STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/12/2023	
	PROVIDER OR SUPPLIE	LTERNATIVES SE IN	1031 W	ADDRESS, CITY, STATE, ZIP COD VEST ST LBANY, IN 47150	
	T			T	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
W 0000					
Bldg. 00	Dates of Survey: 10 10/10/23, 10/11/23 Facility Number: 0 Provider Number: AIMS Number: 10 These deficiencies accordance with 46 Quality Review of	0664 15G127 00234310 reflect state findings in	W 0000		
W 0111 Bldg. 00	on 10/30/23. 483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's rights. Based on record review and interview for 3 of 3 sampled clients (#1, #2 and #3), the facility failed to access and produce measurable goal data for clients #1, #2 and #3 upon request. Findings include: Client #1's record was reviewed on 10/4/23 at 11:55 AM. The ISP (Individual Support Plan) dated 1/31/23 indicated the following goals: "Domestic Skills- [Client #1] would like to participate in the maintenance of a clean safe environment in which to live, [Client #1] would like to improve his personal independence by being able to complete his daily hygiene routine, [Client #1] would like to		W 0111	Facility Number: 00664 Provider Number: 15G127 AIMS Number: 100234310 PROVIDER: RESCARE COMMUNITY ALT. SE IN. Inc ADDRESS: 1031 West Street New Albany, IN DATE SURVEY COMPLETED October 12, 2023 W 111 CLIENT RECORDS CFR(s): 483.410(c)(1)	et,
LABORATOR	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S.	IGNATURE	TITLE	(X6) DATE
Mark Slau	LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIG Mark Slaughter				11/10/2023

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 disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: XUMY11 Facility ID: 000664 If continuation sheet Page 1 of 56

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 10/12/2023 15G127 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **1031 WEST ST** RES CARE COMMUNITY ALTERNATIVES SE IN NEW ALBANY, IN 47150 (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 increase his independence by being able to The facility will develop and manage his money, [Client #1] wants to increase maintain a recordkeeping system his independence by working toward that documents the client's health self-administration of medication skills, [Client #1] care, active treatment, social would like to learn positive coping skills to information, and protection of the increase his ability to manage behaviors so that client's rights. he may increase his overall independence and The Area Supervisor will [Client #1] wants to increase independence by retrain all staff in the facility on having a job." completing goal tracking data on a Client #1's Summary Tool dated June 2023, July daily basis 2023 and August 2023 did not contain a summary The Area Supervisor will of goal data. retrain all staff in the facility on notifying the QIDP if goal tracking Client #2's record was reviewed on 10/4/23 at 1:22 is unavailable in Task Master Pro PM. The ISP dated 1/31/23 indicated the following based on goals being timed out. goals: "[Client #2] will help with mealtime The QAM will retrain the preparation with 2 verbal prompts 80% of QIDP on review Goal Data monthly opportunities for 12 months by 5/5/2023, To at a minimum. increase his personal care skills, [Client #2] wants The QAM will retrain the to increase independence by having a job, To QIDP on reviewing goal tracking improve personal hygiene skills." during IDTs Client #2's Summary Tool dated June 2023, July The QAM will retrain QIDP 2023 and August 2023 did not contain a summary on Goal Tracking data entry and of goal data. review in Task Master Pro. The QIDP will verify Goal Client #3's record was reviewed on 10/4/23 at 2:00 end dates in Task Master Pro and PM. The ISP dated 10/20/22 indicated the verify goal tracking remain current following goals: "Domestic Skills- [Client #3] if data is not current QIPS will would like to participate in the maintenance of a notify the Area Supervision and clean safe environment in which to live, [Client #3] Program Manager who will would like to improve his personal independence in-service DSL and DSPs in the by being able to complete his daily hygiene facility. routine, [Client #3] would like to increase his A member of the independence by being able to manage his Administrative team will conduct a money, [Client #3] wants to increase his monthly site reviews for all clients independence by working toward in facility and the administrator will self-administration of medication skills and [Client hold a weekly ICF meeting to #3] would like to learn positive coping skills to discuss issues that arise in the increase his ability to manage behaviors so that facility. he may increase his overall independence." Client

I f			X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI		00	COMPL		
		15G127	B. WING			10/12/	2023	
NAME OF D	PROVIDER OR SUPPLIER		S	TREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER		1	031 W	EST ST			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	١	NEW ALBANY, IN 47150				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	I	D	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PRI	EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	T	`AG	DEFICIENCY		DATE	
		l dated June 2023, July 2023 and			=5			
	_	ot contain a summary of goal			Persons Responsible: AED,			
	data				Quality Assurance Manager, C	ŲΑ		
	The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 10/4/23 at 8:36				Coordinator/QIDP Manager,			
					Program Manager, Area Supervisor, QIDP, Direct Supp	ort		
	· · · · · · · · · · · · · · · · · · ·	s requested to provide 3			Lead, and DSP.	JOIL		
					Edda, and Bor .			
	months of goal data summaries for clients #1, #2 and #3.							
	The QIDP was interviewed on 10/4/23 at 11:37							
	AM. The QIDP indicated she was having difficulty locating the goal data summaries on the							
facility's electronic record keeping system.								
	tacinty's electronic record keeping system.							
	The QIDP was inte	rviewed on 10/4/23 at 12:15 PM.						
	The QIDP indicated	d she was unable to obtain goal						
		l progression. The QIDP						
		not review goal data to show						
		ts met their goal criteria during						
		Interdisciplinary Team)						
	meetings.							
	The OAM (Ouality	Assurance Manager) was						
		4/23 at 12:45 PM. The QAM						
	indicated client reco	ords should be accessible and						
	available upon requ	iest.						
	9-3-1(a)							
W 0125	483.420(a)(3)							
		F CLIENTS RIGHTS						
Bldg. 00		ensure the rights of all						
		e, the facility must allow and						
	-	ual clients to exercise their						
	-	f the facility, and as						
		ited States, including the						
	-	aints, and the right to due						
	process.	on, record review and	W 012		Facility Number: 00664		11/17/2022	
	Dasca on ouservalle	on, record review and	W 012	ر.	i acility intullibel. 00004		11/17/2023	

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 3 of 56

<u> </u>					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUIL	LDING	00	COMPLETED
		15G127	B. WING	G		10/12/2023
		<u> </u>	' 	STREET A	ADDRESS, CITY, STATE, ZIP COD	1
NAME OF I	PROVIDER OR SUPPLIEF	8			EST ST	
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			LBANY, IN 47150	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		sampled clients (#1, #2 and			Provider Number: 15G127	
		ed to ensure clients #1, #2 and			AIMS Number: 100234310	
	#3's rights were not restricted without due process. Findings include: Observations were completed at the group home on 10/3/23 from 4:43 PM to 7:00 PM.				DDOVIDED: DESCADE	
					PROVIDER: RESCARE COMMUNITY ALT. SE IN. Inc	
					ADDRESS: 1031 West Stree	
					New Albany, IN	٠,
					DATE SURVEY COMPLETED) .
					October 12, 2023	'
DSP #1 (Direct Support Professional) unlocked the pantry in the kitchen containing all the				W 125 PROTECTION OF		
				CLIENTS RIGHTS CFR(s):		
	non-perishable food in the home at 4:58 PM.				483.420(a)(3)	
		vas reviewed on 10/4/23 at 11:55			The facility must ensure	
		vidual Support Plan) dated			rights of all clients. Therefore,	
		ne following rights restrictions:			facility must allow and encour	·
	_	, freedom of movement			individual clients to exercise the	
		ss to finances, medications and			rights as clients the facility, ar	
	· ·	I'm safe- behavior management			as citizens of the United State	es,
	strategies).				including the right to file	
	G1:	. 1 10/4/22 + 1.22			complaints, and the right to du	ie
		vas reviewed on 10/4/23 at 1:22			process.	
	· ·	ridual Support Plan) dated ne following rights restrictions:			QIDP will update ISP on	
		freedom of movement			client rights restrictions and	<u>, </u>
	·	os, medications, door alarms,			request HRC as required after reviewing Client #1's ISP	
		l, smoking supervision and			(Individual Support Plan) for the	ne
	alone time.	, omeaning super vision and			following rights restrictions: do	
					alarms, sharps, freedom of	
	Client #3's record w	vas reviewed on 10/4/23 at 2:00			movement (supervision), acce	ess to
		vidual Support Plan) dated			finances, medications and YS	
	`	the following rights			You're safe, I'm safe behavior	
		arms, sharps, access to			management strategies.	
	finances and medic	-			QIDP will update ISP on	ı
					client rights restrictions and	
	The QIDP (Qualifie	ed Intellectual Disability			request HRC as required after	r
	Professional) and D	OSP #1 were interviewed on			reviewing Client #2's ISP	
	10/3/23 at 5:55 PM	. DSP #1 indicated she wasn't			(Individual Support Plan) for tl	ne
	sure why the pantry	was locked. The OIDP			following rights restrictions ac	

11/14/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

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 COMPLETED 00 B. WING 10/12/2023 15G127 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **1031 WEST ST** RES CARE COMMUNITY ALTERNATIVES SE IN NEW ALBANY, IN 47150 (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 indicated the panty was locked because some to finances, freedom of movement clients ate whole loaves of bread in the middle of (supervision), sharps, medications, door alarms, lighters the night. kept locked, smoking supervision DSP #2 was interviewed on 10/4/23 at 6:34 AM. and alone time. DSP #2 indicated the locked pantry had been Staff will be retrained on approved by HRC (Human Rights Committee) as a updated BSP rights restriction. QIDP will update ISP on client rights restrictions and The QIDP was interviewed on 10/4/23 at 4:36 PM. request HRC as required after The QIDP indicated the locked pantry should be reviewing Client #3's record was listed in clients' plans as a rights restriction. reviewed on 10/4/23 at ISP (Individual Support Plan) for the 9-3-2(a) following rights restrictions: door alarms, sharps, access to finances and medications. The QIDP will review all remaining Clients ISPs in the facility for client rights restrictions and request HRC as required after review and make updates to the ISP based on recommendations from the IDT comprised of para-professionals. The QIPD will retrain all staff in the facility on any updated plans as required. QAM will retrain QIDP on updating Clients BSP and requesting HRC as required. A member of the Administrative team will conduct a monthly site reviews for all clients

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

Event ID:

XUMY11

Facility ID: 000664

facility.

If continuation sheet

in facility and the administrator will hold a weekly ICF meeting to discuss issues that arise in the

Page 5 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/12/2023			
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				Persons Responsible: AED, Quality Assurance Manager, C Coordinator/QIDP Manager, Program Manager, Area Supervisor, QIDP, Direct Sup Lead, and DSP. DATE OF COMPLETION: November 17, 2023			
W 0126 Bldg. 00	The facility must e clients. Therefore individual clients to affairs and teach to f their capabilities. Based on record revisampled clients (#2	iew and interview for 1 of 3), the facility failed to develop	W 0126		11/17/2023		
	#2 to manage his fir Findings include:	nagement goal to teach client nances.		Facility Number: 00664 Provider Number: 15G127 AIMS Number: 100234310			
	A review of client # 10/4/23 at 1:22 PM Plan) dated 1/31/23 meal preparation, ir increase his independent	2's record was completed on The ISP (Individual Support indicated the following goals: crease personal care skills, idence by having a job, to ills. Client #2's ISP did not		PROVIDER: RESCARE COMMUNITY ALT. SE IN. Inc ADDRESS: 1031 West Stree New Albany, IN DATE SURVEY COMPLETED October 12, 2023	t,		
	The CFA (Compreh Assessment) dated a unable to make char purchase and neede	densive Functional 8/21/23 indicated client #2 was age correctly when making a d help to make a minor		W 126 PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(4) The facility will ensure the rights of all clients. Therefore,			
	Professional) was in	d Intellectual Disability atterviewed on 10/4/23 at 8:33 icated client #2 was given		facility must allow individual clients to manage their financi affairs and teach them to do s the extent of their capabilities. The QIPD will update CI	o to		

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet

Page 6 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		15G127	B. W	ING	<u> </u>	10/12	/2023
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R			/EST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	_		LBANY, IN 47150		
(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	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		n month and spent all his money			and develop a formal money		
	in one day.				management goal to teach		
	TI OIDD	' 1 10/4/22 / 4.26 PM			client#2 to manage his finance		
	,	erviewed on 10/4/23 at 4:36 PM.			Goals will be updated by		
	-	d some clients had money goals			on the QIDP assessment dev	•	
	and some do not.				a formal money management	-	
	The OAM (Onelity	Assurance Manager) was			to teach client#2 to manage h	IS	
	The QAM (Quality Assurance Manager) was interviewed on 10/5/23 at 11:00 AM. The QAM indicated there was some discussion regarding how client #2 spent all of his money and did not have money for things he wanted. 9-3-2(a)				finances. The QIDP will review all		
					remaining Clients CFAs and r		
					updates to the ISP based on	iiak c	
					recommendations from the ID	т	
					comprised of para-profession	-	
					QIDP will update The IS		
					(Individual Support Plan) base		
					assessment.	•	
					The QIDP will retrain all	staff	
					in the facility on updated ISP.		
					A member of the		
					Administrative team will condi	uct a	
					monthly site reviews for all cli	ents	
					in facility and the administrate	r will	
					hold a weekly ICF meeting to		
					discuss issues that arise in th	е	
					facility.		
					Persons Responsible: AED,		
					Quality Assurance Manager,	QA	
					Coordinator/QIDP Manager,		
					Program Manager, Area		
					Supervisor, QIDP, Direct Sup	port	
					Lead, and DSP.		
					DATE OF COMPLETION:		
					November 17, 2023		
W 0140	483.420(b)(1)(i)						
110	CLIENT FINANC	FS					
Bldg. 00		establish and maintain a					
3. **	_	res a full and complete					

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

Event ID:

