| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 15G745 | A. BUILDING 00<br>B. WING | 01/17/2013 |

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| RES CARE SOUTHEAST INDIANA | 16611 SIMA GRAY RD<br>HENRYVILLE, IN 47126 |

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| W0000 | This visit was for an investigation of complaint #IN00122282.<br><br>Complaint #IN00122282: Substantiated. Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W249 and W9999.<br><br>Dates of survey: January 9, 10, 11, 14 and 17, 2013.<br><br>Facility Number: 011663<br>Provider Number: 15G745<br>AIM Number: 200902020<br><br>Surveyor: Dotty Walton, Medical Surveyor III<br><br>These deficiencies reflect state findings in accordance with 460 IAC 9.<br>Quality Review completed 1/25/13 by Ruth Shackelford, Medical Surveyor III. | W0000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| W0102 | 483.410<br>GOVERNING BODY AND MANAGEMENT<br>The facility must ensure that specific governing body and management requirements are met.<br>Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to meet the Condition of Participation: Governing Body. The Governing Body failed to exercise general operating direction by failing to implement policy/procedure that prohibited staff neglect of client A (failed to prevent client A from swallowing a battery).<br><br>Findings include:<br><br>Please refer to W104 for 1 of 2 sampled clients (A), for the Governing Body's failure to exercise general operating direction over the facility by failing to implement policies and procedures which prohibited client neglect in regards to client A swallowing a battery.<br><br>Please refer to W122 for the Governing Body's failure to meet the Condition of Participation: Client Protections for 1 of 2 sampled clients (A) . The Governing Body failed to ensure the rights of all clients to be free of neglect, by failing to prevent client A's ingestion of metal objects via behavioral interventions and one to one staffing supervision. | W0102 | **W102: Governing Body and Management**<br>The facility must ensure that specific governing body and management requirements are met.<br><br>**Corrective Action (Specific):**<br>The Program Coordinator and staff will be in-serviced on the Abuse, Neglect and Exploitation Policy and Procedure and Client A's Behavior Support Plan and the interventions regarding the 1:1 supervision and ingesting inedible items.<br><br>**How Others Will Be Identified (Systemic):** The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective.<br><br>**Measures to be put in Place:** | 02/16/2013 |

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| | This federal tag relates to complaint #IN00122282.<br><br>9-3-1(a) | | The Program Coordinator and staff will be in-serviced on the Abuse, Neglect and Exploitation Policy and Procedure and Client A's Behavior Support Plan and the interventions regarding the 1:1 supervision and ingesting inedible items.<br><br>**Monitoring of Corrective Action:** The Operations Manager and Program Coordinator will review internal incident reports and ensure that IDT's are held and any programmatic changes occur as indicated and that all staff are in-serviced on those changes.<br><br>**Completion Date: February 16, 2013** | |

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| W0104 | 483.410(a)(1)<br>GOVERNING BODY<br>The governing body must exercise general policy, budget, and operating direction over the facility.<br>Based on record review and interview, the facility's governing body failed, for 6 of 10 facility incidents/reportable/investigations (alleged neglect, 1 of 2 sampled clients, client A) reviewed, to ensure its policies and procedures regarding implementation of program plans and which prohibited staff neglect of clients were implemented.<br><br>Findings include:<br><br>Review of agency reportable and routine incident reports from October 2012 through 1/07/2013 was done on 01/09/13 at 1:30 PM and 1/11/13 at 5:35 PM. The review indicated the following behavioral incidents, Bureau of Developmental Disabilities Services reports, and a substantiated allegation of staff to client neglect involving client A:<br><br>1. 11/27/12 7:50 PM, staff #14 reported client A, "was Restless. [Client A] went To His Room and Swoled (sic.) Quarters '3'." Client A was taken to a local ER/Hospital Emergency Room for X-Rays.<br>BDDS was notified of the incident by the agency on 11/28/12. The BDDS report | W0104 | **W104: Governing Body**<br>The governing body must exercise general policy, budget and operating direction over the facility.<br><br>**Corrective Action: (Specific):** The Program Coordinator and staff will be in-serviced on the Abuse, Neglect and Exploitation Policy and Procedure and Client A's Behavior Support Plan and the interventions regarding the 1:1 supervision and ingesting inedible items. The Operations Manager and Director of Behavior Services will conduct site observations to ensure that Program Plans are being implemented.<br><br>**How Others Will Be Identified: (Systemic):** The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective.<br><br>**Measures to be Put in Place:** The Program Coordinator and staff will be in-serviced on the | 02/16/2013 |

