oses to assist with taking out the	W 0289	Unannounced random da observations began at the Faci on 6/6/2024 to ensure plans are being implemented by staff. Weekday daily observations wi remain in effect for 60 days. Aff 60 days monthly, administrative observations will be conducted The management team began daily update meetings o 6/6/2024, to ensure compliance and implement changes neede developing a plan and implementation of those chang Meetings will continue until conditions are lifted. Members of the administrative team, including managers from Quality, Nursing and Programming, will conduct daily observations on weekday Any issues will be immediately reported to the Facility Team.	lity e II ter e · n e d d es.
	Client B stated he house because "I h A BDS (Bureau of	Disabilities Services) report /20/24 at 9:00 AM. The review		The Facility Maintenance Manger will inspect the site one weekly at a minimum to identify environmental issue that may arise. Facility Staff will monitor home activities and client	ce /
	-BDS report dated	5/18/24 indicated, "[Client D]		interactions daily to ensure the is plans are followed if an issue	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE C A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 05/23/2024	
	PROVIDER OR SUPPLIE		16609	SIMA GRAY RD		
RES CA	RE SOUTHEAST II	NDIANA	HENR	YVILLE, IN 47126		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	,	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
TAG	1	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	-	eremony on 5/17/24. [Client D]		noted the appropriate		
	-	vould like for his housemate,		administrative personnel i.e. Are	ea	
		and watch. [Client B], along		Supervisor, Program Manager,		
		the ceremony, and returned to		Nurse, QIDP or AED immediate	зly	
		pm. Upon their arrival home,		and correction will be made.		
	-	dications and went to their own. Their housemate, [client		The Behavior Consultant,		
	-	and was asking why his		Program Manager, Area Supervisor, Facility Nurse and		
		on an outing and he couldn't		QIDP will proactively monitor		
		ssed with [client C] that he had		clients to ensure plan		
		nunity earlier that day and		implementation.		
		shopping for personal items		The facility will ensure that	ıt 🛛	
		C] attempted to go towards		client A will have someone to		
		m, staff used verbal redirection,		assist him in making decisions		
		nt C] began making threats		regarding informed consent. Ju	ne	
	-	Staff utilized 2 person YSIS		6, 2024 a Health Representative		
		afe- physical intervention		agreed to be client A's HRC.		
	technique), [client	C] was able to get out of the		The facility will ensure tha	ıt	
	hold, and hit [clien	t D] in the face. Staff again		staff are retrained on the ANE		
	attempted 2 person	YSIS, with [client C], again,		policy and the effective		
	getting out of the h	old, making his way to the		implementation of the policy to		
		ulling on it and breaking it. Staff		prevent elopement and client to	1	
		son YSIS and alerted staff on		client aggression between clien	ts	
		e home, who positioned		A, B, C, and D.		
		t of [client B's] bedroom door,		The Program Manager an		
		C] from entering, as [client C]		Area Supervisor retrained staff	on,	
	-	of the YSIS hold staff was		ANE (Abuse, Neglect, and		
		was making threats. Staff		Exploitation) Policy disciplinary		
		he pushed staff out of the		action will be taken if the policy		
		ting [client B]. Staff again		not followed. Area Supervisor a		
		son YSIS, [client C] broke the		will ensure that Policy is followe	¦d,	
		e home. [Client C] walked to the 'highway], with staff following,		and corrective measures are	ha	
		[Client C] returned to the		implemented. Monitoring of will		
		efore staff contacted police for		done by The Program Manager Area Supervisor, and DSL to	,	
		arrived and [client C] returned		ensure all compliance.		
	home."	arrived and [enent C] returned		Staff will complete daily		
	nome.			perimeter checks to include		
	An initial review o	f the facility's BDS reports and		window, door, security system		
		completed on $5/14/24$ at 1:30		check, and gate operations.		