XUMY11 Facility ID: 000664

Page 7 of 56 If continuation sheet

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	
		15G127	B. W	ING		10/12/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			/EST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
		nts' personal funds					
		icility on behalf of clients.	1 11/1	1140	Facility Number: 00664		11/17/2022
), the facility failed to keep an	W	0140	Facility Number: 00664 Provider Number: 15G127		11/17/2023
		g of client #2's personal funds.					
	nemized accounting	g of chefit #2 s personal funds.			AIMS Number: 100234310		
	Findings include:				PROVIDER: RESCARE		
					COMMUNITY ALT. SE IN. Inc	.	
	A review of client #	[‡] 2's financial ledger was			ADDRESS: 1031 West Stree		
		23 at 8:30 AM. The financial			New Albany, IN	•	
		to 9/29/23 indicated a weekly			DATE SURVEY COMPLETED):	
balance of .70 cents for the months of July,				October 12, 2023			
	August and September. Receipts were not available for review.						
					W 140 CLIENT FINANCES		
	· ·	apport Lead) was interviewed			CFR(s): 483.420(b)(1)(i)		
		AM. The DSL indicated client					
		hly check for \$52.00. The DSL			The facility will establish	I	
		s check was cashed each			and maintain a system that		
		was given to client #2. The			assures a full and complete		
		ipts were not kept to account			accounting of clients' persona	I	
	for the \$52.00 each	month spent by client #2.			funds.	toff	
	The OIDP (Qualifie	ed Intellectual Disability			The Facility will retrain s on the standard of maintaining		
		nterviewed on 10/4/23 at 8:33			system of accounting for clien	-	
	· ·	icated client #2 was given			funds entrusted to the facility.		
	· ·	month and spent all his money			receipts for the purchases mu		
	in one day.	1			be returned to the facility and		
					identify which client funds wer	·e	
	The QIDP was inter	rviewed on 10/4/23 at 4:36 PM.			spent on. The DSL will conduc		
	1	d client #2's receipts should be			weekly reviews of the Client		
	kept to account for	the \$52.00 he received each			Financial Record's to ensure	all	
	month.				transactions have been record	ded	
					and account is balanced. The		
	9-3-2(a)				Program Manager will in-servi		
					the Area Supervisor, and Dire		
					Support Lead on the use of cl	ient	
					finance book.		
					All employees will be		
					trained on the revised standar	rd	

	FOF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/12/2023		
	ROVIDER OR SUPPLIEF E COMMUNITY A	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) and disciplinary action will be given if the standard is not followed. The Facility will ensure the standard is not followed. A member of the Administrative team will condumonthly site reviews for all clie in facility and the administrator hold a weekly ICF meeting to discuss issues that arise in the facility.	hat ation uct a ents r will	(X5) COMPLETION DATE
W 0149 Bldg. 00	written policies an mistreatment, neg Based on record rev sampled clients (#1 implement its writte ensure an incident of resulting in emerge treatment was thore	evelop and implement d procedures that prohibit lect or abuse of the client. riew and interview for 1 of 3), the facility failed to en policy and procedures to of SIB (self-injurious behavior) hey medical evaluation and ughly investigated within 5 orrective measures were	W 01	149	Persons Responsible: AED, Quality Assurance Manager, C Coordinator/QIDP Manager, Program Manager, Area Supervisor, QIDP, Direct Supplead, and DSP. DATE OF COMPLETION: November 17, 2023 Facility Number: 00664 Provider Number: 15G127 AIMS Number: 100234310 PROVIDER: RESCARE COMMUNITY ALT. SE IN. Inc. ADDRESS: 1031 West Street New Albany, IN DATE SURVEY COMPLETED October 12, 2023	oort	11/17/2023

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 9 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G127	B. W	ING		10/12/	2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			EST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			LBANY, IN 47150		
(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		COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	AIE	DATE
					W 149 STAFF TREATMENT	OF	
	The facility's BDD	S (Bureau of Developmental			CLIENTS CFR(s): 483.420(d)		
	Disabilities Service	es) reports and investigations			The facility will develop	. ,	
	were reviewed on 1	10/3/23 at 11:53 AM. The review			implement written policies and	t	
	indicated the follow	ving:			procedures that prohibit		
					mistreatment, neglect or abus	e of	
		d 8/15/23 indicated, "It was			the client		
	^ -	asked staff to take him to a			The Facility will retrain s		
	hospital. When staff asked why he needed to go				at the site on the Abuse, Negl	ect	
		t #1] hit himself in the face with			and Exploitation Policy and		
	a closed fist then threatened to further self-harm.				disciplinary action will be give		
	Staff contacted nurse and was advised to				the policy is not followed. Area	a	
	transport [client #1] to [hospital] for evaluation."				Supervisor and Residential		
					Manager will ensure that the		
	And,				Abuse, Neglect and Exploitati		
	WEG1: 4 //13	1 4 1 1 1 20 14			Policy is followed. Monitoring		
		valuated and admitted to			ANE will done by The Program		
		ment. ResCare will maintain al and prepare for discharge."			Manager, Area Supervisor and		
	contact with hospit	at and prepare for discharge.			Residential Manager to ensur incidents of possible abuse,	e all	
	-Self-Injurious Reb	navior (SIB) Investigation dated			neglect and exploitation are		
	8/22/23 indicated the	· · · · · · · · · · · · · · · · · · ·			reported to the QA departmen	nt	
	0/22/23 marcated to	ne renewing.			The facility will retrain st		
	-"This MUST be co	ompleted by the QIDP			at the site on client Behavior	an	
		ual Disabilities Professional)			Support Plan (BSP) and spec	ific	
		y SIB incident and forwarded			physical intervention techniqu		
	· ·	Assurance) Department within			during episodes of physical		
	the 5-day timefram	· -			aggression and the use of You	u're	
					Safe I'm Safe (physical		
	-"[DSP (Direct Sup	pport Professional) #1] on			intervention).		
	8/22/23 stated she	was in the kitchen when [client			The QIDP Review all cli	ents	
	#1] came to her ask	king to be taken to the hospital.			in the facility BSPs to ensure	and	
		e does not recall anything			reactive procedures are accur	ate	
		gered him making this request.			The QAM will retrain QIPD on		
	1 - 1	e asked [client #1] why he			completing investigation within	n 5	
	_	hospital and he just started			Business Days and ensuring		
	_	he face and repeating he wanted			corrective measures are deve	loped	
		l, that he did not belong here,			and implemented to prevent		
		traffic, get hit by a car and die.			recurrence.and reactive meas	sures	
	[DSP #1] stated sho	e called [nurse] who advised to			are in place.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G127	B. W	NG		10/12/	/2023
NAME OF I	ROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					EST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		NEW A	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	take [client #1] to []	hospital] for evaluation."			The Area Supervisor will		
		· -			retrain all staff in the facility or		
	-"Is SIB addressed	in the BSP (Behavior Support			Behavior tracking to ensure		
		follow the plan? No, SIB is not			accurate data is collected.		
	a target behavior.	•			The QIDP will retrain sta	ff on	
					recommendations from the		
	6. Did the client rec	quire first aid or outside medical			investigation to prevent		
	treatment? If so, wh	-			recurrence.and reactive meas	ures	
	Yes, [client #1] was admitted to [hospital].				are in place.		
					The QIDP will retrain sta	ff in	
	7. Does the client have a history of SIB? No.				the event that there are no		
					behaviors staff will note "no		
	8. Has the client ha	d any other incidents of SIB in			behaviors this month" on beha	vior	
	the past week? No.				tracking form.		
					A member of the		
	9. What strategies work to redirect the SIB, are the				Administrative team will condu	ıct a	
	strategies in the BS	P, and are staff implementing			monthly site reviews for all clie	ents	
	them? SIB is not a	target behavior in his BSP."			in facility and the administrator		
					hold a weekly ICF meeting to		
	The review indicate	ed the Investigation was			discuss issues that arise in the	•	
	completed by QAC	(Quality Assurance			facility.		
	Coordinator) on 8/2	22/23 and the signature			-		
	of QAM (Quality A	Assurance Manager) was also			Persons Responsible: AED,		
	listed but not dated.	. The review indicated the			Quality Assurance Manager, 0	QΑ	
	investigation of clie	ent #1's 8/14/23 SIB incident			Coordinator/QIDP Manager,		
	requiring emergenc	y medical evaluation and			Program Manager, Area		
	treatment was comp	oleted on 8/22/23.			Supervisor, QIDP, Direct Supp	ort	
					Lead, and DSP.		
	Client #1's record w	vas reviewed on 10/5/23 at 2:30			DATE OF COMPLETION:		
	PM.				November 17, 2023		
	Client #1's Hospital	Discharge Document dated					
	8/18/23 indicated c	lient #1 was admitted to the					
	hospital on 8/14/23	and discharged on 8/18/23					
	four days later. Clie	ent #1's Hospital Discharge					
	Document dated 8/	18/23 indicated client #1 was					
	admitted for suicida	al ideation with a plan.					
	Client #1's BSP dat	red 4/19/23 indicated the					

A BUILDING QQ COMPLETED 15G127 NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (RECHED THE SUMMARY STATEMENT OF DEFICIENCY ALTERNATIVES OF SUMMARY STATEMENT OF SUMMARY STATEMENT OF DEFICIENCY ALTERNATIVES OF SUMMARY STATEMENT OF SUMMARY STATEMENT OF SUMMARY SUMMARY STATEMENT OF SUMMARY SUMMARY SUMMARY STATEMENT OF SUMMARY SUM	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN X(A) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG FOLUATORY OR LSC IDENTIFYING INFORMATION following: -"TARGET BEHAVIORS AND GOALS Physical aggression towards self: any instance of hitting, scratching, or biting himself. He will also pull his own hair, pick himself, or puncture his own skin." -"Threats of self-harm/or suicide ideation to get attention and get a desired item or result from staff or others. This would also be any actual attempts for suicide. Safety protocol will be followed any time [client #1] makes threats." -"Threats of Self-Harm If he makes statements of self-harm in order to escape responsibility or to get an item or a request fulfilled by staff. At the first sign of suicidal ideation staff will ask [client #1] what is wrong? Continue to talk with	AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER			00		
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RES CARE COMMUNITY ALTERNATIVES SE IN NEW ALBANY, IN 47150	NAME OF P	ROVIDER OR SUPPLIER	₹					
(X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION following: -"TARGET BEHAVIORS AND GOALS Physical aggression towards self: any instance of hitting, scratching, or biting himself. He will also pull his own hair, pick himself, or puncture his own skin." -"Threats of self-harm/or suicide ideation (SI): Any time that [client #1] makes threats of self-harm or makes statements of suicide ideation to get attention and get a desired item or result from staff or others. This would also be any actual attempts for suicide. Safety protocol will be followed any time [client #1] makes these threats." -"Threats of Self-Harm If he makes statements of self-harm in order to escape responsibility or to get an item or a request fulfilled by staff. At the first sign of suicidal ideation staff will ask [client #1] what is wrong? Continue to talk with	RES CAR	RE COMMUNITY A	I TERNATIVES SE IN					
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escape responsibility or to get an item or a request fulfilled by staff. At the first sign of suicidal ideation staff will ask [client #1] what is wrong? Continue to talk with		-"Inreats of Self-H	arm					
fulfilled by staff. At the first sign of suicidal ideation staff will ask [client #1] what is wrong? Continue to talk with		If he makes stateme	ents of self-harm in order to					
At the first sign of suicidal ideation staff will ask [client #1] what is wrong? Continue to talk with		escape responsibilit	ty or to get an item or a request					
[client #1] what is wrong? Continue to talk with		fulfilled by staff.						
[client #1] what is wrong? Continue to talk with		At the first sign of s	suicidal ideation staff will ask					
			_					
In a calm neutral voice request that he calm down and realize that we take this seriously.			•					
and realize that we take this seriously.		and realize that we	take this seriously.					
Immediately begin to keep a close eye on him and		Immediately begin	to keep a close eye on him and					
watch for him to attempt anything.		watch for him to att	tempt anything.					
One stoff should notify the DM (Pesidential		One stoff -1:1 1	tify the DM (Decidential					
One staff should notify the RM (Residential Manager) and the RM will notify the team and			-					
then they will decide if suicide protocol needs to		- '						
be put in place.		-	F					
If it has been put in place and HRC (Human Rights								
Committee) has approved it, then anything in his room that he could hurt himself with needs to be								

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 12 of 56

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE COMPI 10/12				
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION hould be following what the	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE		
	protocol says. If in 24 hours he habelieves the threat oprotocol will be ren If he continues to be team may decide to 24-hour period. Document on ABC Keep in communications	s calmed down and the team of harm is over then the noved. e a threat to himself, then the renew the protocol for another tracker.						
	"Safety Protocol His room will be en pillow, sheet, and b 1:1 staffing: defined hours. That staff wi responsibilities to a there is imminent ri if no assistance is g	I as within eyesight for 4 Il not have any other ny other consumer unless sk of harm to self or others (i.e. iven immediately then the act result in injury to a consumer						
	doorway. If he goes in the doorway to en behavior. During the time that there for his safety of amount of attention 1:1. Being on 1:1 is and we do not want	n open with staff in the sto the restroom, staff will be usure he is displaying safe the is on 1:1, his 1:1 staff is only and should limit the he is receiving from being on s not supposed to be rewarding him enjoying the 1:1 so much res in order to be on 1:1.						

