STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G811	A. BUILDING 00 B. WING	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the pre-determined full recertification and state licensure survey. Dates of Survey: 6/24/24, 6/25/24, 6/26/24, 6/27/24, 6/28/24, 7/1/24 and 7/5/24. Facility Number: 013405 Provider Number: 15G811 AIMS Number: 201267570 These deficiencies also reflect state findings in accordance with 410 IAC 16.2-5. Quality Review of this report completed by #15068 on 7/22/24.	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 the facility failed to meet the Condition of Participation: Governing Body for 1 of 4 sampled clients (#1), plus 3 additional clients (#9, #18 and #21). The facility's governing body failed to exercise operating direction over the facility by failing to ensure the facility was maintained in good repair, to ensure the facility had a complete record for clients #1, #2 and #4 available upon request, to ensure the facility ensured clients #1 and #9 participated in their community outing to eat their food inside a restaurant, to ensure the facility implemented its written policy and procedures to prevent neglect of client #18 regarding elopement from the facility and to develop and implement	W 0102	To correct the deficient practice, all DSP's have been trained on the following: Reporting maintenance issues timely, ensuring clients have a choice to dine in or carry out from restaurants while following plans as written, ResCare ANEM policy and procedure, #2's and all other client dining plans, #3, #6 and all other client BSP's, All client ISP goals completed as written, formally and informally, client dignity, All client adaptive equipment needs and procedures, cleanliness of the facility, infection control prevention, and all client	08/04/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Patrick O'Heran	QAM	08/05/2024

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	safeguards while investigating an elopement incident and to prevent neglect of client #21 and thoroughly investigate the circumstances of an aspiration incident regarding client #21, to ensure the facility ensured the Behavior Technician assisted with intervening during behavioral episodes at the facility, to ensure the facility ensured staff were competent in clients #1 and #4's data collection, client #2's dining plan implementation and clients #3 and #6's BSPs (Behavior Support Plans), to ensure the facility ensured a plan was developed to address client #1's smoking schedule, to ensure the facility implemented client #3's Behavior Support Plan (BSP) and clients #2, #8 and #9's Individual Support Plan (ISP) objectives during formal and informal opportunities, to ensure the facility ensured client #2's feet were clean, client #11 wore a clean shirt, client #12 wore clean shirts and his face was clean after eating and client #10 did not have his shorts on backwards or food around his mouth after eating, to ensure the facility ensured client #1's adaptive supports for hearing instruments were worn and to ensure client #9's adaptive supports for knee pads and a helmet to prevent injury during a fall were worn while he ambulated during his morning routine and to ensure the facilty ensured the group home was clean and sanitary in order to avoid sources and transmission of infections. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for clients #1, #9, #18 and #21. Findings include: 1. The facility's governing body failed to exercise operating direction over the facility by failing to ensure the facility was maintained in good repair,		data collection procedures. All supervisory staff have been trained on the following: Ensuring all records are available in the client's official record to not impede the survey process, Developing and implementing safeguards to prevent neglect and elopement, components of a thorough investigation, Ensuring recommendations are created and implemented, Ensuring appropriate plans are in place for each client. The BC has been trained on intervening, coaching, and modeling. The following has been put in place to prevent reoccurrence: All maintenance issues are being monitored and contracted out for resolution. A staff will be assigned daily to inspect and ensure each client is maintaining their dignity. The PM will review the dignity checklist daily and rectify any issues noted. A table of contents for client charts has been implemented to ensure the QIDP and nursing staff have all records printed and available. Each client's outing will be scheduled weekly by the RM's. Each client will choose the destination and whether to dine in or carry out. This will be documented on the daily assignments log reviewed by the PM weekly. An investigation and peer review conducted for #18. The investigation affecting #21 will be re-opened with an addendum	

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	to ensure the facility had a complete record for clients #1, #2 and #4 available upon request, to ensure the facility ensured clients #1 and #9 participated in their community outing to eat their food inside a restaurant, to ensure the facility implemented its written policy and procedures to prevent neglect of client #18 regarding elopement from the facility and to develop and implement safeguards while investigating an elopement incident and to prevent neglect of client #21 and thoroughly investigate the circumstances of an aspiration incident regarding client #21, to ensure the facility ensured the Behavior Technician assisted with intervening during behavioral episodes at the facility, to ensure the facility ensured staff were competent in clients #1 and #4's data collection, client #2's dining plan implementation and clients #3 and #6's BSPs (Behavior Support Plans), to ensure the facility ensured a plan was developed to address client #1's smoking schedule, to ensure the facility implemented client #3's Behavior Support Plan (BSP) and clients #2, #8 and #9's Individual Support Plan (ISP) objectives during formal and informal opportunities, to ensure the facility ensured client #2's feet were clean, client #11 wore a clean shirt, client #12 wore clean shirts and his face was clean after eating and client #10 did not have his shorts on backwards or food around his mouth after eating, to ensure the facility ensured client #1's adaptive supports for hearing instruments were worn and to ensure client #9's adaptive supports for knee pads and a helmet to prevent injury during a fall were worn while he ambulated during his morning routine and to ensure the facilty ensured the group home was clean and sanitary in order to avoid sources and transmission of infections. Please see W104. 2. The governing body failed to ensure the facility		added with any additional findings. All windows in the facility have been secured within IDOH LSC guidelines, windows are alarmed, a security checklist has been implemented to ensure windows are secured, alarms are mounted, vehicles are locked, and no contraband is on the grounds, a transition IDT has been created to address needs from current placement and moving forward into future placement. All allegations of ANEM will be reviewed by the ED to ensure appropriate safeguards are put in place during the investigation. The regional operations support specialist will review all ANEM investigations to ensure they are thorough; A smoking plan has been created and implemented for client #1. Additional monitoring will be achieved by daily administrative observations to ensure staff are implementing all policies, procedures, documentation, and plans as written. The administrative team will evaluate the observation frequency monthly to determine if the observations should continue, decrease, or increase. The administrative team will meet daily to discuss any or incident follow up in the facility. The lead BC will meet weekly with the BC completing observations to discuss any client's needs, staff training, and any training the BC may need. The QAM will meet	

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	met the Condition of Participation: Client Protections for clients #1, #9, #18 and #21. Please see W122. 5-1.3(a)(1-2)(a)(b)(c) 5-1.5(a)		weekly with all investigators to ensure all investigations have been assigned, investigated thoroughly, and appropriate recommendations are in place. Ongoing monitoring will be achieved by the administrative team completing monthly facility site reviews, record reviews, and quarterly quality and safety reviews for incident patterns, follow up, and thoroughness.	
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 4 of 4 sampled clients (#1, #2, #3 and #4) and 16 additional clients (#5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20), the facility's governing body failed to exercise operating direction over the facility by failing to ensure the facility was maintained in good repair, to ensure the facility had a complete record for clients #1, #2 and #4 available upon request, to ensure the facility ensured clients #1 and #9 participated in their community outing to eat their food inside a restaurant, to ensure the facility implemented its written policy and procedures to prevent neglect of client #18 regarding elopement from the facility and to develop and implement safeguards while investigating an elopement incident and to prevent neglect of client #21 and thoroughly investigate the circumstances of an aspiration incident regarding client #21, to ensure the facility ensured the Behavior Technician assisted with intervening during behavioral episodes at the	W 0104	To correct the deficient practice, all DSP's have been trained on the following: Reporting maintenance issues timely, ensuring clients have a choice to dine in or carry out from restaurants while following plans as written, ResCare ANEM policy and procedure, #2's and all other client dining plans, #3, #6 and all other client BSP's, All client ISP goals completed as written, formally and informally, client dignity, All client adaptive equipment needs and procedures, cleanliness of the facility, infection control prevention, and all client data collection procedures. All supervisory staff have been trained on the following: Ensuring all records are available in the client's official record to not impede the	08/04/2024

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	facility, to ensure the facility ensured staff were competent in clients #1 and #4's data collection, client #2's dining plan implementation and clients #3 and #6's BSPs (Behavior Support Plans), to ensure the facility ensured a plan was developed to address client #1's smoking schedule, to ensure the facility implemented client #3's Behavior Support Plan (BSP) and clients #2, #8 and #9's Individual Support Plan (ISP) objectives during formal and informal opportunities, to ensure the facility ensured client #2's feet were clean, client #11 wore a clean shirt, client #12 wore clean shirts and his face was clean after eating and client #10 did not have his shorts on backwards or food around his mouth after eating, to ensure the facility ensured client #1's adaptive supports for hearing instruments were worn and to ensure client #9's adaptive supports for knee pads and a helmet to prevent injury during a fall were worn while he ambulated during his morning routine and to ensure the facilty ensured the facility was clean and sanitary in order to avoid sources and transmission of infections. Findings include: 1. Observations were conducted on 6/24/24 from 1:00 PM to 3:29 PM and from 4:44 PM to 6:11 PM at the residential living area. These environmental issues affected clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20. At 1:02 PM, the Pacer hallway bathroom was observed to be missing tile and base board trim on and/or around the floor. At 2:17 PM, in the dining area missing base board trim along the floor was observed. At 5:16 PM, client #4's bedroom wall was observed to have a large area above his bed with paint missing. The area was approximately a 2-foot by 2-foot area of missing paint.		survey process, Developing and implementing safeguards to prevent neglect and elopement, components of a thorough investigation, Ensuring recommendations are created and implemented, Ensuring appropriate plans are in place for each client. The BC has been trained on intervening, coaching, and modeling. The following has been put in place to prevent reoccurrence: All maintenance issues are being monitored and contracted out for resolution. A staff will be assigned daily to inspect and ensure each client is maintaining their dignity. The PM will review the dignity checklist daily and rectify any issues noted. A table of contents for client charts has been implemented to ensure the QIDP and nursing staff have all records printed and available. Each client's outing will be scheduled weekly by the RM's. Each client will choose the destination and whether to dine in or carry out. This will be documented on the daily assignments log reviewed by the PM weekly. An investigation and peer review conducted for #18. The investigation affecting #21 will be re-opened with an addendum added with any additional findings. All windows in the facility have been secured within IDOH LSC guidelines, windows are alarmed, a security checklist has been	

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	On 6/27/24 at 9:57 AM, the Program Manager (PM) and Quality Assurance Manager (QAM) were interviewed. The PM and QAM were asked about workorders for repair of the missing tile, base board trim and paint on walls. The QAM stated, "Maybe an email chain, but there is no maintenance person. We hired a part-time guy on weekends. We're trying to hire. We contract vendors when we have too. [Program Manager] has made a list of things to send to [Executive Director]. It's been a problem since January (2024). It's been a struggle since the maintenance person's been gone". The QAM was asked how the facility should be maintained. The QAM stated, "In a timely manner. Repairs should be timely based on supply". The PM was asked if the facility should be in good repair. The PM stated, "Yes". The PM and QAM indicated no workorders for maintenance repairs could be provided for review. The PM and QAM indicated further follow up was needed to ensure the facility was maintained in good repair. Observations were conducted on 6/24/24 from 1:00 PM to 5:30 PM at the residential living area. These environmental issues affected clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20. At 1:08 PM, the kitchen was missing a drawer on the island facing the wall. There was also a missing drawer on the opposite side of the island on the side that faces the stove. At 1:12 PM the kitchen was observed to be missing paint from the back splash behind the kitchen sink to the window sill. The area was approximately a 1 1/2 foot by 4 foot area of missing paint. Observations were conducted on 6/25/24 from 6:05 AM until 8:26 AM and 11:15 AM until 12:34		implemented to ensure windows are secured, alarms are mounted, vehicles are locked, and no contraband is on the grounds, a transition IDT has been created to address needs from current placement and moving forward into future placement. All allegations of ANEM will be reviewed by the ED to ensure appropriate safeguards are put in place during the investigation. The regional operations support specialist will review all ANEM investigations to ensure they are thorough; A smoking plan has been created and implemented for client #1. Additional monitoring will be achieved by daily administrative observations to ensure staff are implementing all policies, procedures, documentation, and plans as written. The administrative team will evaluate the observation frequency monthly to determine if the observations should continue, decrease, or increase. The administrative team will meet daily to discuss any or incident follow up in the facility. The lead BC will meet weekly with the BC completing observations to discuss any client's needs, staff training, and any training the BC may need. The QAM will meet weekly with all investigators to ensure all investigations have been assigned, investigated thoroughly, and appropriate recommendations are in place. Ongoing monitoring	