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| | narrative indicated:<br>"The IDT (interdisciplinary) team has met and [client A] is not allowed to have access to pornography because it will make [client A] depressed and he will engage in self-injurious behavior. [Client A] has a cell phone and had been accessing pornography from the Internet on his phone; when he began having behaviors the BC (Behavior Clinician) and staff asked [client A] what was bothering him. [Client A] reported that when he watched porn (pornography) it causes him to feel depressed and have behaviors. [Client A] got upset because of watching the pornography and went into his room and swallowed three quarters. [Client A] informed staff of what he did and staff took him to ER for observation."<br>The "Plan to Resolve" component of the 11/28/12 BDDS report indicated the following: "The ER physician assessed [client A] and noted that there was (sic.) three quarters in his stomach. The ER physician informed staff that the quarters should pass in a few days. [Client A] is to follow up with his PCP (Primary Care Physician) in two weeks. [Client A] is now home resting with no further complaints. The staff at the house have place (sic.) [client A] on one on one staffing for 24 hours and did a room sweep and removed all items that [client A] would be able to swallow." | | Abuse, Neglect and Exploitation Policy and Procedure and Client A's Behavior Support Plan and the interventions regarding the 1:1 supervision and ingesting inedible items.<br><br>**Monitoring of Corrective Action:** The Operations Manager and Program Coordinator will review internal incident reports and ensure that IDT's are held and any programmatic changes occur as indicated and that all staff are in-serviced on those changes<br><br>**Completion Date: February 16, 2013** | |

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|---|---|---|---|---|

2. 12-02-12 6:20 PM, staff #14 reported client A requested to take a shower. "Wile (sic.) Taking a Shower He Drank some Baby Body wash." Client A was taken to an Urgent Care Center/UCC for evaluation.

3. 12-26-12 8:25 PM, client A indicated he needed to urinate, when he came out of the bathroom, he told staff #13 he had "swallowed some body wash that he had left in there this morning."

4. 12-27-12 2:45 PM, client A was in the facility's office area when three male staff intervened as he took a peer's MP3 player's electrical cord and attempted to ingest it. Staff indicated on the incident report: "[Client A] was walking in circles--looking around, not saying anything to staff, just hanging around. Staff watched [client A] pick a cord out of box (sic.)--pull the end off of it putting into mouth. Staff immediately reacted knocking object out of his mouth. The staff put [client A] on couch holding his hands away from mouth. H/M (House Manager) immediately helped staff hold [client A] down. Another staff [DCS #16] helped get object from hand."

5. 12-28-12 1:45 PM, staff #12 was supervising client A and reported an

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|---|---|---|---|
| | 15G745 | A. BUILDING 00<br>B. WING | 01/17/2013 |

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|---|---|---|---|---|
| | incident wherein client A swallowed a metal hook:<br>"[Client A] was sitting on sofa watching TV. He walked over to (sic.) window to watch (another facility's) behavior that happened on the road. I was between the window and X-mas (Christmas) tree beside [client A]. Because he had been eyeballing X-mas ornaments, I didn't notice him twisting hook off of (sic.) curtain. He swallowed hook without me noticing him. After the incident, he told me he had swallowed something with a smile on his face."<br>Client A was taken to a local ER/ Hospital Emergency Room for evaluation. This 12/28/12 incident was reported to BDDS on 12/29/12 and indicated Client A was admitted to the hospital's Behavioral Unit for "bipolar disorder." X-rays taken in the ER indicated a "foreign body (metal hook) in his small intestine." The metal hook's size was not documented in the BDDS reports. The metal hook's progress through his digestive system was monitored. The hook was removed from his lower bowel by means of an anal probe performed at the hospital according to interview with staff #4 on 1/10/13 at 3:00 PM. Client A was released into the agency's care on 1/4/13.<br><br>6. 1-06-13 2:30 PM, a BDDS report | | | |