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet

Page 13 of 56

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL		
		15G127	B. W	ING		10/12/	/2023	
			•	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	ROVIDER OR SUPPLIEF	ę.		1031 W	EST ST			
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		NEW AI	LBANY, IN 47150			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	-	be conducted in each of the						
		access to each shift. During staff who is not the 1:1 will						
	-							
	search each area and all furnishings in the areas for any item(s) that he could use to cause							
	self-injury (any item he could use to cause							
		item he could break and use to						
	-	rith). When walking into a						
	-	to the 1:1 staff will visually						
		y of the above-mentioned						
	items and seek assis	stance from others to remove						
	anything that is found.							
	He will be restricted from having any item(s)							
		nal possessions) in his						
	-	as items that he could break						
	and use to self-inju	re.						
	He will have the ab	ove listed rights restriction in						
		I safety reasons for 4 hours of						
	-	nute checks for 24 hours, from						
		he behavior without any						
		gression, physical aggression,						
	property destruction							
	area/elopement or S	SIB/SI."						
	Client #1!- I1 202	D2 ADC (Amtagadant D-1						
	_	23 ABC (Antecedent Behavior ting indicated the following:						
	Consequence) track	ang maicated the following:						
	-7/20/23 at 8 PM cl	ient #1 had 8 documented						
		rm/suicidal ideation.						
	-7/22/23 with no tir	ne documented client #1 had 1						
	incident of self-hard	m/suicidal ideation.						
	-7/22/23 with no tir	ne documented indicated client						
		of self-harm/suicidal ideation.						
	"1 nad 2 merdents	or som-maring surcidar ideation.						
	The review indicate	ed there were two 7/22/23 dates						
	listed with no times	s or specific information						

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 14 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/12/2023			ETED	
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD VEST ST	-	
RES CARE COMMUNITY ALTERNATIVES SE IN			NEST 31 NLBANY, IN 47150			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI		(X5)
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	PREFIX TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
	regarding the behav					
	Client #1's 8/2023 A following:	ABC tracking form indicated the				
		M through 6:35 PM client #1 elf-harm/suicidal ideation and				
	2 incidents of physical aggression towards himself.					
		ne documented client #1 had 4				
		rm/suicidal ideation and 4 al aggression towards himself.				
		indicate documentation of the if the incidents were separate.				
	indicate documenta	ABC tracking form did not tion of ABC tracking during 3. The form was blank with no				
	Client #1's Psychiat indicated the follow	rist visit note dated 8/24/23				
	stressed or anxious. into traffic for atten in the home workin questioned about th	have observed SIB when Recent reports of running tion when [unknown staff] was g on behaviors. When at he stated 'It's a joke.' de attempts and thought are 7."				
	interviewed on 10/4 indicated client #1 l plan was dated 4/9/2 target behaviors inc towards himself and	urance Manager) was 1/23 at 12:45 PM. QAM nad a BSP and the most current 23. QAM indicated client #1's lude physical aggression 1 threats to self-harm/suicidal cated the 8/22/23 investigation				

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 15 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		15G127	B. WING		10/12/2023	
			STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8		VEST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	NEW A	ALBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	0 0	s 8/14/23 incident of SIB				
		imentation of the supporting				
		during the investigation. QAM				
		s BSP dated 4/9/23 was				
		ig reviewed as a component of				
		gation. QAM indicated the				
		rance Coordinator) had				
	1 -	stigation. QAM indicated she				
		ervisor and would follow-up to				
		tion's findings regarding				
		towards himself, and threats				
		al ideation not being listed as				
	target behaviors and no history of the behaviors.					
	1	ent #1's BSP dated 4/9/23				
	indicated staff working with client #1 should					
		Supervisor) if client #1				
		nade threats to harm himself.				
	QAM indicated the					
		er) as the person staff should				
	_	tion had changed to AS.				
	1	AS would notify the				
		which included QAM to				
		#1's Safety Protocol should be				
	*	I indicated the 8/22/23				
		t include documentation of				
		determination or analysis				
		nplemented client #1's BSP				
		self-harm or threats of				
		dicated client #1's ABC				
		lient #1 had incidents of				
		towards himself and/or threat				
		al ideation during the months				
	, ,	2023. QAM indicated client				
	_	3 ABC was blank with no				
		ehavioral incidents. QAM				
	,	Interdisciplinary Team) should				
		commendations to prevent				
	recurrence of client	#1's SIB or threats of SIB.				
	QAM was interview	ved on 10/4/23 at 1:47 PM.				

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet

Page 16 of 56

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/12/2023			
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	1031 W	ADDRESS, CITY, STATE, ZIP COD /EST ST LBANY, IN 47150	•
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
		followed-up with QAC			
	~ ~	s BSP and the findings listed in gation. QAM stated, "[QAC]			
	-	A (physical aggression) was an			
		ht on her part." QAM			
	indicated she was n	otified on 8/14/23 regarding			
		f self-harm and physical			
		himself. QAM indicated there			
		tion available to review s other incidents of physical			
		himself or threats of SIB.			
		and procedures were			
		3 at 11:52 AM. The facility's			
		stigating Abuse, Neglect,			
		eatment or a Violation of			
	the following:	policy dated 6/13/23 indicated			
	the following.				
	-"All allegations of	or occurrences of abuse,			
		n, mistreatment or violation of			
	_	ts shall be reported to the			
		ties through the appropriate			
		Is and will be thoroughly the policies of ResCare, local,			
	state and federal gu	•			
		uality Assurance Manager will			
		ive team. A full investigation			
		y investigators who have			
	received training				
	-"One of the investi	gators will complete a detailed			
		ummary based on witness			
	statements and other	r evidence collected."			
	-"5. An investigativ	e peer review committee			
		utive Director will meet to			
		e of the investigation and to			
	ensure that a through	th investigation has been			

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 17 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		15G127	B. WING 10/12/2023			/2023	
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER						
RES CAE	RE COMMUNITY AI	TERNATIVES SE IN	1031 WEST ST NEW ALBANY, IN 47150				
INLO OAI	CE COMMONT I A	TERNATIVES SE IN		NEVVA	LDAN1, IN 47 130		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	completed."						
	0.0.0()						
	9-3-2(a)						
W 0454	400 400(-1)(0)						
W 0154	483.420(d)(3)	TAIT OF OUTENITO					
Dida 00	STAFF TREATME						
Bldg. 00		ave evidence that all					
		are thoroughly investigated.	337.6	1.5.4			11/17/2022
		iew and interview for 1 of 3, the facility failed to ensure	I w (154	Facility Number: 00664		11/17/2023
		arding an incident of client			Provider Number: 00004		
		_			AIMS Number: 100234310		
	#1's SIB (self-injurious behavior) requiring emergency medical evaluation was thoroughly investigated.				Alivis Number, 100234310		
					PROVIDER: RESCARE		
	mvestigated.				COMMUNITY ALT. SE IN. Inc		
	Findings include:				ADDRESS: 1031 West Street		
	i manigs meiade.				New Albany, IN	ι,	
	The facility's BDDS	(Bureau of Developmental			DATE SURVEY COMPLETED)-	
	•	s) reports and investigations			October 12, 2023	·•	
		0/3/23 at 11:53 AM. The review			0010001 12, 2020		
	indicated the follow						
					W 154 STAFF TREATMENT (OF	
	-BDDS report dated	8/15/23 indicated, "It was			CLIENTS CFR(s): 483.420(d)		
	_	asked staff to take him to a			, , , , , ,	· /	
		f asked why he needed to go			The facility will ensure		
	_	#1] hit himself in the face with			evidence that all alleged violat	tions	
	a closed fist then the	reatened to further self-harm.			are thoroughly investigated.		
	Staff contacted nurs	e and was advised to			The Quality Assurance		
	transport [client #1]	to [hospital] for evaluation."			Department will ensure all		
					investigations are completed i	n	
	And,				accordance with the policies o	of	
					ResCare, local, state and fede	eral	
		aluated and admitted to			guidelines.		
		ent. ResCare will maintain			The Quality Assurance		
	contact with hospita	al and prepare for discharge."			Department will be retrained b	-	
					the Associate Executive Direc		
	-	avior (SIB) Investigation dated			on the local, state and federal		
	8/22/23 indicated th	e following:			guidelines for investigations of	f	
					ANE.		
	-"[DSP (Direct Sup	port Professional) #1] on			The Facility will retrain s	taff	

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 18 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	a. Building <u>00</u>			COMPLETED	
		15G127	B. W	NG		10/12/	2023
		<u> </u>		CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			EST ST		
DES CVE		I TEDNIATIVES SE INI			LBANY, IN 47150		
RES CARE COMMUNITY ALTERNATIVES SE IN			INL W A				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		was in the kitchen when [client			on the Abuse, Neglect and		
	_	ting to be taken to the hospital.			Exploitation Policy and		
		e does not recall anything			disciplinary action will be giver		
		gered him making this request.			the policy is not followed. Area	l	
		e asked [client #1] why he			Supervisor and Residential		
	_	hospital and he just started			Manager will ensure that the		
	_	ne face and repeating he wanted			Abuse, Neglect and Exploitation		
		l, that he did not belong here,			Policy is followed. Monitoring		
		traffic, get hit by a car and die.			ANE will done by The Progran		
	[DSP #1] stated she called [nurse] who advised to				Manager, Area Supervisor and		
	take [client #1] to [hospital] for evaluation."				Residential Manager to ensure	e all	
	UI- CID - 111 in 4h - DCD (Debanion Comment				incidents of possible abuse,		
	-"Is SIB addressed in the BSP (Behavior Support				neglect and exploitation are		
	Plan) and did staff follow the plan? No, SIB is not				reported to the QA departmen	t.	
	a target behavior.				The QIPD will review all		
	(D'14 1' 4	. 6. 4 . 1 4 . 1 1. 1			Clients in the facility's BSPs a		
		quire first aid or outside medical			insure reactive procedures ar		
	treatment? If so, wl				accurate and remain up to dat		
	res, [client #1] was	s admitted to [hospital].			The Area Supervisor will		
	7 Door the alient b	ave a history of SIB? No.			retrain all staff in the facility or		
	7. Does the cheft h	lave a history of SIB? No.			completing behavior tracking o	iaia	
	& Hos the client ho	d any other incidents of SIB in			on a daily basis The Area Supervisor will		
	the past week? No.	•			retrain all staff in the facility or		
	the past week! No.				notifying the QIDP if behaviora		
	0 What strategies v	work to redirect the SIB, are the			tracking is unavailable in Task		
	_	P, and are staff implementing			Master Pro based on goals be		
	1 -	target behavior in his BSP."			timed out.	iiig	
	them. SID is not a	unger semuvisi in ins 231.			The QAM will retrain the		
	Client #1's record v	vas reviewed on 10/5/23 at 2:30			QIDP on review Behavior Trac	kina	
	PM.	, as 10, 10, 10, 20 at 210 o			Data monthly at a minimum.	aning	
					The QIDP Review all clie	ents	
	Client #1's Hospita	l Discharge Document dated			in the facility BSPs to ensure a		
	_	lient #1 was admitted to the			reactive procedures are accur		
		and discharged on 8/18/23			The QAM will retrain QIPD on		
		ent #1's Hospital Discharge			completing investigation withir	ı 5	
	· ·	18/23 indicated client #1 was			Business Days and ensuring		
		al ideation with a plan.			corrective measures are devel	oped	
		-			and implemented to prevent	•	
	Client #1's BSP dat	ted 4/19/23 indicated the			recurrence, and reactive meas	sures	
	I		1		l		l

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G127	B. W	ING		10/12/	/2023
				CTDEET /	ADDRESS, CITY, STATE, ZIP COD	<u> — </u>	
NAME OF I	PROVIDER OR SUPPLIE	R			/EST ST		
DES CAI		LTERNATIVES SE IN			LBANY, IN 47150		
NES CAI	NE COMMUNITITY A	ETERNATIVES SE IN		INEVV A	EBANT, IN 47 150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	following:				are in place.		
					The Area Supervisor wil	I	
		VIORS AND GOALS			retrain all staff in the facility or	า	
		n towards self: any instance of			Behavior tracking to ensure		
		or biting himself. He will also			accurate data is collected.		
	-	pick himself, or puncture his			The QIDP will retrain sta	aff on	
	own skin."				recommendations from the		
					investigation to prevent recurr	ence,	
		arm/or suicide ideation (SI):			and reactive measures are in		
		nt #1] makes threats of			place.		
	self-harm or makes statements of suicide ideation				The QIDP will retrain sta	aff in	
	to get attention and get a desired item or result				the event that there are no		
	from staff or others. This would also be any actual				behaviors staff will note "no		
	attempts for suicide. Safety protocol will be				behaviors this month" on beha	avior	
	followed any time [client #1] makes these threats."				tracking form.		
					A member of the		
	-"Threats of Self-H	larm		Administrative team will conduct a			
				monthly site reviews for all clients			
		ents of self-harm in order to			in facility and the administrato	r will	
		ty or to get an item or a request		hold a weekly ICF meeting to			
	fulfilled by staff.				discuss issues that arise in the	е	
					facility.		
	_	suicidal ideation staff will ask			QIDP Staff will be retrain		
	-	wrong? Continue to talk with			on reporting and following SIE		
	him about what is b	pothering him if he is willing.			plan, the Program Manager, A		
					Supervisor and DSL will moni		
		oice request that he calm down			reporting to ensure accurate a		
	and realize that we	take this seriously.			timely reporting by all staff in	ihe	
					facility.		
		to keep a close eye on him and			The QAM will update		
	watch for him to at	tempt anything			investigation form to include r	eview	
	One of 60 1 11	A.C. A. DM (D. 11 411			date by ED and QAM		
		otify the RM (Residential			A member of the	4 -	
	,	RM will notify the team and			Administrative team will condu		
	_	de if suicide protocol needs to			monthly site reviews for all clie		
	be put in place.				in facility and the administrato	r will	
	TC'/ 1 1 · · ·	1 LIDC (II D' 1)			hold a weekly ICF meeting to		
	-	place and HRC (Human Rights			discuss issues that arise in the	e l	
		proved it, then anything in his			facility.		
	room that he could	hurt himself with needs to be	1		Î		I

l f		î ´	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETER B. WING 10/12/202:			
		15G127	B. WI	NG		10/12/	2023
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
DEC CAI		ALTEDNIATIVES SE IN			EST ST LBANY, IN 47150		
RES CARE COMMUNITY ALTERNATIVES SE IN			INEW A	LBANT, IN 47 150			
(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 APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		should be following what the		TAG	DELICE!		DATE
	protocol says.	should be following what the					
					Persons Responsible: AED,		
		as calmed down and the team			Quality Assurance Manager, 0	QΑ	
		of harm is over then the			Coordinator/QIDP Manager,		
	protocol will be re	moved.			Program Manager, Area		
	If he continues to !	be a threat to himself, then the			Supervisor, QIDP, Direct Supp Lead, and DSP.	που	
		o renew the protocol for another			DATE OF COMPLETION:		
	24-hour period.				November 17, 2023		
	Document on ABC	C tracker.					
	Keep in communication with the nurse to						
	determine the need for an inpatient stay at a						
	psych hospital."						
	"Safety Protocol						
	pillow, sheet, and l	mptied completely except for a					
	_	ed as within eyesight for 4					
	_	vill not have any other					
		any other consumer unless					
		risk of harm to self or others (i.e.					
		given immediately then the act					
	_	Il result in injury to a consumer					
	or to the one-to-on	ic statt.)					
	His door will rema	in open with staff in the					
		es to the restroom, staff will be					
		ensure he is displaying safe					
	behavior.						
	During the time the	at he is on 1:1, his 1:1 staff is					
	-	only and should limit the					
	_	n he is receiving from being on					
		is not supposed to be rewarding					
		at him enjoying the 1:1 so much					
	that he has behavio	ors in order to be on 1:1.					

