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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G814	A. BUILDING 00 B. WING	02/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VOCA CORPORATION OF INDIANA	8307 CASTLETON BLVD INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a pre-determined full annual recertification and state licensure survey. This visit resulted in an Immediate Jeopardy. Dates of Survey: 1/28/2020, 1/29/2020, 1/30/2020, 1/31/2020, 2/3/2020 and 2/4/2020. Facility Number: 010453 Provider Number: 15G814 AIMS Number: 201408320 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/13/20.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Governing Body for 2 of 3 sampled clients (#1 and #2). The governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent program intervention neglect, and neglected to ensure clients #1 and #2's supervision needs and program interventions were implemented to address their elopement behaviors and client #2's potential criminal sexual behavior. The governing body failed to exercise general	W 0102	**CORRECTION:** *The facility must ensure that specific governing body and management requirements are met.* Specifically: Client #1 and client #2's Behavior Support Plans were modified to prevent recurrences of elopements. Client #1 received line of sight observation during waking hours, in common areas, and 15-minute checks while sleeping for 21 days and based on interdisciplinary team consensus he currently receives 15-minute checks between 6:00	03/04/2020

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	policy, budget and operating direction over the facility over the facility to ensure the facility met the Condition of Participation: Client Protections for 2 of 3 sampled clients (#1 and #2). Findings include: 1. Please refer to W104. For 2 of 3 sampled clients (#1 and #2), the governing body failed to ensure the facility implemented its written policy and procedures to prevent program intervention neglect, and neglected to ensure clients #1 and #2's supervision needs and program interventions were implemented to address their elopement behaviors and client #2's potential criminal sexual behavior. 2. Please refer to W122. For 2 of 3 sampled clients (#1 and #2), the governing body failed to exercise general policy, budget and operating direction over the facility over the facility to ensure the facility met the Condition of Participation: Client Protections for 2 of 3 sampled clients (#1 and #2). 9-3-1(a)		AM and 10:00 PM. Additionally, client #1 no longer sleeps in a bedroom with an exit door. Client #2 will receive line of sight observation during waking hours, in common areas, and 15-minute checks while sleeping until transition to Waiver is complete. All facility staff have been trained toward proper implementation of the revised plans, and all supervisors and administrative staff responsible for monitoring have been trained toward proper implementation of the revised plans. **PREVENTION:** The Residential Manager or Area Supervisor will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to assuring Behavior Support Plans are implemented as written. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) and the QIDP will conduct daily administrative monitoring during varied shifts/times. After 30 Days, administrative monitoring will occur no less than weekly until all	

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			staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility, which will occur no less than monthly. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative support at the home will include but not be limited to assuring Behavior Support Plans are implemented as written. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff,	

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			Operations Team, Regional Director	
W 0104 Bldg. 00	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 2 of 3 sampled clients (#1 and #2), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure the facility implemented its written policy and procedures to prevent program intervention neglect, and neglected to ensure clients #1 and #2's supervision needs and program interventions were implemented to address their elopement behaviors and client #2's potential criminal sexual behavior. Findings include: Please refer to W149. For 2 of 3 sampled clients (#1 and #2), the governing body failed to ensure the facility implemented its written policy and procedures to prevent program intervention neglect, and neglected to ensure clients #1 and #2's supervision needs and program interventions were implemented to address their elopement behaviors and client #2's potential criminal sexual behavior. 9-3-1(a)	W 0104	**CORRECTION:** *The governing body must exercise general policy, budget, and operating direction over the facility.* Specifically, Client #1 and client #2's Behavior Support Plans were modified to prevent recurrences of elopements. Client #1 received line of sight observation during waking hours, in common areas, and 15-minute checks while sleeping for 21 days and based on interdisciplinary team consensus he currently receives 15-minute checks between 6:00 AM and 10:00 PM. Additionally, client #1 no longer sleeps in a bedroom with an exit door. Client #2 will receive line of sight observation during waking hours, in common areas, and 15-minute checks while sleeping until transition to Waiver is complete. All facility staff have been trained toward proper implementation of the revised plans, and all supervisors and administrative staff responsible for monitoring have been trained toward proper implementation of the revised plans.	03/04/2020

