

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G352	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/15/2014
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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN	STREET ADDRESS, CITY, STATE, ZIP CODE 240 1ST ST NE LINTON, IN 47441
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W000000	<p>This visit was for the investigation of complaint #IN00153303.</p> <p>Complaint #IN00153303: Substantiated. Federal/state deficiencies related to the allegation are cited at W102, W104, W122, W149 and W154.</p> <p>Survey Dates: September 11, 12 and 15, 2014</p> <p>Facility Number: 000868 Provider Number: 15G352 AIM Number: 100249190</p> <p>Surveyor: Steven Schwing, QIDP</p> <p>These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 9/19/14 by Ruth Shackelford, QIDP.</p>	W000000		
W000102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview for 3 of 15 incident/investigative reports reviewed affecting clients A, F and G, the</p>	W000102	<p>PROVIDER IDENTIFICATION #: 15G352 NAME OF PROVIDER:</p>	10/15/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>facility failed to meet the Condition of Participation: Governing Body. The Governing Body failed to conduct thorough investigations of incidents at the workshop. The Governing Body failed to implement its written policies and procedures to prevent abuse, neglect, and/or mistreatment of clients A, F and G. The Governing Body failed to ensure the facility's administrative staff were able to recognize allegations of abuse, neglect, and/or mistreatment and conduct thorough investigations. The Governing Body failed to ensure the administrative staff were able to identify the need of investigations to address abuse, neglect and/or mistreatment.</p> <p>Findings include:</p> <p>1. Please refer to W104. For 3 of 15 incident/investigative reports reviewed affecting clients A, F and G, the facility's Governing Body failed to conduct thorough investigations of incidents at the workshop. The Governing Body failed to failed to implement its written policies and procedures to prevent abuse, neglect, and/or mistreatment of clients A, F and G. The Governing Body failed to ensure the facility's administrative staff were able to recognize allegations of abuse, neglect, and/or mistreatment and conduct thorough investigations. The</p>		<p>RESCARE COMMUNITY ALT., SOUTH CENTRAL ADDRESS: 240 1st Street NE SURVEY EVENT ID #: E90P11 DATE SURVEY COMPLETED: 9/15/2014</p> <p>PROVIDER'S PLAN OF CORRECTION</p> <p><u>W 102: GOVERNING BODY AND MANAGEMENT</u> The facility must ensure that specific governing body and management requirements are met.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> ·All appropriate parties have been in-serviced on failure to follow, ResCare policy and procedures to prevent abuse, neglect and or mistreatment of clients. (ATTACHMENT A) ·All appropriate parties have been in-serviced on failure to identify, definition of and identifying all issues of abuse, neglect, and mistreatment. (ATTACHMENT A) ·All appropriate parties have been in-serviced on failure to follow ResCare policy on completing a thorough investigation. (ATTACHMENT A) ·All appropriate parties have been in-serviced on failure to follow state guidelines on completing a thorough investigation, including at the workshop. (ATTACHMENT A) ·All appropriate parties have 				

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	<p>Governing Body failed to ensure the administrative staff were able to identify the need of investigations to address abuse, neglect and/or mistreatment.</p> <p>2. Please refer to W122. For 3 of 15 incident/investigative reports reviewed affecting clients A, F and G, the Governing Body failed to meet the Condition of Participation: Client Protections. The Governing Body failed to ensure the rights of all clients to be free of abuse and neglect. The Governing Body failed to implement its policies and procedures prohibiting client abuse, neglect and/or mistreatment. The Governing Body failed to implement its policies and procedures to prevent to client to client abuse (clients A and G) and investigate incidents on 7/21/14 and 8/7/14 while client F was at the workshop.</p> <p>This federal tag relates to complaint #IN00153303.</p> <p>9-3-1(a)</p>		<p>received investigation training per ResCare policy and Procedure from Regional Quality Assurance Manager. (ATTACHMENT B)</p> <p>How we will identify others:</p> <ul style="list-style-type: none"> ·All allegations of abuse/neglect/mistreatment will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A) ·All falls and injuries of unknown source will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A) ·All investigations will be reviewed by a peer committee for thoroughness and recommendations, and then forwarded to Director of Operations General Manager (DOGM) for final recommendations and review. (ATTACHMENT A,D) ·All injuries of unknown source will be investigated to determine how the injury occurred, could it have been prevented, and can we prevent it in the future. (ATTACHMENT A,C) ·All workshop incidents will be reviewed to determine if they were investigated thoroughly, and/or investigated by ResCare to ensure a thorough investigation is completed. (ATTACHMENT A,F) <p>Measures to be put in place:</p> <ul style="list-style-type: none"> ·Program Manager and/or Executive Director will respond to reports of abuse/neglect/mistreatment allegations with a scope needed 		

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			<p>to begin investigation. (ATTACHMENT A)</p> <ul style="list-style-type: none"> ·Investigation Peer review meeting will be immediately scheduled for five business days to conclude investigation. (ATTACHMENT A) ·All injuries of unknown source will be investigated and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A,C,H) ·All injury of unknown source investigations will include a review of documentation or Nursing/programming assessment to determine if a plan/plan change is needed. (ATTACHMENT A,C,H) ·All workshop incidents will be reviewed to determine if they were investigated thoroughly, and/or investigated by ResCare to ensure a thorough investigation is completed. (ATTACHMENT A,F) ·Residential Manager or assigned designee will do an active treatment observation at the workshop monthly to ensure all individuals are free from abuse and neglect. (ATTACHMENT G) <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·Peer Review Committee will meet five days after an investigation is opened to discuss recommendations and thoroughness of investigation. (ATTACHMENT A) ·After Committee review all investigations will be sent to 		

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W000104	<p>483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 3 of 15 incident/investigative reports reviewed affecting clients A, F and G, the facility's Governing Body failed to conduct thorough investigations of incidents at the workshop. The Governing Body failed to failed to implement its written policies and procedures to prevent abuse, neglect, and/or mistreatment of clients A, F and G. The Governing Body failed to ensure the facility's administrative staff were able to recognize allegations of abuse, neglect, and/or mistreatment and conduct</p>	W000104	<p>DOGM for final review and recommendations. <u>(ATTACHMENT A)</u> ·All incident report data will be reviewed by safety committee. ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. ·Residential Manager or assigned designee will do an active treatment observation at the workshop monthly to ensure all individuals are free from abuse and neglect. <u>(ATTACHMENT G)</u></p> <p>Completion Date:</p> <p>PROVIDER IDENTIFICATION #: 15G352 NAME OF PROVIDER: RESCARE COMMUNITY ALT., SOUTH CENTRAL ADDRESS: 240 1st Street NE SURVEY EVENT ID #: E90P11 DATE SURVEY COMPLETED: 9/15/2014</p> <p>PROVIDER'S PLAN OF CORRECTION <u>W 104: GOVERNING BODY AND MANAGEMENT</u> The governing body must exercise general policy, budget, and operating direction over the facility. Corrective action:</p>	10/15/2014	

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	<p>thorough investigations. The Governing Body failed to ensure the administrative staff were able to identify the need of investigations to address abuse, neglect and/or mistreatment.</p> <p>Findings include:</p> <p>1. Please refer to W149. For 3 of 15 incident/investigative reports reviewed affecting clients A, F and G, the facility's Governing Body neglected to implement its policies and procedures to prevent to client to client abuse (clients A and G) and investigate incidents on 7/21/14 and 8/7/14 while client F was at the workshop.</p> <p>2. Please refer to W154. For 2 of 15 incident/investigative reports reviewed affecting client F, the facility's Governing Body failed to investigate incidents on 7/21/14 and 8/7/14 while client F was at the workshop.</p> <p>This federal tag relates to complaint #IN00153303.</p> <p>9-3-1(a)</p>		<p>·All appropriate parties have been in-serviced on failure to follow, ResCare policy and procedures to prevent abuse, neglect and or mistreatment of clients. (ATTACHMENT A)</p> <p>·All appropriate parties have been in-serviced on failure to identify, definition of and identifying all issues of abuse, neglect, and mistreatment. (ATTACHMENT A)</p> <p>·All appropriate parties have been in-serviced on failure to follow ResCare policy on completing a thorough investigation. (ATTACHMENT A)</p> <p>·All appropriate parties have been in-serviced on failure to follow state guidelines on completing a thorough investigation, including at the workshop. (ATTACHMENT A)</p> <p>How we will identify others:</p> <p>·All allegations of abuse/neglect/mistreatment will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A)</p> <p>·All falls and injuries of unknown source will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A)</p> <p>·All investigations will be reviewed by a peer committee for thoroughness and recommendations, and then forwarded to Director of Operations General Manager (DOGM) for final recommendations and</p>		