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 21 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/12/2023			
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN	1031 W	ADDRESS, CITY, STATE, ZIP COD /EST ST LBANY, IN 47150	•
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE COMPLETION
TAG	Room sweeps will be areas where he has a the room sweeps a search each area and for any item(s) that self-injury (any item skin with, and any item puncture his skin work room he has access scan the area for any items and seek assist anything that is four the will be restricted (including all person possession as well as and use to self-injure. He will have the abordance for health and 1:1 and then 15-mir time of the end of the display of verbal and property destruction area/elopement or Self-incidents of self-ham area/elopement or Self-ham area/elopement	I from having any item(s) nal possessions) in his as items that he could break re. ove listed rights restriction in safety reasons for 4 hours of nute checks for 24 hours, from ne behavior without any gression, physical aggression, n, leaving assigned IB/SI." 3 ABC (Antecedent Behavior ing indicated the following: itent #1 had 8 documented rm/suicidal ideation. ne documented client #1 had 1	TAG	DEPICIENCY	DATE

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 22 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED		
		15G127	B. WING		10/12/2023
NAME OF T	DROWNER OF CURPLIES		STREE	T ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF		1031	WEST ST	
	RE COMMUNITY A	LTERNATIVES SE IN	NEW	ALBANY, IN 47150	<u>-</u>
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE CONTENTION
TAG	regarding the behav	LISC IDENTIFYING INFORMATION	TAG	Daneta.veri	DATE
	regarding the behav	1013.			
	Client #1's 8/2023 A following:	ABC tracking form indicated the			
	-8/1/23 from 6:30 P	M through 6:35 PM client #1			
		elf-harm/suicidal ideation and			
		cal aggression towards			
	himself.				
	-8/14/23 with no tir	ne documented client #1 had 4			
incidents of self-harm/suicidal ideation and 4					
	incidents of physica	al aggression towards himself.			
	The review did not indicate documentation of the specific behavior or if the incidents were separate.				
	specific benavior of	if the incidents were separate.			
	Client #1's 9/2023 A	ABC tracking form did not			
		tion of ABC tracking during			
	the month of 9/2023	3. The form was blank with no			
	data.				
	Client #1's Psychiat	rist visit note dated 8/24/23			
	indicated the follow				
		have observed SIB when			
		Recent reports of running			
		tion when [unknown staff] was			
		g on behaviors. When at he stated 'It's a joke.'			
	_	ide attempts and thought are			
	taken very seriously	-			
		urance Manager) was			
		1/23 at 12:45 PM. QAM			
		had a BSP and the most current 23. QAM indicated client #1's			
	_	lude physical aggression			
	~	d threats to self-harm/suicidal			
		cated the 8/22/23 investigation			

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 23 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			
		15G127	B. WING		10/12/2023	
NAME OF T	DOMINED OF CHIRD TER		STREE	T ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF	C	1031	WEST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	NEW ALBANY, IN 47150			
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE COM EL TOTA	
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE	
		s 8/14/23 incident of SIB				
		umentation of the supporting during the investigation. QAM				
		s BSP dated 4/9/23 was				
		ng reviewed as a component of				
		gation. QAM indicated the				
		urance Coordinator) had				
		stigation. QAM indicated she				
		ervisor and would follow-up to				
		ation's findings regarding				
		towards himself, or threats of				
	1	deation was listed as not target				
		story of the behaviors. QAM				
	indicated client #1's BSP dated 4/9/23 indicated					
	staff working with client #1 should notify the AS					
	_	f client #1 harmed himself or				
		m himself. QAM indicated the				
		(Residential Manager) as the				
	person staff should	contact but the position had				
	changed to AS. QA	M indicated the AS would				
	notify the administr	rative team which included				
	QAM to determine	if client #1's Safety Protocol				
	should be implemen	nted. QAM indicated the				
	8/22/23 investigation	on did not include				
	documentation of fi	_				
		alysis regarding if staff				
	_	#1's BSP strategies regarding				
		of self-harm. QAM indicated				
		cking indicated client #1 had				
		al aggression towards himself				
		-harm/suicidal ideation during				
	· ·	and August 2023. QAM				
		s September 2023 ABC was				
		mentation of behavioral				
	incidents.					
	1	ved on 10/4/23 at 1:47 PM.				
	1	followed-up with QAC				
		s BSP and the findings listed in				
	the 8/22/23 Investig	gation. QAM stated, "[QAC]				

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 24 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r /	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 15G127	A. BUILDING 00 COMPLETED B. WING 10/12/2023			
		130127	<u> </u>		10/12/2023	
NAME OF I	PROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP COD WEST ST		
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		NEW ALBANY, IN 47150		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE COM EL TOT	
W 0156 Bldg. 00	said the SIB and PA unfortunate oversig indicated she was n client #1's threats of aggression towards was not documental regarding client #1's aggression towards 9-3-2(a) 483.420(d)(4) STAFF TREATME The results of all in reported to the addrepresentative or accordance with Stages don record revisampled clients (#1's an investigation reg #1's SIB (self-injurisemergency medical investigated within incident. Findings include: The facility's BDDS Disabilities Service were reviewed on 1 indicated the follow -BDDS report dated reported [client #1] hospital. When staff to a hospital, [client a closed fist then the Staff contacted nurse	nvestigations must be ministrator or designated to other officials in State law within five working int. view and interview for 1 of 3), the facility failed to ensure arding an incident of client ous behavior) resulting in evaluation and treatment was 5 business days of the 6 (Bureau of Developmental is) reports and investigations 0/3/23 at 11:53 AM. The review	W 0156	Facility Number: 00664 Provider Number: 15G127 AlMS Number: 100234310 PROVIDER: RESCARE COMMUNITY ALT. SE IN. In ADDRESS: 1031 West Stre New Albany, IN DATE SURVEY COMPLETE October 12, 2023 W 156 STAFF TREATMENT CLIENTS CFR(s): 483.420(c) The facility will ensure results of all investigations may be reported to the administrate designated representative or other officials in accordance State law within five working	et, D: OF D(4) the sust stor or to with	

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 25 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			COMPLETED	
		15G127	B. W	ING	10/12/2023		
		<u>l</u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	2			/EST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE	
					of the incident.		
	And,				The Quality Assurance		
					Department will ensure all		
		aluated and admitted to			investigations are completed i		
		nent. ResCare will maintain			accordance with the policies of		
	contact with hospita	al and prepare for discharge."			ResCare, local, state and fede	eral	
	0.101	· (GID) I · · · · · · · · · · ·			guidelines.		
		avior (SIB) Investigation dated			The Quality Assurance		
	8/22/23 indicated the	ne following:			Department will be retrained by	•	
	UTL: MITTER 1	l.da.d.la.da. OIDB			the Associate Executive Direct		
		ompleted by the QIDP			on the local, state and federa		
	(Qualified Intellectual Disabilities Professional)				guidelines for investigations o	Ť	
	within 5 days of any SIB incident and forwarded				ANE.	ee	
		Assurance) Department within			The Facility will retrain s	тап	
	the 5-day timeframe	e."			on the Abuse, Neglect and		
	The	. 1 41 T			Exploitation Policy and	: .	
		ed the Investigation was			disciplinary action will be give		
		(Quality Assurance			the policy is not followed. Area	a	
		2/23 and the signature of			Supervisor and Residential		
		urance Manager) was also The review indicated the			Manager will ensure that the		
		ent #1's 8/14/23 SIB incident			Abuse, Neglect and Exploitation		
	_				Policy is followed. Monitoring		
	treatment was comp	y medical evaluation and			ANE will done by The Program		
	u camient was comp	Dieteu OII 0/22/23.			Manager, Area Supervisor and		
	OAM was intention	ved on 10/3/23 at 11:05 AM.			Residential Manager to ensur	c all	
	-	d allegations should be			incidents of possible abuse, neglect and exploitation are		
		ated within 5 business days of			reported to the QA departmen		
	the alleged incident				The QIPD will review all		
	ane aneged meident	•			Clients in the facility's BSPs a		
	9-3-2(a)				insure reactive procedures ar		
) 5 2(u)				accurate and remain up to date		
					The Area Supervisor wil		
					retrain all staff in the facility or		
					completing behavior tracking		
					on a daily basis	uuiu	
					The Area Supervisor wil	1	
					retrain all staff in the facility or		
					notifying the QIDP if behavior		
				tracking is unavailable in Task			

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

PRINTED: 11/14/2023 FORM APPROVED OMB NO. 0938-039

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUAND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 15G127 B. WING		onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 10/12/2023	
	ROVIDER OR SUPPLIE	R ALTERNATIVES SE IN	1031 V	ADDRESS, CITY, STATE, ZIP COD VEST ST ALBANY, IN 47150	
(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 B: CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
				Master Pro based on goals it timed out. The QAM will retrain the QIDP on review Behavior Tre Data monthly at a minimum. The QIDP Review all of in the facility BSPs to ensure reactive procedures are according investigation with Business Days and ensuring corrective measures are develoand implemented to prevent recurrence, and reactive meare in place. The Area Supervisor we retrain all staff in the facility of Behavior tracking to ensure accurate data is collected. The QIDP will retrain so recommendations from the investigation to prevent recurand reactive measures are in place. The QIDP will retrain so the event that there are no behaviors staff will note "no behaviors this month" on beit tracking form. A member of the Administrative team will condemnthly site reviews for all of in facility and the administrative hold a weekly ICF meeting to discuss issues that arise in the facility. QIDP Staff will be retrained to prevent manager, Supervisor and DSL will more supervisor and supervisor an	ne acking elients e and urate on nin 5 greloped assures vill on taff on trence, n taff in havior duct a elients tor will on he sined eliB Area

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 27 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	iumber a. building <u>00</u>		00	COMPLETED	
		15G127	B. WI	B. WING		10/12/2023	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	₹		1	/EST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OI	R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
					reporting to ensure accurate a		
					timely reporting by all staff in t	ne	
					facility. The QAM will update		
					investigation form to include re	aview	
					date by ED and QAM	, v i C v v	
					A member of the		
					Administrative team will condu	ıct a	
					monthly site reviews for all clie		
					in facility and the administrato	r will	
					hold a weekly ICF meeting to		
					discuss issues that arise in the)	
					facility.		
					Persons Responsible: AED,	2.4	
					Quality Assurance Manager, (ЗА	
					Coordinator/QIDP Manager,		
					Program Manager, Area	a a rt	
					Supervisor, QIDP, Direct Supple Lead, and DSP.	JOH	
					DATE OF COMPLETION:		
					November 17, 2023		
					1.00001117, 2020		
W 0157	483.420(d)(4)						
		ENT OF CLIENTS					
Bldg. 00		ation is verified, appropriate					
	corrective action i	nust be taken.					
	Based on record re	view and interview for 1 of 3	W_0	157			11/17/2023
), the facility failed to develop			Facility Number: 00664		
	•	rective measures regarding			Provider Number: 15G127		
	l	rious behavior management			AIMS Number: 100234310		
	needs.						
					PROVIDER: RESCARE		
	Findings include:				COMMUNITY ALT. SE IN. Inc		
	TEL C 11: 1 DDD				ADDRESS: 1031 West Street	i,	
	· ·	S (Bureau of Developmental			New Albany, IN		
		es) reports and investigations			DATE SURVEY COMPLETED	:	
1	were reviewed on 1	0/3/23 at 11:53 AM. The review			October 12, 2023		

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 28 of 56

PRINTED: 11/14/2023

	T OF HEALTH AND HU R MEDICARE & MEDIO						RM APPROVED IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		ľ í	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			SURVEY LETED /2023	
NAME OF PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD VEST ST			
RES CA	RE COMMUNITY A	LTERNATIVES SE IN	N	EW A	LBANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE	П		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		FIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	indicated the follow	R LSC IDENTIFYING INFORMATION ving:	TZ	4G	DEFICIENC!)		DATE
	-BDDS report date	d 8/15/23 indicated, "It was			W 157 STAFF TREATMENT	OF	
		asked staff to take him to a			CLIENTS CFR(s): 483.420(d))(4)	
	_	ff asked why he needed to go					
		t #1] hit himself in the face with			The facility will ensure t		
		reatened to further self-harm.			results of all investigations m		
		se and was advised to			be reported to the administration		
	transport [client #1] to [hospital] for evaluation."			designated representative or		
	And,				other officials in accordance versions of the state law within five working of the st		
	Allu,				of the incident.	uays	
	"[Client #1] was ev	valuated and admitted to			The Quality Assurance		
		nent. ResCare will maintain			Department will ensure all		
		al and prepare for discharge."			investigations are completed	in	
	•				accordance with the policies		
	-Self-Injurious Beh	navior (SIB) Investigation dated			ResCare, local, state and fed		
	8/22/23 indicated to	he following:			guidelines.		
					The Quality Assurance		
		pport Professional) #1] on			Department will be retrained	by	
		was in the kitchen when [client			the Associate Executive Direct	ctor	
		king to be taken to the hospital.			on the local, state and federa		
		e does not recall anything			guidelines for investigations of	of	
		gered him making this request.			ANE.		
	1	e asked [client #1] why he			The Facility will retrain s	staff	
	_	hospital and he just started he face and repeating he wanted			on the Abuse, Neglect and		
	_	l, that he did not belong here,			Exploitation Policy and disciplinary action will be give	n if	
		traffic, get hit by a car and die.			the policy is not followed. Are		
		e called [nurse] who advised to			Supervisor and Residential	u	
		hospital] for evaluation."			Manager will ensure that the		
		1]			Abuse, Neglect and Exploitat	ion	
	-"Is SIB addressed	in the BSP (Behavior Support			Policy is followed. Monitoring		
		follow the plan? No, SIB is not			ANE will done by The Progra		
	a target behavior.	- '			Manager, Area Supervisor an		
					Residential Manager to ensur		
	6. Did the client red	quire first aid or outside medical			incidents of possible abuse,		

treatment? If so, what?