	in congations was		1			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>00</u>	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 05/23/2024
	PROVIDER OR SUPPLIE		16609	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD YVILLE, IN 47126	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
TAG	PM. The review in -BDS report dated reported [client B] daily chores. He be outside. Staff follo highway and contin throwing rocks at c assistance with get 5/16/24 at 10:42 A Bureau of Disabilit accompanying invo conducted. The rev affecting client B: -BDS incident repor was reported [client was immediately for crossed [highway] out of traffic. Polic [client B] nearly ger refusing redirection [client B] returned officers left. [Client strangle himself uskicking at staff. Stat (You're Safe, I'm S times. [Client B] the and exited the hommination of implement 2- person home. The police and alarm being trigger nurse was notified. not receive any sign to monitor [client F] which include 1:1 staff. Staff. Staff. (Human Right behavior plan. Staff. Staff.	R LSC IDENTIFYING INFORMATION dicated the following: 3/18/24 indicated, "Staff was prompted to complete his egan yelling at staff, then ran wed, [client B] made it to the nued to walk, then began ears. Staff contacted police for ting [client B] home."On M, a review of the facility's cless Services (BDS) reports and estigation summaries was riew indicated the following ort dated 2/9/24 indicated, "It tt B] eloped from the house and bollowed by staff. [Client B] multiple times dodging in and e were called to assist due to etting hit by vehicles and n from staff. Police arrived and to the home with staff and the tt B] then began attempting to ing a cord and hitting and aff implemented 2-person YSIS afe) hold for 30 seconds two nen opened his bedroom window e. Staff followed and sight. Staff were able to on YSIS and escort [client B] mrived again due to the window red when [client B] eloped. The Plan to Resolve: [Client B] did ns of injury. Staff will continue B], following his plans in place supervision and YSIS in his nts Committee) approved f will notify [client B's] team of urther incidents have been	TAG	System checks will be verified Area Supervisor, any deficience will be reported the Program Manager and ResCare Maintenance Manager. The IDT will meet to disci- positive reinforcements being added to the BSP's. The BC w update clients A, B, C and D's BSP's to reflect those changes and the staff will be trained on those changes. The facility will ensure that the staff are retrained on proper documenting of the all the clien goals and how to complete the documentation on when a clien goal is not met or completed. The facility will ensure that the BC updates the BSP's to include or not to include the us 911 for emergency intervention shoes being kept in the office of to elopement issues and the 7 day, 24/72 hour safety protoco the removal of items from their rooms. The Facility will ensure the the QIDP is retrained on thoroughly completing investigations on elopements. QIDP will also ensure follow-up IDT's to ensure the clients plan being implemented to prevent potential neglect. The Area Supervisor will ensure that the staff are retrain on proper documenting of the a the client's goals and how to complete the documentation on	uss vill at er at er at s at e of as, due l for hat The on is hed all

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Event ID:

U3OY11 Facility ID: 011664

If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2024	
	PROVIDER OR SUPPLIE		16609	STREET ADDRESS, CITY, STATE, ZIP COD 16609 SIMA GRAY RD		
RES CA (X4) ID PREFIX TAG	(EACH DEFICIE REGULATORY OF reported". -BDS incident rep was reported [client went to another site of [client B] and e B] then ran from s (Behavior Consult [client B] then ran to [client B] hen ran to [client B] hen nea would have to call car and staff place hold to his home a Approximately 10 again from his hou able to place [client and [client B] bega the ground and stat again placed [client	A STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION ort dated 2/15/24 indicated, "It int B] eloped from his house and ite. Staff was able to gain control scort him back to his site. [Client taff onto [highway]. BC ant) followed in her car and in front of traffic. BC explained eded to get in the car, or she the police. [Client B] got in the d [client B] in a 2-person YSIS and [client B] went into his room. minutes later, [client B] eloped use to another site. Staff were ant fighting staff and dropped to rted crawling around. Staff at B] in a 2-person YSIS hold	ID PREFIX TAG	YVILLE, IN 47126 PROVIDERS PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) when a client's goal is no completed. The QIPM will ense the QIDP is retrained on thoroughly completing investigations on elopen QIDP will also ensure fo IDT's to ensure the clien being implemented to pr potential neglect. Persons Responsible: If Director, AED, Program Maintenance Manager, O Assurance, Quality Assu Manager, QIDPM, Direc Nursing, Nurse, Area Su QIDP, DSL, and DSP.	ULD BE PROPRIATE ot met or sure that hents. The llow-up its plan is revent Executive Manager, Quality irance tor of ipervisor,	(X5) COMPLETIO DATE