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			<p>review. (ATTACHMENT A,D)</p> <ul style="list-style-type: none"> ·All injuries of unknown source will be investigated to determine how the injury occurred, could it have been prevented, and can we prevent it in the future. (ATTACHMENT A,C) ·All workshop incidents will be reviewed to determine if they were investigated thoroughly, and/or investigated by ResCare to ensure a thorough investigation is completed. (ATTACHMENT A,F) <p>Measures to be put in place:</p> <ul style="list-style-type: none"> ·Program Manager and/or Executive Director will respond to reports of abuse/neglect/mistreatment allegations with a scope needed to begin investigation. (ATTACHMENT A) ·Investigation Peer review meeting will be immediately scheduled for five business days to conclude investigation. (ATTACHMENT A) ·All injuries of unknown source will be investigated and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A,C,H) ·All injury of unknown source investigations will include a review of documentation or Nursing/programming assessment to determine if a plan/plan change is needed. (ATTACHMENT A,C,H) ·All workshop incidents will be reviewed to determine if they were investigated thoroughly, 		

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W000122	483.420 CLIENT PROTECTIONS		<p>and/or investigated by ResCare to ensure a thorough investigation is completed. <u>(ATTACHMENT A,F)</u></p> <ul style="list-style-type: none"> ·Residential Manager or assigned designee will do an active treatment observation at the workshop monthly to ensure all individuals are free from abuse and neglect. <u>(ATTACHMENT G)</u> <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·Peer Review Committee will meet five days after an investigation is opened to discuss recommendations and thoroughness of investigation.<u>(ATTACHMENT A)</u> ·After Committee review all investigations will be sent to DOGM for final review and recommendations.<u>(ATTACHMENT A)</u> ·All incident report data will be reviewed by safety committee. ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. ·Residential Manager or assigned designee will do an active treatment observation at the workshop monthly to ensure all individuals are free from abuse and neglect. <u>(ATTACHMENT G)</u> <p>Completion Date:</p>		

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	<p>The facility must ensure that specific client protections requirements are met. Based on record review and interview for 3 of 15 incident/investigative reports reviewed affecting clients A, F and G, 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 abuse and neglect. The facility failed to implement its policies and procedures prohibiting client abuse, neglect and/or mistreatment. The facility failed to implement its policies and procedures to prevent to client to client abuse (clients A and G) and investigate incidents on 7/21/14 and 8/7/14 while client F was at the workshop.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. Please refer to W149. For 3 of 15 incident/investigative reports reviewed affecting clients A, F and G, the facility neglected to implement its policies and procedures to prevent to client to client abuse (clients A and G) and investigate incidents on 7/21/14 and 8/7/14 while client F was at the workshop. 2. Please refer to W154. For 2 of 15 incident/investigative reports reviewed affecting client F, the facility failed to investigate incidents on 7/21/14 and 	W000122	<p>PROVIDER IDENTIFICATION #: 15G352 NAME OF PROVIDER: RESCARE COMMUNITY ALT., SOUTH CENTRAL ADDRESS: 240 1st Street NE SURVEY EVENT ID #: E90P11 DATE SURVEY COMPLETED: 9/15/2014 PROVIDER'S PLAN OF CORRECTION <u>W 122: CLIENT PROTECTIONS</u> The facility must ensure that specific client protections requirements are met.</p> <p>Corrective action: -All appropriate parties have been in-serviced on failure to follow, ResCare policy and procedures to prevent abuse, neglect and or mistreatment of clients. <u>(ATTACHMENT A)</u> -All appropriate parties have been in-serviced on failure to identify, definition of and identifying all issues of abuse, neglect, and mistreatment. <u>(ATTACHMENT A)</u> -All appropriate parties have been in-serviced on failure to follow ResCare policy on completing a thorough investigation. <u>(ATTACHMENT A)</u> -All appropriate parties have been in-serviced on failure to follow state guidelines on completing a thorough investigation, including at the workshop. <u>(ATTACHMENT A)</u></p> <p>How we will identify others: -All allegations of abuse/neglect/mistreatment will be reported to Program Manager then relayed to Executive Director immediately. <u>(ATTACHMENT A)</u> -All investigations will be reviewed by</p>	10/15/2014

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	<p>8/7/14 while client F was at the workshop.</p> <p>This federal tag relates to complaint #IN00153303.</p> <p>9-3-2(a)</p>		<p>a peer committee for thoroughness and recommendations, and then forwarded to Director of Operations General Manager (DOGM) for final recommendations and review. (ATTACHMENT A,D)</p> <p>-All workshop incidents will be reviewed to determine if they were investigated thoroughly, and/or investigated by ResCare to ensure a thorough investigation is completed. (ATTACHMENT A,F)</p> <p>Measures to be put in place:</p> <p>-Program Manager and/or Executive Director will respond to reports of abuse/neglect/mistreatment allegations with a scope needed to begin investigation. (ATTACHMENT A)</p> <p>-Investigation Peer review meeting will be immediately scheduled for five business days to conclude investigation. (ATTACHMENT A)</p> <p>-All injuries of unknown source will be investigated and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A,C,H)</p> <p>-All injury of unknown source investigations will include a review of documentation or Nursing/programming assessment to determine if a plan/plan change is needed. (ATTACHMENT A,C,H)</p> <p>-All workshop incidents will be reviewed to determine if they were investigated thoroughly, and/or investigated by ResCare to ensure a thorough investigation is completed. (ATTACHMENT A,F)</p> <p>-Residential Manager or assigned designee will do an active treatment observation at the workshop monthly to ensure all individuals are free from abuse and neglect. (ATTACHMENT G)</p> <p>Monitoring of Corrective Action:</p> <p>-Peer Review Committee will meet</p>		

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 15 incident/investigative reports reviewed affecting clients A, F and G, the facility neglected to implement its policies and procedures to prevent to client to client abuse (clients A and G) and investigate incidents on 7/21/14 and 8/7/14 while client F was at the workshop.	W000149	five days after an investigation is opened to discuss recommendations and thoroughness of investigation. (ATTACHMENT A) ·After Committee review all investigations will be sent to DOGM for final review and recommendations. (ATTACHMENT A) ·All incident report data will be reviewed by safety committee. ·Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. ·Residential Manager or assigned designee will do an active treatment observation at the workshop monthly to ensure all individuals are free from abuse and neglect. (ATTACHMENT G) Completion Date:	10/15/2014		PROVIDER IDENTIFICATION #: 15G352 NAME OF PROVIDER: RESCARE COMMUNITY ALT., SOUTH CENTRAL ADDRESS: 240 1st Street NE SURVEY EVENT ID #: E90P11 DATE SURVEY COMPLETED: 9/15/2014 PROVIDER'S PLAN OF CORRECTION <u>W 149: STAFF TREATMENT OF CLIENTS</u>	

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	<p>Findings include:</p> <p>On 9/11/14 at 1:50 PM, the facility's incident/investigative reports were reviewed and indicated the following:</p> <p>1) On 7/21/14 at 12:45 PM, the ResCare Incident Report indicated, in part, "[Client F] was picked up from w/s (workshop) and informed staff he had cut his leg. Staff asked w/s staff about a report. They stated they hadn't filled one out. Staff called nurse and team lead, was told to take him to the ER (emergency room)." The facility did not conduct an investigation of the incident.</p> <p>A [name of workshop] Incident Report, dated 7/21/14, was completed by workshop staff #3. The report indicated, "[Client F] was helping staff move boxes. [Client F] came up to the staff table and told staff he cut his leg. [Client F] said he cut his leg on the garage door. It was his lower right leg. Staff asked him to go clean the cut up and then staff had [client F] put a Band-Aid on it."</p> <p>A [name of workshop] Incident Report, dated 7/21/14, was completed by workshop staff #2. The report indicated, "[Client F] was assisting staff with moving items. [Client F] came up to me</p>		<p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Corrective action:</p> <ul style="list-style-type: none"> -All appropriate parties have been in-serviced on failure to follow, ResCare policy and procedures to prevent abuse, neglect and or mistreatment of clients. (ATTACHMENT A) -All appropriate parties have been in-serviced on failure to identify, definition of and identifying all issues of client to client abuse. (ATTACHMENT A) -All appropriate parties have been in-serviced on failure to follow ResCare policy on completing an investigation of client to client abuse at the workshop. (ATTACHMENT A) -All appropriate parties have been in-serviced on failure to follow state guidelines on completing a thorough investigation, including at the workshop. (ATTACHMENT A) <p>How we will identify others:</p> <ul style="list-style-type: none"> -All allegations of abuse/neglect/mistreatment will be reported to Program Manager then relayed to Executive Director immediately. (ATTACHMENT A) -All allegations of abuse/neglect/mistreatment, client to client, injury at the workshop will be reviewed by Clinical Supervisor or appropriate parties to determine if a ResCare investigation is indicated. (ATTACHMENT F) <ul style="list-style-type: none"> -All investigations completed on any incident occurring at the workshop will be forwarded to the appropriate parties for review and recommendations -All investigations completed on any incident occurring at the workshop will be presented to IDT/Peer Review 		