Yes, [client #1] was admitted to [hospital].

neglect and exploitation are

reported to the QA department. The QIPD will review all

STATEMENT OF DEFICIENCIES X1) P		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
	15G127		B. WING 10/12/2023			/2023	
			STREET ADDRESS, CITY, STATE, ZIP COD				
NAME OF I	PROVIDER OR SUPPLIEF	₹			/EST ST		
DEC CAI		LTERNATIVES SE IN			LBANY, IN 47150		
RES CAI	RE COMMUNITY A	LIERNATIVES SE IN		NEVV A	LBAN1, IN 47 150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	7. Does the client h	ave a history of SIB? No.			Clients in the facility's BSPs a	nd	
					insure reactive procedures ar	е	
	8. Has the client ha	d any other incidents of SIB in			accurate and remain up to dat	e.	
	the past week? No.				The Area Supervisor will		
					retrain all staff in the facility or	1	
	_	work to redirect the SIB, are the			completing behavior tracking of	data	
	strategies in the BS	P, and are staff implementing			on a daily basis		
	them? SIB is not a	target behavior in his BSP."			The Area Supervisor will		
					retrain all staff in the facility or	1	
	Client #1's record v	vas reviewed on 10/5/23 at 2:30			notifying the QIDP if behaviora	al	
	PM.				tracking is unavailable in Task		
					Master Pro based on goals be	ing	
	Client #1's Hospital Discharge Document dated			timed out.			
	8/18/23 indicated c	lient #1 was admitted to the		The QAM will retrain the			
	hospital on 8/14/23	and discharged on 8/18/23			QIDP on review Behavior Tracking		
	four days later. Clie	ent #1's Hospital Discharge		Data monthly at a minimum.			
	Document dated 8/	18/23 indicated client #1 was	The QIDP Review all clients				
	admitted for suicida	al ideation with a plan.			in the facility BSPs to ensure a	and	
					reactive procedures are accur	ate	
	Client #1's BSP dat	ted 4/19/23 indicated the			The QAM will retrain QIPD on		
	following:				completing investigation withir	า 5	
					Business Days and ensuring		
		VIORS AND GOALS			corrective measures are deve	loped	
	,	towards self: any instance of			and implemented to prevent		
		or biting himself. He will also			recurrence, and reactive meas	sures	
	-	ick himself, or puncture his			are in place.		
	own skin."				The Area Supervisor will		
					retrain all staff in the facility or	1	
		rm/or suicide ideation (SI):	Behavior tracking to ensure				
		nt #1] makes threats of			accurate data is collected.		
		statements of suicide ideation			The QIDP will retrain sta	ff on	
		get a desired item or result			recommendations from the		
		. This would also be any actual			investigation to prevent recurr	ence,	
	_	e. Safety protocol will be			and reactive measures are in		
	followed any time [[client #1] makes these threats."			place.		
					The QIDP will retrain sta	ff in	
	-"Threats of Self-H	arm			the event that there are no		
					behaviors staff will note "no		
		ents of self-harm in order to			behaviors this month" on beha	avior	
	escape responsibilit	ty or to get an item or a request			tracking form.		

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		15G127	B. W	ING		10/12	/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	1	
NAME OF P	PROVIDER OR SUPPLIE	R			EST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN			LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	fulfilled by staff.				A member of the		
					Administrative team will cond		
	_	suicidal ideation staff will ask			monthly site reviews for all cli		
		wrong? Continue to talk with			in facility and the administrate		
	nim about what is l	oothering him if he is willing.			hold a weekly ICF meeting to		
	In a colm mayare1	oign request that he calm days			discuss issues that arise in the	е	
		oice request that he calm down			facility. OIDP Staff will be retrai	nad	1
	and realize that we	take this seriously.					
	Immediately bacin	to keep a close eye on him and			on reporting and following SII		
	watch for him to at				plan, the Program Manager, A Supervisor and DSL will mon		
	watch for filli to at	tempt anything			1 · · · · · ·		
	One staff should notify the RM (Residential			reporting to ensure accurate and timely reporting by all staff in the			
	Manager) and the RM will notify the team and				facility.	uic	
		de if suicide protocol needs to			The QAM will update		
	be put in place.	ao na amanao processa nasaas co		investigation form to include review			
					date by ED and QAM	011011	
	If it has been put in	n place and HRC (Human Rights			QIDP will update The IS	SP.	
	_	proved it, then anything in his			(Individual Support Plan) bas		
		hurt himself with needs to be			assessment.		
	removed and staff	should be following what the			The QIDP will retrain all	staff	
	protocol says.	_			in the facility on updated ISP.		
					A member of the		
	If in 24 hours he ha	as calmed down and the team			Administrative team will cond	uct a	
	believes the threat	of harm is over then the			monthly site reviews for all cli	ents	
	protocol will be rea	noved.			in facility and the administrate	or will	
					hold a weekly ICF meeting to		
		be a threat to himself, then the			discuss issues that arise in th	е	
		renew the protocol for another			facility.		
	24-hour period.						
					Persons Responsible: AED,		1
	Document on ABC	tracker.			Quality Assurance Manager,	QA	
		at the second			Coordinator/QIDP Manager,		1
	1 -	ation with the nurse to			Program Manager, Area		
		for an inpatient stay at a			Supervisor, QIDP, Direct Sup	port	
	psych hospital."				Lead, and DSP.		
	11C-C D				DATE OF COMPLETION:		
	"Safety Protocol	mention of community of the second form			November 17, 2023		
		mptied completely except for a					
	pillow, sheet, and b	olanket.					

		X1) PROVIDER/SUPPLIER/CLIA	l í		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		15G127	B. W.	B. WING		10/12	/2023
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
DEC CAI		LTERNATIVES OF IN		1031 W			
RES CAI	RE COMMUNITY A	LTERNATIVES SE IN		NEW AL	LBANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION d as within eyesight for 4	+	TAG	DEFICIENCE		DATE
	_	ill not have any other					
		ny other consumer unless					
	_	isk of harm to self or others (i.e.					
		given immediately then the act					
	_	l result in injury to a consumer					
	or to the one-to-one	e staff.)					
	His door will remai	in open with staff in the					
		s to the restroom, staff will be					
	in the doorway to e	nsure he is displaying safe					
	behavior.						
	During the time the	at he is on 1:1, his 1:1 staff is					
	-	only and should limit the					
	The state of the s	he is receiving from being on					
		s not supposed to be rewarding					
		t him enjoying the 1:1 so much					
		rs in order to be on 1:1.					
	D 311	1 1 1 1 1 61					
	_	be conducted in each of the access to each shift. During					
		staff who is not the 1:1 will					
	_	d all furnishings in the areas					
		he could use to cause					
		n he could use to puncture his					
		item he could break and use to					
	puncture his skin w	rith). When walking into a					
		to the 1:1 staff will visually					
		y of the above-mentioned					
		stance from others to remove					
	anything that is fou	nd.					
	He will be restricted	d from having any item(s)					
		onal possessions) in his					
		as items that he could break					
	and use to self-inju	re.					
	II	and the dutation of the state of					
		ove listed rights restriction in last safety reasons for 4 hours of					

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 32 of 56

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	· ′	ILDING	NSTRUCTION 00	(X3) DATE COMPL 10/12/	ETED
	PROVIDER OR SUPPLIEF	LTERNATIVES SE IN	•	1031 W	DDRESS, CITY, STATE, ZIP COD EST ST BANY, IN 47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	time of the end of the						
	I	23 ABC (Antecedent Behavior ting indicated the following:					
	,	ient #1 had 8 documented rm/suicidal ideation.					
	-7/22/23 with no tir incident of self-harm	ne documented client #1 had 1 m/suicidal ideation.					
		ne documented indicated client of self-harm/suicidal ideation.					
		ed there were two 7/22/23 dates or specific information viors.					
	Client #1's 8/2023 A following:	ABC tracking form indicated the					
	had 2 incidents of s	PM through 6:35 PM client #1 elf-harm/suicidal ideation and cal aggression towards					
	incidents of self-har	me documented client #1 had 4 rm/suicidal ideation and 4 al aggression towards himself.					
		indicate documentation of the rif the incidents were separate.					
	indicate documenta	ABC tracking form did not tion of ABC tracking during 3. The form was blank with no					

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

Event ID:

 $XUMY11 \quad \ \ {\rm Facility\ ID:} \quad \ 000664$

If continuation sheet Page 33 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/12/2023
ROVIDER OR SUPPLIER				-
E COMMUNITY AL	TERNATIVES SE IN			
SUMMARY S	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP	BE COMPLETION
	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
data.				
-				
stressed or anxious. into traffic for attent in the home working questioned about the Discussed that suici	Recent reports of running tion when [unknown staff] was g on behaviors. When at he stated "It's a joke." de attempts and thought are			
interviewed on 10/4 indicated client #1 h plan was dated 4/9/2 target behaviors inc towards himself and ideation. QAM indicated client #1's should include docu evidence reviewed of indicated client #1's documented as bein the 8/22/23 investig QAC (Quality Assu completed the invest was the QAC's superclarify the investigal physical aggression self-harm suicidal in behaviors and no his indicated client #1's staff working with conference (Area Supervisor) if made threats to harm BSP listed the RM (person staff should of the staff would be the staff should of the staff should should be staff should sh	/23 at 12:45 PM. QAM and a BSP and the most current 23. QAM indicated client #1's lude physical aggression I threats to self-harm/suicidal cated the 8/22/23 investigation is 8/14/23 incident of SIB mentation of the supporting during the investigation. QAM BSP dated 4/9/23 was g reviewed as a component of ation. QAM indicated the rance Coordinator) had tigation. QAM indicated she revisor and would follow-up to tion's findings regarding towards himself, or threats of deation was listed as not target story of the behaviors. QAM BSP dated 4/9/23 indicated elient #1 should notify the AS folient #1 harmed himself or in himself. QAM indicated the Residential Manager) as the contact but the position had			
)	ROVIDER OR SUPPLIER SUMMARY S (EACH DEFICIENCE REGULATORY OR data. Client #1's Psychiat indicated the follow -"Staff reports they stressed or anxious. into traffic for attent in the home working questioned about the Discussed that suici taken very seriously QAM (Quality Assu- interviewed on 10/4 indicated client #1 h plan was dated 4/9/2 target behaviors inci towards himself and ideation. QAM indicated client #1's should include docu- evidence reviewed or indicated client #1's documented as bein the 8/22/23 investig QAC (Quality Assu- completed the inves- was the QAC's supe- clarify the investigal physical aggression self-harm suicidal in behaviors and no his indicated client #1's staff working with or (Area Supervisor) if made threats to harm BSP listed the RM (person staff should	IDENTIFICATION NUMBER 15G127 ROVIDER OR SUPPLIER EE COMMUNITY ALTERNATIVES SE IN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION data. Client #1's Psychiatrist visit note dated 8/24/23 indicated the following: -"Staff reports they have observed SIB when stressed or anxious. Recent reports of running into traffic for attention when [unknown staff] was in the home working on behaviors. When questioned about that he stated "It's a joke." Discussed that suicide attempts and thought are taken very seriously." QAM (Quality Assurance Manager) was interviewed on 10/4/23 at 12:45 PM. QAM indicated client #1 had a BSP and the most current plan was dated 4/9/23. QAM indicated client #1's target behaviors include physical aggression towards himself and threats to self-harm/suicidal ideation. QAM indicated the 8/22/23 investigation regarding client #1's 8/14/23 incident of SIB should include documentation of the supporting evidence reviewed during the investigation. QAM indicated client #1's BSP dated 4/9/23 was documented as being reviewed as a component of the 8/22/23 investigation. QAM indicated the QAC (Quality Assurance Coordinator) had completed the investigation. QAM indicated the QAC's supervisor and would follow-up to clarify the investigation's findings regarding physical aggression towards himself, or threats of self-harm suicidal ideation was listed as not target behaviors and no history of the behaviors. QAM indicated client #1's BSP dated 4/9/23 indicated staff working with client #1 harmed himself or made threats to harm himself. QAM indicated the BSP listed the RM (Residential Manager) as the person staff should contact but the position had	ROVIDER OR SUPPLIER E COMMUNITY ALTERNATIVES SE IN SUMMARY STATEMENT OF DEFICIENCIE (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION data. Client #1's Psychiatrist visit note dated 8/24/23 indicated the following: -"Staff reports they have observed SIB when stressed or anxious. Recent reports of running into traffic for attention when [unknown staff] was in the home working on behaviors. When questioned about that he stated "It's a joke." Discussed that suicide attempts and thought are taken very seriously." QAM (Quality Assurance Manager) was interviewed on 10/4/23 at 12.45 PM. QAM indicated client #1 had a BSP and the most current plan was dated 4/9/23. QAM indicated client #1's target behaviors include physical aggression towards himself and threats to self-harm/suicidal ideation. QAM indicated the 8/22/23 investigation regarding client #1's BSP dated 4/9/23 was documented as being reviewed as a component of the 8/22/23 investigation. QAM indicated the QAC (Quality Assurance Coordinator) had completed the investigation. QAM indicated the QAC (Quality Assurance Coordinator) had completed the investigation. QAM indicated the QAC (Quality Assurance Coordinator) had completed the investigation of findings regarding physical aggression towards himself, or threats of self-harm suicidal ideation was listed as not target behaviors and no history of the behaviors. QAM indicated client #1's BSP dated 4/9/23 indicated staff working with client #1 should notify the AS (Area Supervisor) if client #1 harmed himself or made threats to harm himself. QAM indicated the BSP listed the RM (Residential Manager) as the person staff's hould contact but the position had