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|---|---|---|---|---|
| | dated 1/07/2013 documented client A had ingested inedible items again: "[Client A] was at the group home and walked away from his one on one staff and walked to the other side of the house and took the battery out of the remote and swallowed it. Staff transported [client A] to the ER for observation. [Client A's] one on one staff has been placed on administrative leave pending a QA (Quality Assurance) investigation." The BDDS report indicated client A had been admitted to the hospital via the ER and QA was investigating the situation.<br>The Investigation was finished on 1/11/13 and reviewed at 5:35 PM.<br><br>The investigation's "summary of evidence" component indicated:<br><br>"On 1-6-2013 at 6:00 AM [Direct Contact Staff/DCS #17], SA (Support Associate) asked [DCS #15], SA if she would take over his 1 on 1 shift (one to one supervision) with [client A], Individual so that he could go and get [client A's] medications ready. [DCS #15] agreed and walked over to [client A's] side of the house and took over the 1:1 staffing for [client A]. Around 6:30 AM [DCS #17] stated that [DCS #15] walked into the office without [client A] and when [DCS #17] questioned her about where [client A] was, [DCS #15] told [DCS #17] that | | | |

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| | [client A] was asleep.<br>Approximately 3-5 minutes later [client A] walked in to (sic.) the office and informed [DCS #15] and [DCS #17] that he had taken a battery out of the remote and swallowed it.<br>Staff transported [client A] to the [local] County ER for evaluation and he was admitted to the behavior unit at [the local] County Hospital."<br><br>"[Client A], Individual was interviewed on 1-10-2013; he stated that he woke up and found a remote and took a battery out of the remote and swallowed it. He stated that there wasn't any staff around."<br><br>The conclusion and findings component of the investigation indicated the following:<br><br>"It is the conclusion of the investigation committee that there was a violation in [agency] Policy and Procedure and failure to implement [client A's] Behavior Support Plan as written and in-serviced. [DCS #15], SA failed to implement [client A's] Behavior Support Plan as implemented and in-serviced which resulted in [client A] gaining access to a battery and swallowing it."<br>The investigation's findings were forwarded to the HR/Human Resources Director #19 for review and the | | | |

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|---|---|---|---|
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| | "appropriate disciplinary action to be taken."<br><br>The "Abuse/Neglect/Exploitation Policy and Procedure" component of the agency's Operational Policy and Procedure Manual (revised 07/02/2012) was reviewed on January 9, 2013 at 2:05 PM. The review indicated the agency prohibited neglect of clients. The definitions of neglect were as follows:<br>"F. Neglect--Program Implementation/Intervention Definition:<br>1. Failure to provide goods and/or services necessary for the individual to avoid physical harm.<br>2. Intentional failure to implement a support plan, inappropriate application intervention, etc. which may result in jeopardy without qualified person notification/review."<br><br>On 1/10/13 at 1:30 PM, client A's record indicated a Behavior Support Plan/BSP dated 12/24/12 which indicated the client had a history of swallowing objects and required close supervision to prevent this. An IDT (Interdisciplinary Team) meeting and inservice for staff dated 1/03/13 was also reviewed. The IDT was conducted by the Behavioral Specialist and outlined the plan to keep client A safe upon his return from the behavior unit after ingesting the | | | |

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|---|---|---|---|---|
| | metal hook by having a one to one staff assigned to him 24 hours a day.<br><br>Residential agency administrative staff #1 was interviewed on January 9, 2013 at 1:30 PM and indicated the incident on 1/06/13 involving client A swallowing a (triple A sized) battery while under the supervision of staff #15 was being investigated as an allegation of possible neglect.<br>Human Resources Manager staff #19 was contacted on January 14, 2013 at 4:35 PM and indicated staff #15 had violated agency policy by neglecting to provide supervision with client A and the staff's employment had been terminated.<br><br>This federal tag relates to complaint #IN00122282.<br><br>9-3-1(a) | | | |