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	PM at the residential living area. At 6:20 AM there was black ash on the brick/stone wall on the front porch of the building. There were 3 cigarette butts on a piece of stone that stuck out from the brick wall. There was a plastic spoon and a banana peel on the front porch. At 12:23 PM client #1 was showing the surveyor his bedroom he shares with client #10. At 12:24 PM client #1 stated, "my bedroom smells terrible, [client #10] pees in our room." Client #1 stated, "I have told staff about it." On 6/27/24 at 9:57 AM, the Program Manager (PM) and Quality Assurance Manager (QAM) were interviewed. The PM and QAM were asked about work orders for repair of the missing tile, base board trim and paint on walls. The QAM stated, "Maybe an email chain, but there is no maintenance person. We hired a part-time guy on weekends. We're trying to hire. We contract vendors when we have to. [Program Manager] has made a list of things to send to [Executive Director]. It's been a problem since January (2024). It's been a struggle since the maintenance person's been gone". The QAM was asked how the facility should be maintained. The QAM stated, "In a timely manner. Repairs should be timely based on supply". The PM was asked if the facility should be in good repair. The PM stated, "Yes". The PM and QAM indicated no work orders for maintenance repairs could be provided for review. The PM and QAM indicated further follow up was needed to ensure the facility was maintained in good repair. Observations were conducted at the facility on 6/24/24 from 1:00 PM to 3:29 PM, on 6/25/24 from 5:50 AM to 9:15 AM and 10:46 AM to 11:42 AM and on 6/27/24 from 11:52 AM to 12:18 PM.		will be achieved by the administrative team completing monthly facility site reviews, record reviews, and quarterly quality and safety reviews for incident patterns, follow up, and thoroughness.	

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	During the observations, the following issues were noted affecting clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20: -There was a strong odor in the Colts hallway outside clients #1 and #10's bedroom and the bathroom with a sink and toilet, across the hall from their bedroom. -In the Colts hallway bathroom with a toilet and sink, there were missing tiles in front of the toilet measuring 12 inches by 4 inches. - In the Colts hallway bathroom with the shower and bathtub, there were missing tiles at the threshold going into the shower measuring 12 inches by 6 inches. DSP (Direct Support Professional) #10 was interviewed on 6/27/24 at 12:12 PM. DSP #10 indicated the bathroom in the Colts hallway with the toilet and sink was the toilet the clients use. DSP #10 indicated clients urinate on the bathroom floor causing an odor. An observation was conducted at the agency on 6/27/24 from 11:00 AM through 11:25 AM. Clients #1 and #12's shared bedroom had a strong unpleasant odor. Client #15's bedroom had an overpowering pungent odor. SS (Shift Supervisor) was interviewed on 6/27/24 at 11:12 AM. SS indicated clients #1 and #12's bedroom had a strong unpleasant odor. SS was interviewed on 6/27/24 at 11:19 AM. SS indicated client #15's room had a strong unpleasant odor. 2. The governing body failed to ensure the facility had a complete record for clients #1, #2 and #4 available upon request. Please see W111.			

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	3. The governing body failed to ensure the facility ensured clients #1 and #9 participated in their community outing to eat their food inside a restaurant. Please see W136. 4. The governing body failed to ensure the facility implemented its written policy and procedures to prevent neglect of client #18 regarding elopement from the facility and to develop and implement safeguards while investigating an elopement incident, and to prevent neglect of client #21 and thoroughly investigate the circumstances of an aspiration incident regarding client #21. Please see W149. 5. The governing body failed to ensure the facility thoroughly investigated the circumstances of an aspiration incident regarding client #21. Please see W154. 6. The governing body failed to ensure the facility developed and implemented safeguards while investigating an elopement incident regarding client #18. Please see W155. 7. The governing body failed to ensure the facility ensured the Behavior Technician assisted with intervening during behavioral episodes at the facility for clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20. Please see W164. 8. The governing body failed to ensure the facility ensured staff were competent in clients #1 and #4's data collection, client #2's dining plan implementation and clients #3 and #6's BSPs (Behavior Support Plans). Please see W189. 9. The governing body failed to ensure the facility			

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	ensured a plan was developed to address client #1's smoking schedule. Please see W240. 10. The governing body failed to ensure the facility implemented client #3's Behavior Support Plan (BSP) and clients #2, #8 and #9's Individual Support Plan (ISP) objectives during formal and informal opportunities. Please see W249. 11. The governing body failed to ensure the facility ensured client #2's feet were clean, clients #11 wore a clean shirt, client #12 wore clean shirts and his face was clean after eating and client #10 did not have his shorts on backwards or food around his mouth after eating. Please see W268. 12. The governing body failed to ensure the facility ensured client #1's adaptive supports for hearing instruments were worn and to ensure client #9's adaptive supports for knee pads and a helmet to prevent injury during a fall were worn while he ambulated during his morning routine. Please see W436. 13. The governing body failed to ensure the facility ensured the group home was clean and sanitary in order to avoid sources and transmission of infections for clients #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20.. Please see W454. 5-1.3(a)(1-2)(a)(b)(c) 5-1.5(a)			
W 0111 Bldg. 00	483.410(c)(1) CLIENT RECORDS The facility must develop and maintain a recordkeeping system that documents the client's health care, active treatment, social information, and protection of the client's			

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	rights. Based on record review and interview for 3 of 4 sampled clients (#1, #2 and #4), the facility failed to have a complete record for clients #1, #2 and #4 available upon request. Findings include: 1. On 6/26/24 at 9:35 AM, a review of client #1's record was conducted. The review indicated the following healthcare and program records were not maintained with current documentation in client #1's record: Interdisciplinary team meeting (IDT) minutes. Quarterly reviews for program plan progress. Human Rights Committee (HRC) approvals. Quarterly pharmacy reviews Discharge criteria On 6/27/24 at 9:57 AM, an interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) and Quality Assurance Manager (QAM). The QIDP and QAM were asked about client #1's IDTs, quarterly reviews, HRCs and pharmacy reviews. The QAM stated, "It was not printed". The QIDP stated, "I know how to move around Teams (electronic system)". The QAM stated, "We have TMP (electronic record)... and we have paper charts. Currently everything should be in there (charts). The things we're failing to provide, were not printed... The working thing (recordkeeping) is Teams and the current system is the chart. We're not there yet to give you access. It's really only the progress notes". The QAM was asked about the recordkeeping system and availability of pharmacy reviews. The QAM stated, "I would like to give them to you. I have them. The ones I'm able to see are not signed by the doctor". The	W 0111	To correct the deficient practice, the individuals responsible for records have been trained ensuring all records are available in the client's official record in order to not impede the survey process. A table of contents for client charts has been implemented to ensure the QIDP and nursing staff have all records printed and available. To ensure no others were affected a review of all clients will be conducted. Ongoing monitoring will be achieved by the record reviews.	08/04/2024

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	QAM was asked if the pharmacy reviews were maintained in TMP. The QAM stated, "Yes, I'll look for the signed ones".2. Client #2's record was reviewed on 6/26/24 at 11:29 AM. The following documents were missing from client #2's record: 1. HRC (Human Rights Committee) approval of client #2's ISP (Individual Support Plan) and BSP (Behavior Support Plan) with restrictions. 2. Pharmacy review of client #2's medications. 3. The IDT (Interdisciplinary Team) meeting notes. 4. The quarterly reviews of client #2's ISP and BSP objectives.3. On 6/26/24 at 11:02 AM, a review of client #4's record was conducted. The review indicated the following healthcare and program records were not maintained with current documentation in client #4's record: Interdisciplinary team meeting (IDT) minutes. Quarterly reviews for program plan progress. Human Rights Committee (HRC) approvals. Quarterly pharmacy reviews. On 6/27/24 at 9:57 AM, an interview was conducted with the Qualified Intellectual Disabilities Professional (QIDP) and Quality Assurance Manager (QAM). The QIDP and QAM were asked about client #4's IDTs, quarterly reviews, HRCs and pharmacy reviews. The QAM stated, "It was not printed". The QIDP stated, "I know how to move around Teams (electronic system)". The QAM stated, "We have TMP (electronic record)... and we have paper charts. Currently everything should be in there (charts). The things we're failing to provide, were not printed... The working thing (recordkeeping) is Teams and the current system is the chart. We're not there yet to give you access. It's really only			

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	the progress notes". The QAM was asked about the recordkeeping system and availability of pharmacy reviews. The QAM stated, "I would like to give them to you. I have them. The ones I'm able to see are not signed by the doctor". The QAM was asked if the pharmacy reviews were maintained in TMP. The QAM stated, "Yes, I'll look for the signed ones".			
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 the facility failed to meet the Condition of Participation: Client Protections for 1 of 4 sampled clients (#1), plus 3 additional clients (#9, #18 and #21). The facility failed to ensure clients #1 and #9 participated in their community outing to eat their food inside a restaurant and the facility failed to implement its written policy and procedures to prevent neglect of client #18 regarding elopement from the facility and to develop and implement safeguards while investigating an elopement incident and to prevent neglect of client #21 and thoroughly investigate the circumstances of an aspiration incident regarding client #21. Findings include: 1. The facility failed to ensure clients #1 and #9 participated in their community outing to eat their food inside a restaurant. Please see W136. 2. The facility failed to implement its written policy and procedures to prevent neglect of client #18 regarding elopement from the facility and to develop and implement safeguards while	W 0122	To correct the deficient practice, all DSP's have been trained the following: ensuring clients have a choice to dine in or use carry out while following plans as written, and ResCare ANEM policy and procedure. All supervisory staff have been trained the following: Developing and implementing safeguards to prevent neglect and elopement, components of a thorough investigation, Ensuring appropriate plans are in place for each client. The following has been put in place to prevent recurrence: Each client's outing will be scheduled weekly by the RM's, client will choose the destination and whether to dine in or use carry out. This will be documented on the daily assignments log reviewed by the PM weekly. An investigation and peer review conducted for #18. The investigation affecting #21 will be re-opened with an addendum added with any additional findings.	08/04/2024

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	investigating an elopement incident and to prevent neglect of client #21 and thoroughly investigate the circumstances of an aspiration incident regarding client #21. Please see W149. 3. The facility failed to thoroughly investigate the circumstances of an aspiration incident regarding client #21. Please see W154. 4. The facility failed to develop and implement safeguards while investigating an elopement incident regarding client #18. Please see W155. 5-1.2(v)(2)(5)		All windows in the facility have been secured within IDOH LSC guidelines, windows are alarmed, a security checklist has been implemented to ensure windows are secured, alarms are mounted, vehicles are locked, and no contraband is on the grounds, a transition IDT has been created to address needs from current placement and moving forward into future placement. All allegations of ANEM will be reviewed by the ED to ensure appropriate safeguards are put in place during the investigation. The regional operations support specialist will review all ANEM investigations to ensure they are thorough. Additional monitoring will be achieved by daily administrative observations to ensure staff are implementing all policies, procedures, documentation, and plans as written. The administrative team will evaluate the observation frequency monthly to determine if the observations should continue, decrease, or increase. The administrative team will meet daily to discuss any needs or incident follow up in the facility. Ongoing monitoring will be achieved by the administrative team completing monthly facility site reviews, record reviews, and quarterly quality and safety reviews for incident patterns, follow up, and thoroughness.	