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	<p>and said he cut his right lower leg on the garage door. When I looked (sic) it the cut was barely bleeding. I asked him to go clean it with water. When he came back I gave him a bandage to put on."</p> <p>A [name of workshop] Incident Report, dated 7/21/14, was completed by workshop staff #1. The report indicated, "Loading boxes onto cart from car to bring into (illegible) workshop. [Client F] bumped his right leg on edge of cart. [Workshop staff #4] sent him into workshop to have CRC's (Clinical Resource Consultants) check on him. He said he was fine. Scratch was cleaned & Band-Aid applied. [Workshop staff #1] later asked [client F] if he was OK & he said he was fine." The report indicated, "Leg cleaned & Band-Aid applied by [client F]." The section titled "Actions taken to assure that there is not a recurrence of this incident" indicated, "Make sure [client F] knows not to stand close to loading cart."</p> <p>An Interdisciplinary Team Meeting note (documented by the group home staff), dated 7/31/14, involving the workshop Division Director (DD) and the group home Qualified Intellectual Disabilities Professional (QIDP) indicated, "Discussed w/ (with) [DD] the incident that took place on 7/21/14 with client [F]."</p>		<p>(workshop) for final recommendations and implementation.</p> <ul style="list-style-type: none"> -An IDT/Peer Review will be scheduled with workshop staff five (5) days from investigation start, to ensure compliance. -All internal investigations will be reviewed by a peer committee for thoroughness and recommendations, and then forwarded to Director of Operations General Manager (DOGM) for final recommendations and review. (ATTACHMENT A) -All workshop incidents will be reviewed to determine if they were investigated thoroughly, and/or investigated by ResCare to ensure a thorough investigation is completed. (ATTACHMENT F) <p>Measures to be put in place:</p> <ul style="list-style-type: none"> -Program Manager and/or Executive Director will respond to reports of abuse/neglect/mistreatment allegations with a scope needed to begin investigation. (ATTACHMENT A) -Investigation Peer review meeting will be immediately scheduled for five business days to conclude investigation. (ATTACHMENT A) -All injuries of unknown source will be investigated and an IDT will be done to discuss needed measures of prevention. (ATTACHMENT A,C,H) -All injury of unknown source investigations will include a review of documentation and/or Nursing/programming assessment to determine if a plan/plan change is needed. (ATTACHMENT A,C) -All workshop incidents will be reviewed to determine if they were investigated thoroughly, and/or investigated by ResCare to ensure a thorough investigation is completed. (ATTACHMENT F) -Residential Manager or assigned designee will do an active treatment observation at the workshop monthly to 		

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	<p>Client was injured @ (at) ws (workshop) & staff failed to complete an incident report the day of incident. Staff had [client F] clean his own wound & staff did not notify ResCare staff or nurse. Explained to [DD] this could of (sic) been a report of abuse & neglect on ws staff & would be if it happens again. ([DD] was on vacation that week.) [DD] stated she would retrain her staff on incident reporting, wound care & who to notify. [Client F] was taken to the ER by ResCare staff & treated. (See ER note)."</p> <p>An Individual Support List and Progress Review form, not dated, was completed by the Division Director of the workshop during the Interdisciplinary Team Meeting on 7/31/14. The note indicated, "Meeting with [QIDP] about incident report on [client F]. Assured [QIDP] that I will retrain staff on reportable incident, about writing up incident reports immediately and for staff to clean the wound and bandage if necessary. Let supervisor know about an incident and they can determine if ResCare nurse needs to be called or if we need to transport to Emergency room. I also shared with [QIDP] that I feel that sometimes we report things that may not be reportable but would rather report and let them tell me that it isn't reportable. [QIDP] stated that this could have been a</p>		<p>ensure all individuals are free from abuse and neglect. (ATTACHMENT G)</p> <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> -Peer Review Committee will meet five days after an investigation is opened to discuss recommendations and thoroughness of investigation. (ATTACHMENT A) -After Committee review all investigations will be sent to DOGM for final review and recommendations. (ATTACHMENT A) -All investigations completed on any incident occurring at the workshop will be presented to IDT/Peer Review (workshop) for final recommendations and implementation. -An IDT/Peer Review will be scheduled with workshop staff five (5) days from investigation start, to ensure compliance. -All internal investigations will be reviewed by a peer committee for thoroughness and recommendations, and then forwarded to Director of Operations General Manager (DOGM) for final recommendations and review. (ATTACHMENT A) -All workshop incidents will be reviewed to determine if they were investigated thoroughly, and/or investigated by ResCare to ensure a thorough investigation is completed. (ATTACHMENT F) -Clinical Supervisor and appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law. -Residential Manager or assigned designee will do an active treatment observation at the workshop monthly to ensure all individuals are free from abuse and neglect. (ATTACHMENT 		

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	<p>reportable incident on abuse and neglect but [QIDP] asked [Clinical Supervisor] not to report us that I was on vacation."</p> <p>The Emergency Room Visit Form, dated 7/21/14, indicated client F received a tetanus shot due to a cut on his leg that was repaired.</p> <p>A witness statement form, dated 7/21/14 at 3:45 PM, indicated client F reported, "I was helping one of the bosses @ workshop [name of workshop staff #1] unload some boxes out of her car and I was using the metal cart to put the boxes on and there was a sharp edge on the cart, I went to open the garage door and cut my leg on the cart. I told [name of workshop staff #2] I cut my leg on the cart and she was teasing me about cutting my leg off. [Workshop staff #2] gave me a Band-Aid and I used a paper towel with water on it to clean my leg. This happened between 1:30 and 2pm. I told group home staff as soon as they got to workshop and showed them my leg."</p> <p>A witness statement form, dated 7/21/14 at 4:00 PM, indicated staff #4, who picked up client F from the workshop, indicated, in part, "I went into the workshop to pick up the guys and [client F] approached me telling me he cut his leg. I asked him to show me and he did.</p>		<p><u>G)</u> Completion Date:</p>				

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	<p>I asked workshop staff and [workshop staff #2] stated she hadn't done an incident report but if we needed one she would give it to us tomorrow. I told her yes we would need one. I got back to the group home and called our team lead and nurse. The nurse told me to take him to the ER for a tetnus (sic) shot and to get it checked. At the ER they used Dermabond glue to seal the cut and gave [client F] a tetnus (sic) shot."</p> <p>On 9/11/14 at 1:52 PM, staff #6 indicated client F notified staff (staff #4) of cut. Client F needed a tetanus shot and dermabond to close the cut. Staff #6 indicated client F went to the CRC at the workshop. The CRC instructed him to clean his wound himself and gave him a Band-Aid.</p> <p>On 9/11/14 at 2:06 PM, client F indicated the workshop did not give him any medical treatment after he told them he cut his leg. Client F indicated the workshop staff instructed him to wash the cut with water and he put a Band-Aid on the cut. Client F indicated the group home nurse assessed the wound but not the workshop staff. Client F indicated he informed staff #4 when she picked him up at the end of the day. Client F indicated he was taken to the ER and had to get a shot.</p>			