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			PREVENTION: The Residential Manager or Area Supervisor will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to assuring Behavior Support Plans are implemented as written. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) and the QIDP will conduct daily administrative monitoring during varied shifts/times. After 30 Days, administrative monitoring will occur no less than weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility, which will occur no less than monthly. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: · The role of the administrative monitor is not	

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			simply to observe & Report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative support at the home will include but not be limited to assuring Behavior Support Plans are implemented as written. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 3 sampled clients (#1 and #2). The facility failed to implement its written policy and procedures to prevent program intervention neglect, and neglected to ensure clients #1 and #2's supervision needs and	W 0122	**CORRECTION:** *The facility must ensure that specific client protections requirements are met.* Specifically, the governing body facilitated the following: Client #1 and client #2's Behavior Support Plans were modified to prevent recurrences of	03/04/2020

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	program interventions were implemented to address their elopement behaviors and client #2's potential criminal sexual behavior. This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 1/29/2020 at 3:45 PM when the facility neglected to ensure clients #1 and #2's supervision and program intervention needs were implemented to prevent client #1's elopement behavior and client #2's elopement and potential criminal sexual behavior. AS (Area Supervisor) and PM (Program Manager) were notified of the Immediate Jeopardy on 1/29/2020 at 3:45 PM. The Immediate Jeopardy began on 1/27/2020 when the facility neglected client #1 regarding his supervision needs to prevent elopement behaviors. The facility submitted a plan to remove the Immediate Jeopardy on 1/30/2020 at 12:28 PM. The facility's plan entitled, "Allegation for Removal of Immediate Jeopardy dated 1/30/2020 indicated the following: -"ResCare/VOCA Corporation of Indiana has taken the following steps to have the Immediate Jeopardy status removed. Client Protections: Failure to prevent neglect by failure to provide supervision and program implementation regarding elopement in the community." -"The following Behavior Support Plan revisions have been implemented: [Client #2] will receive line of sight observation during waking hours, in common areas, and 15-minute checks while sleeping until transition to		elopements. Client #1 received line of sight observation during waking hours, in common areas, and 15-minute checks while sleeping for 21 days and based on interdisciplinary team consensus he currently receives 15-minute checks between 6:00 AM and 10:00 PM. Additionally, client #1 no longer sleeps in a bedroom with an exit door. Client #2 will receive line of sight observation during waking hours, in common areas, and 15-minute checks while sleeping until transition to Waiver is complete. All facility staff have been trained toward proper implementation of the revised plans, and all supervisors and administrative staff responsible for monitoring have been trained toward proper implementation of the revised plans. **PREVENTION:** The Residential Manager or Area Supervisor will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to assuring Behavior Support Plans are implemented as written. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP	

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	Waiver is complete. [Client #1] will receive line of sight observation during waking hours, in common areas, and 15-minute checks while sleeping for 7 days and after 7 days, the interdisciplinary team will re-evaluate to determine if 24/7 15-minute checks will be sufficient. [Client #1] has moved into a bedroom that does not have am exit door." -"All supervisors and administrative staff responsible for monitoring have been trained toward proper implementation of the revised plans. All facility staff have been trained toward proper implementation of the revised plans. A Residential Manager will be in place 24-hours per day and Area Supervisors and administrative staff will be present for no less than two hours on each shift to monitor the effectiveness of the protective measures and provide additional training and coaching as needed. The QIDP (Qualified Intellectual Disabilities Professional) will also maintain a daily presence in the home." -"Pursuant to the fact that the interdisciplinary team has developed appropriate protective measures by revising [client #1] and [client #2's] Behavior Support Plans to address elopement and the governing body has established monitoring to evaluate and ensure the effectiveness to the plan, the issues resulting in Immediate Jeopardy at the ResCare/VOCA corporation of Indiana facility on [group home address] have been resolved." Based on observation, record review and interview, it was determined the facility's 1/30/2020 Allegation for Removal of Immediate Jeopardy had removed the Immediate Jeopardy. The Immediate Jeopardy was removed on		Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) and the QIDP will conduct daily administrative monitoring during varied shifts/times. After 30 Days, administrative monitoring will occur no less than weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility, which will occur no less than monthly. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and	