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W 0136 Bldg. 00	483.420(a)(11) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the opportunity to participate in social, religious, and community group activities. Based on observation, record review and interview for 1 of 4 sampled clients (#1), plus 1 additional client (#9), the facility failed to ensure clients #1 and #9 participated in their community outing to eat their food inside a restaurant. Findings include: 1. Observations were conducted on 6/24/24 from 1:00 PM until 5:30 PM at the residential living area. At 1:30 PM client #1 was sitting on the front porch of the residential living area with a take out container of chicken wings from a local chicken wing restaurant. Client #1 had chicken wings, french fries and a bottle of soda pop. At 1:32 PM the PM (Program Manager) stated, "[Client #1] had his personal outing today and he chose a local chicken wing restaurant and brought his food back to the facility to eat." Observations were conducted on 6/24/24 from 4:24 PM until 5:30 PM at the recreational building. At 4:49 PM client #1 was in the recreational building eating his dinner. Client #1 had chicken wings from a local chicken wing restaurant and french fries for dinner. Client #1 stated, "I saved my leftovers for dinner today. Client #1's record review was completed on 6/26/24 at 9:35 AM. Client #1's ISP (Individualized Support Plan) dated 5/15/24 indicated, "Needs:....to improve social interaction."	W 0136	To correct the deficient practice, all DSP's have been trained the following: ensuring clients have a choice to dine in or use carry out while following plans as written. Each client's outing will be scheduled weekly by the RM's, each client will choose the destination and whether to dine in or use carry out. This will be documented on the daily assignments log reviewed by the PM weekly. Additional monitoring will be achieved by daily administrative observations to ensure staff are implementing all policies, procedures, documentation, and plans as written. The administrative team will evaluate the observation frequency monthly to determine if the observations should continue, decrease, or increase. The administrative team will meet daily to discuss any needs or incident follow up in the facility. Ongoing monitoring will be achieved by the QIDP completing monthly reviews of community outings.	08/04/2024

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	On 6/25/24 at 12:25 PM an interview with client #1 was conducted. Client #1 stated,"I would like to eat inside at resturants, but they don't let me." On 6/27/24 at 9:57 AM, the Program Manager (PM) and Quality Assurance Manager (QAM) were interviewed. The PM and QAM were asked about the expectation for the implementation of community integration through weekly community outings. The PM stated, "They (clients) should have, yes". The PM was asked to describe client #1's weekly community integration activities. The PM stated, "[Client #1] went to [restaurant] and got his chicken wings and then goes to [name of convenient store] to get a soda." The PM was asked about eating food purchased inside the restaurants or if client #1 brought those foods back to the residence to eat them. The PM stated, "Sometimes they do. Typically, they go get what they want, fast food, [name of store #1], [name of store #1]. Typically, they bring the food back. They go in and pick out what they are wanting". The QAM stated, "It takes further planning for outings due to supervision...". 2. On 6/27/24 at 9:16 AM, a focused review of client #9's record was conducted. The review indicated the following: Individual Support Plan (ISP) dated 10/25/23 indicated, "Needs:... Desensitization Community Integration Skills...". On 6/27/24 at 9:57 AM, the Program Manager (PM) and Quality Assurance Manager (QAM) were interviewed. The PM and QAM were asked about the expectation for the implementation of community integration through weekly community outings. The PM stated, "They (clients) should have, yes". The PM was asked to describe client #9's weekly community integration activities. The			

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	PM stated, "[Client #9] went to [restaurant] and got his soft tacos and then goes to [name of convenient store] to get a couple of doughnuts". The PM was asked about eating food purchased inside the restaurants or if client #9 brought those foods back to the residence to eat them. The PM stated, "Sometimes they do. Typically, they go get what they want, fast food, [name of store #1], [name of store #1]. Typically, they bring the food back. They go in and pick out what they are wanting". The QAM stated, "It takes further planning for outings due to supervision...".			
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 additional (clients #18 and #21), the facility failed to implement its written policy and procedures to prevent neglect of client #18 regarding elopement from the facility and to develop and implement safeguards while investigating an elopement incident, and to prevent neglect of client #21 and thoroughly investigate the circumstances of an aspiration incident regarding client #21. Findings include: 1. QAM (Quality Assurance Manager) was interviewed on 6/27/24 at 9:17 AM. QAM indicated client #18 had eloped from the agency during the previous night (6/26/24). QAM indicated an off-duty staff member had seen client #18 at a nearby gas station at 10:51 PM and called the facility to report it. QAM indicated staff had seen client #18 at 10:45 PM. QAM indicated client	W 0149	To correct the deficient practice, all DSP's have been trained the ResCare ANEM policy and procedure. All supervisory staff have been trained the following: Developing and implementing safeguards to prevent neglect and elopement, components of a thorough investigation, ensuring recommendations are created and implemented. The following has been put in place to prevent recurrence: An investigation and peer review was conducted for #18. The investigation affecting #21 will be re-opened with an addendum added with any additional findings. All allegations of ANEM will be reviewed by the ED to ensure appropriate safeguards are put in place during the investigation. , the regional	08/04/2024

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	#18 was believed to have been gone for 13 minutes. QAM indicated client #18 returned to the agency with bottles of alcohol, soft drinks and candy he had stolen. QAM indicated client #18 drank the alcohol before staff could confiscate it from him. QAM indicated client #18 was sent to the ER (Emergency Room) for evaluation after the incident. QAM indicated client #18 eloped from a window in a peer's room. QAM indicated client #18 then went over the facility fence behind the gym and was placed on 1:1 supervision when he returned to the facility. QAM indicated client #18 was not on line of sight or 1:1 supervision while inside of the facility at the time of the 6/26/24 incident. QAM indicated client #18 was not on 10 or 15 minute checks at the time of the 6/26/24 incident. QAM indicated client #18 had transferred to the agency from another agency owned/operated facility on 5/3/24 after being discharged from an acute psychiatric facility. QAM indicated client #18's behavioral needs were assessed upon his admission to the facility. An additional BDS (Bureau of Disabilities Services) report was provided on 6/29/24 at 10:16 AM and was reviewed on 6/29/24 at 10:30 AM. The additional BDS report indicated the following: -BDS report dated 6/28/24 indicated, "On June 27, 2024 at 4:43 PM, [client #18] was in the dayroom when he observed members of administration placing alarms on the facility windows due to [client #18] eloping on 6/26/24... per his plan. [Client #18] then began laughing in a 'manic' tone and stated that he would not stop trying to escape the building and that if he was unsuccessful, he would kill himself. He then stated that the alarms were a joke and that he could disable them. [Client #18] would continue talking about escaping. He then began to state		operations support specialist will review all ANEM investigations to ensure they are thorough. Additional monitoring will be achieved by daily administrative observations to ensure staff are implementing all policies, procedures, documentation, and plans as written. The administrative team will evaluate the observation frequency monthly to determine if the observations should continue, decrease, or increase. The administrative team will meet daily to discuss any needs or incident follow up in the facility. Ongoing monitoring will be achieved by the administrative team completing monthly facility site reviews, record reviews, and quarterly quality and safety reviews for incident patterns, follow up, and thoroughness.	

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	that he was not afraid to kill someone or himself and continued talking about suicidal/homicidal ideations. [Client #18's] team decided that he needed to be sent to the ER (Emergency Room) for psyche (sic) evaluation. EMT's (Emergency Medical Technicians) and police officers were called and arrived on campus. [Client #18] willingly got into the ambulance and was transported to [hospital Emergency Room] to be evaluated with staff following behind. [Client #18] was evaluated and was admitted to [behavioral health facility] where he is still currently admitted. Date of discharge and discharge instructions are unknown at this time." -An additional BDS report was provided on 06/27/2024 6:15 PM and reviewed upon receipt. The 6/27/24 BDS report indicated the following: -"On June 26, 2024 at 10:45 PM staff observed [client #18] use the restroom and then return to his bedroom. At 10:51 PM, RM (unspecified Residential Manager) received a call from an off-shift staff (unspecified) stating they had seen [client #18] at a local gas station (0.3 miles from campus). Staff immediately began to search for [client #18] on and off campus. Staff found [client #18] in the recreational room on campus. They observed that [client #18] had stolen several items, including three 1.5 oz (ounce) bottles of alcohol. [Client #18] consumed the alcohol before staff could confiscate it. Nursing advised staff to transport [client #18] to the [hospital emergency room] for evaluation due to a potential reaction between the alcohol and his medication but [client #18] refused to go. Staff then called for an ambulance who transported [client #18] to the ER (Emergency Room) for evaluation. Medical staff evaluated [client #18]			

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	and made the following diagnosis: 'Normal exam'. Discharge instructions state to follow up with primary care physician as needed. [Client #18] returned to campus where he began to threaten to physically harm staff, including killing them. Staff spoke with [client #18] who requested a PRN (as needed) (medication) for agitation. Nurse (unspecified) assessed [client #18] and administered a behavioral PO (by mouth) PRN. [Client #18] was able to use his coping skills and he calmed down. He then laid down and appeared to fall asleep without further issues. Staff sat outside [client #18's] door while he slept. [Client #18] also had a 1:1 (staff to client ratio) staff while he was awake until his team was able to meet the following morning." And, "Staff will continue to follow [client #18's] guardian and HRC (Human Rights Committee) approved BSP (Behavior Support Plan) and ISP (Individual Support Plan). Staff will continue to educate [client #18] on using his coping skills when he becomes upset. Alarms were installed on all doors and windows with guardian and HRC approval. [Client #18's] supervision level was changed to a 1:1 staff 24/7." Client #18's record was reviewed on 7/1/24 at 10 AM. Client #18's BSP dated 4/4/24 indicated the following: -"[Client #18] is transitioning from [County Jail] to a Rescare ESN (Extensive Support Needs) home in [town]. Due to recent criminal involvement and homelessness, [client #18] has stayed in jail until a more suitable placement is available."			

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	-"When out in the community, [client #18] needs to be watched very closely as he has a history of stealing items, including knives and vape supplies." -"[Client #18] has a long history of physical aggression, self-injurious behavior, property destruction, elopement, stealing, homicidal statements and verbal aggression." -"Shoes: Due to elopement and thefts [client #18] will no longer have free access to shoes. All shoes to be stored in office when not on outing with staff." -"Due to housemates ' incidents of poor social interactions with other housemates, [client #18] will be restricted from entering any other private bedroom besides his own room. Other housemates will not be allowed to enter his room for any reason." -"Due to special circumstances [client #18] will be placed on 1:1 supervision until such time as the team determines fit to change. This is defined as staff in same room and able to see him at all times. The bedroom door will remain open. The exception is while in the bathroom, the door will be left open and staff will verbally check in with him every 1-2 minutes. 1:1 staff will sign on and off of the enhanced supervision log." -"Due to excessive leaving assigned area/elopement risks in the home, window and door alarms will be placed on the doors and windows of the home." -"Resident who is placed on 1:1 defined as within eyesight: [client #18].			

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	Instructions: ·1:1 is at all times and is defined as: within eyesight with the staff in the same room. The staff that is 1:1 is to remain in a response stance." Client #18's Incident Reports Form dated 11/1/23 through 5/2/24 indicated the following: -3/15/24, "[Client #18] was laying down in his room, he got up to use the restroom multiple times, which staff noted to be unusual behavior for him. Staff was monitoring [client #18] once he returned to his room and saw him go to the other side of his room, then staff heard his curtains open. Staff went to [client #18's] room and saw [client #18] had climbed out of his window. Staff stood at the window and prompted [client #18] to return back inside. [Client #18] returned inside without further issue." -3/15/24, "There are alarms on the windows in the home, installed by [company], which are supposed to alert when they have been opened or the alarm has been tampered with. Staff assessed the alarms, and they were missing pieces. [Company] will be contacted. Maintenance went to the home on 3/16, the alarm and the alarm panel was (sic) reset and are currently in working order. Staff will complete window and panel checks to ensure there are no alerts or issues with the alarms." -3/28/24, "Staff reported [client #18] was standing outside in the courtyard being antagonized by [previous placement peer] through the window. [Previous placement peer] continued to antagonize [client #18] even when prompted to stop. Staff redirected [client #18] away from the window and he walked inside. When [client #18] returned outside, he had a firearm in his hand,			

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making threats towards [previous placement peer]. Staff immediately asked [client #18] for the weapon, and he relinquished it without incident. Staff contacted police and monitored [client #18] until they arrived."