	 back of the van, gr swinging it at staff [client B] and place hold and transport [client B] arrived a medical services) B] to the ER (eme Plan to Resolve: [4 ER and admitted t for further treatme contact with the hold discharge". On 5/16/24 at 11:3 B's record was con the following: Behavior Support 	On 5/16/24 at 11:34 AM, a focused review of client B's record was conducted. The review indicated he following: Behavior Support Plan (BSP) dated 11/30/23 ndicated, "Target Behaviors: Elopement; 0		DATE OF COMPLETION 6/14/2024	Ν.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 15G746 B. WING 05/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16609 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Measured/Data Collection: Leaving the area with the intent to escape staff supervision at home or in community ... Client Specific Restrictions:... Limited Phone Use; Due to an increase in behaviors, including elopement, [client B] will be limited to speaking with his family ... twice per week at a scheduled date and time ... Supervision; Due to decrease in elopement, [client B] will be removed from 1:1 and placed on line of sight during waking hours. This is defined as staff being able to see him at all times, but they do not need to be in the same room ... Door and Window Alarms; Alarms are placed on bedroom windows, exterior doors and the kitchen door due to client risk of elopements... These alarms notify staff of door or window opening and do not limit opening or other use ... Preventative Procedures: -Do not be bossy with [client B]- ask don't tell... -Keep him busy... -Always utilize redirection before physical redirection. YSIS physical intervention aspects should be used only when there is imminent threat or danger to others. Otherwise, physical intervention will only escalate behaviors... -Always allow for choices and give him options with literal phrasing (not joking or sarcastic)... -It is best to redirect [client B] in a non-confrontational manner and not in front of his peers... -Allow [client B] to help with chores around the house as much as possible ... -Use positive statements... -Do not make promises to him or tell him "NO", if Event ID: U30Y11 Facility ID: 011664 Page 67 of 77 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP CC SIMA GRAY RD	DD	
RES CA	RE SOUTHEAST I	NDIANA		YVILLE, IN 47126		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORR		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF	OULD BE PROPRIATE	COMPLETIC
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	-	mething that you are unsure				
		et him know that you will look				
	into it. Ask the RN	A (Residential Manager, Q				
	(Qualified Intellec	tual Disabilities Professional), or				
	BC (Behavior Cor	nsultant). If you do have an item				
	that he is requesting	ng, let him know when he can				
	have it. Always fo	llow through with that you are				
	telling him					
	-Do not engage in	horse play or sarcasm				
	-Provide abundant	specific praise (That is great				
	how you INSERT	ACTIVITY so nicely)				
	-Allow daily alone	e time in his room				
		if an appointment or activity is				
	coming up to avoi					
	-Maintain persona	-				
	-	to be getting agitated, as				
		ng trouble expressing his				
		ge in his demeanor: Explain to				
	-	isten to what he has to say as				
		nmunicate without yelling,				
	cursing, or making					
		gather his thoughts and				
		you and give him opportunities				
	to express himself					
	-	n solve the problem and verbally				
	praise him for spea	aking appropriately and				
	waiting					
	-	ughout the day to use an				
		f voice and appropriate				
	personal space					
		e basic role play when teaching				
	him new tasks	1, 5, 6				
		essary due to limited cognitive				
	-	y to retain information				
	-	time to respond to questions.				
		ask him the same questions in				
		r demand him to respond				
	-	r that physical redirection is the				
	last resort techniqu					
	-	nonverbals (arms crossed in				
	-De aware of your	nonverbais (anns crossed m				

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/23/2024	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP C 16609 SIMA GRAY RD		D	
RES CA	RE SOUTHEAST I	NDIANA	HENRY	/VILLE, IN 47126		
(X4) ID PREFIX	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETIO