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	2/3/2020 at 11:21 AM. While the Immediate Jeopardy was removed on 2/3/2020, the facility remained out of compliance at the Condition Level in that the facility needed to demonstrably implement, monitor and model the appropriate provision of client supports to prevent neglect in the home. Observations were conducted at the group home on 1/30/2020 from 12:35 PM through 1:35 PM. Client #1 was in the home throughout the observation period. Client #1 was in line of sight supervision of his staff throughout the observation period. Client #2 was not present in the home during the observation period. AS (Area Supervisor) #2 was interviewed on 1/30/2020 at 12:44 PM. AS #2 indicated he was at the home completing 2 hour administrative monitoring. AS #2 indicated all staff had been retrained on clients #1 and #2's BSP (Behavior Support Plans) and monitoring protocols. AS #2 indicated client #1 was on line of sight supervision during wake hours and on 15 minute checks in his room. AS #2 indicated client #2 was on line of sight supervision during wake hours and on 15 minute checks. Observations were conducted at the group home on 1/31/2020 from 8:30 AM through 10:15 AM. Client #1 was present in the home throughout the observation period. Staff maintained client #1 in line of sight supervision throughout the observation period. Client #2 was on an outing from 8:30 AM through 9:42 AM. Staff maintained client #2 in line of sight supervision from 9:42 AM through the end of the observation period at 10:15 AM. PM #3 was interviewed on 1/31/2020 at 8:30		training as needed. Administrative support at the home will include but not be limited to assuring Behavior Support Plans are implemented as written. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	AM. PM #3 indicated client #1 was present in the home. PM #3 indicated he was providing administrative monitoring to ensure staff kept clients #1 and #2 in line of sight supervision while in common areas of the home and 15 minute checks while in their bedrooms. PM #3 indicated staff working in the home had been trained on clients #1 and #2's BSP's and monitoring protocols. Client #1 was interviewed on 1/31/2020 at 9:35 AM. Client #1 declined to be interviewed. Client #2 was interviewed on 1/31/2020 at 9:54 AM. Client #2 declined to be interviewed. Staff #2 was interviewed on 1/31/2020 at 9:55 AM. Staff #2 indicated he had been trained on clients #1 and #2's BSP's and monitoring protocols. Staff #2 indicated clients #1 and #2 were on line of sight supervision while in the home's common areas and on 15 minute checks while in their rooms. Observations were conducted at the group home on 2/3/2020 from 10:00 AM through 11:00 AM. Clients #1 and #2 were not present in the home. Clients #1 and #2 were in the community on an outing. PM (Program Manager) #2 and PM #3 were present in the home. PM #2 was interviewed on 2/3/2020 at 10:15 AM. PM #2 indicated he had been at the home since 8:00 AM and had completed a 2 hour administrative monitoring session. PM #2 indicated PM #3 had come to the home to relieve him of the administrative monitoring role at the home. PM #2 indicated clients #1 and #2's BSP's and monitoring protocols were being implemented by staff. PM #2 indicated he was			

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	there to ensure staff implemented line of sight supervision for both clients #1 and #2 in common areas of the home and 15 minute checks while in their bedrooms. PM #2 indicated all staff working at the home had been trained on clients #1 and #2's BSPs and protocols. Findings include: Please refer to W149. For 2 of 3 sampled clients (#1 and #2), the facility failed to implement its written policy and procedures to prevent program intervention neglect, and neglected to ensure clients #1 and #2's supervision needs and program interventions were implemented to address their elopement behaviors and client #2's potential criminal sexual behavior. 9-3-2(a)			
W 0149 Bldg. 00	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 observation, interview and record review for 2 of 3 sampled clients (#1 and #2), the facility failed to implement its written policy and procedures to prevent program intervention neglect, and neglected to ensure clients #1 and #2's supervision needs and program interventions were implemented to address their elopement behaviors and client #2's potential criminal sexual behavior. Findings include: QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 1/28/2020 at 2:15 PM. QIDP indicated client #1 had eloped	W 0149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically: Client #1 and client #2’s Behavior Support Plans were modified to prevent recurrences of elopements. Client #1 received line of sight observation during waking hours, in common areas, and 15-minute checks while sleeping for 21 days and based on interdisciplinary team	03/04/2020