And,

-"[Client #18] stated he found the weapon in a staff members car and hid it in the house. [Client #18] was arrested and taken to [County jail]. There is no court date set at this time. Initial exploration into the incident determined the weapon belonged to [previous placement staff] and was in the vehicle of another [previous placement staff]. Both employees were placed on administrative leave pending investigation. Management went to the home immediately and sweeps of the house were completed, ensuring there were no other weapons on the property. All employees were contacted and trained on not bringing weapons onto the property and always keeping their vehicles locked. Administrative drop ins will take place in the home to ensure staff are following policies and procedures."

Client #18's IDT form dated 5/2/24 indicated client #18 was transferring from another agency operated ESN home after being discharged from an acute psychiatric facility. The 5/2/24 IDT indicated the following:

-"PURPOSE OF MEETING: Transition Meeting."

-"Discussed that this is a locked facility with a gate. [Client #18's guardian] says he is very good at escape."

The 5/2/24 IDT did not include recommendations, review or discussion or client #18's behavioral

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	support needs regarding window alarms, monitoring of the alarms for functionality or address the agency's plan to ensure staff locked their vehicles. The IDT did not address how the facility would ensure client #18 did not enter peers' rooms for access to restricted items. Client #18's 6/19/24 IDT note indicated the following: -"On 6/18/24, [client #18] was found to have a sharp piece of Plexiglass wrapped in a strap handle. Additionally, he wrote and posted a 'kill list' in the dayroom last evening including the names of 2 of his treatment team members at ResCare. A routine room sweep on 6/19/24 uncovered a hidden vape and [client #18] admitted to contacting people 'in the community' to drop off contraband items at the fence of our property. Upon searching the area by the fence, staff found chargers, vapes, and other items. Apparently, these items are being left for him but [client #18] would not disclose who is leaving them. [Client #18] also reported to staff that someone in the community is bringing him bottles of alcohol and leaving them by the fence. He states that he drank some of the bottles that were left. Team is concerned about the potential for weapons to be delivered. [Client #18] reported in front of a staff member that his brother was 'cash-apping' people in the community to bring contraband items to [client #18]. [Client #18's guardian] says this is possible but not probable. Team would also like to continue to hold off on community outings at this time due to his ongoing statements about robbing the gas station or breaking out of the facility and his overall unstable behaviors. Supervision outside of residential building will be direct line of			

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	sight by staff. RECOMMENDATIONS: Team agrees to put in place a contraband protocol which would remove all personal items from [client #18] at this time. He would still have his bed and his daily clothing and other needs, but all other personal items that can be made into weapons or that can hide/store weapons would be removed from his possession. His Switch (electronic game device) would also be taken away at this time since [client #18] is reaching out though several social media sites to strangers and has stated that these strangers are the ones leaving him contraband items. This restriction would be reviewed every 7 days and should be removed if [client #18] is demonstrating safe and non-aggressive behaviors for 7 days. Outings to be reviewed again in 14 days. Supervision outside of residential building will be direct line of sight. 5 minute checks inside residential." Client #18's record indicated documentation of 5 minute checks was completed on 6/27/24 from 8 AM through 12:30 AM on 6/28/24. Additional documentation of 5 minute checks was not available for review. An email was received from QAM (Quality Assurance Manger) on 06/27/2024 3:28 PM. The was reviewed upon receipt and indicated, "I wanted to inform you [ED (Executive Director) and I have ensured all 70 windows in the facility are secured. Additionally, alarms have been placed on the outside until a professional installer can install permanent ones. All other items from the 6-27-24 IDT (Interdisciplinary Team) regarding [client #18] have been implemented." An email was received from QAM (Quality			

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	Assurance Manager) on 06/28/2024 at 12:42 PM. The email was reviewed upon receipt and indicated, "This is the documentation (client #18's 5-minute checks) that was able to be produced." QAM was interviewed on 6/28/24 at 11:47 AM. QAM indicated client #18 had an IDT on 6/8/24 which he did not participate in. QAM indicated client #18 was restricted from access to the Internet during the 6/8/24 IDT. QAM indicated on 6/19/24 client #18's IDT met. QAM stated he was not present at the 6/19/24 meeting , "What I think I know; he was getting other people's electronics during that 11 day time period. That is my understanding. My understanding is they put in some sign in/ sign out for devices. That is my knowledge of it. He was claiming he was somehow getting people to freely bring him things. This young man, you know, you never know". QAM indicated client #18's IDT on 6/19/24 indicated client #18 was on 5 minute checks inside of the facility. QAM indicated staff should document the completed 5-minute checks on a 5-minute check form. QAM indicated there should be documentation of 5-minute checks for client #18 from 6/19/24 forward. QAM indicated client #18's elopement on 6/26/24 was being investigated and it was not known if staff had been completing 5 minute checks on client #18 at the time of his elopement. QAM indicated on 6/26/24 client #18 was seen by staff at 10:45 PM and then the facility received a report from an off duty staff who witnessed client #18 at a gas station at 10:52 PM. An observation was conducted at the facility on 6/27/24 from 11:00 AM through 11:25 AM. The residential facility has 18 bedrooms. Client #18's bedroom was located on a hall/wing with room #11 directly across the hall, room #17 to the			

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	immediate right of client #18's room with a shared bathroom connecting the two rooms and rooms #12, #13, #14, #15 and #16 also nearby. Client #18's bedroom had Plexiglass screwed over top of the windows. There were screws missing from the plex-glass attachment. Room #15's windows were not covered with Plexiglass. The windows had screws located in them to prevent the window from opening. The windows are loose and able to be pulled out and away from the window frame. Room #14's window was not secure and room #13's window did not have Plexiglass but had screws to prevent it from opening. SS (Shift Supervisor) #3 was interviewed on 6/27/24 at 11:12 AM. SS #3 indicated the windows in room #15 were damaged and loose. SS #3 indicated client #18 had to be monitored and redirected out of the room. SS #3 stated, "I'm concerned about the windows in here." SS #3 was interviewed on 6/27/24 at 10:27 AM. SS #3 indicated client #18 was on 5-minute checks when inside of his room and his door should remain open. SS #3 indicated client #18 was on line of sight supervision while outside. SS #3 indicated there had been an incident of client #18 breaking a piece of his Plexiglass window off within the past 2 weeks. SS #3 indicated the facility had replaced the Plexiglass and client #18 was threatening to go out of the window. SS #3 indicated staff were told to keep their vehicles locked while parked at the agency but there was no monitoring to ensure vehicles were locked. SS #3 indicated client #18 had eloped from client #11's window in room #11. SS #3 indicated client			

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	#11's windows had not been blocked from opening and client #18 was able to get out of it. SS #3 indicated client #7 had a behavior and was able to open his window in an attempt to get out in room #17 next to client #18's room. ED and QAM were interviewed on 6/27/24 at 12:55 PM. ED indicated the facility was still investigating client #18's 6/26/24 elopement incident. ED indicated the facility was going to secure all of the windows and have a professional agency come in and evaluate the window security. ED indicated he was aware of client #18's behavioral history and an incident of client #18 obtaining and brandishing a firearm after stealing it from a staff's vehicle. ED indicated the agency did not have a policy in place to ensure staff were securing their vehicles. ED indicated he had not checked the windows to ensure they were secured since client #18's elopement incident. 2. PM (Program Manager) was interviewed on 6/24/24 at 12:45 PM. PM indicated the facility had 1 death in the past year. PM indicated the facility had completed a mortality review/investigation of client #21's death. QAM (Quality Assurance Manager) provided an electronic copy of client #21's Mortality review on 6/24/24 at 2:53 PM. Client #21's 5/31/24 Mortality Investigation was reviewed on 6/25/24 at 11 AM. Client #21's Mortality Investigation indicated client #21 was discharged from the agency on 5/22/24. Client #21 was admitted to an agency owned/operated waiver home. Client #21 died at the waiver home on 5/23/24. The facility's BDS (Bureau of Disabilities Services) reports and Investigations were reviewed on 6/24/24 at 2:42 PM. The review indicated the			

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	following: -"On May 15, 2024 at 6:19 PM [client #21] was sitting in the dayroom eating dinner when he began to cough while eating causing food to fly out of his mouth. Staff immediately advised nursing. Nursing checked on [client #21] and delivered 2 back blows, stating she was sending [client #21] to [county hospital emergency room]. Staff transported [client #21] to the ER (Emergency Room) where he was evaluated by medical staff. The following diagnosis was made: 'Aspiration Pneumonia' Discharge instructions state: 'Return or contact your physician immediately if your condition worsens or changes unexpectedly, if not improving as expected, or if other problems arise'. [Client #21] was prescribed Levaquin (antibiotic) 500 MG (milligram): take 1 tablet orally every 24 hours for 7 days. [Client #21] returned to residential without further issues." And, "Staff will continue to monitor [client #21] and report any changes to his treatment team. Nursing and staff will follow discharge instructions given." -Follow-up BDS report dated 5/21/24 indicated, "1. What food item was the individual choking on during this incident? A pureed chicken patty. 2. Was the individual's dining/choking plan being implemented correctly at the time of the incident? Yes. 3. Please provide an update on the individual's current health condition. [Client #21] is stable without further issues." -Investigation Summary dated 5/21/24 indicated the following: -"[SS #3]: Stated she was trained on [client #21's]			

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	plan. Stated [client #21] choked on a pureed chicken patty. Stated she was [client #21's] assigned staff and was 18 inches away from [client #21] when incident occurred. Stated [client #21] appeared to cough with a struggle and that food came out of his mouth onto the table. Stated she asked for nursing assistance and that nursing delivered 2 back blows as well as gave [client #21] a drink to try to wash down any food and then advised staff to transport [client #21] to the [county emergency room]. Stated he had the proper utensils needed, per his plan." -"[LPN (licensed practical nurse) #3]: Stated that the reason that he choked was because the food was ground up instead of pureed. Stated that it was too dry and granular-like when it should be moist/wet and almost liquid. Stated that pureed food is in [client #21's] plan. Stated that she delivered 2 back blows that 'kind of' cleared out the food but that [client #21] continued to cough. Stated she was afraid that he had aspirated and told staff to transport him to the ER immediately. Stated that [client #21] aspirated and that is why he was put on Levaquin." -"Factual Findings: [Client #21's] diet (sic) plan states that due to his choking risk, for all meals and snacks, [client #21] will have an assigned staff who will be available to assist in maintaining [client #21] safety while he is eating. [Client #21's] diet plan states that his diet is to be pureed with thin liquids using a wedge cup made to prevent aspiration, set to ½ open; He will use a small spoon. [Client #21] choked on a pureed chicken patty.			

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	Staff stated that [client #21's] food was properly pureed. Nursing stated that [client #21] food was not pureed and was 'granular-like' but her meal observation for dinner on 5.15.24 stated that all consumers diet plans were properly followed." -"Conclusion: Staff followed [client #21's] diet plan properly. Staff followed ResCare Policy and Procedure correctly." Client #21's record was reviewed on 6/25/24 at 4:00 PM. Client #21's Dining Plan dated 5/10/24 indicated the following: -"Becomes agitated at times if he can't drink or eat immediately. Eats too fast and needs prompts to slow down. Food Texture: Pureed Fluid Texture: Thin liquids in sip cup only Dietary Restrictions or Supplements: Needs to eat prior to drinking fluids at meals. May have drinks during the day as wanted. Make sure documenting fluid intake on TMP (electronic charting system) and notify the nurse if eating less than 50% of his meals." -"Provide prompts and reminders to eat and drink at a slow pace." Client #21's Dining and Aspiration Health Risk Plan (DAHRP) dated 9/13/23 indicated the following: -"Choking and Aspiration, potential related to			

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	eating too fast." -"Triggers to NOTIFY NURSE Coughing with signs of struggle (watery eyes, drooling, facial redness. Wet vocal quality. Vomiting. Sudden change in breathing. Watery eyes. Total meal refusal x 2. Pocketing of food in mouth. Feeling Full or belching during meal." -"CALL 911 if .... [Client #21] appears gravely ill or you are concerned about his immediate health. [Client #21] is having trouble swallowing and/or has food lodged in his throat. [Client #21] is having trouble breathing or is wheezing, especially after eating." -"[Client #21's] safety will be maintained during eating & drinking and he will not have an incident of choking or aspiration through 9/2024. Ensure SAFETY first! In the event of an emergency take care of [client #21] FIRST then notify appropriate personnel if choking incident occurs immediately implement back blows first and abdominal thrusts if necessary 1. Provide diet as ordered by physician. 2. Regular diet with thin liquids. Avoid caffeine and chocolate per guardian request. 3. [Client #21] should eat at dining room table where staff are present. 4. Encourage [client #21] to eat/drink slowly, take small bites and drinks, encourage to clear throat between bites. 5. Stop meal if [client #21] reports feeling full or begins belching during the meal.			