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 34 of 56

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/12/2023
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	1031 W	ADDRESS, CITY, STATE, ZIP COD EST ST LBANY, IN 47150	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
	notify the administrative team which included QAM to determine if client #1's Safety Protocol should be implemented. QAM indicated the 8/22/23 investigation did not include documentation of finding of fact and determination or analysis regarding if staff implemented client #1's BSP strategies regarding self-harm or threats of self-harm. QAM indicated client #1's ABC tracking indicated client #1 had incidents of physical aggression towards himself and/or threat of self-harm/suicidal ideation during the months of July and August 2023. QAM indicated client #1's September 2023 ABC was blank with no documentation of behavioral incidents. QAM indicated the IDT (Interdisciplinary Team) should review and make recommendations to prevent recurrence of client #1's SIB or threats of SIB. QAM was interviewed on 10/4/23 at 1:47 PM. QAM indicated she followed-up with QAC regarding client #1's BSP and the findings listed in the 8/22/23 Investigation. QAM stated, "[QAC] said the SIB and PA (physical aggression) was an unfortunate oversight on her part." QAM indicated she was notified on 8/14/23 regarding client #1's threats of self-harm and physical aggression towards himself. QAM indicated there was not documentation available to review regarding client #1's other incidents of physical aggression towards himself or threats of SIB. 9-3-2(a)			
W 0159	483.430(a) QIDP			
Bldg. 00	Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who-			

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 35 of 56

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
15G127		B. WING 10/12/2023			10/12/2023		
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			/EST ST		
DES CAI	DE COMMI INITY A	LTERNATIVES SE IN			LBANY, IN 47150		
NES CAI	NE COMMUNITITY A	ALTERNATIVES SE IN		INEVV A	EBANT, IN 47 150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		on, record review and	W ()159	Facility Number: 00664	11/17/2023	
		s sampled clients (#1, #2 and #3)			Provider Number: 15G127		
		client (#8), the QIDP (Qualified			AIMS Number: 100234310		
		ities Professional) failed to					
	integrate, coordinat	te and monitor: 1) timely access			PROVIDER: RESCARE		
		l by client #2, 2) include client			COMMUNITY ALT. SE IN. Inc		
		n the IDT (Interdisciplinary			ADDRESS: 1031 West Stree	t,	
		ensure cigarettes were available			New Albany, IN		
	_	t #2's smoking schedule, 4)			DATE SURVEY COMPLETED):	
		ed active treatment schedules			October 12, 2023		
	_	#1, #2 and #3's training goals					
		, 5) collect data to monitor goal					
		nts #1, #2 and #3's ISPs			W 159 QIDP CFR(s): 483.430	(a)	
		t Plans), and 6) review and					
	_	CFA (Comprehensive			The Facility will ensure e	each	
	Functional Assessn	nent) following a decline in his		client's active treatment program		am	
	health.				is integrated, coordinated and		
					monitored by a qualified		
	Findings include:				intellectual disability professio	nal	
					The QAM will inservice t		
		d was reviewed on 10/4/23 at			QIDP on including call clients	in	
		's 6/13/23 smoking schedule			the facility in all IDTs		
		e/IDT (Interdisciplinary Team)			The QIPD will update CI	=A	
		ment the cost of cigarettes for			and develop a formal money		
	[client #2] if he is v	willing to attend workshop."			management goal to teach cli	ents	
					in the facility to manage their		
	· ·	upport Lead) and QIDP were			finances.		
		03/23 at 5:53 PM. The DSL			Goals will be updated ba		
		had been out of cigarettes for a			on the QIDP assessment deve		
		licated client #2 purchased			a formal money management	-	
		his own cigarettes with the \$52			to teach clients how to manag	е	
		d. The QIDP indicated when			his finances.	_	
		cigarettes the facility would			QIDP will update The IS		
	1 .	arettes. The DSL indicated			(Individual Support Plan) base	ed on	
		ed for the clients from the			assessment.		
		the check was ready to be			The QIDP will retrain all	staff	
		one week from the date of			in the facility on updated ISP.		
	request.				The Area Supervisor wil		
					retrain staff on ResCare check		
	Client #8 was inter	viewed on 10/3/23 at 4:24 PM.			request policy and ensure fun	ds	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		15G127	B. W	ING		10/12	/2023
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			EST ST		
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		NEW ALBANY, IN 47150			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Client #8 indicated he can request money from the				are available for client use.		
		t a week before he received the			All staff in the facility will	be	
	money. The QIDP was interviewed on 10/4/23 at 4:36 PM.				retrained on client#2 smoking		
					policy and the DSL will ensure		
					cigarettes are available per pla	an	
		d clients can request funds			requirement.		
		The QIDP indicated the funds			A member of the		
	_	n the business office. The			Administrative team will condu		
	-	ce the funds were available			monthly site reviews for all clie		
	there was a three day wait before the check could				in facility and the administrato	r will	
	be given to the clien	nts.			hold a weekly ICF meeting to		
					discuss issues that arise in the	9	
	The QAM (Quality Assurance Manager) was interviewed on 10/5/23 at 11:00 AM. The QAM				facility.		
		•					
		ere requested from the facility's			Persons Responsible: AED,		
		QAM indicated the check was			Quality Assurance Manager, (ĮΑ	
		ice and held for two days to			Coordinator/QIDP Manager,		
		e in the account. The QAM			Program Manager, Area		
		was requested on Monday, it			Supervisor, QIDP, Direct Supp	oort	
	_	ked up by the client and staff			Lead, and DSP.		
	_	e QAM indicated a discussion			DATE OF COMPLETION:		
	_	f a client did not receive funds			November 17, 2023		
	in a timely manner.						
	2 The OIDD foiled	to include client #2's					
	,	IDT meetings. Please see					
	W209.	112 1 moonings. I lease see					
	200.						
	3. The OIDP failed	to ensure cigarettes were					
	-	nent client #2's smoking					
	schedule. Please se						
		-					
	4. The QIDP failed	to ensure individualized active					
	-	s incorporated client					
		ining goals throughout the day.					
	Please see W250.						
	5 The OIDD foiled	to collect data to monitor goal					
	-	nts #1, #2 and #3's ISP goals.					
	Please see W252	115 #1, #2 and #3 5 13F goals.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION <u>00</u>	(X3) DATE SURVEY COMPLETED 10/12/2023	
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
W 0200	6. The QIDP failed to review and update client #2's CFA following a decline in his health to reassess his ability to safely access the community independently. Please see W259. 9-3-3(a)				
W 0209 Bldg. 00	INDIVIDUAL PROGRAM PLAN Participation by the client, his or her parent (if the client is a minor), or the client's legal guardian is required unless the participation is unobtainable or inappropriate. Based on record review and interview of 1 of 3 sampled clients (#2), the facility failed to include client #2's participation in the IDT (Interdisciplinary Team) meetings. Findings include: A review of client #2's record was completed on 10/4/23 at 1:22 PM. The IDT (Interdisciplinary Team) meeting signature sheet did not have client #2's signature for IDT notes dated 4/14/23 and 8/25/23 when the team met and discussed his request for alone time. The QIDP (Qualified Intellectual Disability Professional) was interviewed on 10/4/23 at 4:36 PM. The QIDP indicated if a client participated in	W 0209	Facility Number: 00664 Provider Number: 15G127 AIMS Number: 100234310 PROVIDER: RESCARE COMMUNITY ALT. SE IN. Inc. ADDRESS: 1031 West Street New Albany, IN DATE SURVEY COMPLETED October 12, 2023 W 209 INDIVIDUAL PROGRA PLAN CFR(s): 483.440(c)(2) The Facility will ensure ecclient's the client's, legal guard	t, : M	
	the IDT meeting their signature would be on the attendance sheet. The QIDP indicated client #2's signature was not on the signature page for his IDT meetings dated 4/14/23 and 8/25/23. 9-3-4(a)		participation in the individuals program plan unless participat is unobtainable. The QAM will in-service QIDP on including call clients the facility in all IDTs A member of the Administrative team will condu	the in	

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet

Page 38 of 56

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

PRINTED: 11/14/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 10/12/2023	
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY)	(X5) COMPLETION DATE	
			monthly site reviews for all clie in facility and the administrator hold a weekly ICF meeting to discuss issues that arise in the facility.	r will	
			Persons Responsible: AED, Quality Assurance Manager, C Coordinator/QIDP Manager, Program Manager, Area Supervisor, QIDP, Direct Supp Lead, and DSP. DATE OF COMPLETION: November 17, 2023		
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 1 of 3 sampled clients (#2), the facility failed to have cigarettes available in order to implement client #2's smoking schedule. Findings include: Observations were completed at the group home on 10/3/23 from 4:43 PM to 7:00 PM and on 10/4/23 from 6:33 AM to 9:38 AM. Client #2 did not smoke during these observations.	W 0249	Facility Number: 00664 Provider Number: 15G127 AIMS Number: 100234310 PROVIDER: RESCARE COMMUNITY ALT. SE IN. Inc ADDRESS: 1031 West Street New Albany, IN DATE SURVEY COMPLETED October 12, 2023	i,	

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 39 of 56

CENTERS FOR MEDICARE & MEDICAID SERVICES						OM	B NO. 0938-039
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		15G127	B. W	ING		10/12/	/2023
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		1031 W	ADDRESS, CITY, STATE, ZIP COD VEST ST LLBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	I		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
	-The special service 06/13/2023 indicate "[Client #2] will no every 2 hours. [Cli locked until it is tim staff will then provicigarette. On the of #2] with (1) lozeng as recommended by Staff will provide [6:00 AM (if he is at AM, 12:00 PM, 2:0 PM, 10:00 PM (if he is at AM, 10:00 PM (if he is at AM, 10:00 PM).	e plan smoking schedule dated ed: t smoke more than 1 cigarette ent #2's] cigarettes will be kept the for him to have a cigarette, the [Client #2] with one of thour, staff will provide [Client et e or (1) piece of nicotine gum, whis physician. Client #2] with (1) cigarette at: wake) 6:00 PM, 8:00 AM, 10:00 0 PM, 4:00 PM, 6:00 PM, 8:00 e is awake), 12:00 AM (if he is			W 249 PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(1) As soon as the interdisciplinary team has formulated a client's individual program plan, each client mu- receive a continuous active treatment program consisting needed interventions and ser in sufficient number and frequ to support the achievement or objectives identified in the individual program plan. The Area Supervisor wi retrain staff on ResCare chec	of vices uency f the	
	awake) and 6:00 Al ResCare/IDT is wil	f he is awake), 4:00 PM (if he is M (if he is awake). ling to supplement the cost of t #2] if he is willing to attend			request policy and ensure fur are available for client use. All staff in the facility wil retrained on client#2 smoking policy and the DSL will ensure ciggaretts are available per place.	ll be I e	
	interviewed on 10/0 indicated client #2 l week. The DSL ind tobacco and rolled l a month he received	apport Lead) and QIDP were 03/23 at 5:53 PM. The DSL and been out of cigarettes for a cicated client #2 purchased his own cigarettes with the \$52 dt. The QIDP indicated when cigarettes the facility would rettes.			A member of the Administrative team will cond monthly site reviews for all cli in facility and the administrate hold a weekly ICF meeting to discuss issues that arise in th facility.	ents or will	
	The nurse indicated cessation program.	viewed on 10/3/23 at 4:35 PM. client #2 was on a smoking The nurse indicated as part of ility agreed to pay for client			Persons Responsible: AED, Quality Assurance Manager, Coordinator/QIDP Manager, Program Manager, Area		

#2's cigarettes if he was unable to afford them.