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	from the group home on 1/27/2020 at 10:00 PM. QIDP #1 indicated client #1 had not been located and was missing. QIDP stated, "At 10:00 PM, [client #1] was on the house phone. [Staff #1] needed to use the phone to clock out at the end of her shift. [Staff #1] asked [client #1] for the phone and asked [client #1] to take a plate he had been using to the kitchen. [Client #1] ended the call and went to the garage. Five minutes later, [staff #1] and another staff (didn't know name) realized [client #1] was not in the garage." QIDP #1 indicated the agency had administrative staff searching the area, police had been contacted and client #1's guardian had been notified. QIDP #1 indicated client #1's targeted behaviors included, but were not limited, to sexually inappropriate behaviors and elopement. When asked if any of the other clients in the home had elopement risks, QIDP #1 indicated client #2 had a recent elopement incident. Observations were conducted at the group home on 1/28/2020 from 4:45 PM through 6:15 PM. Client #1 was not present in the home. Staff #1 was interviewed on 1/28/2020 at 5:26 PM. Staff #1 indicated she had worked a 2:00 PM to 10:00 PM shift at the home on 1/27/2020. Staff #1 indicated she had finished her work duties at 10:00 PM and asked client #1 who was utilizing the house phone to let her use the house phone to clock out. Staff #1 indicated client #1 ended his phone call on the house phone, took his dishes to the kitchen and then went to the home's garage area. Staff #1 indicated the home's garage area was a place utilized by client #1 for leisure or relaxation activities. Staff #1 indicated she went to the garage to check on client #1 five minutes later and discovered client #1 was missing. Staff #1		consensus he currently receives 15-minute checks between 6:00 AM and 10:00 PM. Additionally, client #1 no longer sleeps in a bedroom with an exit door. Client #2 will receive line of sight observation during waking hours, in common areas, and 15-minute checks while sleeping until transition to Waiver is complete. All facility staff have been trained toward proper implementation of the revised plans, and all supervisors and administrative staff responsible for monitoring have been trained toward proper implementation of the revised plans. **PREVENTION:** The Residential Manager or Area Supervisor will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to assuring Behavior Support Plans are implemented as written. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) and the QIDP will conduct daily administrative monitoring during varied shifts/times. After 30 Days,	

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	indicated she communicated client #1's absence with the overnight shift staff. Staff #1 began walking through the neighborhood while one of the two overnight staff utilized the van to search the area. Staff #1 indicated she attempted to contact the on-call supervisor to report client #1's elopement. Staff #1 stated, "We were having trouble. It keep going to voicemail. The people we were trying to contact was going to voicemail." Staff #1 indicated she assisted in searching for client #1 until 3 AM on the morning of 1/28/2020. Staff #1 indicated client #1 had sexual misconduct behaviors (public masturbation) and required 24 hour supervision. Staff #1 indicated client #1 was not assessed as currently having alone time/unsupervised time in the community. Observations were conducted at the group home on 1/29/2020 from 7:45 AM through 3:50 PM. Client #1 was present in the home. HM (Home Manager) #1 was interviewed on 1/29/2020 at 7:45 AM. HM #1 indicated client #1 was found on 1/28/2020 at 8:43 PM. HM #1 indicated client #1 was located in the community at a restaurant where he had previously been employed. HM #1 indicated a body check was completed and client #1 was without injury or complaint. HM #1 indicated client #1 returned to the home without incident. HM #1 indicated she had worked with the QIDP to complete an IDT (Interdisciplinary Team) meeting and training with staff regarding client #1's line of sight supervision protocol and 15 minute checks. Client #1 was interviewed on 1/29/2020 at 8:12 AM. Client #1 declined to participate in the interview process.		administrative monitoring will occur no less than weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility, which will occur no less than monthly. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative support at the home will include but not be limited to assuring Behavior Support Plans are implemented as written. **RESPONSIBLE PARTIES:** QIDP,	