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	6. Medications should be given as ordered by physician. 7. Monitor for triggers during meal, if noted stop the meal and notify nursing. 8. If choking occurs start life saving techniques and call 911. 9. Nurse will document all episodes of choking in the medical notes and ensure that [client #21] is evaluated by physician immediately following a choking incident. 10. Staff will monitor for, note, record & report to nurse immediately any cold/flu symptoms or temperature of 100 degrees or greater. 11. Staff will report any shortness of breath, difficulty breathing, and/or wheezing to nurse immediately. 12. Staff will report decreased appetite, not wanting to drink fluids, weakness and/or fatigue to nursing immediately. 13. Nurse will assess [client #21] should any of the above symptoms occur or send him out for medical evaluation." Client #21's Nursing Case Notes dated 5/15/24 through 5/21/24 indicated the following: -5/15/24 note by LPN #3, "[Client #21] was eating dinner (pureed) when he started choking, hard in catching his breath, he went to his room and to cough with struggles; he tried laying down, still coughing; sending to [hospital ER] to be evaluated." The facility's Clinical Decision Support: Recommended Order Framework protocol dated January 2018 indicated the following: -"Choking/Aspiration · Send to hospital for evaluation. · Temperature and vitals every 8 hours for 24			

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	hours." Client #21's Nursing notes indicated client #21's vitals were documented on 5/20/24 and 5/21/24. There was not documentation of vitals being documented on 5/16/24 every 8 hours for 24 hours after client #21's aspiration incident. QAM sent an email on 06/26/2024 3:35 PM. The email was reviewed upon receipt and indicated, "Attached is the section (clinical decision support document) I read out loud earlier. It is an example of standing physicians orders the physician could sign off on. Not so much a policy." SS #3 was interviewed on 6/27/24 at 10:27 AM. SS #3 indicated nursing completed observations of meals. SS #3 indicated the nurse observing the meal should ensure staff are following client dining plans correctly. SS #3 indicated she was working with client #21 during the 5/15/24 incident. SS #3 indicated client #21's meal was pureed chicken but was not able to recall other food items served that day. SS #3 indicated client #21 had eaten his chicken and then started coughing. SS # stated, "Sounded like (he was) a little stuffy with the first cough. Didn't think too much- then continued coughing and (food) flew out of his mouth on the table." SS #3 indicated she went to the nurses station and LPN #3 came out to assist with client #21. SS #3 indicated LPN #3 delivered back blows to client #21 and instructed her to give client #21 a drink. SS #3 indicated LPN #3 had been in the dining area during the meal but had stepped back inside of the nurse station at some point. SS #3 stated she "knew [client #21's] food was fixed right. Wasn't watery. It was pureed- should not have been an issue." SS #3 indicated she worked with client #21 the next day 5/16/24 and was not aware of any			

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	monitoring for signs/symptoms of aspiration. QAM was interviewed on 6/26/24 at 9:49 AM. QAM indicated he supervised QAC. QAM indicated QAC was not available for interview (vacation) but had completed the 5/21/24 Investigation regarding client #21's choking and aspiration event on 5/15/24. QAM indicated nursing staff should observe meal times and ensure staff are providing clients with the correct meal consistency. QAM indicated nursing staff completed a meal observation checklist after an observation of the meal. QAM indicated LPN #3 was interviewed as part of the 5/21/24 Investigation. QAM indicated LPN #3's interview was not consistent with her documentation on the meal checklist she completed. QAM indicated in the verbal interview LPN #3 had concerns regarding client #21's food consistency on 5/15/24 but in her written documentation she noted there were no issues with the consistency. QAM indicated the discrepancy was not clarified in the investigation to determine if client #21's meal was the correct consistency. QAM indicated the investigation did not address or clarify if LPN #3 was actively monitoring the meal or if she was in the nurses station at the time of the meal. QAM indicated the facility did not have an aspiration protocol or policy. QAM indicated there was general guidance from the Nurse Desk Reference (NDR) or internal clinical decision support document (CDSD). QAM indicated the NDR/CDSD recommendations included vitals every 8 hours for the first 24 hours after an aspiration event. QAM indicated the investigation did not address or clarify if client #21's vitals were taken every 8 hours for the first 24 hours after the incident. QAM indicated after an investigation was completed by QAC the administrative team should complete a Peer Review of the			

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	investigation. QAM indicated the Peer Review process discussed thoroughness of an investigation and was used as a process to develop recommendations to prevent recurrence. QAM indicated the investigation did not include documentation of recommendations to prevent recurrence. QAM indicated there had not been a Peer Review completed regarding client #21's 5/21/24 Investigation. DON (Director of Nursing) was interviewed on 6/26/24 at 10:18 AM. DON indicated LPN #3 was her direct report and was not available for interview. DON indicated LPN #3 had communicated with her about the 5/15/24 incident but DON had not been consulted or interviewed during the 5/21/24 investigation process. DON indicated she had not participated in a Peer Review or discussion about the incident or investigation to identify corrective measures. DON indicated the facility did not have an aspiration protocol and was not aware of the NDR or CDSD. DON stated nursing staff should monitor each meal "to see that they're getting the correct consistency." QAM was interviewed on 6/24/24 at 12:45 PM. QAM indicated the facility's ANE (Abuse, Neglect, Exploitation) policy should be implemented, allegations of ANE should be thoroughly investigated with safeguards in place during the investigation and corrective measures to prevent recurrence of ANE should be developed and implemented. The facility's policy and procedures were reviewed on 6/24/24 at 3 PM. The facility's Reporting and Investigation Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individuals Rights policy dated 11/10/23 indicated			

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	15G811	A. BUILDING 00 B. WING	07/05/2024

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	the following: -"ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare, local, state and federal guidelines." -"ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights. These include and are defined as any of the following: corporal punishment i.e. forced physical activity, contingent exercise, hitting, pinching, the application of pain or noxious stimuli, the use of electric shock, the infliction of physical pain, seclusion in an area which exit is prohibited, negative practice or overcorrection, visual or facial screening, verbal abuse including screaming, swearing, name-calling, belittling, damaging an individual's self-respect or dignity, failure to follow physician's orders, denial of sleep, shelter, food, drink, physical movement for prolonged periods of time, Medical treatment or care or use of bathroom facilities." -"The Program Manager will assign an investigative team . A full investigation will be conducted by investigators who have received training from Labor Relations Association and ResCare's internal procedures on investigations."-"The assigned investigator will complete a detailed investigative case summary based on witness statements and			

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	other evidence collected. When all witness statements, documentation, etc. provide evidence that the allegation is substantiated then the ANE allegation is substantiated."-"7. An investigative peer review committee chosen by the Executive Director will meet to discuss the outcome of the investigation and to ensure that a thorough investigation has been completed. Members of the committee must include at least one of the investigators, the Executive Director or designee, Program Manager for Supported Living, and a Human Resources representative."5-1.2(v)(2)(5)			
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 record review and interview for 1 additional (client #21), the facility failed to thoroughly investigate the circumstances of an aspiration incident regarding client #21. Findings include: PM (Program Manager) was interviewed on 6/24/24 at 12:45 PM. PM indicated the facility had 1 death in the past year. PM indicated the facility had completed a mortality review/investigation of client #21's death. QAM (Quality Assurance Manager) provided an electronic copy of client #21's Mortality review on 6/24/24 at 2:53 PM. Client #21's 5/31/24 Mortality Investigation was reviewed on 6/25/24 at 11 AM. Client #21's Mortality Investigation indicated client #21 was discharged from the agency on	W 0154	To correct the deficient practice, supervisory staff have been trained on the following: components of a thorough investigation, ensuring recommendations are created and implemented. The following has been put in place to prevent recurrence: The investigation affecting #21 will be re-opened with an addendum added with any additional findings. All allegations of ANEM will be reviewed by the ED to ensure appropriate safeguards are put in place during the investigation. , the regional operations support specialist will review all ANEM investigations to ensure they are thorough. Additional monitoring will be	08/04/2024

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	5/22/24. Client #21 was admitted to an agency owned/operated waiver home. Client #21 died at the waiver home on 5/23/24. The facility's BDS (Bureau of Disabilities Services) reports and Investigations were reviewed on 6/24/24 at 2:42 PM. The review indicated the following: -"On May 15, 2024 at 6:19 PM [client #21] was sitting in the dayroom eating dinner when he began to cough while eating causing food to fly out of his mouth. Staff immediately advised nursing. Nursing checked on [client #21] and delivered 2 back blows, stating she was sending [client #21] to [county hospital emergency room]. Staff transported [client #21] to the ER (Emergency Room) where he was evaluated by medical staff. The following diagnosis was made: 'Aspiration Pneumonia' Discharge instructions state: 'Return or contact your physician immediately if your condition worsens or changes unexpectedly, if not improving as expected, or if other problems arise'. [Client #21] was prescribed Levaquin (antibiotic) 500 MG (milligram): take 1 tablet orally every 24 hours for 7 days. [Client #21] returned to residential without further issues." And, "Staff will continue to monitor [client #21] and report any changes to his treatment team. Nursing and staff will follow discharge instructions given." -Follow-up BDS report dated 5/21/24 indicated, "1. What food item was the individual choking on during this incident? A pureed chicken patty. 2. Was the individual's dining/choking plan being implemented correctly at the time of the incident? Yes. 3. Please provide an update on the		achieved by daily administrative observations to ensure staff are implementing all policies, procedures, documentation, and plans as written. The administrative team will evaluate the observation frequency monthly to determine if the observations should continue, decrease, or increase. The administrative team will meet daily to discuss any or incident follow up in the facility. The QAM will meet weekly with all investigators to ensure all investigations have been assigned, investigated thoroughly, and appropriate recommendations are in place. Ongoing monitoring will be achieved by the administrative team completing monthly facility site reviews, record reviews, and quarterly quality and safety reviews for incident patterns, follow up, and thoroughness.	

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	individual's current health condition. [Client #21] is stable without further issues." -Investigation Summary dated 5/21/24 indicated the following: -"[SS #3]: Stated she was trained on [client #21's] plan. Stated [client #21] choked on a pureed chicken patty. Stated she was [client #21's] assigned staff and was 18 inches away from [client #21] when incident occurred. Stated [client #21] appeared to cough with a struggle and that food came out of his mouth onto the table. Stated she asked for nursing assistance and that nursing delivered 2 back blows as well as gave [client #21] a drink to try to wash down any food and then advised staff to transport [client #21] to the [county emergency room]. Stated he had the proper utensils needed, per his plan." -"[LPN (licensed practical nurse) #3]: Stated that the reason that he choked was because the food was ground up instead of pureed. Stated that it was too dry and granular-like when it should be moist/wet and almost liquid. Stated that pureed food is in [client #21's] plan. Stated that she delivered 2 back blows that 'kind of' cleared out the food but that [client #21] continued to cough. Stated she was afraid that he had aspirated and told staff to transport him to the ER immediately. Stated that [client #21] aspirated and that is why he was put on Levaquin." -"Factual Findings: [Client #21's] diet (sic) plan states that due to his choking risk, for all meals and snacks, [client #21] will have an assigned staff who will be available to assist in maintaining [client #21] safety while he is eating.			

