STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G807	A. BUILDING 00 B. WING	02/02/2024

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COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

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W 0000 Bldg. 00	This visit was for the investigation of complaints #IN00422381 and #IN00426491. Complaint #IN00422381: Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154, W157, W158, W159 and W186. Complaint #IN00426491: Federal/state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W153, W154, W157, W158, W159 and W186. Survey Dates: January 29, 30, 31, February 1 and 2, 2024. Facility Number: 012632 Provider Number: 15G807 AIMS Number: 201065000 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 2/9/24.	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 for 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the governing body failed to meet the Condition of Participation: Governing Body and Management. The governing body failed to exercise operating direction over the facility by not implementing its	W 0102	**CORRECTION:** *The facility must ensure that specific governing body and management requirements are met.* Specifically: Direct support staff will be retrained regarding the	03/03/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bob Morris	QIDP Manager	02/23/2024

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	written policy and procedures to prevent an incident of client to client aggression where client A pulled a chunk of client C's hair out, to report clients C and D's allegations of being scared of client A to the Bureau of Disabilities Services (BDS) within 24 hours and to investigate the allegations; to ensure staff reported an incident where client A obtained a knife from the medication room immediately to the administrator and to aggressively address and prevent clients A and B's pattern of maladaptive behaviors. The governing body failed to provide a sufficient amount of direct care staff in order to manage and supervise clients A and B according to their program plans and to ensure the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored clients A and B's active treatment programs by conducting regular visits to the home to ensure enough staff were scheduled to manage and supervise clients A and B according to their program plans. Findings include: 1. For 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the governing body failed to exercise operating direction over the facility by not implementing its written policy and procedures to prevent an incident of client to client aggression where client A pulled a chunk of client C's hair out, to report clients C and D's allegations of being scared of client A to BDS within 24 hours and to investigate the allegations; to ensure staff reported an incident where client A obtained a knife from the medication room immediately to the administrator and to aggressively address and prevent clients A and B's pattern of maladaptive behaviors. The governing body failed to provide a sufficient amount of direct care staff in order to manage and		requirement for thorough and co0mplete reporting of incidents. Administrative staff will review details of internal incident documentation, obtaining follow-up information as needed, to assure all required information is reported to the Bureau of Disability Services, Indiana Adult Protective Services, and the police, as required. All facility investigations will be completed by trained investigators. When incidents requiring investigation occur, the Acting QA Manager or designee will assign the investigation to a specific investigator. The QIDP Manager (or QA Manager when the QIDP Manager is the assigned investigator) will conduct follow-up with the investigator to assure completion within required timeframes, and that each allegation is investigated thoroughly. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. In addition to weekly face to face training and follow-up with the Quality Assurance Manager or designee, the investigators will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this	

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	supervise clients A and B according to their program plans and to ensure the QIDP integrated, coordinated and monitored clients A and B's active treatment programs by conducting regular visits to the home to ensure enough staff were scheduled to manage and supervise clients A and B according to their program plans. Please see W104. 2. For 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the governing body failed to meet the Condition of Participation: Client Protections. The governing body failed to implement its written policy and procedures to prevent an incident of client to client aggression where client A pulled a chunk of client C's hair out; to report clients C and D's allegations of being scared of client A to BDS within 24 hours and to investigate the allegations; to ensure staff reported an incident where client A obtained a knife from the medication room immediately to the administrator; to aggressively address and prevent clients A and B's pattern of maladaptive behaviors and to develop and implement effective corrective measures to prevent the aforementioned incidents from occurring. Please see W122. 3. For 2 of 2 clients in the sample (A and B), the governing body failed to meet the Condition of Participation: Facility Staffing. The governing body failed to provide a sufficient amount of direct care staff in order to manage and supervise clients A and B according to their program plans and to ensure the QIDP integrated, coordinated and monitored clients A and B's active treatment programs by conducting regular visits to the home to ensure enough staff were scheduled to manage and supervise clients A and B according to their program plans. Please see W158.		mentorship/training will be development of appropriate scope and conclusions, as well as time management skills to facilitate timely completion if investigations. The training focus will also include assuring all potential witnesses are interviewed and that all allegations are addressed in the investigation. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. When the investigator assigned to the facility is not available, The QIDP Manager or designee assigned by the QA Manager will assume responsibility for completion of required investigations. Specifically for client A: The facility has added an additional 8:00 AM to 8:00 PM direct support staff, so that one team member can be dedicated toward working exclusively with client A, focusing on preventative behavior supports and positive structured activities, as well as providing immediate intervention when client A begins to escalate. Additionally, through ongoing assessment, the interdisciplinary team consensually agrees that client A would have a greater opportunity for success with the wrap-around services available in a CIH Waiver residential setting. The team is working with the Bureau of	

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	This federal tag relates to complaints #IN00422381 and #IN00426491. 9-3-1(a)		Disability Services and a provider chosen by client A's guardian to expedite the transition process. Specifically for client B: Through ongoing assessment, the interdisciplinary team has determined that client B's aggression stems from impulse control challenges. The facility's Behavioral Clinician has modified client A's Behavior Support Plan to include an accountability calendar and token-based behavior improvement program to assist client A with controlling her impulsive behavior. All staff will be trained toward implementation of the revised plan. Staff have received additional training toward implementation of supports that create a therapeutic environment where all clients feel safe, including isolating client A from her housemates when she begins to escalate and assuring staff provides ongoing reassurance to clients B, C and D regarding the team's commitment to keep them safe. For the next 30 days, the QIDP Manager will maintain a presence in the home no less than twice weekly. After 30 days, the QIDP Manager or an assigned QIDP will maintain a presence in the home no less than weekly. The Governing Body has directed the facility to modify the staffing matrix to assure that there are no	

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			less than two staff on duty during the overnight shift and four staff on duty between 8:00 AM and 8:00 PM to provide active treatment and ensure the ability to safely intervene with aggressive behavior during times of peak activity. When sufficient staff assigned to the facility are not available staff will be pulled from other agency facilities, including from facilities outside of Wayne County, when needed. All fill-in staff will receive client specific training prior to working in the facility. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services and distribute the list to administrative staff (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) for review and revision, as needed. The QIDP Manager or designee	

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			will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, (comprised of the Executive Director, Operations Managers, Program Managers, Acting Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager). The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign	

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			an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. When significant incidents occur, including but not limited to aggression and intimidation, the QIDP will contact front line team members and administrative staff and additional professional assistance as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences. When corrective measures are developed by post-investigation administrative level collaboration,	

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			the QA Manger and QIDP Manager will analyze peer review and team meeting documentation to assure all necessary corrective recommendations are included. The Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. The Program Manager will monitor time and attendance records to assure required staffing levels are met. The Program Manager will assist with procuring staff from outside of the facility as needed. An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assure sufficient staff are present and to assist with and monitor skills training, including but not limited to effective application of behavior supports For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Acting Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment	

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			scenarios, including night and weekend observations. After 30 days, administrative monitoring will occur no less than three times 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. Current Operations Team members received training from the QIDP Manager on 12/14/23, to assure a clear understanding of administrative monitoring as defined below. · 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 oversight will include but not be limited to: · Assuring corrective	

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			measures are in place and developed through a collaborative interdisciplinary process. · Assuring behavior supports meet the needs of all clients. · Assuring all clients feel safe. · Speaking with staff and clients and reviewing progress notes and behavior tracking to assure all incidents and allegations are reported as required. · Assuring the QIDP integrates, coordinates, and monitors all aspects of the active treatment program. · Assuring required staffing levels are in place. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, 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 observation, record review and interview for 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the governing body failed to exercise operating direction over the facility by not implementing its written policy and procedures to prevent an incident of client to client aggression where client A pulled a chunk of client C's hair out, to report clients C and D's allegations of being scared of client A to the Bureau of Disabilities Services (BDS) within 24	W 0104	**CORRECTION:** *The governing body must exercise general policy, budget, and operating direction over the facility.* Specifically: Direct support staff will be retrained regarding the requirement for thorough and co0mplete reporting of incidents. Administrative staff will review	03/03/2024

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	hours and to investigate the allegations; to ensure staff reported an incident where client A obtained a knife from the medication room immediately to the administrator and to aggressively address and prevent clients A and B's pattern of maladaptive behaviors. The governing body failed to provide a sufficient amount of direct care staff in order to manage and supervise clients A and B according to their program plans and to ensure the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored clients A and B's active treatment programs by conducting regular visits to the home to ensure enough staff were scheduled to manage and supervise clients A and B according to their program plans. Findings include: 1. For 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the governing body neglected to implement its written policy and procedures to prevent an incident of client to client aggression where client A pulled a chunk of client C's hair out, to report clients C and D's allegations of being scared of client A to BDS within 24 hours and to investigate the allegations; to ensure staff reported an incident where client A obtained a knife from the medication room immediately to the administrator and to aggressively address and prevent clients A and B's pattern of maladaptive behaviors. Please see W149. 2. For 1 of 2 sampled clients (A) and 2 additional clients (C and D), the governing body failed to report clients C and D's allegations of being scared of client A to BDS within 24 hours, in accordance with state law and to ensure staff reported an incident where client A obtained a knife from the medication room immediately to the		details of internal incident documentation, obtaining follow-up information as needed, to assure all required information is reported to the Bureau of Disability Services, Indiana Adult Protective Services, and the police, as required. All facility investigations will be completed by trained investigators. When incidents requiring investigation occur, the Acting QA Manager or designee will assign the investigation to a specific investigator. The QIDP Manager (or QA Manager when the QIDP Manager is the assigned investigator) will conduct follow-up with the investigator to assure completion within required timeframes, and that each allegation is investigated thoroughly. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. In addition to weekly face to face training and follow-up with the Quality Assurance Manager or designee, the investigators will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this mentorship/training will be development of appropriate scope and conclusions, as well as time	

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	administrator. Please see W153. 3. For 1 of 2 sampled clients (A) and 2 additional clients (C and D), the governing body failed to conduct thorough investigations regarding clients C and D's allegations of being scared of client A. Please see W154. 4. For 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the governing body failed to develop and implement effective corrective measures to prevent an incident of client to client aggression where client A pulled a chunk of client C's hair out, clients C and D's allegations of being scared of client A and to prevent clients A and B's pattern of maladaptive behaviors. Please see W157. 5. For 2 of 2 sampled clients (A and B), the governing body failed to ensure the facility's QIDP integrated, coordinated and monitored clients A and B's active treatment programs by not conducting regular visits to the home to ensure enough staff were scheduled to manage and supervise clients A and B according to their program plans. Please see W159. 6. For 2 of 2 sampled clients (A and B), the governing body failed to provide a sufficient amount of direct care staff in order to manage and supervise clients A and B according to their program plans. Please see W186. This federal tag relates to complaints #IN00422381 and #IN00426491. 9-3-1(a)		management skills to facilitate timely completion if investigations. The training focus will also include assuring all potential witnesses are interviewed and that all allegations are addressed in the investigation. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. When the investigator assigned to the facility is not available, The QIDP Manager or designee assigned by the QA Manager will assume responsibility for completion of required investigations. Specifically for client A: The facility has added an additional 8:00 AM to 8:00 PM direct support staff, so that one team member can be dedicated toward working exclusively with client A, focusing on preventative behavior supports and positive structured activities, as well as providing immediate intervention when client A begins to escalate. Additionally, through ongoing assessment, the interdisciplinary team consensually agrees that client A would have a greater opportunity for success with the wrap-around services available in a CIH Waiver residential setting. The team is working with the Bureau of Disability Services and a provider chosen by client A's guardian to expedite the transition process. Specifically for client B: Through	

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			ongoing assessment, the interdisciplinary team has determined that client B's aggression stems from impulse control challenges. The facility's Behavioral Clinician has modified client A's Behavior Support Plan to include an accountability calendar and token-based behavior improvement program to assist client A with controlling her impulsive behavior. All staff will be trained toward implementation of the revised plan. Staff have received additional training toward implementation of supports that create a therapeutic environment where all clients feel safe, including isolating client A from her housemates when she begins to escalate and assuring staff provides ongoing reassurance to clients B, C and D regarding the team's commitment to keep them safe. For the next 30 days, the QIDP Manager will maintain a presence in the home no less than twice weekly. After 30 days, the QIDP Manager or an assigned QIDP will maintain a presence in the home no less than weekly. The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty during the overnight shift and four staff on duty between 8:00 AM and 8:00 PM to provide active treatment and ensure the ability to safely	

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			intervene with aggressive behavior during times of peak activity. When sufficient staff assigned to the facility are not available staff will be pulled from other agency facilities, including from facilities outside of Wayne County, when needed. All fill-in staff will receive client specific training prior to working in the facility. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services and distribute the list to administrative staff (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) for review and revision, as needed. The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required.	

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			Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, (comprised of the Executive Director, Operations Managers, Program Managers, Acting Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager). The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific	

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			components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. When significant incidents occur, including but not limited to aggression and intimidation, the QIDP will contact front line team members and administrative staff and additional professional assistance as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences. When corrective measures are developed by post-investigation administrative level collaboration, the QA Manger and QIDP Manager will analyze peer review and team meeting documentation to assure all necessary corrective recommendations are included.	

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			The Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. The Program Manager will monitor time and attendance records to assure required staffing levels are met. The Program Manager will assist with procuring staff from outside of the facility as needed. An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assure sufficient staff are present and to assist with and monitor skills training, including but not limited to effective application of behavior supports For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Acting Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including night and weekend observations. After 30 days, administrative monitoring will occur no less than three times	

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			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. Current Operations Team members received training from the QIDP Manager on 12/14/23, to assure a clear understanding of administrative monitoring as defined below. · 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 oversight will include but not be limited to: · Assuring corrective measures are in place and developed through a collaborative interdisciplinary process. · Assuring behavior supports	

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			meet the needs of all clients. · Assuring all clients feel safe. · Speaking with staff and clients and reviewing progress notes and behavior tracking to assure all incidents and allegations are reported as required. · Assuring the QIDP integrates, coordinates, and monitors all aspects of the active treatment program. · Assuring required staffing levels are in place. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	
W 0122 Bldg. 00	483.420(a) CLIENT PROTECTIONS The facility must ensure the rights of all clients. Therefore the facility must Based on observation, record review and interview for 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the facility failed to meet the Condition of Participation: Client Protections. The facility failed to implement its written policy and procedures to prevent an incident of client to client aggression where client A pulled a chunk of client C's hair out; to report clients C and D's allegations of being scared of client A to the Bureau of Disabilities Services (BDS) within 24 hours and to investigate the allegations; to ensure staff reported an incident where client A obtained a knife from the medication room immediately to the administrator; to aggressively address and prevent clients A and	W 0122	**CORRECTION:** *The facility must ensure that specific client protections requirements are met.* Specifically, the governing body facilitated the following: Direct support staff will be retrained regarding the requirement for thorough and co0mplete reporting of incidents. Administrative staff will review details of internal incident documentation, obtaining follow-up information as needed, to assure all required information is reported	03/03/2024

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	B's pattern of maladaptive behaviors and to develop and implement effective corrective measures to prevent the aforementioned incidents from occurring. Findings include: 1. For 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the facility neglected to implement its written policy and procedures to prevent an incident of client to client aggression where client A pulled a chunk of client C's hair out, to report clients C and D's allegations of being scared of client A to BDS within 24 hours and to investigate the allegations; to ensure staff reported an incident where client A obtained a knife from the medication room immediately to the administrator; to aggressively address and prevent clients A and B's pattern of maladaptive behaviors and develop and implement effective corrective measures to prevent the aforementioned incidents from occurring. Please see W149. 2. For 1 of 2 sampled clients (A) and 2 additional clients (C and D), the facility failed to report clients C and D's allegations of being scared of client A to BDS within 24 hours, in accordance with state law and to ensure staff reported an incident where client A obtained a knife from the medication room immediately to the administrator. Please see W153. 3. For 1 of 2 sampled clients (A) and 2 additional clients (C and D), the facility failed to conduct thorough investigations regarding clients C and D's allegations of being scared of client A. Please see W154. 4. For 2 of 2 sampled clients (A and B) and 2		to the Bureau of Disability Services, Indiana Adult Protective Services, and the police, as required. All facility investigations will be completed by trained investigators. When incidents requiring investigation occur, the Acting QA Manager or designee will assign the investigation to a specific investigator. The QIDP Manager (or QA Manager when the QIDP Manager is the assigned investigator) will conduct follow-up with the investigator to assure completion within required timeframes, and that each allegation is investigated thoroughly. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. In addition to weekly face to face training and follow-up with the Quality Assurance Manager or designee, the investigators will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this mentorship/training will be development of appropriate scope and conclusions, as well as time management skills to facilitate timely completion if investigations. The training focus will also include assuring all potential witnesses	

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	additional clients (C and D), the facility failed to develop and implement effective corrective measures to prevent an incident of client to client aggression where client A pulled a chunk of client C's hair out, clients C and D's allegations of being scared of client A and to prevent clients A and B's pattern of maladaptive behaviors. Please see W157. This federal tag relates to complaints #IN00422381 and #IN00426491. 9-3-2(a)		are interviewed and that all allegations are addressed in the investigation. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. When the investigator assigned to the facility is not available, The QIDP Manager or designee assigned by the QA Manager will assume responsibility for completion of required investigations. Specifically for client A: The facility has added an additional 8:00 AM to 8:00 PM direct support staff, so that one team member can be dedicated toward working exclusively with client A, focusing on preventative behavior supports and positive structured activities, as well as providing immediate intervention when client A begins to escalate. Additionally, through ongoing assessment, the interdisciplinary team consensually agrees that client A would have a greater opportunity for success with the wrap-around services available in a CIH Waiver residential setting. The team is working with the Bureau of Disability Services and a provider chosen by client A's guardian to expedite the transition process. Specifically for client B: Through ongoing assessment, the interdisciplinary team has determined that client B's aggression stems from impulse	

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			control challenges. The facility's Behavioral Clinician has modified client A's Behavior Support Plan to include an accountability calendar and token-based behavior improvement program to assist client A with controlling her impulsive behavior. All staff will be trained toward implementation of the revised plan. Staff have received additional training toward implementation of supports that create a therapeutic environment where all clients feel safe, including isolating client A from her housemates when she begins to escalate and assuring staff provides ongoing reassurance to clients B, C and D regarding the team's commitment to keep them safe. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services and distribute the list to administrative staff (comprised of the Executive Director, Operations Managers, Program Managers, Quality	

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			Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) for review and revision, as needed. The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, (comprised of the Executive Director, Operations Managers, Program Managers, Acting Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager). The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to	

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			review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. When significant incidents occur, including but not limited to aggression and intimidation, the QIDP will contact front line team members and administrative staff and additional professional assistance as appropriate to convene an interdisciplinary team	

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			meeting to develop protective measures to help reduce and prevent further occurrences. When corrective measures are developed by post-investigation administrative level collaboration, the QA Manger and QIDP Manager will analyze peer review and team meeting documentation to assure all necessary corrective recommendations are included. The Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. The Program Manager will monitor time and attendance records to assure required staffing levels are met. The Program Manager will assist with procuring staff from outside of the facility as needed. An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assure sufficient staff are present and to assist with and monitor skills training, including but not limited to effective application of behavior supports For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Acting Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area	

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			Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including night and weekend observations. After 30 days, administrative monitoring will occur no less than three times 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. Current Operations Team members received training from the QIDP Manager on 12/14/23, to assure a clear understanding of administrative monitoring as defined below. · 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	

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			documented coaching and training as needed. Administrative oversight will include but not be limited to: · Assuring corrective measures are in place and developed through a collaborative interdisciplinary process. · Assuring behavior supports meet the needs of all clients. · Assuring all clients feel safe. Speaking with staff and clients and reviewing progress notes and behavior tracking to assure all incidents and allegations are reported as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	
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, record review and interview for 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the facility neglected to implement its written policy and procedures to prevent an incident of client to client aggression where client A pulled a chunk of client C's hair out, to report clients C and D's allegations of being scared of client A to the Bureau of Disabilities Services (BDS) within 24 hours and to investigate the allegations; to ensure staff reported an incident where client A obtained	W 0149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client.* Specific corrections include: Direct support staff will be retrained regarding the requirement for thorough and complete reporting of incidents.	03/03/2024

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	a knife from the medication room immediately to the administrator; to aggressively address and prevent clients A and B's pattern of maladaptive behaviors and develop and implement effective corrective measures to prevent the aforementioned incidents from occurring. Findings include: 1. An observation was conducted at the group home on 1/29/24 from 10:45 AM to 11:10 AM. Clients A, C and D were present at the group home. The Program Director (PD) indicated client B was hospitalized. Staff #1, #2 and #3 were working during the observation. At 10:52 AM, client C asked to speak with the surveyor. Client C led the surveyor to the living room in the back of the home with her 1 on 1 staff (staff #3). Staff #1 was present in the room. Client C reported client A pulled a chunk of hair out of her head and she was scared of her. Client C indicated she was sitting at the table in the back living room and client A ran back there and reached over staff #1 (1:1 staff at the time of the incident), pulled her hair out then punched staff #1 in the face. Staff #1 confirmed the incident happened. Client C stated, "I'm scared of her. She's going to hurt me. I don't want to live here anymore". Client C indicated client A hit her one other time in November 2023, but she wasn't hurt then. Client C indicated her 1:1 staff has blocked other attempts where client A tried to hit her. Client C indicated she has told staff and supervisors she was scared. An observation was conducted at the group home on 1/29/24 from 3:45 PM to 5:15 PM. Throughout the observation, client A stayed in the back living room with her 1:1 staff working on arts and crafts projects, watching television and playing on her tablet.		Administrative staff will review details of internal incident documentation, obtaining follow-up information as needed, to assure all required information is reported to the Bureau of Disability Services, Indiana Adult Protective Services, and the police, as required. All facility investigations will be completed by trained investigators. When incidents requiring investigation occur, the Acting QA Manager or designee will assign the investigation to a specific investigator. The QIDP Manager (or QA Manager when the QIDP Manager is the assigned investigator) will conduct follow-up with the investigator to assure completion within required timeframes, and that each allegation is investigated thoroughly. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigators will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this mentorship/training will be development of appropriate scope	