Supervisor, QIDP, Direct Support

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>			(X3) DATE SURVEY COMPLETED	
		15G127	B. WI	NG		10/12	/2023
	PROVIDER OR SUPPLIER	LTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
ING	9-3-4(a)	ESC IDENTIFY THE INFORMATION		ing	Lead, and DSP. DATE OF COMPLETION: November 17, 2023		DATE
W 0250	483.440(d)(2)						
Bldg. 00	schedule that outli treatment program available for review Based on observation review of 3 of 3 sand the facility failed to treatment schedules	EMENTATION levelop an active treatment lines the current active in and that is readily w by relevant staff. on, interview and record inpled clients (#1, #2 and #3), ensure individualized active incorporated clients #1, #2 als throughout the day.	W 0	250	Facility Number: 00664 Provider Number: 15G127 AIMS Number: 100234310		11/17/2023
	Findings include: Observations were conducted on 10/4/23 from 6:33 AM to 9:38 AM. Client #2 set the table in the dining room at 7:01 AM. Client #2 sat at the table eating breakfast at 7:27 AM. Client #2 took his dishes to the kitchen at 7:35 AM and put on his oxygen. Client #3 requested the bathroom cleaner at 7:42 AM to clean the two bathrooms upstairs. Client #2 took off his oxygen at 8:11 AM. Client #2 got into bed to take a nap at 8:24 AM. Client #3 played a computer game while talking to an online friend at 9:18 AM. Client #1's record was reviewed on 10/4/23 at 11:55 AM. The active treatment schedule, undated, indicated, "The schedule is intended to direct the intensity of staff training with [client #1]Do the				PROVIDER: RESCARE COMMUNITY ALT. SE IN. Inc ADDRESS: 1031 West Stree New Albany, IN DATE SURVEY COMPLETED October 12, 2023	t,	
					W 250 PROGRAM IMPLEMENTATION CFR(s): 483.440(d)(2) The facility will maintain active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff. The QIDP will review all clients in the facility active	t	
					treatment schedule and make update actives based on this review.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUII	A. BUILDING <u>00</u> COMPLETED			ETED
		15G127	B. WING 10/12/2023			2023	
				CTREET A	DDBECC CITY CTATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
DEC OAE		TEDNIATIVES OF IN	1031 WEST ST				
RES CAR	RES CARE COMMUNITY ALTERNATIVES SE IN			NEW AL	LBANY, IN 47150		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	_{TC}	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	' ⁻	DATE
	following from 9am-4pm daily; work on				The QIPD will review all		
	communication skil	ls, domestic skills, practice			clients goals in the facility and		
		to the park, out to eat.			make update actives based or		
		treatment, search for			this review.		
	employment."	,			The QAM will Retrain the QID	Pon	
	1 3				maintaining an active treatmer		
	Client #2's record w	vas reviewed on 10/4/23 at 1:22			schedule that outlines the curr		
		tment schedule, undated,			active treatment program and		
		edule is intended to direct the			is readily available for review b		
		ining with [client #2]Do the			relevant staff	·	
	-	n-4pm daily; communicating to			The QIDP will retrain all	etaff	
staff where he would like to go for an outing,				in the facility on revised active			
	exercising (sic) -going for a walk, etc. [Client #2]				treatment schedules.		
	may also choose from the following activities that				The DSL will ensure wee	skly	
	-	o: going to movies, shopping,				•	
					staff are following active treatr		
	out to eat."	visiting a park or museum, go			schedules, random periodic dr	-	
	out to cat.				in observations will be done by		
	C1:	10/4/22 -+ 2:00			Area Supervisor weekly to ens		
		vas reviewed on 10/4/23 at 2:00			active treatment schedule is b	eing	
		dated, indicated "The			followed.		
		I to direct the intensity of staff			A member of the		
		#3]Do the following from			Administrative team will condu		
		rk on communication skills,			monthly site reviews for all clie		
		ctice pedestrian skills, go to			in facility and the administrator	r will	
	•	Participate in active treatment,			hold a weekly ICF meeting to		
	search for employm	ient."			discuss issues that arise in the	•	
					facility.		
		viewed on 10/3/23 at 4:01 PM.					
		during the day he wakes up,					
		ns, eats breakfast and spends					
		e rest of the morning. Client #3			Persons Responsible: AED,		
		vnstairs and offered to help			Quality Assurance Manager, C	QA A	
		e he doesn't want to be			Coordinator/QIDP Manager,		
	"cooped up" in his r	room all day.			Program Manager, Area		
					Supervisor, QIDP, Direct Supp	ort	
		viewed on 10/4/23 at 6:33 AM.			Lead, and DSP.		
		he sleeps when he is not			DATE OF COMPLETION:		
	working.				November 17, 2023		
	DSP (Direct Suppor	rt Professional) #1 was					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/12/2023			
	PROVIDER OR SUPPLIER	TERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
	interviewed on 10/4 indicated clients #1, medication goals du client #2 helped to can #1 and #3 had goals #1 indicated the clie and use a local gym DSP #2 was intervied DSP #2 indicated claunce every other mechurch. The QIDP (Qualified Professional) was in PM. The QIDP indicated the the house and staff s	#2 and #3 worked on ring the day. DSP #1 indicated clients to work during the day. DSP ents participated in activities pass to play basketball. Ewed on 10/4/23 at 6:56 AM. ients #1, #2 and #3 attended a nonth hosted by a local d Intellectual Disabilities atterviewed on 10/4/23 at 4:36 cated an activity should be ery 15 to 30 minutes. The schedules were available at should be able to produce yout the clients day time			DATE		
W 0252 Bldg. 00	criteria specified in plan objectives mu measurable terms Based on record and clients (#1, #2, and data in order to more	complishment of the n client individual program ust be documented in . I interview for 3 of 3 sampled #3), the facility failed to collect uitor goal progression of	W 0252	Facility Number: 00664	11/17/2023		
	Plan) goals. Findings include: Client #1's record w	as reviewed on 10/4/23 at 11:55		Provider Number: 15G127 AIMS Number: 100234310 PROVIDER: RESCARE COMMUNITY ALT. SE IN. Inc ADDRESS: 1031 West Stree New Albany, IN			

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 43 of 56

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 10/12/2023 15G127 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **1031 WEST ST** RES CARE COMMUNITY ALTERNATIVES SE IN NEW ALBANY, IN 47150 (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 following goals: "Domestic Skills- [Client #1] DATE SURVEY COMPLETED: would like to participate in the maintenance of a October 12, 2023 clean safe environment in which to live, [Client #1] would like to improve his personal independence by being able to complete his daily hygiene W 252 PROGRAM routine, [Client #1] would like to increase his DOCUMENTATION CFR(s): independence by being able to manage his 483.440(e)(1) money, [Client #1] wants to increase his independence by working toward self-administration of medication skills, [Client #1] The facility will develop and would like to learn positive coping skills to maintain a recordkeeping system increase his ability to manage behaviors so that that documents the client's health he may increase his overall independence and care, active treatment, social [Client #1] wants to increase independence by information, and protection of the having a job." client's rights. The Area Supervisor will Client #1's monthly summaries for June 2023, July retrain all staff in the facility on 2023 and August 2023 were reviewed. The page to completing goal tracking data on a show data progress was blank for each summary. daily basis The Area Supervisor will Client #2's record was reviewed on 10/4/23 at 1:22 retrain all staff in the facility on PM. The ISP dated 1/31/23 indicated the following notifying the QIDP if goal tracking goals: "[Client #2] will help with mealtime is unavailable in Task Master Pro preparation with 2 verbal prompts 80% of based on goals being timed out. opportunities for 12 months by 5/5/2023, To The QAM will retrain the QIDP on review Goal Data monthly increase his personal care skills, [Client #2] wants to increase independence by having a job, To at a minimum. improve personal hygiene skills." The QAM will retrain the QIDP on reviewing goal tracking Client #2's monthly summaries for June 2023, July during IDTs 2023 and August 2023 were reviewed. The page to The QAM will retrain QIDP show data progress was blank for each summary. on Goal Tracking data entry and review in Task Master Pro. Client #3's record was reviewed on 10/4/23 at 2:00 The QIDP will verify Goal PM. The ISP dated 10/20/23 indicated the end dates in Task Master Pro and following goals: "Domestic Skills- [Client #3] verify goal tracking remain current would like to participate in the maintenance of a if data is not current QIPS will clean safe environment in which to live, [Client #3] notify the Area Supervision and would like to improve his personal independence Program Manager who will by being able to complete his daily hygiene in-service DSL and DSPs in the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	ING	00	COMPL	ETED
		15G127	B. WING	B. WING 10/12/2023			2023
			ST	REET A	DDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	L	1031 WEST ST				
RES CAF	RE COMMUNITY AI	LTERNATIVES SE IN	NEW ALBANY, IN 47150				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL					COMPLETION
TAG		LISC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
		would like to increase his			facility.		
		ing able to manage his			A member of the		
	money, [Client #3] wants to increase his				Administrative team will condu		
	independence by wo	_			monthly site reviews for all clie		
		of medication skills and [Client			in facility and the administrator	r will	
	_	earn positive coping skills to			hold a weekly ICF meeting to		
	increase his ability to manage behaviors so that				discuss issues that arise in the)	
	he may increase his overall independence." Client #3's monthly summaries for June 2023, July 2023 and August 2023 were reviewed. The page to show data progress was blank for each summary.				facility.		
					Persons Responsible: AED,		
					Quality Assurance Manager, C	QΑ	
					Coordinator/QIDP Manager,		
	The QIDP was interviewed on 10/4/23 at 11:37				Program Manager, Area		
		nalified Intellectual Disabilities			Supervisor, QIDP, Direct Supp	ort	
	· ·	ated she met with the IDT			Lead, and DSP.		
		eam) quarterly to talk about			DATE OF COMPLETION:		
	goal progress.				November 17, 2023		
	The QIDP was inter	rviewed on 10/4/23 at 12:15 PM.					
	*	I she does not review					
	-	g how often the clients meet					
	their goal criteria du						
	_						
	9-3-4(a)						
W 0259	483.440(f)(2)						
	, , , ,	TORING & CHANGE					
Bldg. 00	At least annually,	the comprehensive					
		nent of each client must be					
	reviewed by the in	terdisciplinary team for					
	relevancy and upo	dated as needed.					
		view and interview of 1 of 3	W 0259)	Facility Number: 00664		11/17/2023
	sampled clients (#2)), the facility failed to review			Provider Number: 15G127		
	_	2's CFA (Comprehensive			AIMS Number: 100234310		
	Functional Assessm	nent) following a decline in his					
	health to reassess hi	is ability to safely access the			PROVIDER: RESCARE		
	community indepen	dently.		1	COMMUNITY ALT. SE IN. Inc.		
					ADDRESS: 1031 West Street	t,	
	Findings include:				New Albany, IN		

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 45 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLET			
		15G127	B. W	ING		10/12/20)23
NAME OF P	ROVIDER OR SUPPLIER	•		1	ADDRESS, CITY, STATE, ZIP COD	_	
				1	VEST ST		
RES CAF	KE COMMUNITY A	LTERNATIVES SE IN		NEW A	LBANY, IN 47150		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE C	COMPLETION
TAG	REGULATORY OR	LISC IDENTIFYING INFORMATION		TAG		\	DATE
	The facility's RDDS	S (Bureau of Developmental			DATE SURVEY COMPLETED October 12, 2023) [;]	
Disabilities Services) reports were reviewed on				October 12, 2023			
		M. The review indicated, the					
	following:						
					W 259 PROGRAM MONITOR	RING	
	-BDDS report dated	1 4/11/23 indicated, "It was			& CHANGE CFR(s): 483.440(f)(2)	
		was at his psychiatrist			Update CFA will be complete	by	
		ne appeared to not feel well.			QIDP		
		ecked [client #2's] oxygen level					
and found oxygen to be 91%. The psychiatrist							
advised [client #2] to be transported to ER				The facility will ensure th			
(Emergency Room) for evaluation."				rights of all clients. Therefore,	the		
	i				facility must allow individual		
	and,			clients to manage their financial affairs and teach them to do so to			
	"Staff two are aut and E	aliant #21 to ED whom he was					
		client #2] to ER where he was 2] was admitted for		the extent of their capabilities.			
	_	re will maintain contact with		The QIPD will update CFA			
	hospital and prepare				and develop a formal money management goal to teach		
	nospitai and prepare	tor discharge.			client#2 to manage his finance	20	
	-BDDS report dated	1 6/5/23 indicated, "Staff			Goals will be updated ba		
	_	appeared to be breathing	on the QIDP assessment develop				
		appeared red. Staff took		a formal money management goal			
	· ·	nd his O2 (oxygen) was 91%.			to teach client#2 to manage h	-	
		2] a PRN (as needed) breathing			finances.		
	treatment and his O	2 dropped to 83%. [Client #2]			The QIDP will review all		
	refused to go to the	hospital. Staff called EMS			remaining Clients CFAs and n	nake	
		al Service) and [client #2]			updates to the ISP based on		
		nospital via ambulance. [Client			recommendations from the ID		
	_	nd advised to be admitted.			comprised of para-professions		
		admission to the hospital and			QIDP will update The IS		
		ainst Medical Advice. [Client			(Individual Support Plan) base	ed on	
		group home with staff. [Client			assessment.		
	-	ter and was advised by ER			The QIDP will retrain all	staff	
		vas at risk, [client #2] still			in the facility on updated ISP.		
	refused treatment as	nd left the hospital."			A member of the		
	and				Administrative team will condu		
	and,				monthly site reviews for all clie	l l	
					a na aciniy ano me aominisiralo	1 VVIII I	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COMPLETEI			ETED	
		15G127	B. W	B. WING			10/12/2023	
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	PROVIDER OR SUPPLIEF	8	1031 WEST ST					
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN		NEW ALBANY, IN 47150				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION		
TAG				TAG			DATE	
	_	nancipated adult with a POA			hold a weekly ICF meeting to discuss issues that arise in the			
	(Power of Attorney) in place. An IDT (Interdisciplinary Team) will be held to discuss [Client #2's] medical condition and come up with a plan to address [client #2's] medical needs to ensure his health and safety. [Client #2] is doing well at this time, with no further complaints or concerns reported by staff." -BDDS report dated 6/8/23 indicated, "It was reported the nurse was assessing [client #2] when he appeared to have labored breathing. The nurse				facility.	=		
					lacinty.			
					Persons Responsible: AED,			
					Quality Assurance Manager, 0	QΑ		
					Coordinator/QIDP Manager,			
					Program Manager, Area			
					Supervisor, QIDP, Direct Supp	oort		
					Lead, and DSP.			
					DATE OF COMPLETION:			
	advised [client #2] to go to the hospital for				November 17, 2023			
	evaluation and he agreed. Staff transported [client							
	#2] to the ER at [ho	ospital]."						
	and							
	and,							
	"[Client #2] was ev	aluated and admitted to the						
	_	osis of Dyspnea (labored						
		restricted airway and difficulty						
		poxia (absence of oxygen in the						
		t care plan is to treat with						
	steroids (inflammat	ion), breathing treatments and						
	O2 (oxygen). [Clien	nt #2] did not test positive for						
	any respiratory infe	ctions. [Facility] will maintain						
	contact with hospita	al and prepare for discharge."						
	-	d 9/24/23 indicated, "It was						
	-	nt #2] was eating a pork chop						
	-	ughed, lost consciousness,						
	fell backwards onto	nis bladder. [Client #2] became						
		er. Staff called 911. EMS						
		rted [client #2] to the ER for						
	evaluation."	rea [shelle "2] to the ERC for						
	- / 41-441-011							
	and,							
	, ,							
	"[Client #2] was ev	aluated in the ER and						

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 47 of 56

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CO A. BUILDING B. WING						
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST					
RES CAF	RE COMMUNITY A	LTERNATIVES SE IN	NEW A	LBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	choking episode, sy consciousness), uns [tests] completed. F Care Physician) in specialist as indicate been trained on the follow up appointm monitor [client #2, instructions, and no [Client #2's] dining regular diet and lique reviewed by ResCamade as needed after Client #2's record w PM. -The BSP (Behavior indicates, "ALONE #2's] alone time has a staff following him health issues. Due to potential to have an in the community at the community	pecified type. [Labs] and follow up with PCP (Primary I to 2 days, follow-up with any ed and discussed. Staff have orders and will schedule the ent. Staff will continue to follow all discharge tify the nurse of any changes. plan is in place and current for aids. His dining plan will be re LPN and changes will be er follow-ups." Take reviewed on 10/4/23 at 1:22 TIME PROTOCOL: [client been restricted unless he has m in the community due to his to the lack of oxygen and his issue, he needs supervision						

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet

Page 48 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 15G127		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 10/12/2023		
	PROVIDER OR SUPPLIER RE COMMUNITY ALTERNATIVES SE IN	STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	from school/work unattended, can go to/return from recreation activities unattended, walks alone and walks up/down stairs alone."					
	The HRP (High Risk Plan) dated 10/3/23 for client #2's Postural Hypotension (low blood pressure that occurs when standing up from sitting, laying down or bending over) indicates: "Triggers to NOTIFY NURSE -Most people have no symptoms but the following may occur: Dull headaches, dizziness or blurred vision. CALL 911 if new onset of slurred speech, uncomfortable pressure, fullness, squeezing or pain in the center of the chest lasting more than a few minutes, pain spreading to the shoulders, neck or arms. It may feel like pressure, tightness, burning, or heavy weight. It may be located in the chest, upper abdomen, neck, jaw, or inside the arms or shoulders, chest discomfort with lightheadedness, fainting, sweating, nausea or shortness of breath, anxiety, nervousness and/or cold, sweaty skin, paleness or pallor or increased or irregular heart rate."					
	The nurse was interviewed on 10/3/23 at 4:35 PM. The nurse stated, "[Client #2] is a long time heavy smoker. He has seen his primary and pulmonary doctor and they have gone over dignity of risk. He chooses to smoke." The nurse indicated an incident when client #2 bent over to sweep up dust. The nurse indicated when client #2 stood up, he became dizzy and staff caught him before falling.					
	Client #2 and the QIDP were interviewed on 10/3/23 at 5:58 PM. Client #2 indicated he would like his alone time back. The QIDP indicated client #2 no longer has alone time because he passed out and it was not safe for him to be unsupervised.					