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[Client #21's] diet plan states that his diet is to be pureed with thin liquids using a wedge cup made to prevent aspiration, set to ½ open; He will use a small spoon.

[Client #21] choked on a pureed chicken patty. Staff stated that [client #21's] food was properly pureed. Nursing stated that [client #21] food was not pureed and was 'granular-like' but her meal observation for dinner on 5.15.24 stated that all consumers diet plans were properly followed."

-"Conclusion: Staff followed [client #21's] diet plan properly. Staff followed ResCare Policy and Procedure correctly."

Client #21's record was reviewed on 6/25/24 at 4:00 PM.
Client #21's Dining Plan dated 5/10/24 indicated the following:

-"Becomes agitated at times if he can't drink or eat immediately. Eats too fast and needs prompts to slow down.

Food Texture:
Pureed

Fluid Texture:
Thin liquids in sip cup only

Dietary Restrictions or Supplements:
Needs to eat prior to drinking fluids at meals. May have drinks during the day as wanted. Make sure documenting fluid intake on TMP (electronic charting system) and notify the nurse if eating less than 50% of his meals."

-"Provide prompts and reminders to eat and drink

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	at a slow pace." Client #21's Dining and Aspiration Health Risk Plan (DAHRP) dated 9/13/23 indicated the following: -"Choking and Aspiration, potential related to eating too fast." -"Triggers to NOTIFY NURSE Coughing with signs of struggle (watery eyes, drooling, facial redness. Wet vocal quality. Vomiting. Sudden change in breathing. Watery eyes. Total meal refusal x 2. Pocketing of food in mouth. Feeling Full or belching during meal." -"CALL 911 if .... [Client #21] appears gravely ill or you are concerned about his immediate health. [Client #21] is having trouble swallowing and/or has food lodged in his throat. [Client #21] is having trouble breathing or is wheezing, especially after eating." -"[Client #21's] safety will be maintained during eating & drinking and he will not have an incident of choking or aspiration through 9/2024. Ensure SAFETY first! In the event of an emergency take care of [client #21] FIRST then notify appropriate personnel if choking incident occurs immediately implement back blows first and abdominal thrusts if necessary 1. Provide diet as ordered by physician. 2. Regular diet with thin liquids. Avoid caffeine and chocolate per guardian request.			

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	3. [Client #21] should eat at dining room table where staff are present. 4. Encourage [client #21] to eat/drink slowly, take small bites and drinks, encourage to clear throat between bites. 5. Stop meal if [client #21] reports feeling full or begins belching during the meal. 6. Medications should be given as ordered by physician. 7. Monitor for triggers during meal, if noted stop the meal and notify nursing. 8. If choking occurs start life saving techniques and call 911. 9. Nurse will document all episodes of choking in the medical notes and ensure that [client #21] is evaluated by physician immediately following a choking incident. 10. Staff will monitor for, note, record & report to nurse immediately any cold/flu symptoms or temperature of 100 degrees or greater. 11. Staff will report any shortness of breath, difficulty breathing, and/or wheezing to nurse immediately. 12. Staff will report decreased appetite, not wanting to drink fluids, weakness and/or fatigue to nursing immediately. 13. Nurse will assess [client #21] should any of the above symptoms occur or send him out for medical evaluation." Client #21's Nursing Case Notes dated 5/15/24 through 5/21/24 indicated the following: -5/15/24 note by LPN #3, "[Client #21] was eating dinner (pureed) when he started choking, hard in catching his breath, he went to his room and to cough with struggles; he tried laying down, still coughing; sending to [hospital ER] to be evaluated."			

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	The facility's Clinical Decision Support: Recommended Order Framework protocol dated January 2018 indicated the following: -"Choking/Aspiration · Send to hospital for evaluation. · Temperature and vitals every 8 hours for 24 hours." Client #21's Nursing notes indicated client #21's vitals were documented on 5/20/24 and 5/21/24. There was not documentation of vitals being documented on 5/16/24 every 8 hours for 24 hours after client #21's aspiration incident. QAM sent an email on 06/26/2024 3:35 PM. The email was reviewed upon receipt and indicated, "Attached is the section (clinical decision support document) I read out loud earlier. It is an example of standing physicians orders the physician could sign off on. Not so much a policy." SS #3 was interviewed on 6/27/24 at 10:27 AM. SS #3 indicated nursing completed observations of meals. SS #3 indicated the nurse observing the meal should ensure staff are following client dining plans correctly. SS #3 indicated she was working with client #21 during the 5/15/24 incident. SS #3 indicated client #21's meal was pureed chicken but was not able to recall other food items served that day. SS #3 indicated client #21 had eaten his chicken and then started coughing. SS # stated, "Sounded like (he was) a little stuffy with the first cough. Didn't think too much- then continued coughing and (food) flew out of his mouth on the table." SS #3 indicated she went to the nurses station and LPN #3 came out to assist with client #21. SS #3 indicated LPN #3 delivered back blows to client #21 and instructed her to give client #21 a drink. SS #3			

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	indicated LPN #3 had been in the dining area during the meal but had stepped back inside of the nurse station at some point. SS #3 stated she "knew [client #21's] food was fixed right. Wasn't watery. It was pureed- should not have been an issue." SS #3 indicated she worked with client #21 the next day 5/16/24 and was not aware of any monitoring for signs/symptoms of aspiration. QAM was interviewed on 6/26/24 at 9:49 AM. QAM indicated he supervised QAC. QAM indicated QAC was not available for interview (vacation) but had completed the 5/21/24 Investigation regarding client #21's choking and aspiration event on 5/15/24. QAM indicated nursing staff should observe meal times and ensure staff are providing clients with the correct meal consistency. QAM indicated nursing staff completed a meal observation checklist after an observation of the meal. QAM indicated LPN #3 was interviewed as part of the 5/21/24 Investigation. QAM indicated LPN #3's interview was not consistent with her documentation on the meal checklist she completed. QAM indicated in the verbal interview LPN #3 had concerns regarding client #21's food consistency on 5/15/24 but in her written documentation she noted there were no issues with the consistency. QAM indicated the discrepancy was not clarified in the investigation to determine if client #21's meal was the correct consistency. QAM indicated the investigation did not address or clarify if LPN #3 was actively monitoring the meal or if she was in the nurses station at the time of the meal. QAM indicated the facility did not have an aspiration protocol or policy. QAM indicated there was general guidance from the Nurse Desk Reference (NDR) or internal clinical decision support document (CDSD). QAM indicated the NDR/CDSD recommendations included vitals			

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	every 8 hours for the first 24 hours after an aspiration event. QAM indicated the investigation did not address or clarify if client #21's vitals were taken every 8 hours for the first 24 hours after the incident. QAM indicated after an investigation was completed by QAC the administrative team should complete a Peer Review of the investigation. QAM indicated the Peer Review process discussed thoroughness of an investigation and was used as a process to develop recommendations to prevent recurrence. QAM indicated the investigation did not include documentation of recommendations to prevent recurrence. QAM indicated there had not been a Peer Review completed regarding client #21's 5/21/24 Investigation. DON (Director of Nursing) was interviewed on 6/26/24 at 10:18 AM. DON indicated LPN #3 was her direct report and was not available for interview. DON indicated LPN #3 had communicated with her about the 5/15/24 incident but DON had not been consulted or interviewed during the 5/21/24 investigation process. DON indicated she had not participated in a Peer Review or discussion about the incident or investigation to identify corrective measures. DON indicated the facility did not have an aspiration protocol and was not aware of the NDR or CDSD. DON stated nursing staff should monitor each meal "to see that they're getting the correct consistency." QAM was interviewed on 6/24/24 at 12:45 PM. QAM indicated the facility's ANE (Abuse, Neglect, Exploitation) policy should be implemented, allegations of ANE should be thoroughly investigated. 5-1.2(v)(2)(5)5-1.2(v)(2)(5)			

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W 0155 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on observation, record review and interview for 1 additional (client #18), the facility failed to develop and implement safeguards while investigating an elopement incident regarding client #18. Findings include: QAM (Quality Assurance Manager) was interviewed on 6/27/24 at 9:17 AM. QAM indicated client #18 had eloped from the agency during the previous night (6/26/24). QAM indicated an off-duty staff member had seen client #18 at a nearby gas station at 10:51 PM and called the facility to report it. QAM indicated staff had seen client #18 at 10:45 PM. QAM indicated client #18 was believed to have been gone for 13 minutes. QAM indicated client #18 returned to the agency with bottles of alcohol, soft drinks and candy he had stolen. QAM indicated client #18 drank the alcohol before staff could confiscate it from him. QAM indicated client #18 was sent to the ER (Emergency Room) for evaluation after the incident. QAM indicated client #18 eloped from a window in a peer's room. QAM indicated client #18 then went over the facility fence behind the gym and was placed on 1:1 supervision when he returned to the facility. QAM indicated client #18 was not on line of sight or 1:1 supervision while inside of the facility at the time of the 6/26/24 incident. QAM indicated client #18 was not on 10 or 15 minute checks at the time of the 6/26/24 incident. QAM indicated client #18 had transferred to the agency from another agency owned/operated facility on 5/3/24 after being	W 0155	To correct the deficient practice, the following has been completed: All supervisory staff have been trained the following: Developing and implementing safeguards to prevent neglect and elopement, components of a thorough investigation. The following has been put in place to prevent reoccurrence: All windows in the facility have been secured within IDOH LSC guidelines, windows are alarmed, a security checklist has been implemented to ensure windows are secured, alarms are mounted, vehicles are locked, and no contraband is on the grounds, a transition IDT has been created to address needs from current placement and moving forward into future placement. All allegations of ANEM will be reviewed by the ED to ensure appropriate safeguards are put in place during the investigation. , the regional operations support specialist will review all ANEM investigations to ensure they are thorough. Additional monitoring will be achieved by daily administrative observations to ensure staff are implementing all policies, procedures, documentation, and plans as written. The administrative team will evaluate the observation frequency monthly	08/04/2024

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	discharged from an acute psychiatric facility. QAM indicated client #18's behavioral needs were assessed upon his admission to the facility. An additional BDS (Bureau of Disabilities Services) report was provided on 6/29/24 at 10:16 AM and was reviewed on 6/29/24 at 10:30 AM. The additional BDS report indicated the following: -BDS report dated 6/28/24 indicated, "On June 27, 2024 at 4:43 PM, [client #18] was in the dayroom when he observed members of administration placing alarms on the facility windows due to [client #18] eloping on 6/26/24... per his plan. [Client #18] then began laughing in a 'manic' tone and stated that he would not stop trying to escape the building and that if he was unsuccessful, he would kill himself. He then stated that the alarms were a joke and that he could disable them. [Client #18] would continue talking about escaping. He then began to state that he was not afraid to kill someone or himself and continued talking about suicidal/homicidal ideations. [Client #18's] team decided that he needed to be sent to the ER (Emergency Room) for psyche (sic) evaluation. EMT's (Emergency Medical Technicians) and police officers were called and arrived on campus. [Client #18] willingly got into the ambulance and was transported to [hospital Emergency Room] to be evaluated with staff following behind. [Client #18] was evaluated and was admitted to [behavioral health facility] where he is still currently admitted. Date of discharge and discharge instructions are unknown at this time." -An additional BDS report was provided on 06/27/2024 6:15 PM and reviewed upon receipt. The 6/27/24 BDS report indicated the following:		to determine if the observations should continue, decrease, or increase. The administrative team will meet daily to discuss any or incident follow up in the facility. The QAM will meet weekly with all investigators to ensure all investigations have been assigned, investigated thoroughly, and appropriate recommendations are in place. Ongoing monitoring will be achieved by the administrative team completing monthly facility site reviews, record reviews, and quarterly quality and safety reviews for incident patterns, follow up, and thoroughness.	