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	On 1/29/24 at 12:00 PM and 1/30/24 at 7:00 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: A 1/16/24 BDS report indicated, "On the evening of 1/15/24, [client A] became agitated during dinner and was playing her music at a high volume. [Client A] indicated she was angry with a housemate because she felt like she was being ignored during the meal. [Client A] stood up and ran toward her housemate [client C]. Staff stood between [client A] and [client C] to block. [Client A] reached over staff and pulled her housemate's hair (sic) staff (sic) continued blocking and [client A] punched staff twice in the face. Staff used agency/plan approved physical redirection in which staff placed her arms on [client A's] torso and turned her away from the housemate. [Client A] told staff she wanted to die and ran into the garage. [Client A] pulled a porcelain doll out of a cabinet, pushed staff out of the way, broke the doll on the ground and cut her left wrist with a piece of the broken doll. One staff called non-emergency dispatch to arrange safe transport to the ER (Emergency Room) while another staff applied pressure to the injury to control the bleeding. Paramedics transported [client A] to the [Hospital Emergency Department] via ambulance. The ER physician closed the laceration with five sutures and admitted her to the hospital for psychiatric observation. The psychiatrist assessed [client A] and arranged for admission at [Behavioral Hospital] located at [address].... Plan to Resolve: [Client A] sustained a 1.5 inch laceration on her left forearm, and she remains hospitalized. ResCare nursing will maintain contact with hospital staf (sic) to assure continuity of care.		and conclusions, as well as time management skills to facilitate timely completion if investigations. The training focus will also include assuring all potential witnesses are interviewed and that all allegations are addressed in the investigation. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. When the investigator assigned to the facility is not available, The QIDP Manager or designee assigned by the QA Manager will assume responsibility for completion of required investigations. Specifically for client A: The facility has added an additional 8:00 AM to 8:00 PM direct support staff, so that one team member can be dedicated toward working exclusively with client A, focusing on preventative behavior supports and positive structured activities, as well as providing immediate intervention when client A begins to escalate. Additionally, through ongoing assessment, the interdisciplinary team consensually agrees that client A would have a greater opportunity for success with the wrap-around services available in a CIH Waiver residential setting. The team is working with the Bureau of Disability Services and a provider chosen by client A's guardian to	

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	[Client A] has a history of verbal and physical aggression, self-injury and suicidal ideation addressed in her Behavior Support Plan, which staff followed. The Interdisciplinary team will meet to develop additional supports". A 1/20/24 Investigative Summary indicated the following: Investigation interview with client C: "[Client A] pulled my hair. [Staff #1] tried to stop her. [Client A] was mad. It was scary. I don't want her here. Staff keep me safe. Staff did their best. I do yell at [client A] and it gets her mad. This time I didn't say anything to her and she still got mad at me". Investigation interview with Staff #1: "[Client C] was sitting int (sic) eh (sic) back living room eating dinner with her one-to-one staff. I was her one to one. [Client A] stated, 'I will rip that b***** head off'. I blocked [client A's] path to [client C]. [Client A] charged towards [client C] and reached over staff, puling (sic) [client C's] hair. Staff intervened and blocked, and [client A] punched me twice in the face. [Client A] was verbally redirected to her bedroom. I sat with [client C] and offered one-to-one talk and coping skills. [Client C] said she was scared of her housemates. I assessed her injury, but [client C] refused to let me measure the injury. Staff note (sic) a red spot in the middle of [client C's] head and hair missing. [Client C] remained calm for the rest of the night". Investigation interview with staff #2: "[Client A] was sitting at the table with me and [client D]. [Client A] became agitated due to [client C] ignoring her. At serving time at dinner, I sat down with [client D] while [client A] ate her		expedite the transition process. Specifically for client B: Through ongoing assessment, the interdisciplinary team has determined that client B's aggression stems from impulse control challenges. The facility's Behavioral Clinician has modified client A's Behavior Support Plan to include an accountability calendar and token-based behavior improvement program to assist client A with controlling her impulsive behavior. All staff will be trained toward implementation of the revised plan. Staff have received additional training toward implementation of supports that create a therapeutic environment where all clients feel safe, including isolating client A from her housemates when she begins to escalate and assuring staff provides ongoing reassurance to clients B, C and D regarding the team's commitment to keep them safe. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or	

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	dinner. I offered coping skills while [client A] at (sic) her dinner. She was mad because [client C] had been ignoring her. [Client A] became aggravated, stood up and yelled, 'I will rip that b***** head off'. Staff did verbally redirect her but [client A] stood up and charged toward the back living room where [client C] was eating her dinner and charged toward [client C]. [Staff #1] intervened and blocked [client A's] path to [client C]. [Client A] reached over [staff #1] and pulled out some of [client C's] hair. Staff, [staff #3] and me, did YSIS (You're Safe, I'm Safe) physical redirection and escorted [client A] to her room for one-to-one and coping skills. [Client A] said, 'I don't give a f***, I'm going to kill myself'. She stood up and charged into the garage, with staff behind her. We blocked and verbally redirected her away from the filing cabinet. [Client A] pushed past us and opened the filing cabinet and found a porcelain doll. I verbally redirected her and [client A] attempted to throw the doll at staff. We verbally redirected and blocked [client A] from throwing the doll and she smashed the doll down on the floor. [Client A] managed to pick up a shard from the broken doll and sliced her left forearm. Staff applied pressure to the wound and offered coping skills until non-emergency services arrived. [Client A] became verbally aggressive stating, 'I don't give a f***. I'm going to Jail'." Investigation interview with staff #3: "I prompted [client D] to get up for dinner, when [client A] charged into the back living room at [client C]. [Staff #1] intervened and blocked [client A's] path to [client C]. [Client A] reached over staff and pulled [client C's] hair. YSIS (physical redirection) was implemented, and [client A] punched [staff #1] in the face. YSIS redirection was used to get [client A] to her room, for one-to-one talk and coping skills. [Client A]		designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services and distribute the list to administrative staff (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) for review and revision, as needed. The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, (comprised of the Executive Director, Operations	

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	returned to the dining table but became agitated and started toward the garage. Staff intervened but [client A] shoved staff out of the way. [Client A] ran to the file cabinet and stated, 'I'm going to find something to kill myself with'. Staff, [staff #2] and me, verbally redirected and [client A] said, 'I don't give a f***'. [Client A] found a porcelain doll, staff verbally redirected, and [client A] threw the doll on the floor and broke it. Staff verbally redirected and [client A] lunged for a piece of the porcelain and sliced her left wrist. Staff blocked and intervened and got the piece of porcelain. Staff verbally redirected [client A] back to her room and applied pressure to the wound on her left wrist. Staff called non-emergency and offered [client A] one-to-one talk and coping skills until non-emergency (sic) arrived. Non-emergency arrived and [client A] remained verbally aggressive to them. Non-emergency transported [client A] to [hospital]". Factual Findings: "-[Client A] was hospitalized throughout the course of the Investigation and was not available to testify. -[Client A] pulled [client C's] hair on 1/15/24. -Staff positioned herself to block but [client A] was able to reach over her to access [client C's] hari (sic). -[Client A] obtained and broke a porcelain doll on 1/15/24 and used a broken pice (sic) to cut her left forearm. -Staff attempted to block her access to the doll and to block her from cutting herself but were unsuccessful. -Staff obtained the broken piece of the doll to prevent further injury and performed first aid until paramedics arrived. -[Client A] sustained a 1.5 inch laceration on her left forearm.		Managers, Program Managers, Acting Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager). The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team	

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	-[Client C] sustained a one-inch red area on her scalp with evidence of missing hair. -[Client A's] Behavior Support Plan includes physical aggression and self-injury as target behaviors". Conclusion: "1. The evidence substantiates that [client A] pulled [client C's] hair on 1/15/24. 2. The evidence substantiates that [client A] caused Injury to [client C] on 1 /15/24. 3. The evidence substantiates that [client A] caused Injury to herself on 1/15/24. 4. The evidence does not substantiate that [client A's] Behavior Support Plan failed to address physical aggression and self-injury. 5. The evidence does not substantiate that staff failed to implement [client A's] Behavior Supports appropriately. 6. The evidence does not substantiate that staff failed to follow ResCare policies and procedures". Recommendations: 1. Continue to implement [client A's] Behavior Supports as written. 2. Behavioral Clinician to discuss current challenges with [client A's] guardian to evaluate past approaches that achieved success for incorporation into current plan". A review of the 1/20/24 Investigative Summary indicated there was no documentation the facility reported client C indicating she was scared of her housemate to BDS within 24 hours and there was no documentation indicating the facility conducted an investigation regarding client C's allegation. On 1/29/24 at 4:37 PM, staff #2 was interviewed. Staff #2 stated, "[Client C] has been telling me		members. When significant incidents occur, including but not limited to aggression and intimidation, the QIDP will contact front line team members and administrative staff and additional professional assistance as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences. When corrective measures are developed by post-investigation administrative level collaboration, the QA Manger and QIDP Manager will analyze peer review and team meeting documentation to assure all necessary corrective recommendations are included. The Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. The Program Manager will monitor time and attendance records to assure required staffing levels are met. The Program Manager will assist with procuring staff from outside of the facility as needed. An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assure sufficient staff are present and to assist with and	

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	she's scared to live here since I started in December (2023) and nobody is doing anything. The day she (client A) pulled her hair out she cried uncontrollably. What can we do? She (client A) got in the med (medication) room one day. She slipped through me and [staff #3] and got a butcher knife out of the med room. Thank goodness it had a cover on it. We got it away from her then she went to the garage and broke a porcelain doll and cut her arm. Her arm was bleeding everywhere". There was no documentation indicating the incident with the knife was reported to BDS or addressed in the Investigative Summary. On 1/31/24 at 3:10 PM, client A was interviewed with the Behavior Clinician (BC) present. Client A indicated after she pulled client C's hair out she ran into the medication room and got a knife out of the sharps box. Client A indicated she wanted to hurt herself. Client A indicated staff #1, staff #2 and staff #3 were all trying to get the knife away from her. Client A demonstrated what she did with the knife by putting her hands together as if she was holding a knife then raised her arms above her head and made a stabbing motion. Client A indicated it was towards staff #3. Client A indicated the medication room door and the door to the closet where the medication and the sharps box are stored was open. Client A stated, "The doors are locked now. They were never locked before. I'm not thinking about what I'm doing when I'm having a behavior. I shouldn't have done it and I know better. I'm not going to do this (hurt people) anymore". Client A indicated after they got the knife away from her she ran to the garage and broke a doll then used a piece of glass to cut her arm. Client A indicated she went to the hospital and had to get 5 stitches.		monitor skills training, including but not limited to effective application of behavior supports For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Acting Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including night and weekend observations. After 30 days, administrative monitoring will occur no less than three times 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. Current Operations Team members received training from the QIDP Manager on 12/14/23, to assure a clear understanding of administrative monitoring as defined below. · 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	

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	On 1/30/24 at 4:26 PM, staff #3 was interviewed. Staff #3 denied there was an incident with client A obtaining a knife from the medication room on 1/15/24. On 1/30/24 at 5:13 PM, staff #1 was interviewed. Staff #1 denied there was an incident with client A obtaining a knife from the medication room on 1/15/24. A review of the investigation witness statements completed on 1/15/24 by staff #1, staff #2 and staff #3 did not report client A obtaining access to a knife. On 1/30/24 at 11:00 AM, client A's record was reviewed. Client A's 1/19/24 (revised 1/27/24) Behavior Support Plan (BSP) indicated the following: -Client A's target behaviors included physical aggression, verbal aggression, self-injury behavior, elopement, task refusal/non-compliance, suicidal ideation, inappropriate sexual behaviors, disruptive behaviors and impulse control issues. -Client A was restricted from sharps. -Client A was on enhanced supervision/secured residential environment: "To protect client from placing herself at risk of harm and exploitation outside of the residential environment without supervision of staff". -Modified Enhanced Supervision (MES) Protocols: "When [client A] demonstrates she may be a threat to herself (through the expression of suicidal ideations or other high intensity		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 oversight will include but not be limited to: · Assuring corrective measures are in place and developed through a collaborative interdisciplinary process. · Assuring behavior supports meet the needs of all clients. · Assuring all clients feel safe. · Speaking with staff and clients and reviewing progress notes and behavior tracking to assure all incidents and allegations are reported as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	

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	displays of behaviors), supervision will move from Modified Enhanced Supervision (sic) to Enhanced Supervision (sic) protocols. During these displays, [client A] needs the support and heightened supervision protocols that Enhanced Supervision provide; these specific measures are to be implemented when [client A] is potentially a threat to herself or others while at home and in the community. MES means that [client A] is on Enhanced Supervision and not able to enter the community. The MES protocol (when implemented) will be evaluated every 2-hours by the RM (Residential Manager)/AS (Area Supervisor)/QIDP (Qualified Intellectual Disabilities Professional) and Behaviorist. Any item/belonging of [client A's] deemed by staff to be a dangerous object/belongings (example: belts, cords) should be removed from her bedroom until the displays of behavior have ceased and [client A] has displayed a state of calm for a minimum period of 2-hours or until safe to return those items. [Client A] should not be unsupervised during this period and the staff should record [client A's] movements/activities on the 15-minute check sheet/paperwork which should be maintained in [client A's] documentation binder. Preventive/Proactive Procedures: 3. The doors to the Med Room will remain closed and locked at all times.... 7. At the first sign of a precursor behavior by [client A] or any of the housemates, lock the sharps (or items which can easily be made into a sharp) which includes, eating utensils (such as forks, spoons, knives), cooking utensils (spatulas, wooden spoons, serving spoons, measuring cups, measuring spoons, ice cream scoops, pizza cutters, whisk, cookie cutters, meat thermometers, potato peelers). Any cleaning solutions or chemicals which could be ingested should also be secured, including cleaning			

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	chemicals. These items should remain secured until the immediate risk from exposure has passed and/or until [client A] has been assessed as being in control of herself (physically) and emotions and no longer poses a risk of danger to herself and/or others within the immediate environment". On 1/29/24 at 11:15 AM, the Program Director (PD) was interviewed. The PD stated, "[Client C] tells everyone she is afraid of her (client A) but she'll yell and scream from the other side of the house how she hates her and is going to kill her mom. [Client A] was finally tired of it and went after her. [Staff #1] wasn't able to stop her because [client A] punched her in the face. [Client A] pulled a chunk of hair out of her (client C's) head then ran to the garage and cut her arm with a broken doll. She ended up with 5 stitches". The PD indicated client to client aggression was abuse and the facility should prevent abuse of the clients. On 1/31/24 at 9:30 AM, the Qualified Intellectual Disabilities Professional Manager/Qualified Intellectual Disabilities Professional (QIDPM/QIDP) and the Operations Support Specialist were interviewed. The QIDPM indicated client to client aggression was abuse and the facility should prevent abuse of the clients. The QIDPM/QIDP indicated if a client reported being scared of another client, protective measures should be implemented to help the client feel safe. The QIDPM/QIDP indicated he first became aware of the allegation while he was conducting the investigation. The QIDPM/QIDP indicated client C's report of not feeling safe should have been reported to BDS and investigated. On 1/31/24 at 3:28 PM, the QIDPM/QIDP was interviewed. The QIDPM/QIDP indicated he was			

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	not aware of the incident with the knife until the AS reported it to him last night (1/30/24). The QIDPM/QIDP indicated staff should have included the information in their witness statements and it should have been immediately reported to the administrator. On 1/31/24 at 4:00 PM, the PD was interviewed. The PD indicated nobody reported anything about client A obtaining a knife. The PD indicated client C has reported she was scared of client A several times, but they also get along fine at times. 2. An observation was conducted at the group home on 1/29/24 from 3:45 PM to 5:15 PM. At 3:50 PM, client A introduced herself and indicated she had been in and out of the psychiatric hospital since she moved in three months ago. Client A showed the surveyor her forearms which both had multiple pink scars. Client A also showed some pink scars on both sides of her neck. Client A indicated the scars were from her cutting herself. Client A showed the surveyor her room which contained nothing but her bed, bedding on the bed and a television. Client A indicated she was restricted from her personal belongings and they were being stored in the garage until she earned them back. On 1/29/24 at 12:00 PM and 1/30/24 at 7:00 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: -A 1/26/24 BDS report indicated the following incident occurred on 1/25/24 at 3:00 PM: "Moments after [client A] returned home from overnight psychiatric detention (previously reported incident #1542101), she became anxious			

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	and agitated and requested her PRN (as needed) medication. Staff offered verbal redirection to preferred activities, coping skills and one-to-one talk but [client A] grew progressively more upset. Staff obtained approval and administered haloperidol (for behavior) 5mg (milligrams). [Client A] listened to music and remained calm for approximately two hours. [Client A] re-escalated after speaking to her mother who suggested a smoking schedule (a support that produced successful results in the past). [Client A] punched the wall. When staff blocked, she spit on them. She picked up a piece of wood (sic) brandished it at staff and ran toward them. Staff blocked and [client A] ran out the door and down the road. Staff followed and called 911 for assistance. Police arrived and [client A] began yelling at the responding officers. The police took [client A] home and spoke to [client A] in her room and she told them that she wanted to kill her self (sic). Police arranged for EMS (emergency medical services) to transport [client A] to the [Hospital Emergency Department], where the behavior team evaluated her and determined she did not meet the criteria for in-patient treatment. The psychiatrist discharged [client A] to ResCare staff the following afternoon with no new orders. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. The psychiatrist diagnosed [client A] with suicidal ideation, impulse control disorder, agitation, and aggressive behavior and released her to ResCare staff with no new orders. Plan to Resolve: [Client A] had no new injuries and staff provided her with post-incident supportive conversation (sic) [Client A] has a history of verbal and physical aggression, self-injury, elopement, and suicidal ideation addressed in her Behavior Support Plan.... Staff will continue to implement the			

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	proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences". -A 1/25/24 BDS report indicated the following incident occurred on 1/24/24 at 5:30 PM: "On the evening of 1/24/24, [client A] was eating popcorn and watching a movie with staff. Without displaying precursor behavior, [client A] stood up and told staff she was 'about to have a behavior', and walked to her bedroom. Staff offered one-to-one talk and coping skills. [Client A] said she wanted to die and requested her agitation PRN. Staff offered verbal redirection to preferred activities, coping skills and one-to-one talk but [client A] grew progressively more upset. Staff obtained approval and administered haloperidol 5mg. The medication never reached efficacy and [client A] continued to escalate. [Client A] walked to the garage and hit the punching bag. She picked up a clock and broke a piece off to use to harm herself. Staff placed her into a two-person You're Safe, I'm Safe hold. When [client A] appeared to calm, staff released the hold and she asked for a glass of water. As staff was assisting her, [client A] began punching the window and staff blocked. [Client A] asked staff to accompany her to the garage so she could hit the punching bag. Upon entering the garage, [client A] pulled a cord out of a box, ran back into the house and attempted to put the cord around her neck. Staff approached and she dropped the cord, punched staff in the face twice and pulled staffs (sic) hair. [Client A] disengaged with staff and ran into the living room towards her housemates. Staff blocked her from hitting her peers and she hit staff and bent staffs (sic) fingers back. Staff placed her in a two-person You're Safe, I'm Safe hold. Staff encouraged coping skills and [client A] continued yelling, using profanity, and asking to be allowed			

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	to die. The behavioral clinician encouraged [client A's] housemates to move to a different area of the house. Staff released the hold and complied with [client A's] request for a glass of water. [Client A] drank the water and pulled a decoration off the wall, broke it in half. Staff successfully obtained the broken decoration, but [client A] then ran out the front door. She sat on the porch swing and had one-to-one talk with staff. [Client A] stood up and ran down the street, with staff following within arm's reach. [Client A] ignored staff redirection and picked up a lantern. Staff attempted to get [client A] to give them the lantern and [client A] threw the lantern onto the ground and hit staff in the face. [Client A] attempted to get a piece of broken glass from the lantern. Staff blocked and [client A] spit in staffs (sic) face and picked up a piece of glass and ran across the street. Staff followed and [client A] continued to spit on staff as they attempted to intervene. [Client A] began cutting her left forearm and the sides of her neck with the glass. Staff called 911 for assistance. Police and EMS arrived. [Client A] dropped the glass, flirted briefly with the police officer, and got into the ambulance without issues. EMS transported [client A] to the [Hospital Emergency Department], where the behavior team evaluated her and admitted her for overnight psychiatric observation. [Client A] remained in psychiatric detention through the night. The psychiatrist discharged [client A] to ResCare staff the following afternoon with no new orders. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. It should be noted that [client A] reescalated shortly after returning home. This incident will be reported separately. Plan to Resolve: [Client A] sustained a 7cm (centimeter) by 7cm abrasion with interspersed superficial cuts on her left forearm, a			

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	7cm by 3cm abrasion with interspersed superficial cuts on the right side of her neck, a 7cm by 2cm abrasion with interspersed superficial cuts on the left side of her neck, 2 1cm bruises on her right bicep and a 2cm bruise on her right forearm. Staff will document the healing process of the affected areas on an injury follow-up flow sheet. [Client A] has a history of verbal and physical aggression, self-injury, elopement, and suicidal ideation addressed in her Behavior Support Plan. [Client A] does not have plan approved alone time but was never away from staff supervision. The use of You're Safe, I'm Safe holds and PRN haloperidol has guardian and Human Rights Committee approval and is included in her plan. The three holds lasted a total of 15 minutes, with repositioning for comfort every two to three minutes. Staff will continue to implement the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences". -A 1/7/24 BDS report indicated, "On the afternoon of 1/6/24, [client A] arrived home from the hospital (previously reported incident #1536863) and became agitated when staff requested to perform a physical assessment. [Client A] began yelling, and attempted to strike her head on the floor but staff blocked. Staff offered coping skills and one-to-one talk and [client A] refused and continued yelling. [Client A] then stood up and grabbed her fan off her bedroom desk and tried wrapping the cord around her neck. When staff tried to intervene, [client A] threw the fan at staff, causing it to break. [Client A] continued yelling at staff while staff was preforming (sic) a bedroom sweep, per her plan. Staff tried offering coping skills and one to one talk with [client A], but she (sic) biting her right			