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	Additional BDDS reports were received via email on 1/29/2020 at 10:07 PM. The additional BDDS reports were reviewed upon receipt on 1/29/2020 at 10:10 PM. The review indicated the following: 1. BDDS report dated 1/28/2020 indicated, "On 01/27/20, [client #1] became angry when staff prompted him to complete a phone call and finish cleaning up after himself. [Client #1] ran through the house and exited through the garage. Staff attempted to follow, but he had evaded line of sight. Staff notified the supervisor and filed a missing person report with the police. Supervisors, direct support staff and administrative staff initiated a search and contacted [client #1's] friends and family in an effort to determine a possible location, (sic) without success. [Client #1] remains missing and ResCare supervisors and administrative staff are continuing to search and partner with law enforcement to locate him. It should be noted that [client #1] does not currently have plan approved alone time. [Client #1] has a history of elopement addressed in his Behavior Support Plan, which staff followed. Staff will continue to follow the proactive and reactive strategies in [client #1's] plan to prevent further occurrences. Upon his return, [client #1] will receive line of sight observation while awake and 15-minute checks while sleeping for 72 hours, post incident, per his plan. The administrative team was informed of the incident immediately. The interdisciplinary team will meet to discuss preventative measures for elopement." -Follow-up BDDS report dated 1/29/2020 indicated, "[Client #1] was located at [restaurant]		Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, BDDS Generalist, Regional Director	

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at 8:30 pm, on 1/28/20 and returned to the residence. [Client #1] was assessed completely by the residential manager upon his return and did not sustain any injuries during the incident. [Client #1] received emotional support from staff. The Area Supervisor and administrative team were notified of [client #1's] return.

[Client #1] has a history of elopement addressed in his Behavior Support Plan, which staff followed. It should be noted that [client #1] does not have plan approved alone time. The [QIDP (Qualified Intellectual Disabilities Professional) #1] immediately implemented the following protective measures; Line of Sight during awake hours when in common areas (including the garage) for 72 hours following the incident and documented 15-minute checks during waking and sleeping hours for the next 72 hours. Staff were trained on the protective measures immediately by the administrative staff. Staff will continue to follow the proactive and reactive strategies in [client #1's] plan to prevent further occurrences. The Interdisciplinary team met on 01/29/20 to discuss strategies to prevent future occurrences. The team will meet again before the 72 hours expiration to reassess the situation."

Client #1's record was reviewed on 1/29/2020 at 9:00 AM. Client #1's ISP (Individual Support Plan) dated 11/21/19 indicated the following:

-"Currently, [client #1's agency team] is working with [client #1] on how to give distance when communicating with females and not touching a female without her approval or consent."

-"[Client #1] has a history of inappropriate (sic) touching women."

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	-"Intermediate Objective. Given 3 examples and 3 verbal prompts and staff assistance, [client #1] will approach a female appropriately daily, 75% of opportunities for 3 consecutive months." Client #1's BSP (Behavior Support Plan) dated 11/21/19 indicated the following: -"Freedom of Movement: [Client #1] requires 24 hour supervision." -"[Client #1] has a history of engaging in self-injurious behaviors and recently documented incidents of public masturbation and inappropriate behavior of a sexual in (sic) nature." -"3/15/19: Revised BSP: Due to to recent incident, Risk of Elopement was added to the BSP to reduce and prevent future occurrences." -"Public Masturbation: defined as masturbating in public areas while in the home, van or in the presence of another individual. This also includes public sexual intimacy with a partner." -"Inappropriate Sexual Behavior: defined as any time an attempt is made to touch or engage in sexual behavior that is not consensual to both parties. This includes touching and suggestive comments to staff and other adults or visitors." -"Self- Injurious Behaviors/Suicidal Gestures: defined as any time he voices to staff that he is thinking about engaging in any behavior that is intended to harm/hurt himself or end his life or gestures that, if not stopped, could end his life. Includes any statements about not wanting to live anymore, or any time he is hitting his head or other body part against any hard surface, biting			