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| W0122 | 483.420<br>CLIENT PROTECTIONS<br>The facility must ensure that specific client protections requirements are met.<br><br>Based on record review and interview for 1 of 2 sampled clients (A), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to ensure the rights of all clients to be free of neglect, by failing to prevent client A's ingestion of metal objects via behavioral interventions (one to one staffing).<br><br>Findings include:<br><br>The facility failed to ensure the rights of all clients to be free of neglect, by failing to prevent client A's ingestion of metal objects via behavioral interventions (one to one staffing).<br><br>Please refer to W149 for 1 of 2 sampled clients (A), for the facility's failure to implement written policies and procedures which prohibited neglect of clients.<br><br>This federal tag relates to complaint #IN00122282.<br><br>9-3-2(a) | W0122 | **W122: Client Protections**<br>The facility must ensure that specific client protections requirements are met<br><br>**Corrective Action- (Specific):**<br>The Program Coordinator and staff will be in-serviced on the Abuse, Neglect and Exploitation Policy and Procedure and Client A's Behavior Support Plan and the interventions regarding the 1:1 supervision and ingesting inedible items. The Operations Manager and Director of Behavior Services will conduct site observations to ensure that Program Plans are being implemented.<br><br>**How others will be identified:**<br>**(Systemic)** The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective.<br><br>**Measures to be put in place:**<br>The Program Coordinator and staff will be in-serviced on the Abuse, Neglect and Exploitation Policy and Procedure and Client A's Behavior Support Plan and | 02/16/2013 |

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| | | | the interventions regarding the 1:1 supervision and ingesting inedible items. The Operations Manager and Director of Behavior Services will conduct site observations to ensure that Program Plans are being implemented.<br><br>**Monitoring of Corrective Action:** The Operations Manager and Program Coordinator will review internal incident reports and ensure that IDT's are held and any programmatic changes occur as indicated and that all staff are in-serviced on those changes.<br><br>**Completion Date: February 16, 2013** | |

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| W0149 | 483.420(d)(1)<br>STAFF TREATMENT OF CLIENTS<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br>Based on record review and interview, for 6 of 10 facility incidents/reportable/investigations (alleged neglect, 1 of 2 sampled clients, client A) reviewed, the facility failed to implement policies and procedures which prohibited staff neglect of client A by failing to ensure staff monitored him according to his behavior program to prevent his ingesting foreign objects (a battery from a television's remote control device, coins, liquid soap, and a metal hook).<br><br>Findings include:<br><br>Review of agency reportable and routine incident reports from October 2012 through 1/07/2013 was done on 01/09/13 at 1:30 PM and 1/11/13 at 5:35 PM. The review indicated the following behavioral incidents, Bureau of Developmental Disabilities Services reports, and a substantiated allegation of staff to client neglect involving client A:<br><br>1. 11/27/12 7:50 PM, staff #14 reported client A, "was Restless. [Client A] went To His Room and Swoled (sic.) Quarters '3'." Client A was taken to a local | W0149 | **W 149: Staff Treatment of Clients** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. **Corrective Action: (Specific):** The Program Coordinator and staff will be in-serviced on the Abuse, Neglect and Exploitation Policy and Procedure and Client A's Behavior Support Plan and the interventions regarding the 1:1 supervision and ingesting inedible items. The Program Coordinator and staff will be in-serviced on appropriate and timely documentation of behaviors on the A-B-C data sheet. The Operations Manager and Director of Behavior Services will conduct site observations to ensure that Program Plans are being implemented. **How others will be identified: (Systemic):** The Operations Manager for Supported Group Living and Program Coordinator will review all individuals Program Plans and ensure that each plan specifically meets the needs of all individuals. All Program Plans will be reviewed at least quarterly to ensure that all plans remain effective. . **Measures to be put in place:** The Program Coordinator and staff will be | 02/16/2013 |

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|---|---|---|---|
| | 15G745 | A. BUILDING 00<br>B. WING | 01/17/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RES CARE SOUTHEAST INDIANA | 16611 SIMA GRAY RD<br>HENRYVILLE, IN 47126 |