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	wrist. Staff preformed (sic) a bit (sic) release technique and blocked [client A] from harming herself. [Client A] then sat on her bed and started using coping skills. Staff offered [client A] a PRN to help calm her down and [client A] agreed to PRN. Staff obtained approval and administered haloperidol 5mg. [Client A] continued yell and threaten staff and housemates. [Client A] ran out of her bedroom towards dining area and a housemate, in a threatening manner. Staff blocked and implemented a two-person You're safe, I'm Safe hold. When she began to calm, staff released the hold. Staff offered verbal redirection, coping skills and one-to one talk. [Client A] walked to her bedroom and began scratching an existing abrasion on the top of her left forearm with fingernails. Staff blocked and [client A] slapped staffs (sic) hand away. Staff offered verbal redirection, coping skills and one-to-one talk and [client A] ran out of her bedroom and knocked over the Christmas tree. Staff tried verbally redirecting her, but [client A] grabbed a Christmas decoration and attempted to strike her head on it. When staff tried to intervene, [client A] put the decoration down and walked back to her bedroom. [Client A] continued yelling. After the medication took effect, [client A] calmed and resumed her evening routine. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. Plan to Resolve: [Client A] had no new injuries and received post-incident supportive conversation. [Client A] has a history of verbal and physical aggression, property destruction and self-injury addressed in her Behavior Support Plan. The use of PRN Haloperidol and You're Safe I'm Safe holds has guardian and Human Rights Committee Approval			

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	and is included in her plan. The hold lasted for four minutes with repositioning for comfort after two minutes. Staff will continue to implement the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences". -A 1/6/24 BDS report indicated, "On 1/5/24, [client A] was in the kitchen assisting with preparing supper. She called for another staff and when she asked [client A] to wait a second, [client A] began yelling, using profanity, and making threats. [Client A] then ran out the front door with staff following. Staff encouraged [client A] to calm herself and she continued walking. She entered a neighbor's yard and punched a tree with her right hand. [Client A] spoke with staff and her Behavioral Clinician and she calmed and returned inside her house. She ate supper and took her dishes to the kitchen, slammed the kitchen door and began threatening to harm staff. She entered the bathroom took the mirror off the wall, and ran out the home's front door, with staff following. [Client A] ran down the street, with staff maintaining line of sight and she laid down in the road. Staff encouraged [client A] to calm and she stood up and continued running. She laid down again and struck her forehead on the road. [Client A] continued running and turned onto the sidewalk on [highway]. She laid down on the sidewalk and again made contact with her forehead. Staff called 911 for assistance. Police arrived and [client A] began hitting the front door of a house. Police prompted her to sit down and she began yelling at the police. She laid on the sidewalk and tapped her head and then resumed hitting the door. Police arranged for EMS to			

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	transport [client A] to [Hospital] where she was placed on Immediate Psychiatric Detention. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. [Client A] was released to ResCare staff on the afternoon of 1/6/24 and returned home without incident. Plan to Resolve: [Client A] sustained a two-centimeter superficial cut on her left index finger and a three-centimeter circular abrasion on her forehead prior to being detained by the police. Staff will document the healing process of the affected areas on an injury follow-up flow sheet and will monitor [client A] for signs and symptoms of concussion for 72 hours. [Client A] has a history of verbal and physical aggression, elopement and self-injury addressed in her Behavior Support Plan. [Client A] does not have plan approved alone time but was never away from staff supervision. Staff will continue to implement the proactive and reactive strategies in her plan to help reduce and prevent further occurrences". -Four additional BDS reports dated 12/1/23, 11/20/23, 11/16/23 and 11/7/23 were reviewed. Those incidents included elopement, property destruction, laying in the road and banging her head on the ground, self-injurious behavior, physical aggression, police involvement and psychiatric evaluations/admissions at the hospital. On 1/30/24 at 11:00 AM, client A's record was reviewed. Client A's 1/19/24 (revised 1/27/24) Behavior Support Plan (BSP) indicated the following: -Client A's target behaviors included physical			

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	aggression, verbal aggression, self-injury behavior, elopement, task refusal/non-compliance, suicidal ideation, inappropriate sexual behaviors, disruptive behaviors and impulse control issues. -Client A was restricted from sharps. -Client A was on enhanced supervision/secured residential environment: "To protect client from placing herself at risk of harm and exploitation outside of the residential environment without supervision of staff". -Modified Enhanced Supervision (MES) Protocols: "W hen [client A] demonstrates she may be a threat to herself (through the expression of suicidal ideations or other high intensity displays of behaviors), supervision will move from Modified Enhanced Supervision (sic) to Enhanced Supervision (sic) protocols. During these displays, [client A] needs the support and heightened supervision protocols that Enhanced Supervision provide; these specific measures are to be implemented when [client A] is potentially a threat to herself or others while at home and in the community. MES means that [client A] is on Enhanced Supervision and not able to enter the community. The MES protocol (when implemented) will be evaluated every 2-hours by the RM (Residential Manager)/AS (Area Supervisor)/QIDP (Qualified Intellectual Disabilities Professional) and Behaviorist. Any			

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	item/belonging of [client A's] deemed by staff to be a dangerous object/belongings (example: belts, cords) should be removed from her bedroom until the displays of behavior have ceased and [client A] has displayed a state of calm for a minimum period of 2-hours or until safe to return those items. [Client A] should not be unsupervised during this period and the staff should record [client A's] movements/activities on the 15-minute check sheet/paperwork which should be maintained in [client A's] documentation binder. Preventive/Proactive Procedures: 3. The doors to the Med Room will remain closed and locked at all times.... 7. At the first sign of a precursor behavior by [client A] or any of the housemates, lock the sharps (or items which can easily be made into a sharp) which includes, eating utensils (such as forks, spoons, knives), cooking utensils (spatulas, wooden spoons, serving spoons, measuring cups, measuring spoons, ice cream scoops, pizza cutters, whisk, cookie cutters, meat thermometers, potato peelers). Any cleaning solutions or chemicals which could be ingested should also be secured, including cleaning chemicals. These items should remain secured until the immediate risk from exposure has passed and/or until [client A] has been assessed as being in control of			

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	herself (physically) and emotions and no longer poses a risk of danger to herself and/or others within the immediate environment". Interdisciplinary Team (IDT) Meeting notes dated 1/16/24 indicated the team met to discuss the incident which occurred on 1/15/24. The team agreed to develop a smoking schedule to decrease client A's fixation on smoking or running out of cigarettes, to add impulse control to the BSP and define the kitchen access restriction in the BSP.The only other IDT meeting was client A's 30 day meeting where goals and the BSP were developed. On 1/30/24 at 1:20 PM, the Behavior Clinician (BC) was interviewed. The BC indicated client A has made multiple threats and attempts to attack her peers and staff have been successful with blocking all of the attempts but two. The BC indicated client A targets client C, but client A has 1:1 staffing so staff is always with her. The BC indicated when client A starts to escalate, the other clients are moved to a different location so they aren't around her. The BC indicated YSIS isn't always effective with client A due to her size. The BC stated, "If YSIS isn't effective they continue to try. A lot of times she is able to break away. She will go out, elope then the neighbors call the police. 911 is called when they (staff) can't control her. The premeditation is what			

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	scares me. This last incident she premeditated how she could get in the kitchen. She looks for everything with glass in so she can hurt herself". The BC was asked if there were enough staff to effectively implement the BSPs. The BC stated, "On a normal day to day basis, yes. If we could have an extra person on a day when we have behaviors that would be great". The BC indicated client A's behavior started to escalate after Christmas and it has continued to escalate since then. The BC was asked if client A was appropriately placed. The BC stated, "At this point, if we could narrow it down to what is going on with her we could help more. I think the restrictions are making it worse. She came from waiver with little restrictions. The dual diagnosis makes it hard. I am working with her Psychiatrist to figure out if her medication is even effective. We are talking about safely weaning her off and slowly putting her back on meds. At this point I am not 100% sure is she is appropriate here". On 1/31/24 at 9:30 AM, the QIDPM/QIDP and the OSS were interviewed. The QIDPM/QIDP indicated the last time he visited the home was in late November or early December 2023. The QIDPM/QIDP indicated client A's behavioral episodes have increased in the last month. The QIDPM/QIDP indicated client A asks for			

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	her PRN when she feels anxious and it has helped her calm down at times. The QIDPM/QIDP stated, "The other piece of this is [client A] came to us with a completely inaccurate and inappropriate list of diagnoses. They (BC and Psychiatrist) are working on clearing up the diagnostic mess. Her psych (psychiatric) team is working to figure out what she needs to get her back on track. The Operations Manager has authorized an additional staff. Originally we were discussing 1:1. However, that tends to increase her anxiety. We need someone completely dialed in to her at all times. We are not calling it a 1:1 because that gives staff the idea they are to all be in her business. We are going to have a single staff assigned to work with [client A] for skills training, recreational opportunities and they will be trained to be tuned in on precursor behaviors. The 3rd staff will be from 8:00 AM to 8:00 PM, 7 days a week. When she is agitated in the evening we will keep that staffing in place. They will be trained to the effect that they are 1:1. Another staff will cover if they have to go to bathroom. We are also talking about switching out staff throughout the shift. With that in place in addition to [client C's] 1:1 there will be 2 additional staff in the home for either [client A] or [client B]. When they escalate it takes more than 1 staff. Once			

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	again we are being reactive I know. There is no easy answer for that. [PD] has been asking for additional staff over there since before they came. We need the resources in place. There isn't a paper trail saying we don't have enough staff. The Governing Body reads these reports (incident reports and BDS reports). The ED (Executive Director) sees every BDS report. The team as a whole sees all of it. That is our focus right now. We are going to talk with guardian to see if she will approve (plan). The 1:1 will help keep people safe". The QIDPM/QIDP indicated staffing levels should be based on the needs of the clients. The QIDPM/QIDP was asked if there was a sufficient amount of staff to implement plans effectively, provide needed care and services to prevent injuries and keep clients safe. The QIDPM/QIDP stated, "No, there is no way". The QIDPM/QIDP was asked what was being done to ensure client A's safety. The QIDPM/QIDP stated, "There were no additional protective measures put in place". 3. On 1/29/24 at 12:00 PM and 1/30/24 at 7:00 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: -A 1/15/24 BDS report indicated, "On 1/14/24 with no apparent precursor behavior, [client B] became agitated and began threateningto stab staff			

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	and housemates. Staff redirected her verbally and offered coping skills, but [client B] continued to escalate. Staffprovided one-to-one talk and [client B] calmed, took her midday medication and ate her lunch. Moments later, she began yellingand threatening again. When a housemate walked by, [client B] pulled out a pen she had hidden under her shirt and made stabbingmotions toward staff and the housemate. Staff blocked and [client B] released the pen. She continued yelling and threatening andstaff attempted to place [client B] in a You're Safe, I'm Safe hold but were unable to implement it, due to the intensity of [client B's]aggression. [Client B] agreed to take her PRN medication to help her calm down. Staff obtained approval and administered Igalmi120mcg (micrograms). The medication was not effective and [client B] remained agitated and aggressive. The team determined [client B] needed an emergency psychiatric evaluation and contacted non-emergency dispatch to arrange for transportation. Police and paramedics arrived, and [client B] attempted to stab herself. Staff blocked, police intervened, placed her in handcuffe (sic) and the paramedics transported [client B] to the [Hospital Emergency Department]. The ER psychiatrist assessed [client B], diagnosed her with Impulse Control Disorder and			

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	admitted her for acute inpatient treatment. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. Plan to Resolve: [client B] was not injured prior to being detained by police and EMS. She remains hospitalized, and ResCare nursing will remain in communication with the hospital to assure continuity of care. [Client B] has a history of agitation, verbal and physical aggression addressed in her Behavior Support Plan. The use of PRN Igalmi and You're Safe, I'm Safe holds has guardian and Human Rights Committee Approval and is included in her plan".-A 1/14/24 BDS report indicated, "On 1/13/24 with no apparent precursor behavior, [client B] became agitated and asked to have talk1:1 with staff. After staff offered coping skills, [client B] agreed to take her PRN medication to help her calm down. Staff obtainedapproval and administered Igalmi 120mcg. [Client B] then became verbally aggressive yelling about 'all the trauma she deals with'. Staff offered coping skills and continued to talk with her encouraging her to calm herself. Without success [client B] got up andattempted to leave the home but staff blocked. [Client B] continued yelling and staff offered coping skills and 1:1 conversation. After the medication took effect, [client B] calmed and resumed her			

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	normal routine. When prompted to take her evening medications,[client B] re-escalated and began yelling and attempted to exit the house. Staff blocked and [client B] pulled a pen out of her pocketand stabbed staff multiple times while pushing past staff and entering the front yard. Staff implemented a two-person You'reSafe, I'm Safe hold. [Client B] let go of the pen and staff released the hold. [Client B] remained combative and refused to enter thehouse, and staff re-implemented the hold. Once calm, staff released the hold and [client B] went into the house. [Client B] went to her bedroom and continued yelling and threatening staff. Staff continued to offer coping skills and [client B] took her medication and was calm for the remainder of the evening. Staff were in communication with the supervisor, nurse, behavioral clinician, andadministrative team throughout the day and evening. Plan to Resolve: [Client B] was not injured and received post-incident supportive conversation. [Client B]has a history of agitation, verbal and physical aggression addressed in her Behavior Support Plan. The use of PRN Igalmi and You're Safe, I'm Safe Holds has guardian and Human Rights Committee Approval and is included in her plan. Each hold lasted for seven minutes with repositioning for comfort every two to three minutes. Staff will continue to implement the			

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	proactive and reactive strategies in [client B's] plan to help reduce and prevent further occurrences".-A 1/7/24 BDS report indicated, "On 1/6/24, one of [client B's] housemates ran towards her aggressively, but was not able to make contact because staff blocked. [Client B] became agitated towards her housemate and began yelling. Staff verbally redirected [client B] and offered coping skills and one-to-one talk, and [client B] took her evening medication. Moments later, [client B] again became re-escalated. Staff verbally redirected [client B] and offered one-to-one talk, and staff walked with [client B] to the garage, to retrieve her jacket, per her request. While in the garage [client B] pushed down two dressers blocking staffs path and ran out of the garage door. Staff followed behind [client B] keeping her in line-of-sight. Staff caught up to [client B] and remained within arm's reach. [Client B] began yelling and attempted to run in front of moving cars on the road. Staff was able to block and offer coping skills. A passing sheriff deputy noticed the situation and stopped to assist. The sheriff arranged for EMS to transport [client B] to [Hospital]. When staff arrived at [Hospital] [client B] was laying in the hospital bed calmly but became agitated when the nurse entered the room. [Client B] began yelling at ResCare staff and threw			

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	staffs (sic) cellphone (sic), breaking it. Emergency Department staff intervened, and ResCare staff offered [client B] coping skills, without success. ER staff gave [client B] an injection to help her calm down. After being assessed by the [Hospital] behavior team [client B] was admitted on an immediate Psychiatric Detention. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. Plan to Resolve: [Client B] was not injured prior to being detained by the Sheriff and EMS. [Client B] has a history of verbal and physical aggression, elopement and self-injury addressed in her Behavior Support Plan. [Client B] does not have plan approved alone time but was never away from staff supervision. [Client B] remains hospitalized. ResCare nursing will remain in communication with the hospital to assure continuity of care".-A 12/28/23 BDS report indicated, "On 12/27/23, [client B] became agitated due to a housemate's extended episode of yelling. [Client B] stood up and walked out the front door. Staff attempted to block but she pushed them out of the way and began walking down the street with staff walking beside her offering verbal redirection. [Client B] continued walking and resisting staff efforts to convince her to return to the house. Staff called the police			

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	non-emergency number for assistance. Police arrived and [client B] began threatening the officers. Police placed [client B] in handcuffs for safety and transported her to [Hospital] for a psychiatric evaluation. At the ER, [client B] remained agitated, and the psychiatrist placed her on a 24-48 hour hold. The [Hospital] behavior team released [client B] to ResCare staff on the afternoon of 12/28/23, with a prescription for Oxcarbazepine (for behavior) 300 MG twice daily. Plan to Resolve: [Client B] was not injured prior to being detained by the police. When she returned home, staff completed a physical assessment and noted the following: a two-inch by four-inch superficial abrasion on her right collar bone, a one-inch purple bruise on her left buttocks, a one-inch superficial scratch on her left forearm, a half-inch purple bruise on her left upper arm, a one-inch brown bruise on her left inner thigh, and one-inch and half-inch purple bruises on her upper chest. Staff will document the healing process of the affected areas on an injury follow-up flow sheet. [Client B] is receiving ongoing supportive conversation and reassurance from her team. [Client B] has a history of verbal aggression and elopement addressed in her Behavior Support Plan. She does not have plan approved alone time but was never away from direct staff supervision. Staff will			

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	continue to implement the proactive and reactive strategies in her plan to help reduce and prevent further occurrences".-A 12/27/23 BDS report indicated, "On 12/26/23, [client B] refused to eat breakfest (sic) and lunch. At 12:00 PM [client B] began pacing through the house and refused her afternoon insulin (for diabetes). Staff offered one-to-one talks and coping skills throughout the day. As the afternoon progressed, [client B] began yelling and hit and scratched staff. Verbal redirection and blocking was (sic) ineffective, and staff placed her in a two-person You're Safe, I'm Safe Hold. [Client B] became calm and staff released the hold. [Client B] apologized and took her 5:00 PM medication and ate supper wither housemates. [Client B] remained on 15-minute checks per new admission protocol. Staff checked on [client B] in her bedroom and saw her attempting to ties shoelaces around her neck. Staff cut the laces and removed them from her room and placed her on one-to-one supervision for safety. [Client B] grabbed staff by the hair and pulled staffs (sic) head forcefully against the wall. Staff placed her in a two-person You're Safe, I'm Safe Hold. When [client B] became calm, staff released the hold. [Client B] said she was going to turn on her television to listen to music, but instead punched the television, causing it to			

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	break. She attempted to pull the television off of the wall mounting and when staff blocked, she resumed hitting them. Staff placed her in a third two-person You're Safe, I'm Safe Hold. [Client B] became calm and staff released the hold. She sat on her bed and began scratching her left forearm. Staff redirected her verbally and encouraged coping skills. Staff played music for [client B] and she calmed and resumed her evening routine. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. Plan to Resolve: [Client B] received post incident supportive conversation and reassurance. She sustained three, two-inch superficial horizontal scratches on her left forearm. Staff provided first aid and will document the healing process on an injury follow-up flow sheet. [Client B] has a history of verbal and physical aggression, agitation, anxiety, and self-injurious behaviors addressed in her Behavior Support Plan. The use of You're Safe, I'm Safe has guardian and Human Rights Committee approval and is included in her plan. The holds lasted for four minutes, six minutes, and five minutes with repositioning for comfort every two to three minutes minutes. Staff will continue to implement the proactive and reactive strategies in [client B's] plan to help reduce and prevent further			

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	occurrences".-Five additional BDS reports dated 12/16/23, 12/11/23, 12/10/23, 12/3/23 and 12/2/23 were reviewed. Those incidents included breaking items to cause harm to herself, striking her head on the wall, attempting to put her finger in an electrical outlet, elopement, property destruction, laying in the road, physical aggression, police involvement and psychiatric evaluations/admissions at the hospital.On 1/31/24 at 1:30 PM, client B's record was reviewed.Client B's 1/10/24 BSP indicated the following:-Target behaviors included physical aggression, verbal aggression, self-injury behavior, disruptive behaviors, non-compliance with health and safety (refusing medication and medical appointments), elopement and impulse control issues. -Client B was on enhanced supervision/secured residential environment: "To protect client from placing herself at risk of harm and exploitation outside of the residential environment without supervision of staff".-Modified Enhanced Supervision (MES) Protocols: "When [client B] demonstrates she may be a threat to herself (through the expression of suicidal ideations or other high intensity displays of behaviors), supervision will move from Modified Enhanced Supervision (sic) to Enhanced Supervision (sic) protocols. During these displays, [client B] needs the support and			

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	heightened supervision protocols that Enhanced Supervision provide; these specific measures are to be implemented when [client B] is potentially a threat to herself or others while at home and in the community. MES means that [client B] is on Enhanced Supervision and not able to enter the community. The MES protocol (when implemented) will be evaluated every 2-hours by the RM (Residential Manager)/AS (Area Supervisor)/QIDP (Qualified Intellectual Disabilities Professional) and Behaviorist. Any item/belonging of [client B's] deemed by staff to be a dangerous object/belongings (example: belts, cords) should be removed from her bedroom until the displays of behavior have ceased and [client B] has displayed a state of calm for a minimum period of 2-hours or until safe to return those items. [Client B] should not be unsupervised during this period and the staff should record [client B's] movements/activities on the 15-minute check sheet/paperwork which should be maintained in [client B's] documentation binder. Preventive/Proactive Procedures: 7. At the first sign of a precursor behavior by [client B] or any of the housemates, lock the sharps (or items which can easily be made into a sharp) which includes, eating utensils (such as forks,			

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	spoons, knives), cooking utensils (spatulas, wooden spoons, serving spoons, measuring cups, measuring spoons, ice cream scoops, pizza cutters, whisk, cookie cutters, meat thermometers, potato peelers). Any cleaning solutions or chemicals which could be ingested should also be secured, including cleaning chemicals. These items should remain secured until the immediate risk from exposure has passed and/or until [client B] has been assessed as being in control of herself (physically) and emotions and no longer poses a risk of danger to herself and/or others within the immediate environment". On 1/30/24 at 1:20 PM, the Behavior Clinician (BC) was interviewed. The BC indicated client B was still adjusting to the group home as she just moved in on 11/27/23. The BC indicated client B was not safe when she displays behaviors of eloping, laying in road, banging her head, cutting herself and wrapping shoestrings around her neck. The BC indicated physical redirection was successful with client B. On 1/31/24 at 9:30 AM, the QIDPM/QIDP and the OSS were interviewed. The QIDPM/QIDP indicated the last time he visited the home was in late November or early December 2023. The QIDPM/QIDP indicated client B has been hospitalized a lot of the time she has been placed so there hasn't been much time for her to adjust to			

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	living at the group home. The QIDPM/QIDP indicated staff should have prevented the behaviors from occurring. The QIDPM/QIDP indicated client B's BSP was being updated as they learn more about her. 4. On 1/29/24 at 12:00 PM and 1/30/24 at 7:00 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:-A 1/22/24 Incident Report indicated, "[Client C] was sitting in dining room playing on tablet with 1:1 (staff) when [client C] suddenly began crying. [Client C] got up from table and walked to (sic) room. Staff followed. [Client C] sat in her closet and cried loudly, staff offered 1:1 talk and asked [client C] what was wrong. [Client C] yelled, 'I'm scared'. Staff asked [client C] why and offered coping skills. [Client C] stated, 'because her (sic) is coming back'. Staff asked [client C] who she was referring to. [Client C] stated housemates name (client A).... [Client C] continued crying loudly and gagged multiple times...."There was no documentation indicating the allegation of client C being scared was reported to BDS or investigated.-An 11/16/23 Incident Report indicated, "... [Client A] became aggressive because of dinner taking too long to cook. [Client A] became PA (physically aggressive) towards housemate and staff blocked and initiated			