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	himself, slapping himself, cutting self (sic) or scratching himself intentionally or other behaviors that have the potential to leave a reddened mark or leave an injury to himself." -"Leaving Assigned Area/Elopement: is defined as [client #1] leaving or attempting to leave his designated area without staff or attempts to leave the designated area without staff supervision while out in the community." -"For leaving assigned area/elopement: -Immediately attempt to block and redirect to other area/activity. -Immediately follow the person and call for staff to notify the RM (Residential Manager) of the situation. -If [client #1] has left the property: continue to follow the individual and attempt to redirect. -If staff has lost sight of the individual: attending staff will immediately notify (the) supervisor who will call 911 according to protocol and tell them that a person that we serve has left (the) assigned area. -The supervisor will designate necessary staff to search for the individual in the community with staff searing in the following locations: across the street in the nearby neighborhood, any other area/direction where the, [client #1], seems to have gone (and the) entire neighborhood." -"Basic Moves: -Personal Space/Prepared Stance: maintain visual, 1 'A arm's (sic) length away, feet shoulder width apart and body at 45 degree angle, hands in non-threatening position, non-threatening tone of			

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voice.

-Blocking aggression or swinging objects: from prepared stance, raise both arms parallel to each other and sweep in the direction of the blow with your outside forearms, resume prepared stance.

-Physical Redirection: from behind the individual, pin individual's arms between elbow and shoulder with your forearms, tuck head or lean back to avoid head butts, lock hips, move the person to a safe area, release hold, resume prepared stance."

-"Advanced Moves:
-One Person Standing Restraint/Escort: approach from rear, slide one arm across the back to grasp the person's furthest forearm in an overhand grip, lock hips, reach across your own body to grasp the person's forearm in an underhand grip; can escort the person to safety or away from a reinforcing situation.

-Two Person Seated Restraint: one staff approach from each side with one taking the leading role, reach across the individual's back to grasp the individual's outside forearm using an overhand grip, reach across your own body to grasp the individual's wrist closest to you with an underhand grip. Hips should be snug for stability. Draw the person's elbow backward and secure snugly over your hip. Keep head tucked or away to avoid bites/head-butts.

-Two Person Lift: use a lifting belt if possible, use the same hold as the two person standing/seated restraint, keep inside knee down and outside knee up, count to 3 and lift together at a 43 degree angle.

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	-Two Person Standing to Supine Restraint: One staff approach on each side with one assuming the lead, grasp the individual's wrist with your outside arm, place inside legs and hips behind the person with their heels behind the individual's heels, use inside hand to support under the individual's shoulders, take a step forward with outside leg and lower the individual to the floor on inside leg while keeping hips close. Slide arms out from under the individual's shoulders once they are on the floor and place hand on their shoulder. Hold their wrist and should to the floor while keeping hips close. Optional: a staff to secure the legs by wrapping their arms around the individual's thighs just above the knees, a staff to secure the individual's head." Client #1's Functional Assessment dated 2020 (no month/date specified) indicated client #1 needed physical prompting regarding his assessed abilities and needs for supports for traveling around the neighborhood, identifying public transit signs and location of buildings by a street number. 2. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 1/28/2020 at 2:27 PM. The review indicated the following: -BDDS report dated 1/15/2020 indicated, "On 01/14/20, while one staff were (sic) passing medications and the other staff were (sic) playing cards with four other individuals in the home, (sic) [client #2] left the residence and started to ride his bicycle in the neighborhood independently. It should be noted that [client #2] had his Alone Time recently suspended due to a prior incident. ResCare staff lost sight of [client #2] and shortly thereafter received a report from			

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the [Police Department] that [client #2] followed a female on his bicycle who has (sic) just gotten off the school bus and spoke to her in a sexually explicit manor (sic). Police spoke to [client #2] and staff, [client #2] returned to the house and the police left without taking further action. No one sustained any injuries during the incident. The Area Supervisor and all elements of the administrative team were notified.

[Client #2] has a history of Sexual Preoccupation addressed in his Behavior Support Plan. Staff will continue to follow the proactive and reactive strategies in [client #2's] plan to prevent further occurrences. The QIDP immediately implemented the following protective measures; 1.) Documented 15-Minute checks during waking and sleeping hours. 2.) Line of Sight of staff while in common areas during waking hours. 3.) Suspension from riding his bicycle out in the neighborhood due to inappropriate behaviors. 4.) The Interdisciplinary Team will meet on 01/15/20 to discuss a Safety Plan to be put in place to reduce and prevent sexually inappropriate behaviors. An investigation into the alleged incident is underway."