TAG		OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	before it escalates Property Destructi	ve or Redirect the problem to Physical Aggression or on ower struggle with him				
	Reactive Procedur -Verbally redirect house -Engage him in pr his area -If he is attempting he go for a walk w away from the sou frustrating/botheri attempt to leave on him and continuer assigned area or an solve with him -If he complies pro- with him on what -If he does not cor (Area Supervisor) of the incident -If while at the hou is walking in the no staff will block hin -If the behavior per driveway, staff wi I'm Safe/Physical with the one-person behavior persists s two-person physical Interdisciplinary T 12/6/23 indicated, agitated due to hou ran out the back do group home with s	es: Elopement; him back to his side of the eferred activity with the staff in g to leave an area, request that vith staff and/or go to an area arce of what may be ng him. If he continues to r does leave, immediately follow to redirect him back to the n area where you can problem ovide abundant praise and work is bothering him nply, immediately notify the AS and BC (Behavior Consultant) me, he is attempting to leave and leighborhood or toward the road n from going that direction ersist and he gets to the end of ll implement YSIS (You're Safe, Behavioral Intervention) starting on physical redirection. If the ttaff will implement the				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 15G746 B. WING 05/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16609 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE were reported... Plan of Action: Staff will continue to follow plans in place... [Behavior Consultant] and [Qualified Intellectual Disabilities Professional] have met w/ (with) his mother ... [Client B] currently talks with mom daily (with staff monitoring) but not sure that is a good idea and would like to limit his phone conversations with his family and restrict to twice a week, currently calls daily at 8 AM. [Client B] will not be able to go on home visit for the holidays due to family issues... Limit calls to Mom to twice a week with specific dates/times and parameters if she does not answer and implement a phone log... Believed he possibly has schizoaffective ([Director of Nursing] suggested getting gene testing to determine at next appt (appointment) and possibly having a medication adverse effect with the Halo (Haldol/ schizophrenia) injection monthly. Increase in behaviors as it gets closer to next dose, supposed to receive every 14 days. [Program Director] suggested a PRN (as needed) medication ... ". Interdisciplinary Team Meeting (IDT) dated 3/4/24 indicated, "Behavioral: Client's BSP address elopement with reactive strategies. Staff are often right next to client, and he will move to go to his room and turn and run. Team has worked to monitor client at all times. However, it has been demonstrated that the more attention [client B] gets, the more he acts out ... Include any IDT Recommendations:... [Client B] did not leave the property. [Client B] was never U30Y11 Event ID: Facility ID: 011664 Page 70 of 77 FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet

06/26/2024

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	PROVIDER OR SUPPLIE	ER		t address, city, state, zip 9 SIMA GRAY RD	COD	
RES CA	RE SOUTHEAST I	NDIANA		RYVILLE, IN 47126		
(X4) ID PREFIX		Y STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION		(X5) COMPLETIO
TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE
IAU		f. [Client B] was never in	IAU			DATE
	-	self or others. Staff were				
	-	. Team moved [client B] to office				
		ovide added supervision and				
	attention	ovide added supervision and				
	attention					
	Team Discussion:	Team reviewed a pattern of				
		ents on [client B's] part. Team				
	_	neet to address these changes.				
	We admitted a new	w client to the home and as of				
	3/1/24 (when) we	transitioned a client out of				
	[group home] and	admitted another new client.				
	This is an extreme	amount of change for [client B]				
	to deal with. We n	noved him on $3/1/24$ from his old				
	room to one on the	e side of the office. Team agrees				
	that this will let hi	m have the attention of the staff				
	on that side of the	home and separate him from				
	the new clients wh	nere they are on one-to-one				
	staffing and can't a	address his issues as quickly".				
		2 AM, the Nurse and Program				
		e interviewed. The Nurse and PD				
		client B's pattern of elopement,				
	-	vioral health facilities following				
	1	ts to the highway with				
		for changes to his program				
	~	ctive safety protocol for 24 to 72				
		oval of his shoes. The PD				
		led to follow up with the				
		ual Disabilities Professional				
		l provide more follow-up. At				
		returned and stated, "No IDT				
		om behavioral health facility #1).				
		erapy because he'll refuse.				