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	YSIS to keep housemate A (unknown) safe. Housemate B (unknown) assisted with helping turn off stove while [client A] was in YSIS. [Client A] attempted to attack housemate B as she walked by. [Client A] was threatening to cut her own throat with things in the kitchen. [Client A] threatened to cut her wrist. She stated, 'I want to cut my wrist and die. I just want to hit my artery and bleed out'. [Client A] asked if there was any injections to calm. 'Pills don't work for me. I need help because I want to kill myself'. Suicidal and homicidle (sic) threats against housemates A, B and C plus staff, BC and PD. Behaviors escalated, 911 was called for assistance for psych evaluation. Housemate A ran in other room and stated, 'I'm scared and I want my daddy'. Housemate B tearful (sic) stated, 'I'm scared she's going to beat me up and kill me'. Housemate C stated, 'I'm scared of her, that she's going to cut her open'. [Client A] was taken to [hospital] for psych evaluation".There was no documentation indicating housemates A, B and C being scared was reported BDS or investigated. On 1/31/24 at 9:30 AM, the QIDPM/QIDP and the OSS were interviewed. The QIDPM/QIDP indicated the allegations of the clients being scared should have been reported to BDS and investigated. The QIDPM/QIDP indicated the facility had an			

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	abuse/neglect policy which prohibits abuse and neglect of the clients and the policy should be implemented as written. The agency's Abuse, Neglect, Exploitation, Mistreatment Operating Standard dated 2/26/18 was reviewed on 1/31/24 at 3:40 PM and indicated the agency "strictly prohibited abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights". "ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of RESCARE, Rescare, and local, state and federal guidelines."This federal tag relates to complaints #IN00422381 and #IN00426491. 9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on observation, record review and interview for 1 of 2 sampled clients (A) and 2 additional clients (C and D), the facility failed to report clients C and D's allegations of being scared of client A to the Bureau of Disabilities Services (BDS) within 24 hours, in accordance with state law and to ensure staff reported an	W 0153	**CORRECTION:** *The facility must ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials*	03/03/2024

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	incident where client A obtained a knife from the medication room immediately to the administrator. Findings include: 1. An observation was conducted at the group home on 1/29/24 from 10:45 AM to 11:10 AM. Clients A, C and D were present at the group home. The Program Director (PD) indicated client B was hospitalized. Staff #1, #2 and #3 were working during the observation. At 10:52 AM, client C asked to speak with the Surveyor. Client C led the surveyor to the living room in the back of the home with her 1 on 1 staff (staff #3). Staff #1 was present in the room. Client C reported client A pulled a chunk of hair out of her head and she was scared of her. Client C indicated she was sitting at the table in the back living room and client A ran back there and reached over staff #1 (1:1 staff at the time of the incident), pulled her hair out then punched staff #1 in the face. Staff #1 confirmed the incident happened. Client C stated, "I'm scared of her. She's going to hurt me. I don't want to live here anymore". Client C indicated client A hit her one other time in November 2023, but she wasn't hurt then. Client C indicated her 1:1 staff has blocked other attempts where client A tried to hit her. Client C indicated she has told staff and supervisors she was scared. An observation was conducted at the group home on 1/29/24 from 3:45 PM to 5:15 PM. Throughout the observation, client A stayed in the back living room with her 1:1 staff working on arts and crafts projects, watching television and playing on her tablet. On 1/29/24 at 12:00 PM and 1/30/24 at 7:00 AM, a review of the facility's incident/investigative reports was conducted and indicated the		*in accordance with State law through established procedures.* Specifically: Direct support staff will be retrained regarding the requirement for thorough and complete reporting of incidents. Administrative staff will review details of internal incident documentation, obtaining follow-up information as needed, to assure all required information is reported to the Bureau of Disability Services, Indiana Adult Protective Services, and the police, as required. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services and distribute the list to administrative staff (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) for review and revision, as needed.	

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	15G807	A. BUILDING 00 B. WING	02/02/2024

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	following: A 1/16/24 BDS report indicated, "On the evening of 1/15/24, [client A] became agitated during dinner and was playing her music at a high volume. [Client A] indicated she was angry with a housemate because she felt like she was being ignored during the meal. [Client A] stood up and ran toward her housemate [client C]. Staff stood between [client A] and [client C] to block. [Client A] reached over staff and pulled her housemate's hair (sic) staff (sic) continued blocking and [client A] punched staff twice in the face. Staff used agency/plan approved physical redirection in which staff placed her arms on [client A's] torso and turned her away from the housemate. [Client A] told staff she wanted to die and ran into the garage. [Client A] pulled a porcelain doll out of a cabinet, pushed staff out of the way, broke the doll on the ground and cut her left wrist with a piece of the broken doll. One staff called non-emergency dispatch to arrange safe transport to the ER (Emergency Room) while another staff applied pressure to the injury to control the bleeding. Paramedics transported [client A] to the [Hospital Emergency Department] via ambulance. The ER physician closed the laceration with five sutures and admitted her to the hospital for psychiatric observation. The psychiatrist assessed [client A] and arranged for admission at [Behavioral Hospital] located at [address].... Plan to Resolve: [Client A] sustained a 1.5 inch laceration on her left forearm, and she remains hospitalized. ResCare nursing will maintain contact with hospital staf (sic) to assure continuity of care. [Client A] has a history of verbal and physical aggression, self-injury and suicidal ideation addressed in her Behavior Support Plan, which staff followed. The Interdisciplinary team will meet		The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional	

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	to develop additional supports". A 1/20/24 Investigative Summary indicated the following: Investigation interview with client C: "[Client A] pulled my hair. [Staff #1] tried to stop her. [Client A] was mad. It was scary. I don't want her here. Staff keep me safe. Staff did their best. I do yell at [client A] and it gets her mad. This time I didn't say anything to her and she still got mad at me". Investigation interview with Staff #1: "[Client C] was sitting int (sic) eh (sic) back living room eating dinner with her one-to-one staff. I was her one to one. [Client A] stated, 'I will rip that b***** head off'. I blocked [client A's] path to [client C]. [Client A] charged towards [client C] and reached over staff, puling (sic) [client C's] hair. Staff intervened and blocked, and [client A] punched me twice in the face. [Client A] was verbally redirected to her bedroom. I sat with [client C] and offered one-to-one talk and coping skills. [Client C] said she was scared of her housemates. I assessed her injury, but [client C] refused to let me measure the injury. Staff note (sic) a red spot in the middle of [client C's] head and hair missing. [Client C] remained calm for the rest of the night". Investigation interview with staff #2: "[Client A] was sitting at the table with me and [client D]. [Client A] became agitated due to [client C] ignoring her. At serving time at dinner, I sat down with [client D] while [client A] ate her dinner. I offered coping skills while [client A] at her dinner. She was mad because [client C] had been ignoring her. [Client A] became aggravated, stood up and yelled, 'I will rip that b***** head		Director will determine the level of ongoing support needed at the facility. Current Operations Team members received training from the QIDP Manager on 12/14/23, to assure a clear understanding of administrative monitoring as defined below. · 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 oversight will include speaking with staff and clients and reviewing progress notes and behavior tracking to assure all incidents and allegations are reported as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	

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	off'. Staff did verbally redirect her but [client A] stood up and charged toward the back living room where [client C] was eating her dinner and charged toward [client C]. [Staff #1] intervened and blocked [client A's] path to [client C]. [Client A] reached over [staff #1] and pulled out some of [client C's] hair. Staff, [staff #3] and me, did YSIS (You're Safe, I'm Safe) physical redirection and escorted [client A] to her room for one-to-one and coping skills. [Client A] said, 'I don't give a f***, I'm going to kill myself'. She stood up and charged into the garage, with staff behind her. We blocked and verbally redirected her away from the filing cabinet. [Client A] pushed past us and opened the filing cabinet and found a porcelain doll. I verbally redirected her and [client A] attempted to throw the doll at staff. We verbally redirected and blocked [client A] from throwing the doll and she smashed the doll down on the floor. [Client A] managed to pick up a shard from the broken doll and sliced her left forearm. Staff applied pressure to the wound and offered coping skills until non-emergency services arrived. [Client A] became verbally aggressive stating, 'I don't give a f***. I'm going to Jail'." Investigation interview with staff #3: "I prompted [client D] to get up for dinner, when [client A] charged into the back living room at [client C]. [Staff #1] intervened and blocked [client A's] path to [client C]. [Client A] reached over staff and pulled [client C's] hair. YSIS (physical redirection) was implemented, and [client A] punched [staff #1] in the face. YSIS redirection was used to get [client A] to her room, for one-to-one talk and coping skills. [Client A] returned to the dining table but became agitated and started toward the garage. Staff intervened but [client A] shoved staff out of the way. [Client A] ran to the file cabinet and stated, 'I'm going to			

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	find something to kill myself with'. Staff, [staff #2] and me, verbally redirected and [client A] said, 'I don't give a f***'. [Client A] found a porcelain doll, staff verbally redirected, and [client A] threw the doll on the floor and broke it. Staff verbally redirected and [client A] lunged for a piece of the porcelain and sliced her left wrist. Staff blocked and intervened and got the piece of porcelain. Staff verbally redirected [client A] back to her room and applied pressure to the wound on her left wrist. Staff called non-emergency and offered [client A] one-to-one talk and coping skills until non-emergency (sic) arrived. Non-emergency arrived and [client A] remained verbally aggressive to them. Non-emergency transported [client A] to [hospital]". Factual Findings: "-[Client A] was hospitalized throughout the course of the Investigation and was not available to testify. -[Client A] pulled [client C's] hair on 1/15/24. -Staff positioned herself to block but [client A] was able to reach over her to access [client C's] hari (sic). -[Client A] obtained and broke a porcelain doll on 1/15/24 and used a broken pice (sic) to cut her left forearm. -Staff attempted to block her access to the doll and to block her from cutting herself but were unsuccessful. -Staff obtained the broken piece of the doll to prevent further injury and performed first aid until paramedics arrived. -[Client A] sustained a 1.5 inch laceration on her left forearm. -[Client C] sustained a one-inch red area on her scalp with evidence of missing hair. -[Client A's] Behavior Support Plan includes physical aggression and self-injury as target			

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	behaviors". Conclusion: "1. The evidence substantiates that [client A] pulled [client C's] hair on 1/15/24. 2. The evidence substantiates that [client A] caused Injury to [client C] on 1 /15/24. 3. The evidence substantiates that [client A] caused Injury to herself on 1/15/24. 4. The evidence does not substantiate that [client A's] Behavior Support Plan failed to address physical aggression and self-injury. 5. The evidence does not substantiate that staff failed to implement [client A's] Behavior Supports appropriately. 6. The evidence does not substantiate that staff failed to follow ResCare policies and procedures". Recommendations: 1. Continue to implement [client A's] Behavior Supports as written. 2. Behavioral Clinician to discuss current challenges with [client A's] guardian to evaluate past approaches that achieved success for incorporation into current plan". A review of the 1/20/24 Investigative Summary indicated there was no documentation the facility reported client C indicating she was scared of her housemate to BDS within 24 hours. On 1/29/24 at 4:37 PM, staff #2 was interviewed. Staff #2 stated, "[Client C] has been telling me she's scared to live here since I started in December (2023) and nobody is doing anything. The day she (client A) pulled her hair out she cried uncontrollably. What can we do? She (client A) got in the med (medication) room one day. She slipped through me and [staff #3] and got a butcher knife out of the med room. Thank			

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	goodness it had a cover on it. We got it away from her then she went to the garage and broke a porcelain doll and cut her arm. Her arm was bleeding everywhere". There was no documentation indicating the incident with the knife was reported to BDS. On 1/31/24 at 3:10 PM, client A was interviewed with the Behavior Clinician (BC) present. Client A indicated after she pulled client C's hair out she ran into the medication room and got a knife out of the sharps box. Client A indicated she wanted to hurt herself. Client A indicated staff #1, staff #2 and staff #3 were all trying to get the knife away from her. Client A demonstrated what she did with the knife by putting her hands together as if she was holding a knife then raised her arms above her head and made a stabbing motion. Client A indicated it was towards staff #3. Client A indicated the medication room door and the door to the closet where the medication and the sharps box are stored was open. Client A stated, "The doors are locked now. They were never locked before. I'm not thinking about what I'm doing when I'm having a behavior. I shouldn't have done it and I know better. I'm not going to do this (hurt people) anymore". Client A indicated after they got the knife away from her she ran to the garage and broke a doll then used a piece of glass to cut her arm. Client A indicated she went to the hospital and had to get 5 stitches. On 1/30/24 at 4:26 PM, staff #3 was interviewed. Staff #3 denied there was an incident with client A obtaining a knife from the medication room on 1/15/24. On 1/30/24 at 5:13 PM, staff #1 was interviewed. Staff #1 denied there was an incident with client A			

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	obtaining a knife from the medication room on 1/15/24. A review of the investigation witness statements completed on 1/15/24 by staff #1, staff #2 and staff #3 did not report client A obtaining access to a knife. On 1/31/24 at 9:30 AM, the Qualified Intellectual Disabilities Professional Manager/Qualified Intellectual Disabilities Professional (QIDPM/QIDP) and the Operations Support Specialist (OSS) were interviewed. The QIDPM/QIDP indicated client C's report of not feeling safe should have been reported to BDS. On 1/31/24 at 3:28 PM, the QIDPM/QIDP was interviewed. The QIDPM/QIDP indicated he was not aware of the incident with the knife until the AS reported it to him last night (1/30/24). The QIDPM/QIDP indicated staff should have included the information in their witness statements and it should have been immediately reported to the administrator. On 1/31/24 at 4:00 PM, the PD was interviewed. The PD indicated nobody reported anything about client A obtaining a knife. 2. On 1/29/24 at 12:00 PM and 1/30/24 at 7:00 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: -A 1/22/24 Incident Report indicated, "[Client C] was sitting in dining room playing on tablet with 1:1 (staff) when [client C] suddenly began crying. [Client C] got up from table and walked to (sic) room. Staff followed. [Client C] sat in her closet and cried loudly, staff offered 1:1 talk and asked			

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	[client C] what was wrong. [Client C] yelled, 'I'm scared'. Staff asked [client C] why and offered coping skills. [Client C] stated, 'because her (sic) is coming back'. Staff asked [client C] who she was referring to. [Client C] stated housemates name (client A).... [Client C] continued crying loudly and gagged multiple times...." There was no documentation indicating the allegation of client C being scared was reported to BDS. -An 11/16/23 Incident Report indicated, "...[Client A] became aggressive because of dinner taking too long to cook. [Client A] became PA (physically aggressive) towards housemate and staff blocked and initiated YSIS to keep housemate A (unknown) safe. Housemate B (unknown) assisted with helping turn off stove while [client A] was in YSIS. [Client A] attempted to attack housemate B as she walked by. [Client A] was threatening to cut her own throat with things in the kitchen. [Client A] threatened to cut her wrist. She stated, 'I want to cut my wrist and die. I just want to hit my artery and bleed out'. [Client A] asked if there was any injections to calm. 'Pills don't work for me. I need help because I want to kill myself'. Suicidal and homicidle (sic) threats against housemates A, B and C plus staff, BC and PD. Behaviors escalated, 911 was called for assistance for psych evaluation. Housemate A ran in other room and stated, 'I'm scared and I want my daddy'. Housemate B tearful (sic) stated, 'I'm scared she's going to beat me up and kill me'. Housemate C stated, 'I'm scared of her, that she's going to cut her open'. [Client A] was taken to [hospital] for psych evaluation". There was no documentation indicating housemates A, B and C being scared was reported			

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	BDS. On 1/31/24 at 9:30 AM, the QIDPM/QIDP and the OSS were interviewed. The QIDPM/QIDP indicated the allegations of the clients being scared should have been reported to BDS. This federal tag relates to complaints #IN00422381 and #IN00426491. 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on observation, record review and interview for 1 of 2 sampled clients (A) and 2 additional clients (C and D), the facility failed to conduct thorough investigations regarding clients C and D's allegations of being scared of client A. Findings include: 1. An observation was conducted at the group home on 1/29/24 from 10:45 AM to 11:10 AM. Clients A, C and D were present at the group home. The Program Director (PD) indicated client B was hospitalized. Staff #1, #2 and #3 were working during the observation. At 10:52 AM, client C asked to speak with the Surveyor. Client C led the surveyor to the living room in the back of the home with her 1 on 1 staff (staff #3). Staff #1 was present in the room. Client C reported client A pulled a chunk of hair out of her head and she was scared of her. Client C indicated she was sitting at the table in the back living room and client A ran back there and reached over staff #1 (1:1 staff at the time of the incident), pulled her hair out then punched staff #1 in the face. Staff	W 0154	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically: All facility investigations will be completed by trained investigators. *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically: All facility investigations will be completed by trained investigators. When incidents requiring investigation occur, the Acting QA Manager or designee will assign the investigation to a specific investigator. The QIDP Manager (or QA Manager when the QIDP Manager is the assigned investigator) will conduct follow-up with the investigator to assure completion within required timeframes, and that each allegation is investigated	03/03/2024

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	#1 confirmed the incident happened. Client C stated, "I'm scared of her. She's going to hurt me. I don't want to live here anymore". Client C indicated client A hit her one other time in November 2023, but she wasn't hurt then. Client C indicated her 1:1 staff has blocked other attempts where client A tried to hit her. Client C indicated she has told staff and supervisors she was scared. An observation was conducted at the group home on 1/29/24 from 3:45 PM to 5:15 PM. Throughout the observation, client A stayed in the back living room with her 1:1 staff working on arts and crafts projects, watching television and playing on her tablet. On 1/29/24 at 12:00 PM and 1/30/24 at 7:00 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: A 1/16/24 BDS report indicated, "On the evening of 1/15/24, [client A] became agitated during dinner and was playing her music at a high volume. [Client A] indicated she was angry with a housemate because she felt like she was being ignored during the meal. [Client A] stood up and ran toward her housemate [client C]. Staff stood between [client A] and [client C] to block. [Client A] reached over staff and pulled her housemate's hair (sic) staff (sic) continued blocking and [client A] punched staff twice in the face. Staff used agency/plan approved physical redirection in which staff placed her arms on [client A's] torso and turned her away from the housemate. [Client A] told staff she wanted to die and ran into the garage. [Client A] pulled a porcelain doll out of a cabinet, pushed staff out of the way, broke the doll on the ground and cut her left wrist with a piece of the broken		thoroughly. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. In addition to weekly face to face training and follow-up with the Quality Assurance Manager or designee, the investigators will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence. The emphasis of this mentorship/training will be development of appropriate scope and conclusions, as well as time management skills to facilitate timely completion if investigations. The training focus will also include assuring all potential witnesses are interviewed and that all allegations are addressed in the investigation. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. When the investigator assigned to the facility is not available, The QIDP Manager or designee assigned by the QA Manager will assume responsibility for completion of required investigations. **PREVENTION:** The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures	

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	doll. One staff called non-emergency dispatch to arrange safe transport to the ER (Emergency Room) while another staff applied pressure to the injury to control the bleeding. Paramedics transported [client A] to the [Hospital Emergency Department] via ambulance. The ER physician closed the laceration with five sutures and admitted her to the hospital for psychiatric observation. The psychiatrist assessed [client A] and arranged for admission at [Behavioral Hospital] located at [address].... Plan to Resolve: [Client A] sustained a 1.5 inch laceration on her left forearm, and she remains hospitalized. ResCare nursing will maintain contact with hospital staf (sic) to assure continuity of care. [Client A] has a history of verbal and physical aggression, self-injury and suicidal ideation addressed in her Behavior Support Plan, which staff followed. The Interdisciplinary team will meet to develop additional supports". A 1/20/24 Investigative Summary indicated the following: Investigation interview with client C: "[Client A] pulled my hair. [Staff #1] tried to stop her. [Client A] was mad. It was scary. I don't want her here. Staff keep me safe. Staff did their best. I do yell at [client A] and it gets her mad. This time I didn't say anything to her and she still got mad at me". Investigation interview with Staff #1: "[Client C] was sitting int (sic) eh (sic) back living room eating dinner with her one-to-one staff. I was her one to one. [Client A] stated, 'I will rip that b***** head off'. I blocked [client A's] path to [client C]. [Client A] charged towards [client C] and reached over staff, puling (sic) [client C's] hair. Staff intervened and blocked, and [client A]		will be maintained and distributed daily to facility supervisors and the Operations Team, (comprised of the Executive Director, Operations Managers, Program Managers, Acting Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager). The Quality Assurance Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough	

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	punched me twice in the face. [Client A] was verbally redirected to her bedroom. I sat with [client C] and offered one-to-one talk and coping skills. [Client C] said she was scared of her housemates. I assessed her injury, but [client C] refused to let me measure the injury. Staff note (sic) a red spot in the middle of [client C's] head and hair missing. [Client C] remained calm for the rest of the night". Investigation interview with staff #2: "[Client A] was sitting at the table with me and [client D]. [Client A] became agitated due to [client C] ignoring her. At serving time at dinner, I sat down with [client D] while [client A] ate her dinner. I offered coping skills while [client A] at her dinner. She was mad because [client C] had been ignoring her. [Client A] became aggravated, stood up and yelled, 'I will rip that b***** head off'. Staff did verbally redirect her but [client A] stood up and charged toward the back living room where [client C] was eating her dinner and charged toward [client C]. [Staff #1] intervened and blocked [client A's] path to [client C]. [Client A] reached over [staff #1] and pulled out some of [client C's] hair. Staff, [staff #3] and me, did YSIS (You're Safe, I'm Safe) physical redirection and escorted [client A] to her room for one-to-one and coping skills. [Client A] said, 'I don't give a f***, I'm going to kill myself'. She stood up and charged into the garage, with staff behind her. We blocked and verbally redirected her away from the filing cabinet. [Client A] pushed past us and opened the filing cabinet and found a porcelain doll. I verbally redirected her and [client A] attempted to throw the doll at staff. We verbally redirected and blocked [client A] from throwing the doll and she smashed the doll down on the floor. [Client A] managed to pick up a shard from the broken doll and sliced her left forearm. Staff		investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	

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	applied pressure to the wound and offered coping skills until non-emergency services arrived. [Client A] became verbally aggressive stating, 'I don't give a f***. I'm going to Jail'." Investigation interview with staff #3: "I prompted [client D] to get up for dinner, when [client A] charged into the back living room at [client C]. [Staff #1] intervened and blocked [client A's] path to [client C]. [Client A] reached over staff and pulled [client C's] hair. YSIS (physical redirection) was implemented, and [client A] punched [staff #1] in the face. YSIS redirection was used to get [client A] to her room, for one-to-one talk and coping skills. [Client A] returned to the dining table but became agitated and started toward the garage. Staff intervened but [client A] shoved staff out of the way. [Client A] ran to the file cabinet and stated, 'I'm going to find something to kill myself with'. Staff, [staff #2] and me, verbally redirected and [client A] said, 'I don't give a f***'. [Client A] found a porcelain doll, staff verbally redirected, and [client A] threw the doll on the floor and broke it. Staff verbally redirected and [client A] lunged for a piece of the porcelain and sliced her left wrist. Staff blocked and intervened and got the piece of porcelain. Staff verbally redirected [client A] back to her room and applied pressure to the wound on her left wrist. Staff called non-emergency and offered [client A] one-to-one talk and coping skills until non-emergency (sic) arrived. Non-emergency arrived and [client A] remained verbally aggressive to them. Non-emergency transported [client A] to [hospital]". Factual Findings: "-[Client A] was hospitalized throughout the course of the Investigation and was not available to testify.			