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| | ER/Hospital Emergency Room for X-Rays.<br>BDDS was notified of the incident by the agency on 11/28/12. The BDDS report narrative indicated:<br>"The IDT (interdisciplinary) team has met and [client A] is not allowed to have access to pornography because it will make [client A] depressed and he will engage in self-injurious behavior. [Client A] has a cell phone and had been accessing pornography from the Internet on his phone; when he began having behaviors the BC (Behavior Clinician) and staff asked [client A] what was bothering him. [Client A] reported that when he watched porn (pornography) it causes him to feel depressed and have behaviors. [Client A] got upset because of watching the pornography and went into his room and swallowed three quarters. [Client A] informed staff of what he did and staff took him to ER for observation."<br>The "Plan to Resolve" component of the 11/28/12 BDDS report indicated the following: "The ER physician assessed [client A] and noted that there was (sic.) three quarters in his stomach. The ER physician informed staff that the quarters should pass in a few days. [Client A] is to follow up with his PCP (Primary Care Physician) in two weeks. [Client A] is now home resting with no further complaints. The staff at the house have | | in-serviced on the Abuse, Neglect and Exploitation Policy and Procedure and Client A's Behavior Support Plan and the interventions regarding the 1:1 supervision and ingesting inedible items. The Program Coordinator and staff will be in-serviced on appropriate and timely documentation of behaviors on the A-B-C data sheet. The Operations Manager and Director of Behavior Services will conduct site observations to ensure that Program Plans are being implemented.**Monitoring of Corrective Action:** The Operations Manager and Program Coordinator will review internal incident reports and ensure that IDT's are held and any programmatic changes occur as indicated and that all staff are in-serviced on those changes. The Operations Manager and Director of Behavior Services will conduct site observations to ensure that Program Plans are being implemented. **Completion Date: February 16, 2013** | |

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| | place (sic.) [client A] on one on one staffing for 24 hours and did a room sweep and removed all items that [client A] would be able to swallow."<br><br>2. 12-02-12 6:20 PM, staff #14 reported client A requested to take a shower. "Wile (sic.) Taking a Shower He Drank some Baby Body wash." Client A was taken to an Urgent Care Center/UCC for evaluation.<br><br>3. 12-26-12 8:25 PM, client A indicated he needed to urinate, when he came out of the bathroom, he told staff #13 he had "swallowed some body wash that he had left in there this morning."<br><br>4. 12-27-12 2:45 PM, client A was in the facility's office area when three male staff intervened as he took a peer's MP3 player's electrical cord and attempted to ingest it. Staff indicated on the incident report: "[Client A] was walking in circles--looking around, not saying anything to staff, just hanging around. Staff watched [client A] pick a cord out of box (sic.)--pull the end off of it putting into mouth. Staff immediately reacted knocking object out of his mouth. The staff put [client A] on couch holding his hands away from mouth. H/M (House Manager) immediately helped staff hold [client A] down. Another staff [DCS #16] | | | |

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| | helped get object from hand."<br><br>5. 12-28-12 1:45 PM, staff #12 was supervising client A and reported an incident wherein client A swallowed a metal hook:<br>"[Client A] was sitting on sofa watching TV. He walked over to (sic.) window to watch (another facility's) behavior that happened on the road. I was between the window and X-mas (Christmas) tree beside [client A]. Because he had been eyeballing X-mas ornaments, I didn't notice him twisting hook off of (sic.) curtain. He swallowed hook without me noticing him. After the incident, he told me he had swallowed something with a smile on his face."<br>Client A was taken to a local ER/ Hospital Emergency Room for evaluation. This 12/28/12 incident was reported to BDDS on 12/29/12 and indicated Client A was admitted to the hospital's Behavioral Unit for "bipolar disorder." X-rays taken in the ER indicated a "foreign body (metal hook) in his small intestine." The metal hook's size was not documented in the BDDS reports. The metal hook's progress through his digestive system was monitored. The hook was removed from his lower bowel by means of an anal probe performed at the hospital according to interview with staff #4 on 1/10/13 at 3:00 PM. Client A | | | |

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| | was released into the agency's care on 1/4/13.<br><br>6. 1-06-13 2:30 PM, a BDDS report dated 1/07/2013 documented client A had ingested inedible items again: "[Client A] was at the group home and walked away from his one on one staff and walked to the other side of the house and took the battery out of the remote and swallowed it. Staff transported [client A] to the ER for observation. [Client A's] one on one staff has been placed on administrative leave pending a QA (Quality Assurance) investigation." The BDDS report indicated client A had been admitted to the hospital via the ER and QA was investigating the situation.<br>The Investigation was finished on 1/11/13 and reviewed at 5:35 PM.<br><br>The investigation's "summary of evidence" component indicated:<br><br>"On 1-6-2013 at 6:00 AM [Direct Contact Staff/DCS #17], SA (Support Associate) asked [DCS #15], SA if she would take over his 1 on 1 shift (one to one supervision) with [client A], Individual so that he could go and get [client A's] medications ready. [DCS #15] agreed and walked over to [client A's] side of the house and took over the 1:1 staffing for [client A]. Around 6:30 AM [DCS #17] | | | |