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	<p>On 9/11/14 at 2:30 PM, the QIDP indicated she inserviced the DD at workshop about incident reporting.</p> <p>On 9/11/14 at 2:57 PM, staff #4 indicated client F told her he had to clean the cut on his leg. Staff #4 asked the workshop staff for a report regarding the incident and they did not have one. Staff #4 indicated the cut was still seeping blood when she arrived. Staff #4 indicated client F told her he cut his leg on a metal cart. Staff #4 indicated she took client F to the ER and he received a tetanus shot and dermabond to close the cut. Staff #4 stated when she looked at the cut, it looked "pretty bad." Staff #4 indicated client F told her the workshop staff did not provide first aid to his cut. Client F informed her he was given a wet paper towel and a Band-Aid. Staff #4 indicated the workshop did not inform the group home of the incident.</p> <p>On 9/11/14 at 3:00 PM, staff #6 indicated on 7/22/14, the workshop did not have an incident report to give to the group home. Staff #6 indicated she was told the workshop staff did not know what to put on the incident report.</p> <p>On 9/12/14 at 11:52 AM, the Division Director (DD) at the workshop indicated</p>			

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	<p>client F was assisting workshop staff #1 to bring in boxes and he cut his leg on a flatbed metal cart. The DD indicated client F reported to the workshop staff he scraped his leg and said he was okay. Client F told the staff he was bleeding and the staff instructed him to clean it. The DD indicated the staff should have assessed his cut and assisted him with cleaning the wound. The DD indicated an incident report was written on the day of the incident but not given to the group home on the day of the incident. The DD indicated the staff did not provide first aid to client F. The staff should have provided first aid. The DD indicated the group home should have been notified of the injury. The DD indicated the workshop staff received training, prior to the incident and afterwards, on first aid. The DD indicated the staff should have assessed the injury, cleaned and contacted the group home nurse if the staff were unsure of the severity of the injury. The DD indicated the workshop retrained the staff during a staff meeting.</p> <p>On 9/12/14 at 3:59 PM, the DD sent documentation the workshop retrained the staff during a staff meeting on 7/31/14. The staff meeting notes indicated, in part, "...[DD] stated that an incident with one of the group home residents happened while she was on</p>			

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	<p>vacation. The young man had an injury that was not handled properly. [DD] stated that she had already talked with the staff involved with the incident but that she wanted to go over it with everyone else so that there will not be any more misunderstandings. [DD] stated that if a consumer has an injury, that staff is to stop the bleeding and clean and bandage the wound. The staff should consult with a supervisor as to whether or not to take them (sic) the ER. [DD] stated that we always call the guardian and/or home staff even if it is a minor injury just in case the consumer has a problem after they leave our care. [DD] also stated that she expects an incident report done immediately and sent home with the consumer... It was brought up that there had been a miscommunication about the first aid that we were able to administer. Some of the employees thought that we could not treat a consumers (sic) wound. [DD] stated that we can clean it and bandage it but we could not administer any medication like triple antibiotic ointment without a doctor's order to do so for PRN (as needed)."</p> <p>On 9/12/14 at 12:12 PM, the Clinical Supervisor (CS) indicated she did not conduct an investigation. The CS initially indicated she did not think the injury qualified as significant. The CS</p>						

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	<p>stated when asked if she conducted an investigation, "I probably should have done one." The CS indicated the group home met with the workshop but did not implement measures to ensure the group home clients received first aid and medical treatment while at the workshop. The CS indicated the group home should have implemented steps to ensure the clients from the group home received first aid and medical treatment, when needed.</p> <p>On 9/12/14 at 2:06 PM, the Executive Director (ED) indicated she did not recall the incident. The ED indicated if there was an incident at the workshop and the workshop could spell out to the group home what occurred, the group home would take their investigation. The ED indicated the group home would not conduct an investigation if the client was able to relay, completely, what happened. The ED indicated an investigation should have been conducted. The ED indicated she was unsure if she was notified of the incident or not. The ED stated the note in the Division Director's documentation from an IDT dated 7/31/14 was "totally inappropriate." The ED indicated the incident was reported to the Bureau of Developmental Disabilities Services (BDDS). The ED defined neglect as "Doing something or not doing</p>			

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	<p>something that potentially put a client in harm's way." The ED, when asked if the workshop was negligent stated, "If he was there for two hours and that's all they did, then yes. There was a window where he was not treated." The ED indicated the incident should have been investigated.</p> <p>On 9/15/14 at 9:53 AM, the ED indicated in an email, "Yes, I receive all of the BDDS reports. If I have been verbally informed of the incident then I may not have reviewed. Beginning last week, I will be reviewing all to determine if an investigation is warranted, sending out the scope of the investigation and scheduling the review within 5 business days."</p> <p>On 9/12/14 at 2:23 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the note from the 7/31/14 IDT was not accurate regarding asking the CS to not report the workshop for abuse and neglect. The QIDP indicated she told the workshop Division Director the incident was BDDS reportable. The QIDP indicated she discussed with the DD the workshop staff not reporting the incident to the group home and not providing first aid. When asked if the workshop was negligent, the QIDP indicated the workshop could have</p>						

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	<p>provided client F first aid. When asked if ResCare should have investigated the incident, the QIDP indicated the workshop was responsible for conducting the investigation since the incident occurred at their facility.</p> <p>On 9/12/14 at 3:39 PM, the Program Manager (PM) indicated the Executive Director received all the BDDS reports. The PM indicated all the BDDS reports were sent to the ED, CS, Residential Manager, workshop, nurse, BDDS Coordinator and the Director of Operations/General Manager. The PM indicated the group home relied on the workshop to do investigations for incidents at the workshop. The PM stated if the workshop did not conduct an investigation, it would be "our bad for not sitting on them until it was done." The PM indicated the Clinical Supervisor spoke to the workshop staff however there was no documentation of an investigation. The PM stated, "We historically rely on the workshop to do their investigations. We didn't insist on them doing an investigation."</p> <p>2) On 8/7/14 at 9:20 AM, the BDDS report, dated 8/7/14, indicated, in part, "[Division Director (DD)] and [workshop staff #2] were speaking with [client F] about a report from a client that he had</p>			

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	<p>kissed another female client in the building/kitchen that is his girlfriend. This has been addressed on many occasions before. [DD] stated that she had received a (sic) incident report from a clients (sic) home and ask [client F] about it. He said he and girlfriend had just bumped into each other on accident. [DD] stated that the female he kissed said it happen (sic) and he dropped his head and said okay it did. [DD] explain (sic) to [client F] that she will have to go before the HRC (Human Rights Committee) board and they (sic) will not be able to have contact with her at workshop due to repeated issues with kissing and touching. This has been an issue that has been addressed with [client F] before and stated our concern to him of getting accused of Sexual Harassment. He immediately started screaming that he has his rights and that she couldn't do that. That he can talk to anyone. He then picked up a large table we were sitting at and tried to turn it over on [DD]. [DD] and [staff #2] held table down and then he picked up a chair from across the table and threw it at [DD] forcefully hitting her in the head and chest. Then (sic) another chair at her and then went to a small table and tried to throw it at her. [Client F] was cussing and screaming at [DD] the whole time. Trying to get her composer (sic) and leave room he picked up 4 more</p>			

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	<p>chairs and threw them at her as she tried to get out of room. Hitting her and wall and breaking table and objects on wall (sic). He had (sic) door she was trying to get out [staff #2] was trying to stop him and chairs but he would push her up against the walls (sic). [Client F] went over and set (sic) in floor after [DD] left (sic) room.</p> <p>The Town Marshall, [name] was called. He came in and asked [client F] what was wrong and he told officer [name] he doesn't speak to police (sic) officer [name] asked me what had happen (sic) and I explained. [Client F] told officer that if [DD] came back into room he would beat the s--- out of her. Officer [name] said he didn't think so. An Ambulance was called for [DD] and she was taken to [name] Hospital.</p> <p>[Workshop staff #5] arrived to assist as well as other staff present in the building who assisted with the well being of other clients in group hab (habilitation) area. ResCare staff was also called. 9:45 [QIDP] spoke to [workshop staff #2] on phone asking to hold him here until she arrived. Upon arrival of Rescare, myself, [workshop staff #5], [QIDP] and [Rescare staff #7] Home Manager went to kitchen for meeting. [QIDP] said she was shocked that she couldn't believe he would act like this. She asked that he not</p>			