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	-[Client A] pulled [client C's] hair on 1/15/24. -Staff positioned herself to block but [client A] was able to reach over her to access [client C's] hari (sic). -[Client A] obtained and broke a porcelain doll on 1/15/24 and used a broken pice (sic) to cut her left forearm. -Staff attempted to block her access to the doll and to block her from cutting herself but were unsuccessful. -Staff obtained the broken piece of the doll to prevent further injury and performed first aid until paramedics arrived. -[Client A] sustained a 1.5 inch laceration on her left forearm. -[Client C] sustained a one-inch red area on her scalp with evidence of missing hair. -[Client A's] Behavior Support Plan includes physical aggression and self-injury as target behaviors". Conclusion: "1. The evidence substantiates that [client A] pulled [client C's] hair on 1/15/24. 2. The evidence substantiates that [client A] caused Injury to [client C] on 1 /15/24. 3. The evidence substantiates that [client A] caused Injury to herself on 1/15/24. 4. The evidence does not substantiate that [client A's] Behavior Support Plan failed to address physical aggression and self-injury. 5. The evidence does not substantiate that staff failed to implement [client A's] Behavior Supports appropriately. 6. The evidence does not substantiate that staff failed to follow ResCare policies and procedures". Recommendations: 1. Continue to implement [client A's] Behavior Supports as written.			

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	2. Behavioral Clinician to discuss current challenges with [client A's] guardian to evaluate past approaches that achieved success for incorporation into current plan". A review of the 1/20/24 Investigative Summary indicated there was no documentation indicating the facility conducted an investigation regarding client C's allegation of being scared of client A. On 1/31/24 at 9:30 AM, the Qualified Intellectual Disabilities Professional Manager/Qualified Intellectual Disabilities Professional (QIDPM/QIDP) and the Operations Support Specialist (OSS) were interviewed. The QIDPM/QIDP indicated he first became aware of the allegation while he was conducting the investigation. The QIDPM/QIDP indicated client C's report of not feeling safe should have been investigated. 2. On 1/29/24 at 12:00 PM and 1/30/24 at 7:00 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: -A 1/22/24 Incident Report indicated, "[Client C] was sitting in dining room playing on tablet with 1:1 (staff) when [client C] suddenly began crying. [Client C] got up from table and walked to (sic) room. Staff followed. [Client C] sat in her closet and cried loudly, staff offered 1:1 talk and asked [client C] what was wrong. [Client C] yelled, 'I'm scared'. Staff asked [client C] why and offered coping skills. [Client C] stated, 'because her (sic) is coming back'. Staff asked [client C] who she was referring to. [Client C] stated housemates name (client A).... [Client C] continued crying loudly and gagged multiple times...."			

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	There was no documentation indicating the allegation of client C being scared was investigated. -An 11/16/23 Incident Report indicated, "...[Client A] became aggressive because of dinner taking too long to cook. [Client A] became PA (physically aggressive) towards housemate and staff blocked and initiated YSIS to keep housemate A (unknown) safe. Housemate B (unknown) assisted with helping turn off stove while [client A] was in YSIS. [Client A] attempted to attack housemate B as she walked by. [Client A] was threatening to cut her own throat with things in the kitchen. [Client A] threatened to cut her wrist. She stated, 'I want to cut my wrist and die. I just want to hit my artery and bleed out'. [Client A] asked if there was any injections to calm. 'Pills don't work for me. I need help because I want to kill myself'. Suicidal and homicidle (sic) threats against housemates A, B and C plus staff, BC and PD. Behaviors escalated, 911 was called for assistance for psych evaluation. Housemate A ran in other room and stated, 'I'm scared and I want my daddy'. Housemate B tearful (sic) stated, 'I'm scared she's going to beat me up and kill me'. Housemate C stated, 'I'm scared of her, that she's going to cut her open'. [Client A] was taken to [hospital] for psych evaluation". There was no documentation indicating housemates A, B and C being scared was investigated. On 1/31/24 at 9:30 AM, the QIDPM/QIDP and the OSS were interviewed. The QIDPM/QIDP indicated the allegation of the clients being scared should have been investigated. This federal tag relates to complaints #IN00422381			

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	and #IN00426491. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the facility failed to develop and implement effective corrective measures to prevent an incident of client to client aggression where client A pulled a chunk of client C's hair out, clients C and D's allegations of being scared of client A and to prevent clients A and B's pattern of maladaptive behaviors. Findings include: 1. An observation was conducted at the group home on 1/29/24 from 10:45 AM to 11:10 AM. Clients A, C and D were present at the group home. The Program Director (PD) indicated client B was hospitalized. Staff #1, #2 and #3 were working during the observation. At 10:52 AM, client C asked to speak with the surveyor. Client C led the surveyor to the living room in the back of the home with her 1 on 1 staff (staff #3). Staff #1 was present in the room. Client C reported client A pulled a chunk of hair out of her head and she was scared of her. Client C indicated she was sitting at the table in the back living room and client A ran back there and reached over staff #1 (1:1 staff at the time of the incident), pulled her hair out then punched staff #1 in the face. Staff #1 confirmed the incident happened. Client C stated, "I'm scared of her. She's going to hurt me. I don't want to live here anymore". Client C indicated client A hit her one other time in	W 0157	**CORRECTION:** *If the alleged violation is verified, appropriate corrective action must be taken.* Through observation and a review of assessment data, the governing body has determined that this deficient practice could affect all clients who reside in the facility. Specifically for client A: The facility has added an additional 8:00 AM to 8:00 PM direct support staff, so that one team member can be dedicated toward working exclusively with client A, focusing on preventative behavior supports and positive structured activities, as well as providing immediate intervention when client A begins to escalate. Additionally, through ongoing assessment, the interdisciplinary team consensually agrees that client A would have a greater opportunity for success with the wrap-around services available in a CIH Waiver residential setting. The team is working with the Bureau of Disability Services and a provider chosen by client A's guardian to expedite the transition process. Specifically for client B: Through	03/03/2024

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	November 2023, but she wasn't hurt then. Client C indicated her 1:1 staff has blocked other attempts where client A tried to hit her. Client C indicated she has told staff and supervisors she was scared. An observation was conducted at the group home on 1/29/24 from 3:45 PM to 5:15 PM. Throughout the observation, client A stayed in the back living room with her 1:1 staff working on arts and crafts projects, watching television and playing on her tablet. On 1/29/24 at 12:00 PM and 1/30/24 at 7:00 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: A 1/16/24 BDS report indicated, "On the evening of 1/15/24, [client A] became agitated during dinner and was playing her music at a high volume. [Client A] indicated she was angry with a housemate because she felt like she was being ignored during the meal. [Client A] stood up and ran toward her housemate [client C]. Staff stood between [client A] and [client C] to block. [Client A] reached over staff and pulled her housemate's hair (sic) staff (sic) continued blocking and [client A] punched staff twice in the face. Staff used agency/plan approved physical redirection in which staff placed her arms on [client A's] torso and turned her away from the housemate. [Client A] told staff she wanted to die and ran into the garage. [Client A] pulled a porcelain doll out of a cabinet, pushed staff out of the way, broke the doll on the ground and cut her left wrist with a piece of the broken doll. One staff called non-emergency dispatch to arrange safe transport to the ER (Emergency Room) while another staff applied pressure to the injury to control the bleeding. Paramedics		ongoing assessment, the interdisciplinary team has determined that client B's aggression stems from impulse control challenges. The facility's Behavioral Clinician has modified client A's Behavior Support Plan to include an accountability calendar and token-based behavior improvement program to assist client A with controlling her impulsive behavior. All staff will be trained toward implementation of the revised plan. Staff have received additional training toward implementation of supports that create a therapeutic environment where all clients feel safe, including isolating client A from her housemates when she begins to escalate and assuring staff provides ongoing reassurance to clients B, C and D regarding the team's commitment to keep them safe. **PREVENTION:** When significant incidents occur, including but not limited to aggression and intimidation, the QIDP will contact front line team members and administrative staff and additional professional assistance as appropriate to convene an interdisciplinary team meeting to develop protective measures to help reduce and prevent further occurrences. When corrective measures are developed by post-investigation administrative level collaboration,	

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	transported [client A] to the [Hospital Emergency Department] via ambulance. The ER physician closed the laceration with five sutures and admitted her to the hospital for psychiatric observation. The psychiatrist assessed [client A] and arranged for admission at [Behavioral Hospital] located at [address].... Plan to Resolve: [Client A] sustained a 1.5 inch laceration on her left forearm, and she remains hospitalized. ResCare nursing will maintain contact with hospital staf (sic) to assure continuity of care. [Client A] has a history of verbal and physical aggression, self-injury and suicidal ideation addressed in her Behavior Support Plan, which staff followed. The Interdisciplinary team will meet to develop additional supports". A 1/20/24 Investigative Summary indicated the following: Investigation interview with client C: "[Client A] pulled my hair. [Staff #1] tried to stop her. [Client A] was mad. It was scary. I don't want her here. Staff keep me safe. Staff did their best. I do yell at [client A] and it gets her mad. This time I didn't say anything to her and she still got mad at me". Investigation interview with Staff #1: "[Client C] was sitting int (sic) eh (sic) back living room eating dinner with her one-to-one staff. I was her one to one. [Client A] stated, 'I will rip that b***** head off'. I blocked [client A's] path to [client C]. [Client A] charged towards [client C] and reached over staff, puling (sic) [client C's] hair. Staff intervened and blocked, and [client A] punched me twice in the face. [Client A] was verbally redirected to her bedroom. I sat with [client C] and offered one-to-one talk and coping skills. [Client C] said she was scared of her		the QA Manger and QIDP Manager will analyze peer review and team meeting documentation to assure all necessary corrective recommendations are included. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Acting Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including night and weekend observations. After 30 days, administrative monitoring will occur no less than three times 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. Current Operations Team members received training from the QIDP Manager on 12/14/23, to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & report. · When opportunities for	

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	housemates. I assessed her injury, but [client C] refused to let me measure the injury. Staff note (sic) a red spot in the middle of [client C's] head and hair missing. [Client C] remained calm for the rest of the night". Investigation interview with staff #2: "[Client A] was sitting at the table with me and [client D]. [Client A] became agitated due to [client C] ignoring her. At serving time at dinner, I sat down with [client D] while [client A] ate her dinner. I offered coping skills while [client A] at (sic) her dinner. She was mad because [client C] had been ignoring her. [Client A] became aggravated, stood up and yelled, 'I will rip that b***** head off'. Staff did verbally redirect her but [client A] stood up and charged toward the back living room where [client C] was eating her dinner and charged toward [client C]. [Staff #1] intervened and blocked [client A's] path to [client C]. [Client A] reached over [staff #1] and pulled out some of [client C's] hair. Staff, [staff #3] and me, did YSIS (You're Safe, I'm Safe) physical redirection and escorted [client A] to her room for one-to-one and coping skills. [Client A] said, 'I don't give a f***, I'm going to kill myself'. She stood up and charged into the garage, with staff behind her. We blocked and verbally redirected her away from the filing cabinet. [Client A] pushed past us and opened the filing cabinet and found a porcelain doll. I verbally redirected her and [client A] attempted to throw the doll at staff. We verbally redirected and blocked [client A] from throwing the doll and she smashed the doll down on the floor. [Client A] managed to pick up a shard from the broken doll and sliced her left forearm. Staff applied pressure to the wound and offered coping skills until non-emergency services arrived. [Client A] became verbally aggressive stating, 'I don't give a f***. I'm going to Jail'."		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 oversight will include but not be limited to: · Assuring corrective measures are in place and developed through a collaborative interdisciplinary process. · Assuring behavior supports meet the needs of all clients. · Assuring all clients feel safe. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Lead, Direct Support Staff, Operations Team, Regional Director	

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	Investigation interview with staff #3: "I prompted [client D] to get up for dinner, when [client A] charged into the back living room at [client C]. [Staff #1] intervened and blocked [client A's] path to [client C]. [Client A] reached over staff and pulled [client C's] hair. YSIS (physical redirection) was implemented, and [client A] punched [staff #1] in the face. YSIS redirection was used to get [client A] to her room, for one-to-one talk and coping skills. [Client A] returned to the dining table but became agitated and started toward the garage. Staff intervened but [client A] shoved staff out of the way. [Client A] ran to the file cabinet and stated, 'I'm going to find something to kill myself with'. Staff, [staff #2] and me, verbally redirected and [client A] said, 'I don't give a f***'. [Client A] found a porcelain doll, staff verbally redirected, and [client A] threw the doll on the floor and broke it. Staff verbally redirected and [client A] lunged for a piece of the porcelain and sliced her left wrist. Staff blocked and intervened and got the piece of porcelain. Staff verbally redirected [client A] back to her room and applied pressure to the wound on her left wrist. Staff called non-emergency and offered [client A] one-to-one talk and coping skills until non-emergency (sic) arrived. Non-emergency arrived and [client A] remained verbally aggressive to them. Non-emergency transported [client A] to [hospital]". Factual Findings: "-[Client A] was hospitalized throughout the course of the Investigation and was not available to testify. -[Client A] pulled [client C's] hair on 1/15/24. -Staff positioned herself to block but [client A] was able to reach over her to access [client C's] hari (sic).			

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	-[Client A] obtained and broke a porcelain doll on 1/15/24 and used a broken pice (sic) to cut her left forearm. -Staff attempted to block her access to the doll and to block her from cutting herself but were unsuccessful. -Staff obtained the broken piece of the doll to prevent further injury and performed first aid until paramedics arrived. -[Client A] sustained a 1.5 inch laceration on her left forearm. -[Client C] sustained a one-inch red area on her scalp with evidence of missing hair. -[Client A's] Behavior Support Plan includes physical aggression and self-injury as target behaviors". Conclusion: "1. The evidence substantiates that [client A] pulled [client C's] hair on 1/15/24. 2. The evidence substantiates that [client A] caused Injury to [client C] on 1 /15/24. 3. The evidence substantiates that [client A] caused Injury to herself on 1/15/24. 4. The evidence does not substantiate that [client A's] Behavior Support Plan failed to address physical aggression and self-injury. 5. The evidence does not substantiate that staff failed to implement [client A's] Behavior Supports appropriately. 6. The evidence does not substantiate that staff failed to follow ResCare policies and procedures". Recommendations: 1. Continue to implement [client A's] Behavior Supports as written. 2. Behavioral Clinician to discuss current challenges with [client A's] guardian to evaluate past approaches that achieved success for incorporation into current plan".			

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A review of the 1/20/24 Investigative Summary indicated there was no documentation the facility reported client C indicating she was scared of her housemate to BDS within 24 hours and there was no documentation indicating the facility conducted an investigation regarding client C's allegation.

On 1/29/24 at 4:37 PM, staff #2 was interviewed. Staff #2 stated, "[Client C] has been telling me she's scared to live here since I started in December (2023) and nobody is doing anything. The day she (client A) pulled her hair out she cried uncontrollably. What can we do? She (client A) got in the med (medication) room one day. She slipped through me and [staff #3] and got a butcher knife out of the med room. Thank goodness it had a cover on it. We got it away from her then she went to the garage and broke a porcelain doll and cut her arm. Her arm was bleeding everywhere".

There was no documentation indicating the incident with the knife was reported to BDS or addressed in the Investigative Summary.

On 1/31/24 at 3:10 PM, client A was interviewed with the Behavior Clinician (BC) present. Client A indicated after she pulled client C's hair out she ran into the medication room and got a knife out of the sharps box. Client A indicated she wanted to hurt herself. Client A indicated staff #1, staff #2 and staff #3 were all trying to get the knife away from her. Client A demonstrated what she did with the knife by putting her hands together as if she was holding a knife then raised her arms above her head and made a stabbing motion. Client A indicated it was towards staff #3. Client A indicated the medication room door and the

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	door to the closet where the medication and the sharps box are stored was open. Client A stated, "The doors are locked now. They were never locked before. I'm not thinking about what I'm doing when I'm having a behavior. I shouldn't have done it and I know better. I'm not going to do this (hurt people) anymore". Client A indicated after they got the knife away from her she ran to the garage and broke a doll then used a piece of glass to cut her arm. Client A indicated she went to the hospital and had to get 5 stitches. On 1/30/24 at 4:26 PM, staff #3 was interviewed. Staff #3 denied there was an incident with client A obtaining a knife from the medication room on 1/15/24. On 1/30/24 at 5:13 PM, staff #1 was interviewed. Staff #1 denied there was an incident with client A obtaining a knife from the medication room on 1/15/24. A review of the investigation witness statements completed on 1/15/24 by staff #1, staff #2 and staff #3 did not report client A obtaining access to a knife. On 1/30/24 at 11:00 AM, client A's record was reviewed. Client A's 1/19/24 (revised 1/27/24) Behavior Support Plan (BSP) indicated the following: -Client A's target behaviors included physical aggression, verbal aggression, self-injury behavior, elopement, task refusal/non-compliance, suicidal ideation, inappropriate sexual behaviors, disruptive behaviors and impulse control issues. -Client A was restricted from sharps.			

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	-Client A was on enhanced supervision/secured residential environment: "To protect client from placing herself at risk of harm and exploitation outside of the residential environment without supervision of staff". -Modified Enhanced Supervision (MES) Protocols: "When [client A] demonstrates she may be a threat to herself (through the expression of suicidal ideations or other high intensity displays of behaviors), supervision will move from Modified Enhanced Supervision (sic) to Enhanced Supervision (sic) protocols. During these displays, [client A] needs the support and heightened supervision protocols that Enhanced Supervision provide; these specific measures are to be implemented when [client A] is potentially a threat to herself or others while at home and in the community. MES means that [client A] is on Enhanced Supervision and not able to enter the community. The MES protocol (when implemented) will be evaluated every 2-hours by the RM (Residential Manager)/AS (Area Supervisor)/QIDP (Qualified Intellectual Disabilities Professional) and Behaviorist. Any item/belonging of [client A's] deemed by staff to be a dangerous object/belongings (example: belts, cords) should be removed from her bedroom until the displays of behavior have ceased and [client A] has displayed a state of calm for a minimum period of 2-hours or until safe to return those items. [Client A] should not be unsupervised during this period and the staff should record [client A's] movements/activities on the 15-minute check sheet/paperwork which should be maintained in [client A's] documentation binder. Preventive/Proactive Procedures: 3. The doors to the Med Room will remain closed and locked at all			

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	times.... 7. At the first sign of a precursor behavior by [client A] or any of the housemates, lock the sharps (or items which can easily be made into a sharp) which includes, eating utensils (such as forks, spoons, knives), cooking utensils (spatulas, wooden spoons, serving spoons, measuring cups, measuring spoons, ice cream scoops, pizza cutters, whisk, cookie cutters, meat thermometers, potato peelers). Any cleaning solutions or chemicals which could be ingested should also be secured, including cleaning chemicals. These items should remain secured until the immediate risk from exposure has passed and/or until [client A] has been assessed as being in control of herself (physically) and emotions and no longer poses a risk of danger to herself and/or others within the immediate environment". On 1/29/24 at 11:15 AM, the Program Director (PD) was interviewed. The PD stated, "[Client C] tells everyone she is afraid of her (client A) but she'll yell and scream from the other side of the house how she hates her and is going to kill her mom. [Client A] was finally tired of it and went after her. [Staff #1] wasn't able to stop her because [client A] punched her in the face. [Client A] pulled a chunk of hair out of her (client C's) head then ran to the garage and cut her arm with a broken doll. She ended up with 5 stitches". On 1/31/24 at 9:30 AM, the Qualified Intellectual Disabilities Professional Manager/Qualified Intellectual Disabilities Professional (QIDPM/QIDP) and the Operations Support Specialist were interviewed. The QIDPM/QIDP indicated if a client reported being scared of another client, protective measures should be implemented to help the client feel safe. The QIDPM/QIDP indicated he first became aware of the allegation while he was conducting the			

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	investigation. 2. An observation was conducted at the group home on 1/29/24 from 3:45 PM to 5:15 PM. At 3:50 PM, client A introduced herself and indicated she had been in and out of the psychiatric hospital since she moved in three months ago. Client A showed the surveyor her forearms which both had multiple pink scars. Client A also showed some pink scars on both sides of her neck. Client A indicated the scars were from her cutting herself. Client A showed the surveyor her room which contained nothing but her bed, bedding on the bed and a television. Client A indicated she was restricted from her personal belongings and they were being stored in the garage until she earned them back. On 1/29/24 at 12:00 PM and 1/30/24 at 7:00 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: -A 1/26/24 BDS report indicated the following incident occurred on 1/25/24 at 3:00 PM: "Moments after [client A] returned home from overnight psychiatric detention (previously reported incident #1542101), she became anxious and agitated and requested her PRN (as needed) medication. Staff offered verbal redirection to preferred activities, coping skills and one-to-one talk but [client A] grew progressively more upset. Staff obtained approval and administered haloperidol (for behavior) 5mg (milligrams). [Client A] listened to music and remained calm for approximately two hours. [Client A] re-escalated after speaking to her mother who suggested a smoking schedule (a support that produced successful results in the past). [Client A] punched the wall. When staff blocked, she spit on them.			