		ant] even attempted to get him				
		gs down and he won't do that				
		as asked about a safety protocol				
		ed to display behavior and				
	-	the highway. The PD indicated				
	there was a genera	i practice for the				1

AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 05/23/2024	
	PROVIDER OR SUPPLIE		16609	address, city, state, zip co SIMA GRAY RD (VILLE, IN 47126	DD	
NEO OF						
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
	safety and stated, ' don't have access to their things out of no sharps, alarms, their room and sta asked how client H earned his items and stated, "Well, that' PD was asked if sl due to his elopement thought that was in [Behavior Consult them into the close them back). Shoul and have an IDT". On 5/17/24 at 11:1 (BC) was interview client B's pattern of behavioral replace "Yeah, yep it's clies strategies). It's kee BC was asked aboo versus elopement a when a client refus "If it's dangerous, Safe, I'm Safe) with has been aggression normally". The BC between out of boo stated, "The differ escape staff". The staff implementatii intervention YSIS BC stated, "The er will try to implem once less restrictiv attempted should st	¹ a 24-to-72-hour restriction for ¹ The only thing I know, is they to their stuff. They (staff) move their room. It's a blanket thing, staff remove everything out of ff sit at the door". The PD was 3 would know when he had and privileges back. The PD 's based on his behavior". The noes would be kept from client B ent behaviors. The PD stated, "I in the plan. After they elope, ant] has staff take them and put et. I don't know how (they get d have approval, be in the plan, ¹³ AM, the Behavior Consultant wed. The BC was asked about of elopement and positive ment strategies. The BC stated, ent choice (positive replacement eping him (client B) busy". The ut clients being out of bounds and how staff should intervene sed redirection. The BC stated, they can start the YSIS (You're th him (client B), usually there on, he would be redirectable ^C was asked the definition unds versus elopement. The BC ence is off property. Intent to BC was asked to define when on of the physical behavioral should be initiated by staff. The nd of the driveway is where they ent YSIS". The BC was asked re interventions had been staff implement YSIS to prevent dient B. The BC stated, "Yes.				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/23/2024		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CO 16609 SIMA GRAY RD		P COD)	
RES CA	RE SOUTHEAST I	NDIANA	HENF	RYVILLE, IN 47126			
(X4) ID PREFIX	(EACH DEFICIE	' STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE IE APPROPRIATE	(X5) COMPLETIC	
TAG		R LSC IDENTIFYING INFORMATION s a need for a break, not just put	TAG	DEFICIENCY		DATE	
	24-to-72-hour rest from client B's bec they're a danger to could be used to h in place to monitor indicated with the "It's not identified The BC was asked determination for 1 24-to-72-hour safe would. They (staff escalated. Staff wi this included week stated, "Yes". The trained to call her 24-to-72-hour safe "Yep, that's one w me". The BC was BC stated, "Probal who would determ decreased to a leve of items within the protocol. The BC s BC was asked if st communicate the in protocol indicating The BC stated, "N how things are goi lack of strategies c of the safety proto BSP. The BC state approve, they will room. They're (clie B] will use his soc	about the definition of a riction for the removal of items froom. The BC stated, "When themselves. We take items that arm themselves. Staff would be r". The BC was asked if this was clients' BSP. The BC stated, that I see. It's like I described". who would make the the implementation of the ty protocol. The BC stated, "I) will call if it (behaviors) has Il call me". The BC was asked if tends and holidays. The BC BC was asked if staff were for the implementation of the ty protocol. The BC stated, here if it's a new behavior call asked if this was in the BSP. The oby not". The BC was asked ine if the behavior had el of compliance for the return e 24 hour-to-72-hour safety stated, "Me, staff will call". The aff completed shift reports to mplementation of the safety gwhen it began and/or ended. o, they (staff) will let me know ng". The BC was asked about a outlined for the implementation col described within client B's ed, "Ok, I can tell you if I remove everything from the ents') highly dangerous. [Client ks to wrap around his neck, I s removed from the room".					

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G746	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/23/2024	
NAME OF	PROVIDER OR SUPPLIE	ĒR		ADDRESS, CITY, STATE, ZIP CO SIMA GRAY RD	OD	
RES CA	RE SOUTHEAST I	NDIANA	HENR	YVILLE, IN 47126		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORF	RECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	COMPLETIC
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	The BC was asked	l about the removal of client B's				
	-	ractice was due to elopement				
	incidents. The BC	stated, "His shoes remain in the				
	office because of l	nis elopement". The BC was				
	asked how client I	3 would regain his shoes back				
	following an elope	ement incident. The BC stated,				
	"At the quarterly,	we'll discuss that". The BC was				
	asked her thoughts	s on how client B would regain				
	his shoes back. Th	e BC stated, "Stop eloping. If				
	he wants to play b	asketball, he can have them".				
	The BC was asked	l if the shoe restriction should				
	be in client B's BS	P. The BC stated, "I'm sure it is,				
	but will check. I d	o not see it".				