Client #2 was interviewed on 1/28/2020 at 6:03 PM. Client #2 declined to participate in the interview process.

Client #2's record was reviewed on 1/29/2020 at 9:55 AM. Client #2's BSP dated 1/7/2020 indicated the following:

-"Behavioral History: [Client #2, age and diagnosis and family information]. [Client #2] has had a history of physical and verbal aggression. He has also exhibited sexually inappropriate behavior. [Client #2] sexually

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	assaulted two girls at [high school]." -"Due to [client #2's] talking to underage girls, [client #2's] phone calls will be monitored, and Internet disabled on his game. (Added 8/2/18)." -"Sexual Preoccupation: any time [client #2] demonstrates a dysfunctional preoccupation with sexual fantasy, often in combination with an obsessive pursuit of sexual urges or of casual or non-intimate sex, pornography, compulsive masturbation or objectified partner sex. This includes person to person touching others without their permission, sexually inappropriate comments, gestures or actions (exposing himself). This also contact (sic) or access or possession of pornography, obscene matter or child pornography including but not limited to videos, magazines, books, DVD's, TV programs and material downloaded from the Internet via any electronic device or via any printed materials. This also includes contact with underage girls." -"Elopement: Anytime [client #2] makes an attempt or leaves an assigned designated area without the consent of staff personnel. This includes but is not limited to leaving staff's supervision while in the community." -"Staff will monitor phone calls due to talking to underage girls. Staff will look at the caller ID and [client #2] may Answer if it says ResCare. Staff will answer unidentified calls and check to see if it is an under age girl. If it is not an underage girl staff is to allow [client #2] to take the call. Staff doesn't have to listen to his phone calls. If it is an underage girl staff is to end the call. If staff has any doubt that it is an underage girl. Staff should take a name and number."			

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-"24/7 Staff Supervision required."

-"Elopement/Wandering Off
· Immediately attempt to block and redirect to other area/activity
· Immediately follow the person and call for staff to notify the RM (Resident Manager) of the situation.

If the consumer has left the property:
· Continue to follow the individual and attempt to redirect
If staff has lost sight of the individual:

·Attending staff will immediately notify supervisor who will call 911 according to protocol and tell them that a person that we serve has left assigned area."

-"The supervisor will designate necessary staff to search for the individual in the community with staff searching in the following locations. Across the street in the nearby neighborhood. Any other area/direction where the consumer seems to have gone. Entire neighborhood.

Once found, immediately notify the RM/AS to coordinate bringing the individual back to the Group Home. RM will notify administrative staff."

-"Cell Phone Obsession: Calmly offer a distraction to [client #2], it can be asking him to help you or go with you to complete a task, etc. or you can ask [client #2] if he's feeling sad, etc. All cellphones are asked of others to put away and keep out of his eyesight so that he will not begging to question you, ask to see it, take it and

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	hide with it to get on their etc (sic)." If there is someone that is in the home and he notices their phone or begins to bother them about the phone, redirect [client #2] to another activity like drawing, watching TV or calling is grandmother on the house phone." -"Basic Moves: -Personal Space/Prepared Stance: maintain visual, 1 'A arm's (sic) length away, feet shoulder width apart and body at 45 degree angle, hands in non-threatening position, non-threatening tone of voice. -Blocking aggression or swinging objects: from prepared stance, raise both arms parallel to each other and sweep in the direction of the blow with your outside forearms, resume prepared stance. -Physical Redirection: from behind the individual, pin individual's arms between elbow and shoulder with your forearms, tuck head or lean back to avoid head butts, lock hips, move the person to a safe area, release hold, resume prepared stance." -"Advanced Moves: -One Person Standing Restraint/Escort: approach from rear, slide one arm across the back to grasp the person's furthest forearm in an overhand grip, lock hips, reach across your own body to grasp the person's forearm in an underhand grip; can escort the person to safety or away from a reinforcing situation. -Two Person Seated Restraint: one staff approach from each side with one taking the leading role, reach across the individual's back to grasp the individual's outside forearm using an overhand grip, reach across your own body to			