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	<p>go to jail and [workshop staff #5] explain (sic) it may be out of our hands because Officer [name] was talking to (sic) Prosecutor at this moment. After talking [QIDP] wanted to see [client F]. We did ask her to wait for Officer until he was off of (sic) phone. She said she was not worried that he would not do anything to her but she waited. Officer got off of phone and he stated that (sic) Prosecutor stated [client F] has 2 options. 1. not to return to [name of workshop] property or 2. to go to jail. [Client F] was escorted home by [QIDP] along with [Home Manager]. [QIDP] spoke with ResCare and a fax was sent stated that [client F] will no longer be with [name of workshop].</p> <p>[Workshop staff #5] went to hospital to be with [DD] and she was taken home. She is to be off work until Monday. [DD's] left wrist and sternum was (sic) x-rayed with no broken bones. She also lost a diamond setting out of her ring. Diamond was finally found where she had received blows with chairs.</p> <p>[Workshop staff #2] received bruises (sic) and soreness from being pushed into wall but (sic) was no need for doctor care. Any further issues with ResCare clients, ResCare staff will be asked to set (sic) in on meetings."</p>			

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	<p>The workshop's investigation, dated 8/11/14, indicated workshop staff #5 completed the report. The Investigative Report indicated, in part, "I found out that [client F], consumer had been in the conference room with [workshop staff #2] and [DD]. They were talking with him about a compliant (sic) they had received from another consumer. [Client F] became upset and turned over the conference room table and started throwing chairs and tables at [DD]. [Workshop staff #2] was shoved into the wall and attempted to keep him from throwing the conference room table and was trying to help [DD] get out of the room."</p> <p>The workshop's investigation indicated in the Summary of final findings and recommendations section, "During the investigation we found out that one other time [client F] had an incident when he threw objects on 2/18/14. It was as a result (sic) the same subject addressed about staying away from the same female consumer. During this incident he came up to the group hab staff and started cussing and went into the back area hitting his fist on the garage door and breaking a table. [Client F] did injure himself on that day. A state report and an internal report were also done at that time. Also a meeting with ResCare was</p>			

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	<p>held concerning these issues. Due to the level of violent aggression and 'intent to do harm,' it is felt that [client F] should not be allowed to attend [name of workshop] at this current time.</p> <p>Following our 'Removal From Current Services Environment, Discharge, and Transfer Policy (no end of quote), [name of workshop] reserves the right to remove and suspend an individual from a particular services environment if deemed necessary to protect the rights and safety of others served. If it is deemed necessary to do so, a team/IDT meeting will be held to discuss the circumstances leading to the removal, future services, and recommendations, including other positive behavioral methods and crisis intervention techniques which could be initialized.</p> <p>The following criteria is the reason for the recommendation 'Violence or threats against person or property (sic).' With [client F's] physical strength and explosive disorder, [name of workshop] does not feel we can assure the safety of the people we serve and the safety of the staff involved in the incident at this time in the facility. The IDT Team will work for a solution for further serving [client F] in the future. We would also recommend that [client F] receive regular counseling and coaching on how to express ongoing (sic) his feelings when</p>			

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	<p>he initially starts to feel frustrated and angry."</p> <p>There was no documentation the group home investigated the incident.</p> <p>A ResCare Northern Region Quarterly Review, dated 2/27/14, indicated, in part, "Only issue is ws (workshop) behavior last Tues (Tuesday) 2/18/14... Also discussed if ws (workshop) has issues with [client F's] behaviors while @ (at) ws - ws will notify ResCare so they are present when ws discusses issues w/ (with) [client F]."</p> <p>An Interdisciplinary Team Meeting, dated 8/15/14, indicated, in part, "Safety measures put in place to avoid this predicament (sic) we requested this in February - all discipline issues need documented and forwarded to ResCare. All issues of concern need to be completed with ResCare present."</p> <p>On 9/11/14 at 2:30 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated prior to the 8/7/14 incident, she instructed the workshop to contact the group home staff prior to discussing issues with client F. The QIDP indicated client F was hospitalized on 8/7/14 in a psychiatric unit for one week. The QIDP indicated the officer</p>						

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	<p>gave client F two choices, go to jail or to the hospital. On 9/11/14 at 3:17 PM, the QIDP stated the incident was a "provoked behavior" due to the workshop staff meeting with client F without having ResCare staff present. The QIDP indicated the workshop was directed to include ResCare staff when they were going to meet to discuss issues with client F at a quarterly meeting. The QIDP indicated the workshop staff told client F he was not going to be allowed contact with his girlfriend which led to the incident on 8/7/14.</p> <p>On 9/11/14 at 2:06 PM, client F indicated he was kicked out of the workshop due to throwing a table and chairs. Client F indicated he was mad at the Division Director (DD). Client F indicated the DD wanted to keep him and his girlfriend apart.</p> <p>On 9/12/14 at 3:39 PM, the Program Manager (PM) indicated she thought the workshop conducted an investigation of the incident. The PM indicated the group home staff were supposed to be at meetings when the workshop was going to discuss his behavior with him. The PM indicated she was at the meeting following the incident and the workshop admitted they were wrong. They admitted they made a mistake by talking</p>						

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	<p>about the HRC with client F. The PM stated the incident "might not have been so extreme" if the workshop would have contacted the group home prior to discussing the incident with client F.</p> <p>On 9/12/14 at 11:52 AM, the Division Director [DD] at the workshop indicated she received an internal incident report on another client that client F kissed her while at the workshop. The DD indicated the workshop did not promote kissing in the building due to causing all kinds of issues. The DD indicated she spoke to the female client and then called client F to ask him if he kissed her. The DD indicated client F admitted he kissed her. The DD indicated she told client F it was against the rules and he became angry. The DD indicated she did not recall the group home requesting to be at meetings with client F. The DD stated, "Most likely accurate information." The DD indicated the workshop did not contact ResCare on 8/7/14. The DD indicated she thought her discussion with client F was going to be quick. The DD indicated she did not even think about calling ResCare. The DD stated, "thought it was going to be a 3 minute conversation."</p> <p>On 9/12/14 at 12:12 PM, the Clinical Supervisor (CS) indicated ResCare did not conduct an investigation into the</p>			

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	<p>incident. The CS indicated she was not sure if the workshop's investigation was thorough or not. The CS indicated she was under the impression it was their employee and their investigation to conduct. The CS indicated it was the workshop's responsibility to conduct an investigation. The CS indicated she was not aware she needed to conduct an investigation, too. The CS indicated it was not her place to do an investigation involving the workshop's services. The CS indicated she was told by the QIDP, following the 8/7/14 incident, the workshop was supposed to involve ResCare staff in meetings involving client F's behavior.</p> <p>On 9/12/14 at 2:06 PM, the Executive Director (ED) indicated she recalled client F being kicked out of the workshop and a workshop staff was injured. The ED stated, when asked if ResCare investigated the incident, "I am sure we should have investigated it. When different entities do investigations, there are different findings."</p> <p>3) On 5/1/14 at 4:45 PM, client G was asked to return an item (cable cord) he stole. The 5/1/14 Incident Report indicated, in part, "...he became angry and staff prompted him to calm down, he took after a staff and tried to slap them.</p>			

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	<p>He then went into the kitchen and pushed [client A] into the counter and kicked staff in the knee. Staff prompted him to stop and he continued to try to hit staff. 2 staff then did the 2 man restraint." The report indicated, "[Client A] had red mark on his left forearm & left hip, staff monitored this, there was no bruising on hip, bruise developed on forearm."</p> <p>On 9/12/14 at 12:12 PM, the Clinical Supervisor (CS) indicated client to client aggression was considered abuse if there was injury or intent. The CS indicated the facility should prevent abuse of the clients. The CS indicated there was a policy and procedure prohibiting abuse of the clients.</p> <p>On 9/12/14 at 1:04 PM, the facility's 5/28/12 Abuse, Neglect and Exploitation policy indicated, "ResCare will: Ensure all persons served are treated with dignity and respect. Ensure that all persons served are free from abuse, neglect, or exploitation... ResCare does not tolerate abuse, neglect, or exploitation of any persons served. All employees are required to report allegations or suspected incidents of abuse, neglect, and exploitation. All alleged or suspected abuse, neglect, and/or exploitation will be immediately investigated. Appropriate corrective action will be taken to ensure</p>			