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	-"On June 26, 2024 at 10:45 PM staff observed [client #18] use the restroom and then return to his bedroom. At 10:51 PM, RM (unspecified Residential Manager) received a call from an off-shift staff (unspecified) stating they had seen [client #18] at a local gas station (0.3 miles from campus). Staff immediately began to search for [client #18] on and off campus. Staff found [client #18] in the recreational room on campus. They observed that [client #18] had stolen several items, including three 1.5 oz (ounce) bottles of alcohol. [Client #18] consumed the alcohol before staff could confiscate it. Nursing advised staff to transport [client #18] to the [hospital emergency room] for evaluation due to a potential reaction between the alcohol and his medication but [client #18] refused to go. Staff then called for an ambulance who transported [client #18] to the ER (Emergency Room) for evaluation. Medical staff evaluated [client #18] and made the following diagnosis: 'Normal exam'. Discharge instructions state to follow up with primary care physician as needed. [Client #18] returned to campus where he began to threaten to physically harm staff, including killing them. Staff spoke with [client #18] who requested a PRN (as needed) (medication) for agitation. Nurse (unspecified) assessed [client #18] and administered a behavioral PO (by mouth) PRN. [Client #18] was able to use his coping skills and he calmed down. He then laid down and appeared to fall asleep without further issues. Staff sat outside [client #18's] door while he slept. [Client #18] also had a 1:1 (staff to client ratio) staff while he was awake until his team was able to meet the following morning." And,			

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	"Staff will continue to follow [client #18's] guardian and HRC (Human Rights Committee) approved BSP (Behavior Support Plan) and ISP (Individual Support Plan). Staff will continue to educate [client #18] on using his coping skills when he becomes upset. Alarms were installed on all doors and windows with guardian and HRC approval. [Client #18's] supervision level was changed to a 1:1 staff 24/7." Client #18's record was reviewed on 7/1/24 at 10 AM. Client #18's BSP dated 4/4/24 indicated the following: -"[Client #18] is transitioning from [County Jail] to a Rescare ESN (Extensive Support Needs) home in [town]. Due to recent criminal involvement and homelessness, [client #18] has stayed in jail until a more suitable placement is available." -"When out in the community, [client #18] needs to be watched very closely as he has a history of stealing items, including knives and vape supplies." -"[Client #18] has a long history of physical aggression, self-injurious behavior, property destruction, elopement, stealing, homicidal statements and verbal aggression." -"Shoes: Due to elopement and thefts [client #18] will no longer have free access to shoes. All shoes to be stored in office when not on outing with staff." -"Due to housemates ' incidents of poor social interactions with other housemates, [client #18] will be restricted from entering any other private			

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	bedroom besides his own room. Other housemates will not be allowed to enter his room for any reason." -"Due to special circumstances [client #18] will be placed on 1:1 supervision until such time as the team determines fit to change. This is defined as staff in same room and able to see him at all times. The bedroom door will remain open. The exception is while in the bathroom, the door will be left open and staff will verbally check in with him every 1-2 minutes. 1:1 staff will sign on and off of the enhanced supervision log." -"Due to excessive leaving assigned area/elopement risks in the home, window and door alarms will be placed on the doors and windows of the home." -"Resident who is placed on 1:1 defined as within eyesight: [client #18]. Instructions: ·1:1 is at all times and is defined as: within eyesight with the staff in the same room. The staff that is 1:1 is to remain in a response stance." Client #18's Incident Reports Form dated 11/1/23 through 5/2/24 indicated the following: -3/15/24, "[Client #18] was laying down in his room, he got up to use the restroom multiple times, which staff noted to be unusual behavior for him. Staff was monitoring [client #18] once he returned to his room and saw him go to the other side of his room, then staff heard his curtains open. Staff went to [client #18's] room and saw [client #18] had climbed out of his window. Staff stood at the window and prompted [client #18] to return back inside. [Client #18] returned inside without further issue."			

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-3/15/24, "There are alarms on the windows in the home, installed by [company], which are supposed to alert when they have been opened or the alarm has been tampered with. Staff assessed the alarms, and they were missing pieces. [Company] will be contacted. Maintenance went to the home on 3/16, the alarm and the alarm panel was (sic) reset and are currently in working order. Staff will complete window and panel checks to ensure there are no alerts or issues with the alarms."

-3/28/24, "Staff reported [client #18] was standing outside in the courtyard being antagonized by [previous placement peer] through the window. [Previous placement peer] continued to antagonize [client #18] even when prompted to stop. Staff redirected [client #18] away from the window and he walked inside. When [client #18] returned outside, he had a firearm in his hand, making threats towards [previous placement peer]. Staff immediately asked [client #18] for the weapon, and he relinquished it without incident. Staff contacted police and monitored [client #18] until they arrived."

And,

-"[Client #18] stated he found the weapon in a staff members car and hid it in the house. [Client #18] was arrested and taken to [County jail]. There is no court date set at this time. Initial exploration into the incident determined the weapon belonged to [previous placement staff] and was in the vehicle of another [previous placement staff]. Both employees were placed on administrative leave pending investigation. Management went to the home immediately and sweeps of the house were completed, ensuring there were no other

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weapons on the property. All employees were contacted and trained on not bringing weapons onto the property and always keeping their vehicles locked. Administrative drop ins will take place in the home to ensure staff are following policies and procedures."

Client #18's IDT form dated 5/2/24 indicated client #18 was transferring from another agency operated ESN home after being discharged from an acute psychiatric facility. The 5/2/24 IDT indicated the following:

-"PURPOSE OF MEETING: Transition Meeting."

-"Discussed that this is a locked facility with a gate. [Client #18's guardian] says he is very good at escape."

The 5/2/24 IDT did not include recommendations, review or discussion or client #18's behavioral support needs regarding window alarms, monitoring of the alarms for functionality or address the agency's plan to ensure staff locked their vehicles. The IDT did not address how the facility would ensure client #18 did not enter peers' rooms for access to restricted items.

Client #18's 6/19/24 IDT note indicated the following:

-"On 6/18/24, [client #18] was found to have a sharp piece of Plexiglass wrapped in a strap handle. Additionally, he wrote and posted a 'kill list' in the dayroom last evening including the names of 2 of his treatment team members at ResCare.

A routine room sweep on 6/19/24 uncovered a hidden vape and [client #18] admitted to

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	contacting people 'in the community' to drop off contraband items at the fence of our property. Upon searching the area by the fence, staff found chargers, vapes, and other items. Apparently, these items are being left for him but [client #18] would not disclose who is leaving them. [Client #18] also reported to staff that someone in the community is bringing him bottles of alcohol and leaving them by the fence. He states that he drank some of the bottles that were left. Team is concerned about the potential for weapons to be delivered. [Client #18] reported in front of a staff member that his brother was 'cash-apping' people in the community to bring contraband items to [client #18]. [Client #18's guardian] says this is possible but not probable. Team would also like to continue to hold off on community outings at this time due to his ongoing statements about robbing the gas station or breaking out of the facility and his overall unstable behaviors. Supervision outside of residential building will be direct line of sight by staff. RECOMMENDATIONS: Team agrees to put in place a contraband protocol which would remove all personal items from [client #18] at this time. He would still have his bed and his daily clothing and other needs, but all other personal items that can be made into weapons or that can hide/store weapons would be removed from his possession. His Switch (electronic game device) would also be taken away at this time since [client #18] is reaching out though several social media sites to strangers and has stated that these strangers are the ones leaving him contraband items. This restriction would be reviewed every 7 days and should be removed if [client #18] is demonstrating safe and non-aggressive behaviors for 7 days. Outings to be reviewed again in 14 days. Supervision outside			

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	of residential building will be direct line of sight. 5 minute checks inside residential." Client #18's record indicated documentation of 5 minute checks was completed on 6/27/24 from 8 AM through 12:30 AM on 6/28/24. Additional documentation of 5 minute checks was not available for review. An email was received from QAM (Quality Assurance Manger) on 06/27/2024 3:28 PM. The was reviewed upon receipt and indicated, "I wanted to inform you [ED (Executive Director) and I have ensured all 70 windows in the facility are secured. Additionally, alarms have been placed on the outside until a professional installer can install permanent ones. All other items from the 6-27-24 IDT (Interdisciplinary Team) regarding [client #18] have been implemented." An email was received from QAM (Quality Assurance Manager) on 06/28/2024 at 12:42 PM. The email was reviewed upon receipt and indicated, "This is the documentation (client #18's 5-minute checks) that was able to be produced." QAM was interviewed on 6/28/24 at 11:47 AM. QAM indicated client #18 had an IDT on 6/8/24 which he did not participate in. QAM indicated client #18 was restricted from access to the Internet during the 6/8/24 IDT. QAM indicated on 6/19/24 client #18's IDT met. QAM stated he was not present at the 6/19/24 meeting , "What I think I know; he was getting other people's electronics during that 11 day time period. That is my understanding. My understanding is they put in some sign in/ sign out for devices. That is my knowledge of it. He was claiming he was somehow getting people to freely bring him things. This young man, you know, you never			

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	know". QAM indicated client #18's IDT on 6/19/24 indicated client #18 was on 5 minute checks inside of the facility. QAM indicated staff should document the completed 5-minute checks on a 5-minute check form. QAM indicated there should be documentation of 5-minute checks for client #18 from 6/19/24 forward. QAM indicated client #18's elopement on 6/26/24 was being investigated and it was not known if staff had been completing 5 minute checks on client #18 at the time of his elopement. QAM indicated on 6/26/24 client #18 was seen by staff at 10:45 PM and then the facility received a report from an off duty staff who witnessed client #18 at a gas station at 10:52 PM. An observation was conducted at the facility on 6/27/24 from 11:00 AM through 11:25 AM. The residential facility has 18 bedrooms. Client #18's bedroom was located on a hall/wing with room #11 directly across the hall, room #17 to the immediate right of client #18's room with a shared bathroom connecting the two rooms and rooms #12, #13, #14, #15 and #16 also nearby. Client #18's bedroom had Plexiglass screwed over top of the windows. There were screws missing from the plex-glass attachment. Room #15's windows were not covered with Plexiglass. The windows had screws located in them to prevent the window from opening. The windows are loose and able to be pulled out and away from the window frame. Room #14's window was not secure and room #13's window did not have Plexiglass but had screws to prevent it from opening. SS (Shift Supervisor) #3 was interviewed on			

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	6/27/24 at 11:12 AM. SS #3 indicated the windows in room #15 were damaged and loose. SS #3 indicated client #18 had to be monitored and redirected out of the room. SS #3 stated, "I'm concerned about the windows in here." SS #3 was interviewed on 6/27/24 at 10:27 AM. SS #3 indicated client #18 was on 5-minute checks when inside of his room and his door should remain open. SS #3 indicated client #18 was on line of sight supervision while outside. SS #3 indicated there had been an incident of client #18 breaking a piece of his Plexiglass window off within the past 2 weeks. SS #3 indicated the facility had replaced the Plexiglass and client #18 was threatening to go out of the window. SS #3 indicated staff were told to keep their vehicles locked while parked at the agency but there was no monitoring to ensure vehicles were locked. SS #3 indicated client #18 had eloped from client #11's window in room #11. SS #3 indicated client #11's windows had not been blocked from opening and client #18 was able to get out of it. SS #3 indicated client #7 had a behavior and was able to open his window in an attempt to get out in room #17 next to client #18's room. ED and QAM were interviewed on 6/27/24 at 12:55 PM. ED indicated the facility was still investigating client #18's 6/26/24 elopement incident. ED indicated the facility was going to secure all of the windows and have a professional agency come in and evaluate the window security. ED indicated he was aware of client #18's behavioral history and an incident of client #18 obtaining and brandishing a firearm after stealing it from a staff's vehicle. ED indicated the agency did not have a policy in place to ensure staff were securing their vehicles. ED indicated he had not checked the windows to ensure they were secured			