	The BC was asked	l about client B's line of sight				
	supervision. The H	3C stated, "Correct". The BC				
	was asked if staff	did not have to be in the same				
	room as client B.	The BC stated, "Correct".				
		l about client B's positive				
	replacement strate	gies to prevent elopement. The				
	BC stated, "[Clien	t B] likes attention, you don't				
	have do anything.	Just talk with him. The BC was				
	asked about client	B earning one on one time with				
		ed, "We tried that. He did not				
		as asked what were proactive				1
	-	Ild work to help prevent client B				
	-	he BC stated, "Keep him busy is				
		ng him choices. Redirection in				
		al ways, maintaining				
		C was asked about coping				
		t B. The BC stated, "He likes to				
		f to take him to the basketball				
		a lot. He likes the [athletic				
		was asked if client B earned time				
		er. The BC stated, "That's on				
		lay and Friday's". The BC was				
		ad a reward program. The BC				1
		ch, he has where he can lose				
	outings. As long a	s he's not eloping (he can				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 **CENTERS FOR MEDICARE & MEDICAID SERVICES** STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 15G746 05/23/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 16609 SIMA GRAY RD **RES CARE SOUTHEAST INDIANA** HENRYVILLE, IN 47126 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE attend weekly). The BC was asked if there were incentives incorporated into client B's BSP to discourage behavior such as elopement. The BC stated, "Not really". The BC was asked if the surveyor understanding for the pattern of elopement incidents and interviews which indicated physical intervention for the implementation of YSIS, was not always possible as successful strategies to prevent client B from elopement and reaching the highway as an accurate interpretation. The BC stated, "Yes sir". The BC was asked about police involvement and when staff would call 911 to request emergency assistance during client B's elopement on and/or near the highway. The BC stated, "We discuss it. Let me review the plan". The BC was asked if staff should call 911. The BC stated, "Yes, they should, he's (client B) fast. There can be times staff could not stop him from running to implement YSIS". The BC indicated more follow up to ensure a protocol for requesting emergency services was indicated within client B's BSP. On 5/20/24 at 10:46 AM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about clients' being free from abuse and neglect. The QAM stated, "Yes". The QAM was asked about staff implementation of the physical behavioral intervention using YSIS at the end of the driveway to prevent elopement. The QAM stated, "I would say yes, if that's how the plan is written... I would say leaving to go to another area is different than going to the highway". The QAM was asked her knowledge of an overall picture for the number of times client B had eloped which involved placing himself in danger on, across or near the highway for the past 3 to 4 years. The QAM indicated she would review and provide more feedback. U30Y11 Facility ID: 011664 Page 75 of 77 FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: If continuation sheet

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G746		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/23/2024	
	PROVIDER OR SUPPLIE		STREET A 16609 HENRY	D		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR TAG DEFICIENCY)		ULD BE	(X5) COMPLETIC DATE
	through email clie involved the highy with staff in line o elopements, with s 2023 - 8 elopement him, 1 he was out On 5/20/24 at 1:08 Director (AED) w asked about the pa with client B and the where the implement behavioral interve elopement to the he possible. The AEI local law enforcempositive and suppo- elopement incident like a barrier. We ⁴ There was a decree (2024). Some adjut Maybe adding a fe of locked facility] lock our doors. It's have locked doors of the major consitional of locked facility] the level of support more secured and/ from eloping to the think it could be. We the alarm system. AED indicated model level of support ar positive behavioration elopements placint	8 PM, the QAM indicated nt B's elopement history which way as: 2021 - 5 elopements, f sight of him, 2022 - 3 staff in line of sight of him, and ats, with staff in line of sight of of line of sight for 10 seconds. 8 PM, the Assistant Executive as interviewed. The AED was attern of elopement incidents the indication from interviews entation of YSIS physical ntions to prevent client B from tighway may not always be D indicated communication with nent had occurred and was prive to assist during ts. The AED stated, "Nothing we talked about different ideas. ase in elopement since March istments to meds (medications). ence. They talked about [name . We don't have the capability to is my understanding ESN can't . I may be wrong on that. One derations is elopement for [name ". The AED was asked if he felt rt needed for client B was a or locked facility to keep him e highway. The AED stated, "I We've had trial and error with That's to keep people out". The ore follow up to review client B's ad the implementation of 1 supports to prevent g himself in a dangerous r near the highway was needed.				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	x1) provider/supplier/clia identification number 15G746	A. BU	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING		(X3) DATE SURVEY COMPLETED 05/23/2024	
	PROVIDER OR SUPPLIER		-	16609 \$	ADDRESS, CITY, STATE, ZIP COD SIMA GRAY RD VILLE, IN 47126		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	This federal tag rela 9-3-5(a)	tes to complaint #IN00428423.					

U3OY11 Facility ID: 011664