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| | stated that [DCS #15] walked into the office without [client A] and when [DCS #17] questioned her about where [client A] was, [DCS #15] told [DCS #17] that [client A] was asleep.<br>Approximately 3-5 minutes later [client A] walked in to (sic.) the office and informed [DCS #15] and [DCS #17] that he had taken a battery out of the remote and swallowed it.<br>Staff transported [client A] to the [local] County ER for evaluation and he was admitted to the behavior unit at [the local] County Hospital."<br><br>"[Client A], Individual was interviewed on 1-10-2013; he stated that he woke up and found a remote and took a battery out of the remote and swallowed it. He stated that there wasn't any staff around."<br><br>The conclusion and findings component of the investigation indicated the following:<br><br>"It is the conclusion of the investigation committee that there was a violation in [agency] Policy and Procedure and failure to implement [client A's] Behavior Support Plan as written and in-serviced. [DCS #15], SA failed to implement [client A's] Behavior Support Plan as implemented and in-serviced which resulted in [client A] gaining access to a | | | |

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| | battery and swallowing it."<br>The investigation's findings were forwarded to the HR/Human Resources Director #19 for review and the "appropriate disciplinary action to be taken."<br><br>The "Abuse/Neglect/Exploitation Policy and Procedure" component of the agency's Operational Policy and Procedure Manual (revised 07/02/2012) was reviewed on January 9, 2013 at 2:05 PM. The review indicated the agency prohibited neglect of clients. The definitions of neglect were as follows:<br>"F. Neglect--Program Implementation/Intervention Definition:<br>1. Failure to provide goods and/or services necessary for the individual to avoid physical harm.<br>2. Intentional failure to implement a support plan, inappropriate application intervention, etc. which may result in jeopardy without qualified person notification/review."<br><br>Residential agency administrative staff #1 was interviewed on January 9, 2013 at 1:30 PM and indicated the incident on 1/06/13 involving client A swallowing a (triple A sized) battery while under the supervision of staff #15 was being investigated as an allegation of possible | | | |

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| | neglect.<br>Human Resources Manager staff #19 was contacted on January 14, 2013 at 4:35 PM and indicated staff #15 had violated agency policy by neglecting to provide supervision with client A and the staff's employment had been terminated.<br><br>This federal tag relates to complaint #IN00122282.<br><br>9-3-2(a) | | | |

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| W0249 | 483.440(d)(1)<br>PROGRAM IMPLEMENTATION<br>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.<br>Based on record review and interview, for 1 of 2 sampled clients (A), the facility failed to ensure staff implemented behavioral interventions according to the client's Behavior Support Programs.<br><br>Findings include:<br><br>Review of agency reportable and routine incident reports from October 2012 through 1/07/2013 was done on 01/09/13 at 1:30 PM and 1/11/13 at 5:35 PM. The review indicated the following behavioral incidents involving client A:<br><br>12-28-12 1:45 PM, staff #12 was supervising client A and reported an incident wherein client A swallowed a metal hook:<br>"[Client A] was sitting on sofa watching TV. He walked over to (sic.) window to watch (another facility's) behavior that happened on the road. I was between the window and X-mas (Christmas) tree beside [client A]. Because he had been eyeballing X-mas ornaments, I didn't | W0249 | **W249: Program Implementation**<br>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.<br>**Corrective Action: (Specific)**<br>Staff will be retrained on client A's Behavior Support Plan and accompanying ABC (Antecedent/Behavior/Consequence Chart) sheet **How others will be identified: (Systemic):** The Program Coordinator and all staff will be trained on Client A's Behavior Support Plan and accompanying ABC sheet. The Operations Manager or the Program Coordinator will retrain all staff on each Clients Behavior Support Plan at least annually and more frequently as needed. **Measures to be put in place:** Staff will be retrained on client A's Behavior Support Plan and accompanying ABC | 02/16/2013 |