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	She picked up a piece of wood (sic) brandished it at staff and ran toward them. Staff blocked and [client A] ran out the door and down the road. Staff followed and called 911 for assistance. Police arrived and [client A] began yelling at the responding officers. The police took [client A] home and spoke to [client A] in her room and she told them that she wanted to kill her self (sic). Police arranged for EMS (emergency medical services) to transport [client A] to the [Hospital Emergency Department], where the behavior team evaluated her and determined she did not meet the criteria for in-patient treatment. The psychiatrist discharged [client A] to ResCare staff the following afternoon with no new orders. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. The psychiatrist diagnosed [client A] with suicidal ideation, impulse control disorder, agitation, and aggressive behavior and released her to ResCare staff with no new orders. Plan to Resolve: [Client A] had no new injuries and staff provided her with post-incident supportive conversation (sic) [Client A] has a history of verbal and physical aggression, self-injury, elopement, and suicidal ideation addressed in her Behavior Support Plan.... Staff will continue to implement the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences". -A 1/25/24 BDS report indicated the following incident occurred on 1/24/24 at 5:30 PM: "On the evening of 1/24/24, [client A] was eating popcorn and watching a movie with staff. Without displaying precursor behavior, [client A] stood up and told staff she was 'about to have a behavior', and walked to her bedroom. Staff offered one-to-one talk and coping skills. [Client A] said			

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	she wanted to die and requested her agitation PRN. Staff offered verbal redirection to preferred activities, coping skills and one-to-one talk but [client A] grew progressively more upset. Staff obtained approval and administered haloperidol 5mg. The medication never reached efficacy and [client A] continued to escalate. [Client A] walked to the garage and hit the punching bag. She picked up a clock and broke a piece off to use to harm herself. Staff placed her into a two-person You're Safe, I'm Safe hold. When [client A] appeared to calm, staff released the hold and she asked for a glass of water. As staff was assisting her, [client A] began punching the window and staff blocked. [Client A] asked staff to accompany her to the garage so she could hit the punching bag. Upon entering the garage, [client A] pulled a cord out of a box, ran back into the house and attempted to put the cord around her neck. Staff approached and she dropped the cord, punched staff in the face twice and pulled staffs (sic) hair. [Client A] disengaged with staff and ran into the living room towards her housemates. Staff blocked her from hitting her peers and she hit staff and bent staffs (sic) fingers back. Staff placed her in a two-person You're Safe, I'm Safe hold. Staff encouraged coping skills and [client A] continued yelling, using profanity, and asking to be allowed to die. The behavioral clinician encouraged [client A's] housemates to move to a different area of the house. Staff released the hold and complied with [client A's] request for a glass of water. [Client A] drank the water and pulled a decoration off the wall, broke it in half. Staff successfully obtained the broken decoration, but [client A] then ran out the front door. She sat on the porch swing and had one-to-one talk with staff. [Client A] stood up and ran down the street, with staff following within arm's reach. [Client A] ignored staff redirection and picked up a lantern. Staff			

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	attempted to get [client A] to give them the lantern and [client A] threw the lantern onto the ground and hit staff in the face. [Client A] attempted to get a piece of broken glass from the lantern. Staff blocked and [client A] spit in staffs (sic) face and picked up a piece of glass and ran across the street. Staff followed and [client A] continued to spit on staff as they attempted to intervene. [Client A] began cutting her left forearm and the sides of her neck with the glass. Staff called 911 for assistance. Police and EMS arrived. [Client A] dropped the glass, flirted briefly with the police officer, and got into the ambulance without issues. EMS transported [client A] to the [Hospital Emergency Department], where the behavior team evaluated her and admitted her for overnight psychiatric observation. [Client A] remained in psychiatric detention through the night. The psychiatrist discharged [client A] to ResCare staff the following afternoon with no new orders. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. It should be noted that [client A] reescalated shortly after returning home. This incident will be reported separately. Plan to Resolve: [Client A] sustained a 7cm (centimeter) by 7cm abrasion with interspersed superficial cuts on her left forearm, a 7cm by 3cm abrasion with interspersed superficial cuts on the right side of her neck, a 7cm by 2cm abrasion with interspersed superficial cuts on the left side of her neck, 2 1cm bruises on her right bicep and a 2cm bruise on her right forearm. Staff will document the healing process of the affected areas on an injury follow-up flow sheet. [Client A] has a history of verbal and physical aggression, self-injury, elopement, and suicidal ideation addressed in her Behavior Support Plan. [Client A] does not have plan approved alone time but was never away from staff supervision. The use of			

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	You're Safe, I'm Safe holds and PRN haloperidol has guardian and Human Rights Committee approval and is included in her plan. The three holds lasted a total of 15 minutes, with repositioning for comfort every two to three minutes. Staff will continue to implement the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences". -A 1/7/24 BDS report indicated, "On the afternoon of 1/6/24, [client A] arrived home from the hospital (previously reported incident #1536863) and became agitated when staff requested to perform a physical assessment. [Client A] began yelling, and attempted to strike her head on the floor but staff blocked. Staff offered coping skills and one-to-one talk and [client A] refused and continued yelling. [Client A] then stood up and grabbed her fan off her bedroom desk and tried wrapping the cord around her neck. When staff tried to intervene, [client A] threw the fan at staff, causing it to break. [Client A] continued yelling at staff while staff was preforming (sic) a bedroom sweep, per her plan. Staff tried offering coping skills and one to one talk with [client A], but she (sic) biting her right wrist. Staff preformed (sic) a bit (sic) release technique and blocked [client A] from harming herself. [Client A] then sat on her bed and started using coping skills. Staff offered [client A] a PRN to help calm her down and [client A] agreed to PRN. Staff obtained approval and administered haloperidol 5mg. [Client A] continued yell and threaten staff and housemates. [Client A] ran out of her bedroom towards dining area and a housemate, in a threatening manner. Staff blocked and implemented a two-person You're safe, I'm Safe hold. When she began to calm, staff released			

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	the hold. Staff offered verbal redirection, coping skills and one-to one talk. [Client A] walked to her bedroom and began scratching an existing abrasion on the top of her left forearm with fingernails. Staff blocked and [client A] slapped staffs (sic) hand away. Staff offered verbal redirection, coping skills and one-to-one talk and [client A] ran out of her bedroom and knocked over the Christmas tree. Staff tried verbally redirecting her, but [client A] grabbed a Christmas decoration and attempted to strike her head on it. When staff tried to intervene, [client A] put the decoration down and walked back to her bedroom. [Client A] continued yelling. After the medication took effect, [client A] calmed and resumed her evening routine. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. Plan to Resolve: [Client A] had no new injuries and received post-incident supportive conversation. [Client A] has a history of verbal and physical aggression, property destruction and self-injury addressed in her Behavior Support Plan. The use of PRN Haloperidol and You're Safe I'm Safe holds has guardian and Human Rights Committee Approval and is included in her plan. The hold lasted for four minutes with repositioning for comfort after two minutes. Staff will continue to implement the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences". -A 1/6/24 BDS report indicated, "On 1/5/24, [client A] was in the kitchen assisting with preparing supper. She called for another staff and when she asked [client A] to wait a second, [client A] began yelling, using profanity, and			

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	making threats. [Client A] then ran out the front door with staff following. Staff encouraged [client A] to calm herself and she continued walking. She entered a neighbor's yard and punched a tree with her right hand. [Client A] spoke with staff and her Behavioral Clinician and she calmed and returned inside her house. She ate supper and took her dishes to the kitchen, slammed the kitchen door and began threatening to harm staff. She entered the bathroom took the mirror off the wall, and ran out the home's front door, with staff following. [Client A] ran down the street, with staff maintaining line of sight and she laid down in the road. Staff encouraged [client A] to calm and she stood up and continued running. She laid down again and struck her forehead on the road. [Client A] continued running and turned onto the sidewalk on [highway]. She laid down on the sidewalk and again made contact with her forehead. Staff called 911 for assistance. Police arrived and [client A] began hitting the front door of a house. Police prompted her to sit down and she began yelling at the police. She laid on the sidewalk and tapped her head and then resumed hitting the door. Police arranged for EMS to transport [client A] to [Hospital] where she was placed on Immediate Psychiatric Detention. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. [Client A] was released to ResCare staff on the afternoon of 1/6/24 and returned home without incident. Plan to Resolve: [Client A] sustained a two-centimeter superficial cut on her left index finger and a three-centimeter circular abrasion on her forehead prior to being detained by the police. Staff will document the healing			

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	process of the affected areas on an injury follow-up flow sheet and will monitor [client A] for signs and symptoms of concussion for 72 hours. [Client A] has a history of verbal and physical aggression, elopement and self-injury addressed in her Behavior Support Plan. [Client A] does not have plan approved alone time but was never away from staff supervision. Staff will continue to implement the proactive and reactive strategies in her plan to help reduce and prevent further occurrences". -Four additional BDS reports dated 12/1/23, 11/20/23, 11/16/23 and 11/7/23 were reviewed. Those incidents included elopement, property destruction, laying in the road and banging her head on the ground, self-injurious behavior, physical aggression, police involvement and psychiatric evaluations/admissions at the hospital. On 1/30/24 at 11:00 AM, client A's record was reviewed. Client A's 1/19/24 (revised 1/27/24) Behavior Support Plan (BSP) indicated the following: -Client A's target behaviors included physical aggression, verbal aggression, self-injury behavior, elopement, task refusal/non-compliance, suicidal ideation, inappropriate sexual behaviors, disruptive behaviors and impulse control issues. -Client A was restricted from sharps. -Client A was on enhanced supervision/secured residential environment: "To protect client from placing herself at risk of harm and exploitation outside of the residential environment without supervision of staff".			

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	-Modified Enhanced Supervision (MES) Protocols: "When [client A] demonstrates she may be a threat to herself (through the expression of suicidal ideations or other high intensity displays of behaviors), supervision will move from Modified Enhanced Supervision (sic) to Enhanced Supervision (sic) protocols. During these displays, [client A] needs the support and heightened supervision protocols that Enhanced Supervision provide; these specific measures are to be implemented when [client A] is potentially a threat to herself or others while at home and in the community. MES means that [client A] is on Enhanced Supervision and not able to enter the community. The MES protocol (when implemented) will be evaluated every 2-hours by the RM (Residential Manager)/AS (Area Supervisor)/QIDP (Qualified Intellectual Disabilities Professional) and Behaviorist. Any item/belonging of [client A's] deemed by staff to be a dangerous object/belongings (example: belts, cords) should be removed from her bedroom until the displays of behavior have ceased and [client A] has displayed a state of calm for a minimum period of 2-hours or until safe to return those items. [Client A] should not be unsupervised during this period and the staff should record [client A's] movements/activities on the 15-minute check sheet/paperwork which should be maintained i n [client A's] documentation binder. Preventive/Proactive Procedures: 3. The doors to the Med Room will remain closed and locked at all times.... 7. At the first sign of a precursor behavior by [client A] or any of the housemates, lock the sharps (or items which can easily be made into a sharp)			

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	which includes, eating utensils (such as forks, spoons, knives), cooking utensils (spatulas, wooden spoons, serving spoons, measuring cups, measuring spoons, ice cream scoops, pizza cutters, whisk, cookie cutters, meat thermometers, potato peelers). Any cleaning solutions or chemicals which could be ingested should also be secured, including cleaning chemicals. These items should remain secured until the immediate risk from exposure has passed and/or until [client A] has been assessed as being in control of herself (physically) and emotions and no longer poses a risk of danger to herself and/or others within the immediate environment". Interdisciplinary Team (IDT) Meeting notes dated 1/16/24 indicated the team met to discuss the incident which occurred on 1/15/24. The team agreed to develop a smoking schedule to decrease client A's fixation on smoking or running out of cigarettes, to add impulse control to the BSP and define the kitchen access restriction in the BSP.The only other IDT meeting was client A's 30 day meeting where goals and the BSP were developed. On 1/30/24 at 1:20 PM, the Behavior Clinician (BC) was interviewed. The BC indicated client A has made multiple threats and attempts to attack her peers and staff have been successful with blocking all of the attempts but two. The BC indicated client A			

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	targets client C, but client A has 1:1 staffing so staff is always with her. The BC indicated when client A starts to escalate, the other clients are moved to a different location so they aren't around her. The BC indicated YSIS isn't always effective with client A due to her size. The BC stated, "If YSIS isn't effective they continue to try. A lot of times she is able to break away. She will go out, elope then the neighbors call the police. 911 is called when they (staff) can't control her. The premeditation is what scares me. This last incident she premeditated how she could get in the kitchen. She looks for everything with glass in so she can hurt herself". The BC was asked if there were enough staff to effectively implement the BSPs. The BC stated, "On a normal day to day basis, yes. If we could have an extra person on a day when we have behaviors that would be great". The BC indicated client A's behavior started to escalate after Christmas and it has continued to escalate since then. The BC was asked if client A was appropriately placed. The BC stated, "At this point, if we could narrow it down to what is going on with her we could help more. I think the restrictions are making it worse. She came from waiver with little restrictions. The dual diagnosis makes it hard. I am working with her Psychiatrist to figure out if her			

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	medication is even effective. We are talking about safely weaning her off and slowly putting her back on meds. At this point I am not 100% sure is she is appropriate here". On 1/31/24 at 9:30 AM, the QIDPM/QIDP and the OSS were interviewed. The QIDPM/QIDP indicated the last time he visited the home was in late November or early December 2023. The QIDPM/QIDP indicated client A's behavioral episodes have increased in the last month. The QIDPM/QIDP indicated client A asks for her PRN when she feels anxious and it has helped her calm down at times. The QIDPM/QIDP stated, "The other piece of this is [client A] came to us with a completely inaccurate and inappropriate list of diagnoses. They (BC and Psychiatrist) are working on clearing up the diagnostic mess. Her psych (psychiatric) team is working to figure out what she needs to get her back on track. The Operations Manager has authorized an additional staff. Originally we were discussing 1:1. However, that tends to increase her anxiety. We need someone completely dialed in to her at all times. We are not calling it a 1:1 because that gives staff the idea they are to all be in her business. We are going to have a single staff assigned to work with [client A] for skills training, recreational opportunities and they will be trained to be tuned in on			

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	precursor behaviors. The 3rd staff will be from 8:00 AM to 8:00 PM, 7 days a week. When she is agitated in the evening we will keep that staffing in place. They will be trained to the effect that they are 1:1. Another staff will cover if they have to go to bathroom. We are also talking about switching out staff throughout the shift. With that in place in addition to [client C's] 1:1 there will be 2 additional staff in the home for either [client A] or [client B]. When they escalate it takes more than 1 staff. Once again we are being reactive I know. There is no easy answer for that. [PD] has been asking for additional staff over there since before they came. We need the resources in place. There isn't a paper trail saying we don't have enough staff. The Governing Body reads these reports (incident reports and BDS reports). The ED (Executive Director) sees every BDS report. The team as a whole sees all of it. That is our focus right now. We are going to talk with guardian to see if she will approve (plan). The 1:1 will help keep people safe". The QIDPM/QIDP indicated staffing levels should be based on the needs of the clients. The QIDPM/QIDP was asked if there was a sufficient amount of staff to implement plans effectively, provide needed care and services to prevent injuries and keep clients safe. The QIDPM/QIDP stated, "No, there			

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	is no way". The QIDPM/QIDP was asked what was being done to ensure client A's safety. The QIDPM/QIDP stated, "There were no additional protective measures put in place". 3. On 1/29/24 at 12:00 PM and 1/30/24 at 7:00 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: -A 1/15/24 BDS report indicated, "On 1/14/24 with no apparent precursor behavior, [client B] became agitated and began threateningto stab staff and housemates. Staff redirected her verbally and offered coping skills, but [client B] continued to escalate. Staffprovided one-to-one talk and [client B] calmed, took her midday medication and ate her lunch. Moments later, she began yellingand threatening again. When a housemate walked by, [client B] pulled out a pen she had hidden under her shirt and made stabbingmotions toward staff and the housemate. Staff blocked and [client B] released the pen. She continued yelling and threatening andstaff attempted to place [client B] in a You're Safe, I'm Safe hold but were unable to implement it, due to the intensity of [client B's]aggression. [Client B] agreed to take her PRN medication to help her calm down. Staff obtained approval and administered Igalmi120mcg (micrograms). The medication was not effective and [client			

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	B] remained agitated and aggressive. The team determined [client B] needed an emergency psychiatric evaluation and contacted non-emergency dispatch to arrange for transportation. Police and paramedics arrived, and [client B] attempted to stab herself. Staff blocked, police intervened, placed her in handcuffe (sic) and the paramedics transported [client B] to the [Hospital Emergency Department]. The ER psychiatrist assessed [client B], diagnosed her with Impulse Control Disorder and admitted her for acute inpatient treatment. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. Plan to Resolve: [client B] was not injured prior to being detained by police and EMS. She remains hospitalized, and ResCare nursing will remain in communication with the hospital to assure continuity of care. [Client B] has a history of agitation, verbal and physical aggression addressed in her Behavior Support Plan. The use of PRN Igalmi and You're Safe, I'm Safe holds has guardian and Human Rights Committee Approval and is included in her plan".-A 1/14/24 BDS report indicated, "On 1/13/24 with no apparent precursor behavior, [client B] became agitated and asked to have talk1:1 with staff. After staff offered coping skills, [client B] agreed to take her PRN			

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	medication to help her calm down. Staff obtainedapproval and administered Igalmi 120mcg. [Client B] then became verbally aggressive yelling about 'all the trauma she deals with'. Staff offered coping skills and continued to talk with her encouraging her to calm herself. Without success [client B] got up andattempted to leave the home but staff blocked. [Client B] continued yelling and staff offered coping skills and 1:1 conversation. After the medication took effect, [client B] calmed and resumed her normal routine. When prompted to take her evening medications,[client B] re-escalated and began yelling and attempted to exit the house. Staff blocked and [client B] pulled a pen out of her pocketand stabbed staff multiple times while pushing past staff and entering the front yard. Staff implemented a two-person You'reSafe, I'm Safe hold. [Client B] let go of the pen and staff released the hold. [Client B] remained combative and refused to enter thehouse, and staff re-implemented the hold. Once calm, staff released the hold and [client B] went into the house. [Client B] went to her bedroom and continued yelling and threatening staff. Staff continued to offer coping skills and [client B] took her medication and was calm for the remainder of the evening. Staff were in communication with the supervisor, nurse, behavioral clinician, andadministrative team			

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	throughout the day and evening. Plan to Resolve: [Client B] was not injured and received post-incident supportive conversation. [Client B]has a history of agitation, verbal and physical aggression addressed in her Behavior Support Plan. The use of PRN Igalmi and You're Safe, I'm Safe Holds has guardian and Human Rights Committee Approval and is included in her plan. Each hold lasted for seven minutes with repositioning for comfort every two to three minutes. Staff will continue to implement the proactive and reactive strategies in [client B's] plan to help reduce and prevent further occurrences".-A 1/7/24 BDS report indicated, "On 1/6/24, one of [client B's] housemates ran towards her aggressively, but was not able to make contact because staff blocked. [Client B] became agitated towards her housemate and began yelling. Staff verbally redirected [client B] and offered coping skills and one-to-one talk, and [client B] took her evening medication. Moments later, [client B] again became re-escalated. Staff verbally redirected [client B] and offered one-to-one talk, and staff walked with [client B] to the garage, to retrieve her jacket, per her request. While in the garage [client B] pushed down two dressers blocking staffs path and ran out of the garage door. Staff followed behind [client B] keeping her in line-of-sight. Staff			

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	caught up to [client B] and remained within arm's reach. [Client B] began yelling and attempted to run in front of moving cars on the road. Staff was able to block and offer coping skills. A passing sheriff deputy noticed the situation and stopped to assist. The sheriff arranged for EMS to transport [client B] to [Hospital]. When staff arrived at [Hospital] [client B] was laying in the hospital bed calmly but became agitated when the nurse entered the room. [Client B] began yelling at ResCare staff and threw staffs (sic) cellphone (sic), breaking it. Emergency Department staff intervened, and ResCare staff offered [client B] coping skills, without success. ER staff gave [client B] an injection to help her calm down. After being assessed by the [Hospital] behavior team [client B] was admitted on an immediate Psychiatric Detention. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. Plan to Resolve: [Client B] was not injured prior to being detained by the Sheriff and EMS. [Client B] has a history of verbal and physical aggression, elopement and self-injury addressed in her Behavior Support Plan. [Client B] does not have plan approved alone time but was never away from staff supervision. [Client B] remains hospitalized. ResCare nursing will remain in			

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	communication with the hospital to assure continuity of care".-A 12/28/23 BDS report indicated, "On 12/27/23, [client B] became agitated due to a housemate's extended episode of yelling. [Client B] stood up and walked out the front door. Staff attempted to block but she pushed them out of the way and began walking down the street with staff walking beside her offering verbal redirection. [Client B] continued walking and resisting staff efforts to convince her to return to the house. Staff called the police non-emergency number for assistance. Police arrived and [client B] began threatening the officers. Police placed [client B] in handcuffs for safety and transported her to [Hospital] for a psychiatric evaluation. At the ER, [client B] remained agitated, and the psychiatrist placed her on a 24-48 hour hold. The [Hospital] behavior team released [client B] to ResCare staff on the afternoon of 12/28/23, with a prescription for Oxcarbazepine (for behavior) 300 MG twice daily. Plan to Resolve: [Client B] was not injured prior to being detained by the police. When she returned home, staff completed a physical assessment and noted the following: a two-inch by four-inch superficial abrasion on her right collar bone, a one-inch purple bruise on her left buttocks, a one-inch superficial scratch on her left forearm, a half-inch purple bruise on her left			

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	upper arm, a one-inch brown bruise on her left inner thigh, and one-inch and half-inch purple bruises on her upper chest. Staff will document the healing process of the affected areas on an injury follow-up flow sheet. [Client B] is receiving ongoing supportive conversation and reassurance from her team. [Client B] has a history of verbal aggression and elopement addressed in her Behavior Support Plan. She does not have plan approved alone time but was never away from direct staff supervision. Staff will continue to implement the proactive and reactive strategies in her plan to help reduce and prevent further occurrences".-A 12/27/23 BDS report indicated, "On 12/26/23, [client B] refused to eat breakfest (sic) and lunch. At 12:00 PM [client B] began pacing through the house and refused her afternoon insulin (for diabetes). Staff offered one-to-one talks and coping skills throughout the day. As the afternoon progressed, [client B] began yelling and hit and scratched staff. Verbal redirection and blocking was (sic) ineffective, and staff placed her in a two-person You're Safe, I'm Safe Hold. [Client B] became calm and staff released the hold. [Client B] apologized and took her 5:00 PM medication and ate supper wither housemates. [Client B] remained on 15-minute checks per new admission protocol. Staff checked on [client			