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	<p>prevention of any further occurrence. Abuse means the infliction of physical or psychological harm, unreasonable confinement, intimidation, punishment with resulting physical harm, pain or mental anguish or deprivation of goods or services that are necessary to meet essential needs or to avoid physical or psychological harm." The 2/18/10 Investigations policy was reviewed on 9/12/14 at 1:04 PM. The policy indicated, in part, "In order to ensure the health, safety and welfare of the people we support, events or collections of circumstances that are outside of what is normally expected, cannot be explained and understood by the existence of the event, and result in or have the potential to result in injury or abuse, neglect or exploitation to the individual must be investigated. Investigations will be conducted per the protocols listed in the incident management best practices manual... A thorough investigation final report will be written at the completion of the investigation. The report shall include, but is not limited to, the following: description of the allegation or incident, purpose of the investigation, parties providing information, summary of information and findings, description and chronology of what happened, analysis of the evidence, finding of fact and determination as to whether or not</p>						

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W000154	<p>the allegations are substantiated, unsubstantiated or inconclusive, concerns and recommendations, witness statements and supporting documentation, and methods to prevent future incidents."</p> <p>This federal tag relates to complaint #IN00153303.</p> <p>9-3-2(a)</p> <p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview for 2 of 15 incident/investigative reports reviewed affecting client F, the facility failed to investigate incidents on 7/21/14 and 8/7/14 while client F was at the workshop.</p> <p>Findings include:</p> <p>On 9/11/14 at 1:50 PM, the facility's incident/investigative reports were reviewed and indicated the following:</p> <p>1) On 7/21/14 at 12:45 PM, the ResCare Incident Report indicated, in part, "[Client F] was picked up from w/s</p>	W000154	<p>PROVIDER IDENTIFICATION #: 15G352 NAME OF PROVIDER: RESCARE COMMUNITY ALT., SOUTH CENTRAL ADDRESS: 240 1st Street NE SURVEY EVENT ID #: E90P11 DATE SURVEY COMPLETED: 9/15/2014</p> <p>PROVIDER'S PLAN OF CORRECTION <u>W 154: STAFF TREATMENT OF CLIENTS</u> The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Corrective action: ·All appropriate parties have been in-serviced on failure to</p>	10/15/2014

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	<p>(workshop) and informed staff he had cut his leg. Staff asked w/s staff about a report. They stated they hadn't filled one out. Staff called nurse and team lead, was told to take him to the ER (emergency room)." The facility did not conduct an investigation of the incident.</p> <p>A [name of workshop] Incident Report, dated 7/21/14, was completed by workshop staff #3. The report indicated, "[Client F] was helping staff move boxes. [Client F] came up to the staff table and told staff he cut his leg. [Client F] said he cut his leg on the garage door. It was his lower right leg. Staff asked him to go clean the cut up and then staff had [client F] put a Band-Aid on it."</p> <p>A [name of workshop] Incident Report, dated 7/21/14, was completed by workshop staff #2. The report indicated, "[Client F] was assisting staff with moving items. [Client F] came up to me and said he cut his right lower leg on the garage door. When I looked (sic) it the cut was barely bleeding. I asked him to go clean it with water. When he came back I gave him a bandage to put on."</p> <p>A [name of workshop] Incident Report, dated 7/21/14, was completed by workshop staff #1. The report indicated, "Loading boxes onto cart from car to</p>		<p>follow state guidelines on completing a thorough investigation, including at the workshop. (ATTACHMENT A)</p> <ul style="list-style-type: none"> ·All appropriate parties have been in-serviced on failure to follow, ResCare policy and procedures to prevent abuse, neglect and or mistreatment of clients. (ATTACHMENT A) ·All appropriate parties have been in-serviced on failure to identify, definition of and identifying all issues of client to client abuse. (ATTACHMENT A) <p>How we will identify others:</p> <ul style="list-style-type: none"> ·All allegations of abuse/neglect/mistreatment, client to client, injury at the workshop will be reviewed by Clinical Supervisor or appropriate parties to determine if a ResCare investigation is indicated. (ATTACHMENT A,F) ·All investigations completed on any incident occurring at the workshop will be forwarded to the appropriate parties for review and recommendations, ·All investigations completed on any incident occurring at the workshop will be presented to IDT/Peer Review (workshop) for final recommendations and implementation. ·An IDT/Peer Review will be scheduled with workshop staff five (5) days from investigation start, to ensure compliance. ·All workshop incidents will be reviewed to determine if they were investigated thoroughly, 		

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	<p>bring into (illegible) workshop. [Client F] bumped his right leg on edge of cart. [Workshop staff #4] sent him into workshop to have CRC's (Clinical Resource Consultants) check on him. He said he was fine. Scratch was cleaned & Band-Aid applied. [Workshop staff #1] later asked [client F] if he was OK & he said he was fine." The report indicated, "Leg cleaned & Band-Aid applied by [client F]." The section titled "Actions taken to assure that there is not a recurrence of this incident" indicated, "Make sure [client F] knows not to stand close to loading cart."</p> <p>An Interdisciplinary Team Meeting note (documented by the group home staff), dated 7/31/14, involving the workshop Division Director (DD) and the group home Qualified Intellectual Disabilities Professional (QIDP) indicated, "Discussed w/ (with) [DD] the incident that took place on 7/21/14 with client [F]. Client was injured @ (at) ws (workshop) & staff failed to complete an incident report the day of incident. Staff had [client F] clean his own wound & staff did not notify ResCare staff or nurse. Explained to [DD] this could of (sic) been a report of abuse & neglect on ws staff & would be if it happens again. ([DD] was on vacation that week.) [DD] stated she would retrain her staff on</p>		<p>and/or investigated by ResCare to ensure a thorough investigation is completed. (ATTACHMENT A,F)</p> <p>Measures to be put in place:</p> <ul style="list-style-type: none"> ·All workshop incidents will be reviewed to determine if they were investigated thoroughly, and/or investigated by ResCare to ensure a thorough investigation is completed. (ATTACHMENT A,F) ·Residential Manager or assigned designee will do an active treatment observation at the workshop monthly to ensure all individuals are free from abuse and neglect. (ATTACHMENT G) <p>Monitoring of Corrective Action:</p> <ul style="list-style-type: none"> ·All investigations completed on any incident occurring at the workshop will be presented to IDT/Peer Review (workshop) for final recommendations and implementation. ·An IDT/Peer Review will be scheduled with workshop staff five (5) days from investigation start, to ensure compliance. ·All workshop incidents will be reviewed to determine if they were investigated thoroughly, and/or investigated by ResCare to ensure a thorough investigation is completed. (ATTACHMENT A,F) ·Residential Manager or assigned designee will do an active treatment observation at the workshop monthly to ensure all individuals are free from abuse and neglect. (ATTACHMENT G) ·Clinical Supervisor and 	

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	<p>incident reporting, wound care & who to notify. [Client F] was taken to the ER by ResCare staff & treated. (See ER note)."</p> <p>An Individual Support List and Progress Review form, not dated, was completed by the Division Director of the workshop during the Interdisciplinary Team Meeting on 7/31/14. The note indicated, "Meeting with [QIDP] about incident report on [client F]. Assured [QIDP] that I will retrain staff on reportable incident, about writing up incident reports immediately and for staff to clean the wound and bandage if necessary. Let supervisor know about an incident and they can determine if ResCare nurse needs to be called or if we need to transport to Emergency room. I also shared with [QIDP] that I feel that sometimes we report things that may not be reportable but would rather report and let them tell me that it isn't reportable. [QIDP] stated that this could have been a reportable incident on abuse and neglect but [QIDP] asked [Clinical Supervisor] not to report us that I was on vacation."</p> <p>The Emergency Room Visit Form, dated 7/21/14, indicated client F received a tetanus shot due to a cut on his leg that was repaired.</p> <p>A witness statement form, dated 7/21/14</p>		<p>appropriate Management personnel will perform periodic service reviews to ensure that all regulations are being adhered to in accordance with state law.</p> <p>Completion Date:</p>				

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	<p>at 3:45 PM, indicated client F reported, "I was helping one of the bosses @ workshop [name of workshop staff #1] unload some boxes out of her car and I was using the metal cart to put the boxes on and there was a sharp edge on the cart, I went to open the garage door and cut my leg on the cart. I told [name of workshop staff #2] I cut my leg on the cart and she was teasing me about cutting my leg off. [Workshop staff #2] gave me a Band-Aid and I used a paper towel with water on it to clean my leg. This happened between 1:30 and 2pm. I told group home staff as soon as they got to workshop and showed them my leg."</p> <p>A witness statement form, dated 7/21/14 at 4:00 PM, indicated staff #4, who picked up client F from the workshop, indicated, in part, "I went into the workshop to pick up the guys and [client F] approached me telling me he cut his leg. I asked him to show me and he did. I asked workshop staff and [workshop staff #2] stated she hadn't done an incident report but if we needed one she would give it to us tomorrow. I told her yes we would need one. I got back to the group home and called our team lead and nurse. The nurse told me to take him to the ER for a tetnus (sic) shot and to get it checked. At the ER they used Dermabond glue to seal the cut and gave</p>						