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| | notice him twisting hook off of (sic.) curtain. He swallowed hook without me noticing him. After the incident, he told me he had swallowed something with a smile on his face."<br>Client A was taken to a local ER/ Hospital Emergency Room for evaluation. This 12/28/12 incident was reported to BDDS on 12/29/12 and indicated Client A was admitted to the hospital's Behavioral Unit for "bipolar disorder." X-rays taken in the ER indicated a "foreign body (metal hook) in his small intestine." The metal hook's size was not documented in the BDDS reports. The metal hook's progress through his digestive system was monitored. The hook was removed from his lower bowel by means of an anal probe performed at the hospital according to interview with staff #4 on 1/10/13 at 3:00 PM. Client A was released into the agency's care on 1/4/13.<br><br>On 1/10/13 at 1:30 PM, client A's record indicated a Behavior Support Plan/BSP dated 12/24/12 which indicated the client had a history of swallowing objects and required close supervision to prevent this. An IDT (Interdisciplinary Team) meeting and inservice for staff dated 1/03/13 was also reviewed. The IDT was conducted by the Behavioral Specialist and outlined the plan to keep client A safe upon his return | | (Antecedent/Behavior/Consequence Chart) sheet **Monitoring of Corrective Action:** The Operations Manager and Director of Behavior Services will conduct site observations to ensure that the behavioral support plans are being implemented as written.<br>**Completion date: February 16, 2013** | |

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| | from the behavior unit after ingesting the metal hook:<br>"He will have a one to one staff defined as a staff who will be assigned and will be within approximately 5 feet of [client A] at all times except when he is in the bathroom at which point the staff will remain close enough to intervene and in the same room.<br>He will be restricted to specific areas of his home: He can spend time in his bedroom...his door will remain open, the bathroom nearest his bedroom...the door will remain open, the living area nearest his bedroom...and the dining area....He can also only be in the hallway in between the living room and dining area long enough to walk from the living area to the dining room. He will be restricted from all other areas of the home for his safety. If at any time he attempts to deviate to a different area of the home the one on one staff will redirect, if he does not comply staff will redirect and let him know that staff will have to physically assist him if he does not comply...if he does not comply within a reasonable amount of time staff will physically assist him to a different area...."<br>The IDT meeting/training was attended by staff #15. Staff #15 failed to implement client A's one on one behavioral protocol on 1-06-13 at 6:00 AM to 6:30 AM when she left him alone and he came to an | | | |

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| | unapproved area of the facility (second living room area adjacent to the facility's office), found a television remote control and ingested the triple A (AAA) battery contained in the device.<br><br>On 1-06-13 at 6:00 AM, a BDDS report dated 1/07/2013 documented client A had ingested inedible items again: "[Client A] was at the group home and walked away from his one on one staff and walked to the other side of the house and took the battery out of the remote and swallowed it. Staff transported [client A] to the ER for observation. [Client A's] one on one staff has been placed on administrative leave pending a QA (Quality Assurance) investigation." The BDDS report indicated client A had been admitted to the hospital via the ER and QA was investigating the situation.<br>The Investigation was finished on 1/11/13 and reviewed at 5:35 PM.<br><br>The investigation's "summary of evidence" component indicated:<br><br>"On 1-6-2013 at 6:00 AM [Direct Contact Staff/DCS #17], SA (Support Associate) asked [DCS #15], SA if she would take over his 1 on 1 shift (one to one supervision) with [client A], Individual so that he could go and get [client's A] medications ready. [DCS #15] agreed | | | |