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet

Page 49 of 56

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 10/12/2023				
		15G127	B. WIN	·		10/12/	2023
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP COD		
RES CARE COMMUNITY ALTERNATIVES SE IN				1031 W	EST ST _BANY, IN 47150		
	CARE COMMONITY ALTERNATIVES SE IN				_DAN1, IN 47 130		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION PREFTY (EACH CORRECTIVE ACTION SHOULD BE			(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL I SC IDENTIFYING INFORMATION	P	REFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
W 0350	The nurse was interviewed on 10/4/23 at 3:27 PM. The nurse indicated client #2 had passed out once. The nurse indicated client #2 almost fell due to Postural Hypotension. The nurse indicated if client #2 had a coughing spell, she was concerned he may pass out. The nurse indicated client #2 needs staff with him when in the community for his safety. The QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 10/4/23 at 4:36 PM. The QIDP indicated client #2's motor skills have changed. The QIDP indicated client #2 had alone time, but when breathing issues occurred causing him to pass out he is no longer able to have unsupervised time. The QIDP indicated assessments need to be revised if a client's health changes. 9-3-4(a) 483.460(e)(3)						
Bldg. 00	DENTAL SERVICES The facility must provide education and training in the maintenance of oral health. Based on record review and interview of 2 of 3		W 03	550	Facility Number: 00664		11/17/2023
		and #3), the facility failed to			Provider Number: 15G127		
	_	1 and #3's oral health needs ng program goal to address			AIMS Number: 100234310		
	_	nade by their dentist.			PROVIDER: RESCARE		
	Findings include: 1. Client #1's record was reviewed on 10/4/23 at 11:55 AM. The ISP (Individual Support Plan) dated 1/31/23 indicated the following goal: "[Client #1] would like to improve his personal independence by being able to complete his daily hygiene routine. GOAL 2: [client				COMMUNITY ALT. SE IN. Inc ADDRESS: 1031 West Street New Albany, IN		
					DATE SURVEY COMPLETED October 12, 2023	:	
					W 350 DENTAL SERVICES CFR(s): 483.460(e)(3)		

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 50 of 56

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER						COMPLETED		
		15G127	B. Wl	ING		10/12/	/2023	
NAME OF PROVIDER OR SUPPLIER				STREET A	ADDRESS, CITY, STATE, ZIP COD	•		
While Of TROVIDER OR SUITERER				1031 WEST ST				
RES CARE COMMUNITY ALTERNATIVES SE IN				NEW ALBANY, IN 47150				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY		DATE	
		of the opportunities across 12			The Feelite will answer			
		by 4.19.24. Methodology			The Facility will ensure e			
	indicated: Staff will	-			training in the maintenance of			
		to work on hygiene goals			health.	Ulai		
	_	wering, bathing, etc.)"			The QIPD will update cli	ent		
	(Stashing teem, she				goals with facility nursing impu			
	Client #1's dental a	opointment consult record			education and training in the	011		
		cated, "Oral hygiene-fair/poor,			maintenance of oral health			
		gingivitis (inflammation of the			Client Goals will be upda	ated		
		laily gum line brushing to heal			based on Dentist			
	tissues and prevent	decay. Findings of			recommendations by the QIDI	٥.		
	examination: moderate gingivitis."				QIDP will update The IS	Р		
					(Individual Support Plan) base	ed on		
	2. Client #3's record was reviewed on 10/4/23 at				assessment.			
		dated 10/20/22 indicated the			The QIDP will retrain all			
	following goal: [Client #3] would like to improve				in the facility on updated ISP.			
		ndence by being able to			A member of the			
		nygiene routine. [Client #3] will			Administrative team will condu			
		ene routine with two verbal			monthly site reviews for all clie			
		opportunities across 12			in facility and the administrato	r will		
		by 10.23. Methodology			hold a weekly ICF meeting to	_		
		prompt [Client #3] twice it is			discuss issues that arise in the	9		
	showering, bathing,	giene goals(brushing teeth,			facility.			
	snowering, bauning,	, c.c.,						
	-Client #3's Dental	consult record dated 3/29/23						
	indicated, "Oral hyg	giene fair with gingivitis. Needs			Persons Responsible: AED,			
		brushing to heal tissues.			Nurse, DON, Quality Assurance	ce		
	` *	ique) on upper and lower			Manager, QA Coordinator/QID			
	interior." -Client #3's Dental consult record dated 10/4/23 indicated, "Plague/calculus on front gum lines. Brush better daily to heal tissues. Physician				Manager, Program Manager,			
					Supervisor, QIDP, Direct Supp	oort		
					Lead, and DSP.			
					DATE OF COMPLETION:			
					November 17, 2023			
	orders: daily gum li	ne brushing."						
	-Client #3's Dental	consult record dated 3/9/23						
		fair, moderate gingivitis.						
		Physician orders: floss/brush better."						

ľ		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED			
AND PLAN	OI CORRECTION	15G127	B. WING 10/12/2023			
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN		STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	indicated, "Oral hyg with daily gum line Findings: gingivitis The nurse was inter The nurse indicated with heavy plaque a brush his gum line of in-serviced the staff to brush better. The (Qualified Intellectudoes not receive the recommendations. The in-serviced the DSP Professionals) and to	viewed on 10/4/23 at 3:27 PM. client #1 had fair oral hygiene and was recommended to daily. The nurse indicated she to monitor and encourage him nurse indicated the QIDP hal Disability Professional) e dental assessment The nurse indicates she				
	in-service. An e-mail received by the nurse on 10/5/23 at 11:37 AM indicated, she was unable to locate the staff in-service instruction for staff to monitor and encourage better brushing. The nurse indicated they will be retrained. The QIDP was interviewed on 10/4/23 at 4:36 PM. The QIDP indicated the nurse trained staff on medical appointment recommendations and texted the information to the team. The QIDP indicated she was unaware of concerns with client #1 and #3's oral hygiene. The QIDP indicated if tooth brushing was an issue, she would implement a goal in client #1 and #3's Individual Support Plans.					
W 0361	483.460(i) PHARMACY SER	VICES				

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

Event ID:

 $XUMY11 \quad \ \ {\rm Facility\ ID:} \quad \ 000664$

If continuation sheet Page 52 of 56

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	A. BU	X2) MULTIPLE CONSTRUCTION X3) DATE SU A. BUILDING 00 COMPLET B. WING 10/12/20		ETED	
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
Bldg. 00	The facility must parrangements for emergency drugs clients. Drugs and obtained from conpharmacists or the licensed pharmac	provide or make the provision of routine and and biologicals to its d biologicals may be nmunity or contract e facility may maintain a y.					DAIL
	interview for 1 addi failed to have medic	on, record review and itional client (#4), the facility cations stocked in the home 4 missing a medication ordered	W	0361	Facility Number: 00664 Provider Number: 15G127 AIMS Number: 100234310 PROVIDER: RESCARE COMMUNITY ALT. SE IN. Inc. ADDRESS: 1031 West Stree		11/17/2023
	Observations were AM to 9:38 AM.	completed on 10/4/23 from 6:33			New Albany, IN DATE SURVEY COMPLETED October 12, 2023	D:	
	Client #4 came to the med room at 7:44 AM to self-administer his medications. Client #4's Methylphenidate (attention deficit) 20 mg (milligram) was not available.				W 361 PHARMACY SERVICE CFR(s): 483.460(i)	≣S	
	10/04/23 at 2:45 PM dated 9/1/23 indicat "methylphenidate 2 - one tablet by mou Schedule: Daily at 7	0 tab mg ER (extended release) th once daily *no refills*.			Facility administrator retrained staff on QuickMar documentation procedures. S were retrained to understand QuickMar notes and the notification process. Clients #2 Methylphenid (attention deficit) 20 mg has b restocked and available for cli	late een	
	Methylphenidate th in the house. Client focusing at work to medication.	he did not receive his is morning because it was not #4 indicated he had trouble day due to missing his			The Nurse will Staff retrained notifying nurse wher 7days remaining of meds and will be retrained immediately notifying nurse when med is o stock	n ∣Staff	
		rt Professional) #2 was 4/23 at 7:44 AM. DSP #2 ation needed prior			Observations will be complete bi-weekly by the DS and Monthly by area supervis		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 10/12/2023						
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			1031 W	STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR authorization and w pharmacy. The nurse was inter The nurse indicated orders. The nurse in medications when the pack and notify the by the pharmacy. The property of the pharmacy.	ETATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION as not delivered by the viewed on 10/4/23 at 3:27 PM. staff should follow physician dicated staff should reorder here are 7 tablets left in the nurse if they are not delivered he nurse indicated staff would hedication reordering.	ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE				
W 0371 Bldg. 00	assure that clients their own medications team determines to medications is and the physician does Based on observation interview of 1 of 3 stailed to develop a facilient #2 to participal his medication. Findings include: Observations were con 10/3/23 from 4:44 Client #2 came to the DSL (Direct Suppose)	are taught to administer ons if the interdisciplinary hat self-administration of appropriate objective, and if a not specify otherwise. In, record review and ampled clients (#2), the facility formal training objective for ate in the self-administration of sompleted at the group home	W 0371	PROVIDER: RESCARE COMMUNITY ALT. SE IN. Inc ADDRESS: 1031 West Street New Albany, IN DATE SURVEY COMPLETED October 12, 2023	t,			

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet Page 54 of 56

PRINTED: 11/14/2023 FORM APPROVED

CENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	00	COMPLETED		
		15G127	B. WING		10/12/2023	
			CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD VEST ST		
RES CA	RE COMMUNITY A	ALTERNATIVES SE IN		ALBANY, IN 47150		
(VA) ID	CIDAMADV	CTATEMENT OF DEFICIENCIE		, T	(V5)	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
TAG	`	R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPLETION DATE	
IAU		he didn't know the name of his	TAG	W 371 DRUG ADMINISTRATION		
	medication.	the didn't know the name of ms		CFR(s): 483.460(k)(4)	OIN	
	medication.			Ci 1(s). 403.400(k)(4)		
	Observations were completed at the group home			The Facility will ensure		
		33 AM to 9:38 AM.		system for drug administration	and	
			assure that clients are taug			
	Client #2 came to t	the med room at 7:01 AM. DSP		administer their own medication		
		Professional) asked client #2		the interdisciplinary team		
		edication. Client #2 indicated he		determines that self-administra	tion	
		me of his medication. DSP #2		of medications is an appropriat		
	reminded client #2	his Gabapentin was for his arm		objective, and if the physician		
	pain. A review of Client #2's record was completed 10/4/23 at 1:22 PM. The ISP (Individual Support Plan) dated 1/31/23 indicated the following goals: meal preparation, increase personal care skills,			does not specify otherwise.		
				The QIPD will update clie	ent	
				goals to assure that clients are		
				taught to administer their own		
				medications if the interdisciplin	ary	
				team determines that		
		endence by having a job and to		self-administration of medication	ons	
		kills. Client #2's ISP did not		is an appropriate objective, and	d if	
	1	goal for medication		the physician does not specify		
	administration.			otherwise.		
				Client Goals will be upda	ted	
		led Intellectual Disabilities		based on IDT and		
	1	interviewed on 10/4/23 at 4:36		recommendations by the QIDP		
		licated clients should have a		QIDP will update The ISF		
	medication admini	stration goal.		(Individual Support Plan) based	d on	
				assessment.		
	9-3-6(a)			The QIDP will retrain all s		
				in the facility on updated ISP		
				A member of the	-4 -	
				Administrative team will conduct		
				monthly site reviews for all clie		
				in facility and the administrator	WIII	
				hold a weekly ICF meeting to		
				discuss issues that arise in the		
				facility.		
				Persons Responsible: AED,		
	I		1	i eraona iveahonainie. ∀⊏D'	ı	

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

Event ID:

XUMY11 Facility ID: 000664

If continuation sheet

Nurse, DON, Quality Assurance

Page 55 of 56

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

PRINTED: 11/14/2023
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OMB NO. 0938-039

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 15G127	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/12/2023		
NAME OF PROVIDER OR SUPPLIER RES CARE COMMUNITY ALTERNATIVES SE IN			STREET ADDRESS, CITY, STATE, ZIP COD 1031 WEST ST NEW ALBANY, IN 47150				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI TAG DEFICIENCY)		TE	(X5) COMPLETION DATE	
				Manager, QA Coordinator/QID Manager, Program Manager, A Supervisor, QIDP, Direct Supp Lead, and DSP. DATE OF COMPLETION: November 17, 2023	Area		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: XUMY11 Facility ID: 000664 If continuation sheet Page 56 of 56