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	grasp the individual's wrist closest to you with an underhand grip. Hips should be snug for stability. Draw the person's elbow backward and secure snugly over your hip. Keep head tucked or away to avoid bites/head-butts. -Two Person Lift: use a lifting belt if possible, use the same hold as the two person standing/seated restraint, keep inside knee down and outside knee up, count to 3 and lift together at a 43 degree angle. -Two Person Standing to Supine Restraint: One staff approach on each side with one assuming the lead, grasp the individual's wrist with your outside arm, place inside legs and hips behind the person with their heels behind the individual's heels, use inside hand to support under the individual's shoulders, take a step forward with outside leg and lower the individual to the floor on inside leg while keeping hips close. Slide arms out from under the individual's shoulders once they are on the floor and place hand on their shoulder. Hold their wrist and should to the floor while keeping hips close. Optional: a staff to secure the legs by wrapping their arms around the individual's thighs just above the knees, a staff to secure the individual's head." -"[Client #2] is not to speak with females in a public setting without a staff being present. [Client #2] is not to ride his bicycle in the neighborhood. Staff should redirect toward other activities so that [client #2] has limited time on social media." Observations were conducted at the group home on 1/28/2020 from 4:45 PM through 6:15 PM. At 5:48 PM, client #2 finished eating the evening meal with his peers. Client #2 finished eating,			

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	took his dishes to the kitchen and then sat down at the kitchen table away from his peers and staff who were seated at the dining room table (separate areas of the home). Client #2 sat at the kitchen table with a cell phone. Client #2 was not supervised while he had a cell phone. At 6:00 PM, staff and clients entered the home's kitchen area where client #2 was sitting. Client #2 walked into the home's living room area with the cell phone. Client #2 was not supervised with the cell phone as he left the kitchen area and was seated in the home's living room area away from his staff and peers. At 6:03 PM, AS (Area Supervisor) #1 engaged client #2 asking him to show him the cell phone and identify who client #2 was speaking to. Staff #1, PM (Program Manager) #1, AS (Area Supervisor) #1 and QIDP (Qualified Intellectual Disabilities Professional) #1 were interviewed on 1/29/2020 at 3:11 PM. Staff #1 indicated clients #1 and #2 were on line of sight supervision and 15 minute checks when they are in their rooms. Staff #1 indicated client #2 had incidents of riding his bike without supervision. Staff #1 indicated client #2 had YSIS (You're Safe, I'm Safe) (physical management techniques) in his plan to address/prevent targeted behaviors. Staff #1 indicated client #1 did not have YSIS in his BSP to prevent targeted behaviors. QIDP #1 indicated client #1 had an IDT meeting on 1/29/2020 at the home. QIDP #1 indicated staff were being trained on client #1's line of sight and protective measures as they worked in the home. AS #1 indicated client #2 had a personal cell phone. AS #1 indicated client #2's cell phone and social media use should be monitored. AS #1 indicated client #2's cell phone and social media usage should be limited. AS #1 indicated client #2 had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G814	A. BUILDING 00 B. WING	02/04/2020

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a history of talking to underage females. PM #1 and QIDP #1 indicated the police had been involved in the 1/15/2020 incident. QIDP #1 indicated client #2 had left the home unsupervised on his bike, approached an underage female after she got off of a school bus and made sexually inappropriate comments to her. QIDP #1 indicated the parents of the female had not pressed charges but had 30 days to determine if they wanted to press charges against client #2. QIDP #1 indicated client #2 was a 21 year old male. QIDP #1 indicated client #2 had an IDT meeting to discuss and review client #2's needs regarding appropriate boundaries.

QIDP (Qualified Intellectual Disabilities Professional) was interviewed on 1/28/2020 at 2:15 PM. QIDP indicated the facility's abuse and neglect policy should be implemented to prevent abuse, neglect and mistreatment.

The facility's Policy and Procedures were reviewed on 1/29/2020 at 5:00 PM. The facility's Abuse, Neglect, Exploitation (and) Mistreatment Policy dated 2/26/11 indicated the following:

-"Adept staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation or mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and ill be thoroughly investigated under the policies of Adept, ResCare and local, state and federal guidelines."

-"Program intervention neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to implement a support plan...."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	9-3-2(a)			