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| | and walked over to [client A's] side of the house and took over the 1:1 staffing for [client A]. Around 6:30 AM [DCS #17] stated that [DCS #15] walked into the office without [client A] and when [DCS #17] questioned her about where [client A] was, [DCS #15] told [DCS #17] that [client A] was asleep.<br>Approximately 3-5 minutes later [client A] walked in to (sic.) the office and informed [DCS #15] and [DCS #17] that he had taken a battery out of the remote and swallowed it.<br>Staff transported [client A] to the [local] County ER for evaluation and he was admitted to the behavior unit at [the local] County Hospital."<br><br>"[Client A], Individual was interviewed on 1-10-2013; he stated that he woke up and found a remote and took a battery out of the remote and swallowed it. He stated that there wasn't any staff around."<br><br>The conclusion and findings component of the investigation indicated the following:<br><br>"It is the conclusion of the investigation committee that there was a violation in [agency] Policy and Procedure and failure to implement [client A's] Behavior Support Plan as written and in-serviced. [DCS #15], SA failed to implement | | | |

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| | [client A's] Behavior Support Plan as implemented and in-serviced which resulted in [client A] gaining access to a battery and swallowing it."<br><br>Residential agency administrative staff #1 was interviewed on January 9, 2013 at 1:30 PM and indicated the incident on 12/28/12 involving client A swallowing a metal hook while under the supervision of staff #12 was not neglect but failure to implement the client's BSP.<br><br>Human Resources Manager staff #19 was contacted on January 14, 2013 at 4:35 PM and indicated staff #15 had violated agency policy by neglecting to provide supervision with client A on 1/06/13 and the staff had been terminated. Staff #15 had not implemented the client's behavior program.<br><br>This federal tag relates to complaint #IN00122282.<br><br>9-3-4(a) | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 15G745 | A. BUILDING 00<br>B. WING | 01/17/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RES CARE SOUTHEAST INDIANA | 16611 SIMA GRAY RD<br>HENRYVILLE, IN 47126 |

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| W9999 | State Findings<br><br>The following Community Residential Facilities for Persons with Developmental Disabilities Rule was not met:<br><br>460 IAC 9-3-1 Governing body<br><br>Sec. 1. (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.<br><br>This state rule was not met as evidenced by:<br><br>Based on record review and interview, for 1 of 10 incidents reviewed (client A), the facility failed to immediately report (within 24 hours) behavioral episodes involving outside medical treatment for client A.<br><br>Findings include:<br><br>Review of agency reportable and routine incident reports from October 2012 through 1/07/2013 was done on 01/09/13 at 1:30 PM and 1/11/13 at 5:35 PM. The review indicated the following behavioral incident involving client A: | W9999 | **W9999: 460 IAC 9-3-1 Governing Body**<br>Sec 1. (b) The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.<br><br>**Corrective Action: (Specific):** The Quality Assurance team will be retrained that all state reportable incidents will be reported to BDDS per State Law.<br><br>**How others will be identified: (Systemic):** The Quality Assurance team will report all state reportable incidents to BDDS per State Law.<br><br>**Measures to be put in place:** The Quality Assurance team will be retrained that all state reportable incidents will be reported to BDDS per State Law.<br><br>**Monitoring of Corrective Action:** The Director of Supervised Group Living will ensure that all state reportable incidents are reported to BDDS per State Law.<br><br>**Completion date: February 16,** | 02/16/2013 |

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| | 12-02-12 6:20 PM, staff #14 reported client A requested to take a shower. "Wile (sic.) Taking a Shower He Drank some Baby Body wash." Client A was taken to an Urgent Care Center/UCC for evaluation. There was no BDDS report of this incident.<br><br>The "Abuse/Neglect/Exploitation Policy and Procedure" component of the agency's Operational Policy and Procedure Manual (revised 07/02/2012) was reviewed on January 9, 2013 at 2:05 PM. The review indicated the agency prohibited/reported neglect of clients.<br><br>"Procedures...<br>3. The QA (Quality Assurance) Director will report the suspected abuse, neglect and/or exploitation within 24 hours to the appropriate contacts, which may include:<br>F. Bureau of Developmental Disabilities Services (BDDS) (as applicable)...."<br><br>The definitions of neglect were as follows:<br>"F. Neglect--Program Implementation/Intervention Definition:<br>1. Failure to provide goods and/or services necessary for the individual to avoid physical harm." | | **2013** | |

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| | Quality Assurance staff #5 was asked to ensure all reportable incidents were available for review on 1/10/13 at 1:30 PM and again at 2:45 PM. There was no evidence the above behavioral incident had been reported to BDDS.<br><br>This state rule relates to complaint #IN00122282.<br><br>9-3-1(b) | | | |