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	B] in her bedroom and saw her attempting to ties shoelaces around her neck. Staff cut the laces and removed them from her room and placed her on one-to-one supervision for safety. [Client B] grabbed staff by the hair and pulled staffs (sic) head forcefully against the wall. Staff placed her in a two-person You're Safe, I'm Safe Hold. When [client B] became calm, staff released the hold. [Client B] said she was going to turn on her television to listen to music, but instead punched the television, causing it to break. She attempted to pull the television off of the wall mounting and when staff blocked, she resumed hitting them. Staff placed her in a third two-person You're Safe, I'm Safe Hold. [Client B] became calm and staff released the hold. She sat on her bed and began scratching her left forearm. Staff redirected her verbally and encouraged coping skills. Staff played music for [client B] and she calmed and resumed her evening routine. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. Plan to Resolve: [Client B] received post incident supportive conversation and reassurance. She sustained three, two-inch superficial horizontal scratches on her left forearm. Staff provided first aid and will document the healing process on an injury follow-up flow sheet. [Client B] has a history			

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	of verbal and physical aggression, agitation, anxiety, and self-injurious behaviors addressed in her Behavior Support Plan. The use of You're Safe, I'm Safe has guardian and Human Rights Committee approval and is included in her plan. The holds lasted for four minutes, six minutes, and five minutes with repositioning for comfort every two to three minutes minutes. Staff will continue to implement the proactive and reactive strategies in [client B's] plan to help reduce and prevent further occurrences".-Five additional BDS reports dated 12/16/23, 12/11/23, 12/10/23, 12/3/23 and 12/2/23 were reviewed. Those incidents included breaking items to cause harm to herself, striking her head on the wall, attempting to put her finger in an electrical outlet, elopement, property destruction, laying in the road, physical aggression, police involvement and psychiatric evaluations/admissions at the hospital.On 1/31/24 at 1:30 PM, client B's record was reviewed.Client B's 1/10/24 BSP indicated the following:-Target behaviors included physical aggression, verbal aggression, self-injury behavior, disruptive behaviors, non-compliance with health and safety (refusing medication and medical appointments), elopement and impulse control issues. -Client B was on enhanced supervision/secured residential environment:			

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	"To protect client from placing herself at risk of harm and exploitation outside of the residential environment without supervision of staff".-Modified Enhanced Supervision (MES) Protocols: "When [client B] demonstrates she may be a threat to herself (through the expression of suicidal ideations or other high intensity displays of behaviors), supervision will move from Modified Enhanced Supervision (sic) to Enhanced Supervision (sic) protocols. During these displays, [client B] needs the support and heightened supervision protocols that Enhanced Supervision provide; these specific measures are to be implemented when [client B] is potentially a threat to herself or others while at home and in the community. MES means that [client B] is on Enhanced Supervision and not able to enter the community. The MES protocol (when implemented) will be evaluated every 2-hours by the RM (Residential Manager)/AS (Area Supervisor)/QIDP (Qualified Intellectual Disabilities Professional) and Behaviorist. Any item/belonging of [client B's] deemed by staff to be a dangerous object/belongings (example: belts, cords) should be removed from her bedroom until the displays of behavior have ceased and [client B] has displayed a state of calm for a minimum period of 2-hours or until safe to return			

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	those items. [Client B] should not be unsupervised during this period and the staff should record [client B's] movements/activities on the 15-minute check sheet/paperwork which should be maintained in [client B's] documentation binder. Preventive/Proactive Procedures: 7. At the first sign of a precursor behavior by [client B] or any of the housemates, lock the sharps (or items which can easily be made into a sharp) which includes, eating utensils (such as forks, spoons, knives), cooking utensils (spatulas, wooden spoons, serving spoons, measuring cups, measuring spoons, ice cream scoops, pizza cutters, whisk, cookie cutters, meat thermometers, potato peelers). Any cleaning solutions or chemicals which could be ingested should also be secured, including cleaning chemicals. These items should remain secured until the immediate risk from exposure has passed and/or until [client B] has been assessed as being in control of herself (physically) and emotions and no longer poses a risk of danger to herself and/or others within the immediate environment". On 1/30/24 at 1:20 PM, the Behavior Clinician (BC) was interviewed. The BC indicated client B was still adjusting to the group home as she just moved in on 11/27/23. The BC indicated client B was not safe when she displays behaviors of			

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	eloping, laying in road, banging her head, cutting herself and wrapping shoestrings around her neck. The BC indicated physical redirection was successful with client B. On 1/31/24 at 9:30 AM, the QIDPM/QIDP and the OSS were interviewed. The QIDPM/QIDP indicated the last time he visited the home was in late November or early December 2023. The QIDPM/QIDP indicated client B has been hospitalized a lot of the time she has been placed so there hasn't been much time for her to adjust to living at the group home. The QIDPM/QIDP indicated staff should have prevented the behaviors from occurring. The QIDPM/QIDP indicated client B's BSP was being updated as they learn more about her. 4. On 1/29/24 at 12:00 PM and 1/30/24 at 7:00 AM, a review of the facility's incident/investigative reports was conducted and indicated the following:-A 1/22/24 Incident Report indicated, "[Client C] was sitting in dining room playing on tablet with 1:1 (staff) when [client C] suddenly began crying. [Client C] got up from table and walked to room. Staff followed. [Client C] sat in her closet and cried loudly, staff offered 1:1 talk and asked [client C] what was wrong. [Client C]yelled, 'I'm scared'. Staff asked [client C] why and offered coping skills. [Client C] stated, 'because her is coming back'. Staff			

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	asked [client C] who she was referring to. [Client C] stated housemates name (client A).... [Client C] continued crying loudly and gagged multiple times...."There was no documentation indicating the allegation of client C being scared was reported to BDS or investigated.-An 11/16/23 Incident Report indicated, "...[Client A] became aggressive because of dinner taking too long to cook. [Client A] became PA (physically aggressive) towards housemate and staff blocked and initiated YSIS to keep housemate A (unknown) safe. Housemate B (unknown) assisted with helping turn off stove while [client A] was in YSIS. [Client A] attempted to attack housemate B as she walked by. [Client A] was threatening to cut her own throat with things in the kitchen. [Client A] threatened to cut her wrist. She stated, 'I want to cut my wrist and die. I just want to hit my artery and bleed out'. [Client A] asked if there was any injections to calm. 'Pills don't work for me. I need help because I want to kill myself'. Suicidal and homicidle (sic) threats against housemates A, B and C plus staff, BC and PD. Behaviors escalated, 911 was called for assistance for psych evaluation. Housemate A ran in other room and stated, 'I'm scared and I want my daddy'. Housemate B tearful (sic) stated, 'I'm scared she's going to beat me up and kill me'. Housemate C stated, 'I'm scared of her,			

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	that she's going to cut her open'. [Client A] was taken to [hospital] for psych evaluation".On 1/31/24 at 9:30 AM, the QIDPM/QIDP and the OSS were interviewed. The QIDPM/QIDP indicated the incidents should have been prevented and effective corrective measures to prevent recurrence should have been developed and implemented. This federal tag relates to complaints #IN00422381 and #IN00426491. 9-3-2(a)			
W 0158 Bldg. 00	483.430 FACILITY STAFFING The facility must ensure that specific facility staffing requirements are met. Based on observation, record review and interview for 2 of 2 clients in the sample (A and B), the facility failed to meet the Condition of Participation: Facility Staffing. The facility failed to provide a sufficient amount of direct care staff in order to manage and supervise clients A and B according to their program plans and to ensure the Qualified Intellectual Disabilities Professional (QIDP) integrated, coordinated and monitored clients A and B's active treatment programs by conducting regular visits to the home to ensure enough staff were scheduled to manage and supervise clients A and B according to their program plans. Findings include: 1. For 2 of 2 sampled clients (A and B), the facility failed to ensure the QIDP integrated, coordinated and monitored clients A and B's active treatment programs by conducting regular visits to the home to ensure enough staff were scheduled to	W 0158	**CORRECTION:** *The facility must ensure that specific facility staffing requirements are met.* Specific corrections include For the next 30 days, the QIDP Manager will maintain a presence in the home no less than twice weekly. After 30 days, the QIDP Manager or an assigned QIDP will maintain a presence in the home no less than weekly. The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty during the overnight shift and four staff on duty between 8:00 AM and 8:00 PM to provide active treatment and ensure the ability to safely intervene with aggressive behavior during times of peak activity.	03/03/2024

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	manage and supervise clients A and B according to their program plans. Please see W159. 2. For 2 of 2 sampled clients (A and B), the facility failed to provide a sufficient amount of direct care staff in order to manage and supervise clients A and B according to their program plans. Please see W186. This federal tag relates to complaints #IN00422381 and #IN00426491. 9-3-3(a)		When sufficient staff assigned to the facility are not available staff will be pulled from other agency facilities, including from facilities outside of Wayne County, when needed. All fill-in staff will receive client specific training prior to working in the facility. **PREVENTION:** The Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. The Program Manager will monitor time and attendance records to assure required staffing levels are met. The Program Manager will assist with procuring staff from outside of the facility as needed. An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assure sufficient staff are present and to assist with and monitor skills training, including but not limited to effective application of behavior supports. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Acting Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied	

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			shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times 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. Current Operations Team members received training from the QIDP Manager on 12/14/23, to assure a clear understanding of administrative monitoring as defined below. · 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.	

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			Administrative oversight will include: · Assuring the QIDP integrates, coordinates, and monitors all aspects of the active treatment program. · Assuring required staffing levels are in place. **RESPONSIBLE PARTIES:** QIDP, Direct Support Lead, Direct Support Staff, Area Supervisor, Direct Support Staff, Operations Team, Regional Director	
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- Based on observation, review and interview for 2 of 2 sampled clients (A and B), the facility's Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor clients A and B's active treatment programs by not conducting regular visits to the home to ensure enough staff were scheduled to manage and supervise clients A and B according to their program plans. Findings include: For 2 of 2 sampled clients (A and B), the QIDP failed to provide a sufficient amount of direct care staff in order to manage and supervise clients A and B according to their program plans. Please see W186. This federal tag relates to complaints #IN00422381 and #IN00426491.	W 0159	**CORRECTION:** *Each client's active treatment program must be integrated, coordinated, and monitored by a qualified intellectual disability professional.* This deficient practice affected all clients. Specific corrections include: For the next 30 days, the QIDP Manager will maintain a presence in the home no less than twice weekly. After 30 days, the QIDP Manager or an assigned QIDP will maintain a presence in the home no less than weekly. The Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty during the overnight shift and four staff on	03/03/2024

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	9-3-3(a)		duty between 8:00 AM and 8:00 PM to provide active treatment and ensure the ability to safely intervene with aggressive behavior during times of peak activity. When sufficient staff assigned to the facility are not available staff will be pulled from other agency facilities, including from facilities outside of Wayne County, when needed. All fill-in staff will receive client specific training prior to working in the facility. **PREVENTION:** For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Acting Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times 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. Current Operations Team	

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			members received training from the QIDP Manager on 12/14/23, to assure a clear understanding of administrative monitoring as defined below. · 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 oversight will include assuring the QIDP integrates, coordinates, and monitors all aspects of the active treatment program. **RESPONSIBLE PARTIES:** QIDP, Direct Support Lead, Direct Support Staff, Area Supervisor, Direct Support Staff, Operations Team, Regional Director	
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in			

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	accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, record review and interview for 2 of 2 sampled clients (A and B), the facility failed to provide a sufficient amount of direct care staff in order to manage and supervise clients A and B according to their program plans. Findings include: An observation was conducted at the group home on 1/29/24 from 10:45 AM to 11:10 AM. Clients A, C and D were present at the group home. The Program Director (PD) indicated client B was hospitalized. Staff #1, #2 and #3 were working during the observation. At 10:52 AM, client C asked to speak with the Surveyor. Client C led the surveyor to the living room in the back of the home with her 1 on 1 staff (staff #3). Staff #1 was present in the room. Client C reported client A pulled a chunk of hair out of her head and she was scared of her. Client C indicated she was sitting at the table in the back living room and client A ran back there and reached over staff #1 (1:1 staff at the time of the incident), pulled her hair out then punched staff #1 in the face. Staff #1 confirmed the incident happened. Client C stated, "I'm scared of her. She's going to hurt me. I don't want to live here anymore". Client C indicated client A hit her one other time in November 2023, but she wasn't hurt then. Client C indicated her 1:1 staff has blocked other attempts where client A tried to hit her. Client C indicated she has told staff and supervisors she was scared.	W 0186	**CORRECTION:** *The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.* Specifically, the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty during the overnight shift and four staff on duty between 8:00 AM and 8:00 PM to provide active treatment and ensure the ability to safely intervene with aggressive behavior during times of peak activity. When sufficient staff assigned to the facility are not available staff will be pulled from other agency facilities, including from facilities outside of Wayne County, when needed. All fill-in staff will receive client specific training prior to working in the facility. **PREVENTION:** The Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. The Program Manager will monitor time and attendance records to assure required staffing levels are met. The Program Manager will assist	03/03/2024

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	An observation was conducted at the group home on 1/29/24 from 3:45 PM to 5:15 PM. At 3:50 PM, client A introduced herself and indicated she had been in and out of the psychiatric hospital since she moved in three months ago. Client A showed the surveyor her forearms which both had multiple pink scars. Client A also showed some pink scars on both sides of her neck. Client A indicated the scars were from her cutting herself. Client A showed the surveyor her room which contained nothing but her bed, bedding on the bed and a television. Client A indicated she was restricted from her personal belongings and they were being stored in the garage until she earned them back. On 1/29/24 at 12:00 PM and 1/30/24 at 7:00 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: -A 1/16/24 BDS report indicated, "On the evening of 1/15/24, [client A] became agitated during dinner and was playing her music at a high volume. [Client A] indicated she was angry with a housemate because she felt like she was being ignored during the meal. [Client A] stood up and ran toward her housemate [client C]. Staff stood between [client A] and [client C] to block. [Client A] reached over staff and pulled her housemate's hair (sic) staff (sic) continued blocking and [client A] punched staff twice in the face. Staff used agency/plan approved physical redirection in which staff placed her arms on [client A's] torso and turned her away from the housemate. [Client A] told staff she wanted to die and ran into the garage. [Client A] pulled a porcelain doll out of a cabinet, pushed staff out of the way, broke the doll on the ground and cut her left wrist with a piece of the broken doll. One staff called non-emergency dispatch to		with procuring staff from outside of the facility as needed. An Area Supervisor or Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assure sufficient staff are present and to assist with and monitor skills training, including but not limited to effective application of behavior supports. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Acting Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct daily administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, including weekend observations. After 30 days, administrative monitoring will occur no less than three times 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. Current Operations Team members received training from the QIDP Manager on 12/14/23, to	

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	arrange safe transport to the ER (Emergency Room) while another staff applied pressure to the injury to control the bleeding. Paramedics transported [client A] to the [Hospital Emergency Department] via ambulance. The ER physician closed the laceration with five sutures and admitted her to the hospital for psychiatric observation. The psychiatrist assessed [client A] and arranged for admission at [Behavioral Hospital] located at [address].... Plan to Resolve: [Client A] sustained a 1.5 inch laceration on her left forearm, and she remains hospitalized. ResCare nursing will maintain contact with hospital staf (sic) to assure continuity of care. [Client A] has a history of verbal and physical aggression, self-injury and suicidal ideation addressed in her Behavior Support Plan, which staff followed. The Interdisciplinary team will meet to develop additional supports". -A 1/26/24 BDS report indicated the following incident occurred on 1/25/24 at 3:00 PM: "Moments after [client A] returned home from overnight psychiatric detention (previously reported incident #1542101), she became anxious and agitated and requested her PRN (as needed) medication. Staff offered verbal redirection to preferred activities, coping skills and one-to-one talk but [client A] grew progressively more upset. Staff obtained approval and administered haloperidol (for behavior) 5mg (milligrams). [Client A] listened to music and remained calm for approximately two hours. [Client A] re-escalated after speaking to her mother who suggested a smoking schedule (a support that produced successful results in the past). [Client A] punched the wall. When staff blocked, she spit on them. She picked up a piece of wood brandished it at staff and ran toward them. Staff blocked and [client A] ran out the door and down the road.		assure a clear understanding of administrative monitoring as defined below. · 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 required staffing levels are in place. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	Staff followed and called 911 for assistance. Police arrived and [client A] began yelling at the responding officers. The police took [client A] home and spoke to [client A] in her room and she told them that she wanted to kill her self. Police arranged for EMS (emergency medical services) to transport [client A] to the [Hospital Emergency Department], where the behavior team evaluated her and determined she did not meet the criteria for in-patient treatment. The psychiatrist discharged [client A] to ResCare staff the following afternoon with no new orders. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. The psychiatrist diagnosed [client A] with suicidal ideation, impulse control disorder, agitation, and aggressive behavior and released her to ResCare staff with no new orders. Plan to Resolve: [Client A] had no new injuries and staff provided her with post-incident supportive conversation (sic) [Client A] has a history of verbal and physical aggression, self-injury, elopement, and suicidal ideation addressed in her Behavior Support Plan.... Staff will continue to implement the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences". -A 1/25/24 BDS report indicated the following incident occurred on 1/24/24 at 5:30 PM: "On the evening of 1/24/24, [client A] was eating popcorn and watching a movie with staff. Without displaying precursor behavior, [client A] stood up and told staff she was 'about to have a behavior', and walked to her bedroom. Staff offered one-to-one talk and coping skills. [Client A] said she wanted to die and requested her agitation PRN. Staff offered verbal redirection to preferred activities, coping skills and one-to-one talk but			

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	[client A] grew progressively more upset. Staff obtained approval and administered haloperidol 5mg. The medication never reached efficacy and [client A] continued to escalate. [Client A] walked to the garage and hit the punching bag. She picked up a clock and broke a piece off to use to harm herself. Staff placed her into a two-person You're Safe, I'm Safe hold. When [client A] appeared to calm, staff released the hold and she asked for a glass of water. As staff was assisting her, [client A] began punching the window and staff blocked. [Client A] asked staff to accompany her to the garage so she could hit the punching bag. Upon entering the garage, [client A] pulled a cord out of a box, ran back into the house and attempted to put the cord around her neck. Staff approached and she dropped the cord, punched staff in the face twice and pulled staffs (sic) hair. [Client A] disengaged with staff and ran into the living room towards her housemates. Staff blocked her from hitting her peers and she hit staff and bent staffs (sic) fingers back. Staff placed her in a two-person You're Safe, I'm Safe hold. Staff encouraged coping skills and [client A] continued yelling, using profanity, and asking to be allowed to die. The behavioral clinician encouraged [client A's] housemates to move to a different area of the house. Staff released the hold and complied with [client A's] request for a glass of water. [Client A] drank the water and pulled a decoration off the wall, broke it in half. Staff successfully obtained the broken decoration, but [client A] then ran out the front door. She sat on the porch swing and had one-to-one talk with staff. [Client A] stood up and ran down the street, with staff following within arm's reach. [Client A] ignored staff redirection and picked up a lantern. Staff attempted to get [client A] to give them the lantern and [client A] threw the lantern onto the ground and hit staff in the face. [Client A]			

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	attempted to get a piece of broken glass from the lantern. Staff blocked and [client A] spit in staffs (sic) face and picked up a piece of glass and ran across the street. Staff followed and [client A] continued to spit on staff as they attempted to intervene. [Client A] began cutting her left forearm and the sides of her neck with the glass. Staff called 911 for assistance. Police and EMS arrived. [Client A] dropped the glass, flirted briefly with the police officer, and got into the ambulance without issues. EMS transported [client A] to the [Hospital Emergency Department], where the behavior team evaluated her and admitted her for overnight psychiatric observation. [Client A] remained in psychiatric detention through the night. The psychiatrist discharged [client A] to ResCare staff the following afternoon with no new orders. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. It should be noted that [client A] reescalated shortly after returning home. This incident will be reported separately. Plan to Resolve: [Client A] sustained a 7cm (centimeter) by 7cm abrasion with interspersed superficial cuts on her left forearm, a 7cm by 3cm abrasion with interspersed superficial cuts on the right side of her neck, a 7cm by 2cm abrasion with interspersed superficial cuts on the left side of her neck, 2 1cm bruises on her right bicep and a 2cm bruise on her right forearm. Staff will document the healing process of the affected areas on an injury follow-up flow sheet. [Client A] has a history of verbal and physical aggression, self-injury, elopement, and suicidal ideation addressed in her Behavior Support Plan. [Client A] does not have plan approved alone time but was never away from staff supervision. The use of You're Safe, I'm Safe holds and PRN haloperidol has guardian and Human Rights Committee approval and is included in her plan. The three			

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	holds lasted a total of 15 minutes, with repositioning for comfort every two to three minutes. Staff will continue to implement the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences". -A 1/7/24 BDS report indicated, "On the afternoon of 1/6/24, [client A] arrived home from the hospital (previously reported incident #1536863) and became agitated when staff requested to perform a physical assessment. [Client A] began yelling, and attempted to strike her head on the floor but staff blocked. Staff offered coping skills and one-to-one talk and [client A] refused and continued yelling. [Client A] then stood up and grabbed her fan off her bedroom desk and tried wrapping the cord around her neck. When staff tried to intervene, [client A] threw the fan at staff, causing it to break. [Client A] continued yelling at staff while staff was preforming (sic) a bedroom sweep, per her plan. Staff tried offering coping skills and one to one talk with [client A], but she (sic) biting her right wrist. Staff preformed (sic) a bit (sic) release technique and blocked [client A] from harming herself. [Client A] then sat on her bed and started using coping skills. Staff offered [client A] a PRN to help calm her down and [client A] agreed to PRN. Staff obtained approval and administered haloperidol 5mg. [Client A] continued yell and threaten staff and housemates. [Client A] ran out of her bedroom towards dining area and a housemate, in a threatening manner. Staff blocked and implemented a two-person You're safe, I'm Safe hold. When she began to calm, staff released the hold. Staff offered verbal redirection, coping skills and one-to one talk. [Client A] walked to her bedroom and began scratching an existing			

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	abrasion on the top of her left forearm with fingernails. Staff blocked and [client A] slapped staffs (sic) hand away. Staff offered verbal redirection, coping skills and one-to-one talk and [client A] ran out of her bedroom and knocked over the Christmas tree. Staff tried verbally redirecting her, but [client A] grabbed a Christmas decoration and attempted to strike her head on it. When staff tried to intervene, [client A] put the decoration down and walked back to her bedroom. [Client A] continued yelling. After the medication took effect, [client A] calmed and resumed her evening routine. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. Plan to Resolve: [Client A] had no new injuries and received post-incident supportive conversation. [Client A] has a history of verbal and physical aggression, property destruction and self-injury addressed in her Behavior Support Plan. The use of PRN Haloperidol and You're Safe I'm Safe holds has guardian and Human Rights Committee Approval and is included in her plan. The hold lasted for four minutes with repositioning for comfort after two minutes. Staff will continue to implement the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences". -A 1/6/24 BDS report indicated, "On 1/5/24, [client A] was in the kitchen assisting with preparing supper. She called for another staff and when she asked [client A] to wait a second, [client A] began yelling, using profanity, and making threats. [Client A] then ran out the front door with staff following. Staff encouraged [client A] to calm herself and she			

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	continued walking. She entered a neighbor's yard and punched a tree with her right hand. [Client A] spoke with staff and her Behavioral Clinician and she calmed and returned inside her house. She ate supper and took her dishes to the kitchen, slammed the kitchen door and began threatening to harm staff. She entered the bathroom took the mirror off the wall, and ran out the home's front door, with staff following. [Client A] ran down the street, with staff maintaining line of sight and she laid down in the road. Staff encouraged [client A] to calm and she stood up and continued running. She laid down again and struck her forehead on the road. [Client A] continued running and turned onto the sidewalk on [highway]. She laid down on the sidewalk and again made contact with her forehead. Staff called 911 for assistance. Police arrived and [client A] began hitting the front door of a house. Police prompted her to sit down and she began yelling at the police. She laid on the sidewalk and tapped her head and then resumed hitting the door. Police arranged for EMS to transport [client A] to [Hospital] where she was placed on Immediate Psychiatric Detention. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. [Client A] was released to ResCare staff on the afternoon of 1/6/24 and returned home without incident. Plan to Resolve: [Client A] sustained a two-centimeter superficial cut on her left index finger and a three-centimeter circular abrasion on her forehead prior to being detained by the police. Staff will document the healing process of the affected areas on an injury follow-up flow sheet and will monitor [client A] for signs and symptoms of concussion for 72 hours.			