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	<p>[client F] a tetnus (sic) shot."</p> <p>On 9/11/14 at 1:52 PM, staff #6 indicated client F notified staff (staff #4) of cut. Client F needed a tetanus shot and dermabond to close the cut. Staff #6 indicated client F went to the CRC at the workshop. The CRC instructed him to clean his wound himself and gave him a Band-Aid.</p> <p>On 9/11/14 at 2:06 PM, client F indicated the workshop did not give him any medical treatment after he told them he cut his leg. Client F indicated the workshop staff instructed him to wash the cut with water and he put a Band-Aid on the cut. Client F indicated the group home nurse assessed the wound but not the workshop staff. Client F indicated he informed staff #4 when she picked him up at the end of the day. Client F indicated he was taken to the ER and had to get a shot.</p> <p>On 9/11/14 at 2:30 PM, the QIDP indicated she inserviced the DD at workshop about incident reporting.</p> <p>On 9/11/14 at 2:57 PM, staff #4 indicated client F told her he had to clean the cut on his leg. Staff #4 asked the workshop staff for a report regarding the incident and they did not have one. Staff #4</p>				

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	<p>indicated the cut was still seeping blood when she arrived. Staff #4 indicated client F told her he cut his leg on a metal cart. Staff #4 indicated she took client F to the ER and he received a tetanus shot and dermabond to close the cut. Staff #4 stated when she looked at the cut, it looked "pretty bad." Staff #4 indicated client F told her the workshop staff did not provide first aid to his cut. Client F informed her he was given a wet paper towel and a Band-Aid. Staff #4 indicated the workshop did not inform the group home of the incident.</p> <p>On 9/11/14 at 3:00 PM, staff #6 indicated on 7/22/14, the workshop did not have an incident report to give to the group home. Staff #6 indicated she was told the workshop staff did not know what to put on the incident report.</p> <p>On 9/12/14 at 11:52 AM, the Division Director (DD) at the workshop indicated client F was assisting workshop staff #1 to bring in boxes and he cut his leg on a flatbed metal cart. The DD indicated client F reported to the workshop staff he scraped his leg and said he was okay. Client F told the staff he was bleeding and the staff instructed him to clean it. The DD indicated the staff should have assessed his cut and assisted him with cleaning the wound. The DD indicated</p>			

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	<p>an incident report was written on the day of the incident but not given to the group home on the day of the incident. The DD indicated the staff did not provide first aid to client F. The staff should have provided first aid. The DD indicated the group home should have been notified of the injury. The DD indicated the workshop staff received training, prior to the incident and afterwards, on first aid. The DD indicated the staff should have assessed the injury, cleaned and contacted the group home nurse if the staff were unsure of the severity of the injury. The DD indicated the workshop retrained the staff during a staff meeting.</p> <p>On 9/12/14 at 3:59 PM, the DD sent documentation the workshop retrained the staff during a staff meeting on 7/31/14. The staff meeting notes indicated, in part, "...[DD] stated that an incident with one of the group home residents happened while she was on vacation. The young man had an injury that was not handled properly. [DD] stated that she had already talked with the staff involved with the incident but that she wanted to go over it with everyone else so that there will not be any more misunderstandings. [DD] stated that if a consumer has an injury, that staff is to stop the bleeding and clean and bandage the wound. The staff should consult with</p>			

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	<p>a supervisor as to whether or not to take them (sic) the ER. [DD] stated that we always call the guardian and/or home staff even if it is a minor injury just in case the consumer has a problem after they leave our care. [DD] also stated that she expects an incident report done immediately and sent home with the consumer... It was brought up that there had been a miscommunication about the first aid that we were able to administer. Some of the employees thought that we could not treat a consumers (sic) wound. [DD] stated that we can clean it and bandage it but we could not administer any medication like triple antibiotic ointment without a doctor's order to do so for PRN (as needed)."</p> <p>On 9/12/14 at 12:12 PM, the Clinical Supervisor (CS) indicated she did not conduct an investigation. The CS initially indicated she did not think the injury qualified as significant. The CS stated when asked if she conducted an investigation, "I probably should have done one." The CS indicated the group home met with the workshop but did not implement measures to ensure the group home clients received first aid and medical treatment while at the workshop. The CS indicated the group home should have implemented steps to ensure the clients from the group home received</p>						

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	<p>first aid and medical treatment, when needed.</p> <p>On 9/12/14 at 2:06 PM, the Executive Director (ED) indicated she did not recall the incident. The ED indicated if there was an incident at the workshop and the workshop could spell out to the group home what occurred, the group home would take their investigation. The ED indicated the group home would not conduct an investigation if the client was able to relay, completely, what happened. The ED indicated an investigation should have been conducted. The ED indicated she was unsure if she was notified of the incident or not. The ED stated the note in the Division Director's documentation from an IDT dated 7/31/14 was "totally inappropriate." The ED indicated the incident was reported to the Bureau of Developmental Disabilities Services (BDDS). The ED defined neglect as "Doing something or not doing something that potentially put a client in harm's way." The ED, when asked if the workshop was negligent stated, "If he was there for two hours and that's all they did, then yes. There was a window where he was not treated." The ED indicated the incident should have been investigated.</p> <p>On 9/15/14 at 9:53 AM, the ED indicated</p>				

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	<p>in an email, "Yes, I receive all of the BDDS reports. If I have been verbally informed of the incident then I may not have reviewed. Beginning last week, I will be reviewing all to determine if an investigation is warranted, sending out the scope of the investigation and scheduling the review within 5 business days."</p> <p>On 9/12/14 at 2:23 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated the note from the 7/31/14 IDT was not accurate regarding asking the CS to not report the workshop for abuse and neglect. The QIDP indicated she told the workshop Division Director the incident was BDDS reportable. The QIDP indicated she discussed with the DD the workshop staff not reporting the incident to the group home and not providing first aid. When asked if the workshop was negligent, the QIDP indicated the workshop could have provided client F first aid. When asked if ResCare should have investigated the incident, the QIDP indicated the workshop was responsible for conducting the investigation since the incident occurred at their facility.</p> <p>On 9/12/14 at 3:39 PM, the Program Manager (PM) indicated the Executive Director received all the BDDS reports.</p>				

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	<p>The PM indicated all the BDDS reports were sent to the ED, CS, Residential Manager, workshop, nurse, BDDS Coordinator and the Director of Operations/General Manager. The PM indicated the group home relied on the workshop to do investigations for incidents at the workshop. The PM stated if the workshop did not conduct an investigation, it would be "our bad for not sitting on them until it was done." The PM indicated the Clinical Supervisor spoke to the workshop staff however there was no documentation of an investigation. The PM stated, "We historically rely on the workshop to do their investigations. We didn't insist on them doing an investigation."</p> <p>2) On 8/7/14 at 9:20 AM, the BDDS report, dated 8/7/14, indicated, in part, "[Division Director (DD)] and [workshop staff #2] were speaking with [client F] about a report from a client that he had kissed another female client in the building/kitchen that is his girlfriend. This has been addressed on many occasions before. [DD] stated that she had received a (sic) incident report from a clients (sic) home and ask [client F] about it. He said he and girlfriend had just bumped into each other on accident. [DD] stated that the female he kissed said it happen (sic) and he dropped his head</p>			

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	and said okay it did. [DD] explain (sic) to [client F] that she will have to go before the HRC (Human Rights Committee) board and they (sic) will not be able to have contact with her at workshop due to repeated issues with kissing and touching. This has been an issue that has been addressed with [client F] before and stated our concern to him of getting accused of Sexual Harassment. He immediately started screaming that he has his rights and that she couldn't do that. That he can talk to anyone. He then picked up a large table we were sitting at and tried to turn it over on [DD]. [DD] and [staff #2] held table down and then he picked up a chair from across the table and threw it at [DD] forcefully hitting her in the head and chest. Then (sic) another chair at her and then went to a small table and tried to throw it at her. [Client F] was cussing and screaming at [DD] the whole time. Trying to get her composer (sic) and leave room he picked up 4 more chairs and threw them at her as she tried to get out of room. Hitting her and wall and breaking table and objects on wall (sic). He had (sic) door she was trying to get out [staff #2] was trying to stop him and chairs but he would push her up against the walls (sic). [Client F] went over and set (sic) in floor after [DD] left (sic) room.			

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	<p>The Town Marshall, [name] was called. He came in and asked [client F] what was wrong and he told officer [name] he doesn't speak to police (sic) officer [name] asked me what had happen (sic) and I explained. [Client F] told officer that if [DD] came back into room he would beat the s--- out of her. Officer [name] said he didn't think so. An Ambulance was called for [DD] and she was taken to [name] Hospital. [Workshop staff #5] arrived to assist as well as other staff present in the building who assisted with the well being of other clients in group hab (habilitation) area. ResCare staff was also called. 9:45 [QIDP] spoke to [workshop staff #2] on phone asking to hold him here until she arrived. Upon arrival of Rescare, myself, [workshop staff #5], [QIDP] and [Rescare staff #7] Home Manager went to kitchen for meeting. [QIDP] said she was shocked that she couldn't believe he would act like this. She asked that he not go to jail and [workshop staff #5] explain (sic) it may be out of our hands because Officer [name] was talking to (sic) Prosecutor at this moment. After talking [QIDP] wanted to see [client F]. We did ask her to wait for Officer until he was off of (sic) phone. She said she was not worried that he would not do anything to her but she waited. Officer got off of phone and he stated that (sic) Prosecutor</p>						

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	<p>stated [client F] has 2 options. 1. not to return to [name of workshop] property or 2. to go to jail. [Client F] was escorted home by [QIDP] along with [Home Manager]. [QIDP] spoke with ResCare and a fax was sent stated that [client F] will no longer be with [name of workshop].</p> <p>[Workshop staff #5] went to hospital to be with [DD] and she was taken home. She is to be off work until Monday. [DD's] left wrist and sternum was (sic) x-rayed with no broken bones. She also lost a diamond setting out of her ring. Diamond was finally found where she had received blows with chairs.</p> <p>[Workshop staff #2] received bruises (sic) and soreness from being pushed into wall but (sic) was no need for doctor care. Any further issues with ResCare clients, ResCare staff will be asked to set (sic) in on meetings."</p> <p>The workshop's investigation, dated 8/11/14, indicated workshop staff #5 completed the report. The Investigative Report indicated, in part, "I found out that [client F], consumer had been in the conference room with [workshop staff #2] and [DD]. They were talking with him about a compliant (sic) they had received from another consumer. [Client F] became upset and turned over the</p>						

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	<p>conference room table and started throwing chairs and tables at [DD]. [Workshop staff #2] was shoved into the wall and attempted to keep him from throwing the conference room table and was trying to help [DD] get out of the room."</p> <p>The workshop's investigation indicated in the Summary of final findings and recommendations section, "During the investigation we found out that one other time [client F] had an incident when he threw objects on 2/18/14. It was as a result (sic) the same subject addressed about staying away from the same female consumer. During this incident he came up to the group hab staff and started cussing and went into the back area hitting his fist on the garage door and breaking a table. [Client F] did injure himself on that day. A state report and an internal report were also done at that time. Also a meeting with ResCare was held concerning these issues. Due to the level of violent aggression and 'intent to do harm,' it is felt that [client F] should not be allowed to attend [name of workshop] at this current time. Following our 'Removal From Current Services Environment, Discharge, and Transfer Policy (no end of quote), [name of workshop] reserves the right to remove and suspend an individual from a</p>						

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	<p>particular services environment if deemed necessary to protect the rights and safety of others served. If it is deemed necessary to do so, a team/IDT meeting will be held to discuss the circumstances leading to the removal, future services, and recommendations, including other positive behavioral methods and crisis intervention techniques which could be initialized. The following criteria is the reason for the recommendation 'Violence or threats against person or property (sic).' With [client F's] physical strength and explosive disorder, [name of workshop] does not feel we can assure the safety of the people we serve and the safety of the staff involved in the incident at this time in the facility. The IDT Team will work for a solution for further serving [client F] in the future. We would also recommend that [client F] receive regular counseling and coaching on how to express ongoing (sic) his feelings when he initially starts to feel frustrated and angry."</p> <p>There was no documentation the group home investigated the incident.</p> <p>A ResCare Northern Region Quarterly Review, dated 2/27/14, indicated, in part, "Only issue is ws (workshop) behavior last Tues (Tuesday) 2/18/14... Also</p>						

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	<p>discussed if ws (workshop) has issues with [client F's] behaviors while @ (at) ws - ws will notify ResCare so they are present when ws discusses issues w/ (with) [client F]."</p> <p>An Interdisciplinary Team Meeting, dated 8/15/14, indicated, in part, "Safety measures put in place to avoid this predicament (sic) we requested this in February - all discipline issues need documented and forwarded to ResCare. All issues of concern need to be completed with ResCare present."</p> <p>On 9/11/14 at 2:30 PM, the Qualified Intellectual Disabilities Professional (QIDP) indicated prior to the 8/7/14 incident, she instructed the workshop to contact the group home staff prior to discussing issues with client F. The QIDP indicated client F was hospitalized on 8/7/14 in a psychiatric unit for one week. The QIDP indicated the officer gave client F two choices, go to jail or to the hospital. On 9/11/14 at 3:17 PM, the QIDP stated the incident was a "provoked behavior" due to the workshop staff meeting with client F without having ResCare staff present. The QIDP indicated the workshop was directed to include ResCare staff when they were going to meet to discuss issues with client F at a quarterly meeting. The</p>			

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	<p>QIDP indicated the workshop staff told client F he was not going to be allowed contact with his girlfriend which led to the incident on 8/7/14.</p> <p>On 9/11/14 at 2:06 PM, client F indicated he was kicked out of the workshop due to throwing a table and chairs. Client F indicated he was mad at the Division Director (DD). Client F indicated the DD wanted to keep him and his girlfriend apart.</p> <p>On 9/12/14 at 3:39 PM, the Program Manager (PM) indicated she thought the workshop conducted an investigation of the incident. The PM indicated the group home staff were supposed to be at meetings when the workshop was going to discuss his behavior with him. The PM indicated she was at the meeting following the incident and the workshop admitted they were wrong. They admitted they made a mistake by talking about the HRC with client F. The PM stated the incident "might not have been so extreme" if the workshop would have contacted the group home prior to discussing the incident with client F.</p> <p>On 9/12/14 at 11:52 AM, the Division Director [DD] at the workshop indicated she received an internal incident report on another client that client F kissed her</p>						

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NAME OF PROVIDER OR SUPPLIER COMMUNITY ALTERNATIVES SW IN				STREET ADDRESS, CITY, STATE, ZIP CODE 240 1ST ST NE LINTON, IN 47441			
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	<p>while at the workshop. The DD indicated the workshop did not promote kissing in the building due to causing all kinds of issues. The DD indicated she spoke to the female client and then called client F to ask him if he kissed her. The DD indicated client F admitted he kissed her. The DD indicated she told client F it was against the rules and he became angry. The DD indicated she did not recall the group home requesting to be at meetings with client F. The DD stated, "Most likely accurate information." The DD indicated the workshop did not contact ResCare on 8/7/14. The DD indicated she thought her discussion with client F was going to be quick. The DD indicated she did not even think about calling ResCare. The DD stated, "thought it was going to be a 3 minute conversation."</p> <p>On 9/12/14 at 12:12 PM, the Clinical Supervisor (CS) indicated ResCare did not conduct an investigation into the incident. The CS indicated she was not sure if the workshop's investigation was thorough or not. The CS indicated she was under the impression it was their employee and their investigation to conduct. The CS indicated it was the workshop's responsibility to conduct an investigation. The CS indicated she was not aware she needed to conduct an investigation, too. The CS indicated it</p>						

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	<p>was not her place to do an investigation involving the workshop's services. The CS indicated she was told by the QIDP, following the 8/7/14 incident, the workshop was supposed to involve ResCare staff in meetings involving client F's behavior.</p> <p>On 9/12/14 at 2:06 PM, the Executive Director (ED) indicated she recalled client F being kicked out of the workshop and a workshop staff was injured. The ED stated, when asked if ResCare investigated the incident, "I am sure we should have investigated it. When different entities do investigations, there are different findings."</p> <p>This federal tag relates to complaint #IN00153303.</p> <p>9-3-2(a)</p>				