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	[Client A] has a history of verbal and physical aggression, elopement and self-injury addressed in her Behavior Support Plan. [Client A] does not have plan approved alone time but was never away from staff supervision. Staff will continue to implement the proactive and reactive strategies in her plan to help reduce and prevent further occurrences". -Four additional BDS reports dated 12/1/23, 11/20/23, 11/16/23 and 11/7/23 for client A were reviewed. Those incidents included elopement, property destruction, laying in the road and banging her head on the ground, self-injurious behavior, physical aggression, police involvement and psychiatric evaluations/admissions at the hospital. -A 1/15/24 BDS report indicated, "On 1/14/24 with no apparent precursor behavior, [client B] became agitated and began threatening to stab staff and housemates. Staff redirected her verbally and offered coping skills, but [client B] continued to escalate. Staff provided one-to-one talk and [client B] calmed, took her midday medication and ate her lunch. Moments later, she began yelling and threatening again. When a housemate walked by, [client B] pulled out a pen she had hidden under her shirt and made stabbing motions toward staff and the housemate. Staff blocked and [client B] released the pen. She continued yelling and threatening and staff attempted to place [client B] in a You're Safe, I'm Safe hold but were unable to implement it, due to the intensity of [client B's] aggression. [Client B] agreed to take her PRN medication to help her calm down. Staff obtained approval and administered Igalmi 120mcg (micrograms). The medication was not			

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	effective and [client B] remained agitated and aggressive. The team determined [client B] needed an emergency psychiatric evaluation and contacted non-emergency dispatch to arrange for transportation. Police and paramedics arrived, and [client B] attempted to stab herself. Staff blocked, police intervened, placed her in handcuffe (sic) and the paramedics transported [client B] to the [Hospital Emergency Department]. The ER psychiatrist assessed [client B], diagnosed her with Impulse Control Disorder and admitted her for acute inpatient treatment. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. Plan to Resolve: [client B] was not injured prior to being detained by police and EMS. She remains hospitalized, and ResCare nursing will remain in communication with the hospital to assure continuity of care. [Client B] has a history of agitation, verbal and physical aggression addressed in her Behavior Support Plan. The use of PRN Igalmi and You're Safe, I'm Safe holds has guardian and Human Rights Committee Approval and is included in her plan". -A 1/14/24 BDS report indicated, "On 1/13/24 with no apparent precursor behavior, [client B] became agitated and asked to have talk 1:1 with staff. After staff offered coping skills, [client B] agreed to take her PRN medication to help her calm down. Staff obtained approval and administered Igalmi 120mcg. [Client B] then became verbally aggressive yelling about 'all the trauma she deals with'. Staff offered coping skills and continued to talk with her encouraging her to calm herself. Without success [client B] got up and attempted to leave the home but staff blocked. [Client B] continued yelling and staff offered			

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	coping skills and 1:1 conversation. After the medication took effect, [client B] calmed and resumed her normal routine. When prompted to take her evening medications, [client B] re-escalated and began yelling and attempted to exit the house. Staff blocked and [client B] pulled a pen out of her pocket and stabbed staff multiple times while pushing past staff and entering the front yard. Staff implemented a two-person You're Safe, I'm Safe hold. [Client B] let go of the pen and staff released the hold. [Client B] remained combative and refused to enter the house, and staff re-implemented the hold. Once calm, staff released the hold and [client B] went into the house. [Client B] went to her bedroom and continued yelling and threatening staff. Staff continued to offer coping skills and [client B] took her medication and was calm for the remainder of the evening. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the day and evening. Plan to Resolve: [Client B] was not injured and received post-incident supportive conversation. [Client B]has a history of agitation, verbal and physical aggression addressed in her Behavior Support Plan. The use of PRN Igalmi and You're Safe, I'm Safe Holds has guardian and Human Rights Committee Approval and is included in her plan. Each hold lasted for seven minutes with repositioning for comfort every two to three minutes. Staff will continue to implement the proactive and reactive strategies in [client B's] plan to help reduce and prevent further occurrences". -A 1/7/24 BDS report indicated, "On 1/6/24, one of [client B's] housemates ran towards her aggressively, but was not able to make contact because staff blocked. [Client B] became agitated			

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	towards her housemate and began yelling. Staff verbally redirected [client B] and offered coping skills and one-to-one talk, and [client B] took her evening medication. Moments later, [client B] again became re-escalated. Staff verbally redirected [client B] and offered one-to-one talk, and staff walked with [client B] to the garage, to retrieve her jacket, per her request. While in the garage [client B] pushed down two dressers blocking staffs path and ran out of the garage door. Staff followed behind [client B] keeping her in line-of-sight. Staff caught up to [client B] and remained within arm's reach. [Client B] began yelling and attempted to run in front of moving cars on the road. Staff was able to block and offer coping skills. A passing sheriff deputy noticed the situation and stopped to assist. The sheriff arranged for EMS to transport [client B] to [Hospital]. When staff arrived at [Hospital] [client B] was laying in the hospital bed calmly but became agitated when the nurse entered the room. [Client B] began yelling at ResCare staff and threw staffs (sic) cellphone (sic), breaking it. Emergency Department staff intervened, and ResCare staff offered [client B] coping skills, without success. ER staff gave [client B] an injection to help her calm down. After being assessed by the [Hospital] behavior team [client B] was admitted on an immediate Psychiatric Detention. Staff were in communication with the supervisor, nurse, behavioral clinician, and administrative team throughout the incident. Plan to Resolve: [Client B] was not injured prior to being detained by the Sheriff and EMS. [Client B] has a history of verbal and physical aggression, elopement and self-injury addressed in her Behavior Support Plan. [Client B] does not have plan approved alone time but was never away from staff supervision. [Client B] remains hospitalized. ResCare nursing will remain in communication			

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	with the hospital to assure continuity of care". -A 12/28/23 BDS report indicated, "On 12/27/23, [client B] became agitated due to a housemate's extended episode of yelling. [Client B] stood up and walked out the front door. Staff attempted to block but she pushed them out of the way and began walking down the street with staff walking beside her offering verbal redirection. [Client B] continued walking and resisting staff efforts to convince her to return to the house. Staff called the police non-emergency number for assistance. Police arrived and [client B] began threatening the officers. Police placed [client B] in handcuffs for safety and transported her to [Hospital] for a psychiatric evaluation. At the ER, [client B] remained agitated, and the psychiatrist placed her on a 24-48 hour hold. The [Hospital] behavior team released [client B] to ResCare staff on the afternoon of 12/28/23, with a prescription for Oxcarbazepine (for behavior) 300 MG twice daily. Plan to Resolve: [Client B] was not injured prior to being detained by the police. When she returned home, staff completed a physical assessment and noted the following: a two-inch by four-inch superficial abrasion on her right collar bone, a one-inch purple bruise on her left buttocks, a one-inch superficial scratch on her left forearm, a half-inch purple bruise on her left upper arm, a one-inch brown bruise on her left inner thigh, and one-inch and half-inch purple bruises on her upper chest. Staff will document the healing process of the affected areas on an injury follow-up flow sheet. [Client B] is receiving ongoing supportive conversation and reassurance from her team. [Client B] has a history of verbal aggression and elopement addressed in her Behavior Support Plan. She does not have plan approved alone time but was never away from direct staff supervision. Staff will continue to			

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	implement the proactive and reactive strategies in her plan to help reduce and prevent further occurrences". -A 12/27/23 BDS report indicated, "On 12/26/23, [client B] refused to eat breakfest (sic) and lunch. At 12:00 PM [client B] began pacing through the house and refused her afternoon insulin (for diabetes). Staff offered one-to-one talks and coping skills throughout the day. As the afternoon progressed, [client B] began yelling and hit and scratched staff. Verbal redirection and blocking was (sic) ineffective, and staff placed her in a two-person You're Safe, I'm Safe Hold. [Client B] became calm and staff released the hold. [Client B] apologized and took her 5:00 PM medication and ate supper wither housemates. [Client B] remained on 15-minute checks per new admission protocol. Staff checked on [client B] in her bedroom and saw her attempting to ties shoelaces around her neck. Staff cut the laces and removed them from her room and placed her on one-to-one supervision for safety. [Client B] grabbed staff by the hair and pulled staffs (sic) head forcefully against the wall. Staff placed her in a two-person You're Safe, I'm Safe Hold. When [client B] became calm, staff released the hold. [Client B] said she was going to turn on her television to listen to music, but instead punched the television, causing it to break. She attempted to pull the television off of the wall mounting and when staff blocked, she resumed hitting them. Staff placed her in a third two-person You're Safe, I'm Safe Hold. [Client B] became calm and staff released the hold. She sat on her bed and began scratching her left forearm. Staff redirected her verbally and encouraged coping skills. Staff played music for [client B] and she calmed and resumed her evening routine. Staff were in communication with the supervisor, nurse,			

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	behavioral clinician, and administrative team throughout the incident. Plan to Resolve: [Client B] received post incident supportive conversation and reassurance. She sustained three, two-inch superficial horizontal scratches on her left forearm. Staff provided first aid and will document the healing process on an injury follow-up flow sheet. [Client B] has a history of verbal and physical aggression, agitation, anxiety, and self-injurious behaviors addressed in her Behavior Support Plan. The use of You're Safe, I'm Safe has guardian and Human Rights Committee approval and is included in her plan. The holds lasted for four minutes, six minutes, and five minutes with repositioning for comfort every two to three minutes minutes. Staff will continue to implement the proactive and reactive strategies in [client B's] plan to help reduce and prevent further occurrences". -Five additional BDS reports for client B dated 12/16/23, 12/11/23, 12/10/23, 12/3/23 and 12/2/23 were reviewed. Those incidents included breaking items to cause harm to herself, striking her head on the wall, attempting to put her finger in an electrical outlet, elopement, property destruction, laying in the road, physical aggression, police involvement and psychiatric evaluations/admissions at the hospital. On 1/30/24 at 11:00 AM, client A's record was reviewed. Client A's 1/19/24 (revised 1/27/24) Behavior Support Plan (BSP) indicated the following: -Client A's target behaviors included physical aggression, verbal aggression, self-injury behavior, elopement, task refusal/non-compliance, suicidal ideation, inappropriate sexual behaviors,			

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	disruptive behaviors and impulse control issues. -Client A was restricted from sharps. -Client A was on enhanced supervision/secured residential environment: "To protect client from placing herself at risk of harm and exploitation outside of the residential environment without supervision of staff". -Modified Enhanced Supervision (MES) Protocols: "When [client A] demonstrates she may be a threat to herself (through the expression of suicidal ideations or other high intensity displays of behaviors), supervision will move from Modified Enhanced Supervision (sic) to Enhanced Supervision (sic) protocols. During these displays, [client A] needs the support and heightened supervision protocols that Enhanced Supervision provide; these specific measures are to be implemented when [client A] is potentially a threat to herself or others while at home and in the community. MES means that [client A] is on Enhanced Supervision and not able to enter the community. The MES protocol (when implemented) will be evaluated every 2-hours by the RM (Residential Manager)/AS (Area Supervisor)/QIDP (Qualified Intellectual Disabilities Professional) and Behaviorist. Any item/belonging of [client A's] deemed by staff to be a dangerous object/belongings (example: belts, cords) should be removed from her bedroom until the displays of behavior have ceased and [client A] has displayed a state of calm for a minimum period of 2-hours or until safe to return those items. [Client A] should not be unsupervised during this period and the staff should record [client A's] movements/activities on the 15-minute check sheet/paperwork which should be maintained in [client A's] documentation binder.			

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	Preventive/Proactive Procedures: 3. The doors to the Med Room will remain closed and locked at all times.... 7. At the first sign of a precursor behavior by [client A] or any of the housemates, lock the sharps (or items which can easily be made into a sharp) which includes, eating utensils (such as forks, spoons, knives), cooking utensils (spatulas, wooden spoons, serving spoons, measuring cups, measuring spoons, ice cream scoops, pizza cutters, whisk, cookie cutters, meat thermometers, potato peelers). Any cleaning solutions or chemicals which could be ingested should also be secured, including cleaning chemicals. These items should remain secured until the immediate risk from exposure has passed and/or until [client A] has been assessed as being in control of herself (physically) and emotions and no longer poses a risk of danger to herself and/or others within the immediate environment". On 1/31/24 at 1:30 PM, client B's record was reviewed. Client B's 1/10/24 BSP indicated the following: -Target behaviors included physical aggression, verbal aggression, self-injury behavior, disruptive behaviors, non-compliance with health and safety (refusing medication and medical appointments), elopement and impulse control issues. -Client B was on enhanced supervision/secured residential environment: "To protect client from placing herself at risk of harm and exploitation outside of the residential environment without supervision of staff". -Modified Enhanced Supervision (MES) Protocols: "When [client B] demonstrates she			

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	may be a threat to herself (through the expression of suicidal ideations or other high intensity displays of behaviors), supervision will move from Modified Enhanced Supervision (sic) to Enhanced Supervision (sic) protocols. During these displays, [client B] needs the support and heightened supervision protocols that Enhanced Supervision provide; these specifi c measures are to be implemented when [client B] is potentially a threat to herself or others while at home and in the community. MES means that [client B] is on Enhanced Supervision and not able to enter the community. The MES protocol (when implemented) will be evaluated every 2-hours by the RM (Residential Manager)/AS (Area Supervisor)/QIDP (Qualified Intellectual Disabilities Professional) and Behaviorist. Any item/belonging of [client B's] deemed by staff to be a dangerous object/belongings (example: belts, cords) should be removed from her bedroom until the displays of behavior have ceased and [client B] has displayed a state of calm for a minimum period of 2-hours or until safe to return those items. [Client B] should not be unsupervised during this period and the staff should record [client B's] movements/activities on the 15-minute check sheet/paperwork which should be maintained in [client B's] documentation binder. Preventive/Proactive Procedures: 7. At the first sign of a			

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	precursor behavior by [client B] or any of the housemates, lock the sharps (or items which can easily be made into a sharp) which includes, eating utensils (such as forks, spoons, knives), cooking utensils (spatulas, wooden spoons, serving spoons, measuring cups, measuring spoons, ice cream scoops, pizza cutters, whisk, cookie cutters, meat thermometers, potato peelers). Any cleaning solutions or chemicals which could be ingested should also be secured, including cleaning chemicals. These items should remain secured until the immediate risk from exposure has passed and/or until [client B] has been assessed as being in control of herself (physically) and emotions and no longer poses a risk of danger to herself and/or others within the immediate environment". On 1/30/24 at 3:26 PM, staff #2 was interviewed. Staff #2 was asked if enough staff worked at the group home to implement plans and keep the clients safe. Staff #2 stated, "There's not enough. There's just not enough. We have 3 staff (day shift) and on night staff we only have 2. If 2 are 1:1 that leaves the other 2 with nobody". Staff #2 indicated client C was 1:1 24 hours a day. On 1/30/24 at 4:26 PM, staff #3 was interviewed. Staff #3 was asked if enough staff worked at the group home to implement plans and keep the clients safe. Staff #2 stated, "Right now			

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	considering we have at least one 1 on 1. When you have 2 staff for the other 3, it's hard to implement plans sometimes. It would be good to have 4 so there is an extra person if something happens. Three staff is doable when nothing is going on, but during behaviors it isn't enough". On 1/30/24 at 5:13 PM, staff #1 was interviewed. Staff #3 was asked if enough staff worked at the group home to implement plans and keep the clients safe. Staff #1 stated, "We definitely need a 4th. It is not too great. I feel really bad when the other behaviors are happening. [Client D] sometimes has an accident in the middle of behaviors and that leaves her to wait. Three of the 4 girls are 2 person transports. We usually find someone to come in for appointments". Staff #1 was asked how many staff were on each shift. Staff #1 stated, "Three on our shift (day shift) and 2 on overnight. Additional staff might prevent [client A] and [client B's] behaviors. Many times [client A] waits until [Area Supervisor] and [Program Director] leave then she has behaviors". On 1/30/24 at 1:20 PM, the Behavior Clinician (BC) was interviewed. The BC indicated client A has made multiple threats and attempts to attack her peers and staff have been successful with blocking all of the attempts but two. The BC indicated client A targets client C, but client A has 1:1 staffing			

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	so staff is always with her. The BC indicated when client A starts to escalate, the other clients are moved to a different location so they aren't around her. The BC indicated YSIS isn't always effective with client A due to her size. The BC stated, "If YSIS isn't effective they continue to try. A lot of times she is able to break away. She will go out, elope then the neighbors call the police. 911 is called when they (staff) can't control her. The premeditation is what scares me. This last incident she premeditated how she could get in the kitchen. She looks for everything with glass in so she can hurt herself". The BC indicated client A's behavior started to escalate after Christmas and it has continued to escalate since then. The BC indicated client B was still adjusting to the group home as she just moved in on 11/27/23. The BC indicated client B was not safe when she displays behaviors of eloping, laying in road, banging her head, cutting herself and wrapping shoestrings around her neck. The BC indicated physical redirection was successful with client B. The BC was asked if there were enough staff to effectively implement the BSPs. The BC stated, "On a normal day to day basis, yes. If we could have an extra person on a day when we have behaviors that would be great". On 1/31/24 at 9:30 AM, the Qualified			

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	Intellectual Disabilities Professional Manager/Qualified Intellectual Disabilities Professional (QIDPM/QIDP) and the Operations Support Specialist (OSS) were interviewed. The QIDPM/QIDP indicated the last time he visited the home was in late November or early December 2023. The QIDPM/QIDP indicated client A's behavioral episodes have increased in the last month. The QIDPM/QIDP indicated client A asks for her PRN when she feels anxious and it has helped her calm down at times. The QIDPM/QIDP stated, "The other piece of this is [client A] came to us with a completely inaccurate and inappropriate list of diagnoses. They (BC and Psychiatrist) are working on clearing up the diagnostic mess. Her psych (psychiatric) team is working to figure out what she needs to get her back on track. The Operations Manager has authorized an additional staff. Originally we were discussing 1:1. However, that tends to increase her anxiety. We need someone completely dialed in to her at all times. We are not calling it a 1:1 because that gives staff the idea they are to all be in her business. We are going to have a single staff assigned to work with [client A] for skills training, recreational opportunities and they will be trained to be tuned in on precursor behaviors. The 3rd staff will be from 8:00 AM to 8:00 PM, 7 days a week.			

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	When she is agitated in the evening we will keep that staffing in place. They will be trained to the effect that they are 1:1. Another staff will cover if they have to go to bathroom. We are also talking about switching out staff throughout the shift. With that in place in addition to [client C's] 1:1 there will be 2 additional staff in the home for either [client A] or [client B]. When they escalate it takes more than 1 staff. Once again we are being reactive I know. There is no easy answer for that. [PD] has been asking for additional staff over there since before they came. We need the resources in place. There isn't a paper trail saying we don't have enough staff. The Governing Body reads these reports (incident reports and BDS reports). The ED (Executive Director) sees every BDS report. The team as a whole sees all of it. That is our focus right now. We are going to talk with guardian to see if she will approve (plan). The 1:1 will help keep people safe". The QIDPM/QIDP indicated staffing levels should be based on the needs of the clients. The QIDPM/QIDP was asked if there was a sufficient amount of staff to implement plans effectively, provide needed care and services to prevent injuries and keep clients safe. The QIDPM/QIDP stated, "No, there is no way". The QIDPM/QIDP indicated client B has been hospitalized a lot of the			

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	time she has been placed so there hasn't been much time for her to adjust to living at the group home. The QIDPM/QIDP indicated staff should have prevented the behaviors from occurring. The QIDPM/QIDP indicated client B's BSP was being updated as they learn more about her. This federal tag relates to complaints #IN00422381 and #IN00426491. 9-3-3(a)			