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	since client #18's elopement incident. QAM was interviewed on 6/24/24 at 12:45 PM. QAM indicated safeguards should be in place during the investigation of allegations of ANE (Abuse, Neglect, Exploitation). 5-1.2(v)(2)(5)			
W 0164 Bldg. 00	483.430(b)(1) PROFESSIONAL PROGRAM SERVICES Each client must receive the professional program services needed to implement the active treatment program defined by each client's individual program plan. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 16 additional clients (#5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20), the facility failed to ensure the Behavior Technician assisted with intervening during behavioral episodes at the facility. Findings include: An observation was conducted at the facility on 6/24/24 from 3:07 PM to 6:43 PM. Throughout the observation, client #3 engaged in physical aggression towards staff and clients #1, #2, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20 spitting, property destruction, instigating his peers and verbal aggression. The BT was present throughout the observation and did not intervene to assist staff with addressing client #3's behaviors. The BT leaned on a window ledge and observed while staff addressed his behaviors. On 6/26/24 at 3:07 PM, the Behavior Consultant (BC) was interviewed. The BC was asked what	W 0164	To correct the deficient practice, The BC has been trained on intervening, coaching, and modeling. Additional monitoring will be achieved by the lead BC meeting weekly with the BC completing observations to discuss any client's needs, staff training, and any training the BC may need, as well as the ED, PM, or QAM observing the BC once weekly to ensure they are coaching, modeling and intervening. Ongoing monitoring will be achieved by the PM completing random observations of the BC interacting with staff and clients at least monthly.	08/04/2024

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	the BT's job was. The BC stated, "[BT] is hands on, on the floor, go around with in-services with staff and providing training, lots of observations on the floor". The BC indicated the BT was there to ensure staff are getting the in-service information and to provide modeling for the staff during behaviors. The BC indicated the BT reports any issues or concerns back to her so they can be addressed. On 6/27/24 at 10:00 AM, the Site Supervisor (SS) was interviewed. The SS was asked how often the BT was present at the facility. The SS indicated the BT was there on Mondays and Thursdays. The SS indicated the BT brings in-services (trainings) for staff to review, she observes the clients, does the token store for the clients and takes clients for walks to let them vent. The SS indicated the BT does not assist with YSIS (You're Safe, I'm Safe/behavioral intervention) but she would sometimes redirect the clients. Observations were conducted on 6/24/24 from 1:00 PM to 3:29 PM and 4:44 PM to 6:11 PM. Throughout these observations client #3 paced and would make loud vocalizations in the dayroom and adjacent front porch area. At 2:11 PM, client #3 paced back and forth on the front porch and used his hand to hit an exterior window. At 2:13 PM, client #3 repeatedly kicked the exterior door to the dining room from the front porch. Staff #14 remained seated in a chair on the front porch and the Behavior Tech (BT) remained in the dining room. Client #3 was not redirected from kicking the door and continued to pace back and forth on the front porch and make loud vocalizations. At 4:53 PM, client #3 was pacing through the dayroom and went over to the door to the kitchen and slammed it. Client #3 continued to pace			

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	throughout the dayroom and dining room. Client #3 was not redirected from the dayroom area. At 4:56 PM, client #3 spit on client #4 while in the dayroom. The BT used verbal redirection to redirect client #4 to the front porch. Client #3 was not redirected and continued to pace throughout the dayroom. At 4:58 PM, client #3 hit the wall in the dining area of the dayroom with his hand. Client #3 was not provided redirection and the BT did not intervene to deescalate client #3 from further aggression. On 6/24/24 at 5:02 PM, the BT was interviewed. The BT was asked about her role at the facility. The BT indicated she was a contracted behavioral consultant and stated, "I work here 2 days a week". The BT was asked about intervention with client #3 to deescalate client #3 from aggression. The BT stated, "I don't intervene to do the holds (physical intervention)". The BT indicated she reported her observations to the facility's Behavior Clinician (BC) and stated, "I report (observations) to the main BC".QAM (Quality Assurance Manager) was interviewed on 6/25/24 at 8:34 AM. QAM indicated the agency had a full time behavior therapist who worked remotely. QAM indicated the agency had a part-time contractor behavior therapist who worked at onsite at the facility 15 hours of week to provide training for staff and behavioral intervention support. ED (Executive Director) was interviewed on 6/27/24 at 1:49 PM. ED indicated the facility had a part-time contracted behavior therapist in addition to a full time remote behavior therapist. ED indicated the part-time onsite behavior therapist should coach and train staff on client behavior			

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	intervention strategies. ED indicated the onsite behavior therapist should assist staff during behavioral incidents. ED indicated he had concerns regarding the onsite contracted behavior therapist and he would be following up with the contracting agency.			
W 0189 Bldg. 00	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, record review and interview for 4 of 4 sampled clients (#1, #2, #3 and #4), plus 1 additional client (#6), the facility failed to ensure staff were competent in clients #1 and #4's data collection, client #2's dining plan implementation and clients #3 and #6's BSP's (Behavior Support Plans). Findings include: 1) On 6/26/24 at 9:52 AM, a review of client #1's record was conducted. The review indicated the following: No quarterly reviews for client #1's program plan progress were available for review. Client #1's record had monthly summaries with only March, April and May of 2024 available for review. On 6/27/24 at 9:57 AM, the Qualified Intellectual Disabilities Professional (QIDP) and Quality Assurance Manager (QAM) were interviewed. The QAM was asked about client #1's record indicating a lack of quarterly reviews available for review. The QAM stated, "They should be on Teams (electronic system), just not printed for the sample". At 10:48 AM, the QIDP was asked about	W 0189	To correct the deficient practice, all staff have been trained on each clients BSP, ISP, and dining plan. The BC has been trained on intervening, coaching, and modeling. . Additional monitoring will be achieved by the lead BC meeting weekly with the BC completing observations to discuss any client's needs, staff training, and any training the BC may need, as well as the ED, PM, or QAM observing the BC once weekly to ensure they are coaching, modeling and intervening. Ongoing monitoring will be achieved by the PM completing random observations of the BC interacting with staff and clients at least monthly.	08/04/2024

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	client #1's progress for goals and the process for monitoring. The QIDP stated, "Yes. I'm in the process of learning the system. The 100's I've learned, the staff have made notes and sometimes indicate a refusal. I've not had extensive training in this. I've learned when I put a goal in it asks how many prompts. When the staff puts in 3 prompts or less the system puts the goal completed (100%), even if the staff noted refused. I've since learned there is drop box and the DSPs (Direct Support Professional) can click non-compliance and the client does not get credit. There was a time when I was checking the box when the goal was 100% and it kicks it out. I did not know that. I'm slowly learning things to do and not to do and it's distorting the data". The QIDP and QAM indicated client #1's progress for his goals should be maintained through quarterly reviews, but the data collection was not reliable due to the facility learning a new electronic recordkeeping system. 2. Observations were conducted at the facility on 6/24/24 from 1:00 PM to 3:29 PM and on 6/25/24 from 5:50 AM to 9:15 AM and 10:46 AM to 11:42 AM. On 6/24/24 at 2:28 PM client #2 sat at the table with a whole banana. Client #2 ate a few big bites of the banana, then threw part of the banana and peel on the floor. On 6/25/24 at 9:02 AM SS (Site Supervisor) #2 placed a container of dry cereal and a carton of milk on the table in front of client #2. SS #2 opened a muffin and placed the muffin on the table laying it on top of the plastic wrapper. Client #2 picked up the whole muffin and crumbled it with his fingers putting a few pieces in his mouth while the rest of the muffin fell into his lap and			

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	onto the floor. Client #2 used his fingers to grab a handful of dry cereal. He brought his hand to his mouth getting a few pieces of cereal in his mouth while the rest of the cereal fell into his lap and onto the floor. Client #2 stood up and walked around the day room. SS #2 asked client #2 to come back to the table. Client #2 walked over to the table and grabbed a handful of dry cereal and ate while walking around the day room. At 9:09 AM client #2 sat on the couch in the day room. Client #2 stood up and went over to the table and grabbed a handful of dry cereal and ate it. SS #2 asked client #2 to sit down. Client #2 continued to walk around while eating his dry cereal. At 10:51 AM client #2 went into the kitchen. DSP #14 came out of the kitchen with client #2 emptying a sandwich size bag of cut cantaloupe in 1 inch by 2 inch pieces and whole strawberries into a bowl. DSP #14 left to assist another client. Client #2 sat at the table unsupervised eating cantaloupe with his fingers. At 10:53 AM client #2 stood up and went to his room and got into bed. Client #2's record was reviewed on 6/26/24 at 11:29 AM. Client #2's Dining Plan dated 10/2023 indicated the following: "...Food Texture: ¼ inch chopped Food should be moist and tender Specific Skills to Maintain/Acquire: Prompt to assist with meal prep and cleanup. Provide prompts and reminders to eat and drink at a slow pace. Food to be cut into ¼ inch pieces. Sit upright at table for meals.			

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	Monitor for regurgitation and prompt him to stop...." Client #2's High Risk Plan for Choking or Aspiration dated 10/23/23 indicated the following: "...Potential for Choking or Aspiration and Illness due to SIB (Self-Injurious Behaviors) of Causing Self to Regurgitate After Eating and then Consuming the Emesis. Expected Outcome: [Client #2] will not choke, aspirate or consume any non-food substances causing same through 10/2024. Ensure [client #2's] SAFETY first. 1. [Client #2] will have 1 on 1 staffing assigned for meals who will cut up his food into ¼ inch pieces and will prevent him from eating too fast or too much in one setting. 2. Staff are to monitor for indication he is trying to cause himself to regurgitate and redirect him to stop behavior...." Client #2's BSP (Behavior Support Plan) dated 6/21/24 indicated, "...Restrictions: meal/snack supervision...All of [client #2's] food must be cut into ¼ inch pieces due to his choking risk and his tendency to gorge himself. He is on thin liquids. Clothing protectors will be available to help keep [client #2's] clothing clean...." The BC (Behavior Clinician) was interviewed on 6/26/24 at 3:08 PM. The BC indicated client #2 has an assigned staff across all shifts. The BC indicated staff should cut up client #2's food and be in line of sight when he is eating. The PM (Program Manager) was interviewed on 6/27/24 at 9:54 AM. The PM indicated client #2's			

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	dining plan instructed for his food to be cut into 1/4 inch pieces. The PM indicated staff should follow client #2's plan as written. SS #2 was interviewed on 6/27/24 at 10 AM. SS #2 indicated client #2's food should be cut into 1/4 inch pieces including fresh fruit. DSP #10 was interviewed on 6/27/24 at 12:18 PM. DSP #10 indicated client #2's sandwiches should be cut into four pieces. DSP #10 was asked if other foods needed to be cut up according the client #2's dining plan. DSP #10 stated, "I don't believe so." 3. An observation was conducted at the facility on 6/24/24 from 3:07 PM to 6:43 PM. At 3:32 PM, client #3 was singing in the day room. At 3:34 PM, client #3 walked down the hall and slammed a bedroom door then went to the day room, picked a tablet up off the table and moved it to a different table. At 3:42 PM, client #3 walked throughout the building spitting towards staff and his peers. Direct Support Professional (DSP) #10 prompted him to stop spitting. At 3:44 PM, client #3 ran down the hall to the bathroom then slammed the bathroom door. At 3:50 PM, client #3 walked around in the dayroom while holding a football and yelling. DSP #10 raised her voice and prompted client #3 to go outside. At 3:53 PM, client #3 pounded on the outside of the dayroom windows. At 4:09 PM, client #3 walked around the dayroom with DSP #19. Client #3 was carrying a football while pacing, yelling and spitting at the surveyors, staff and his peers. At 4:11 PM, client #3 ran into the kitchen and DSP #19 followed him. Yelling was heard coming from the kitchen. DSP #19 fell out of the doorway to the kitchen and landed on the ground. DSP #19 had her hand covering her left eye and forehead. DSP #10			

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	stated to client #3, "[Client #3] stop, [client #3]". DSP #10 took client #3 out the front door while other staff assisted DSP #19 with getting ice for her head. At 4:17 PM, client #3 was outside punching the day room windows. At 4:20 PM, DSP #19 indicated when client #3 was in the kitchen he picked up a bucket of soapy water and was going to throw it. DSP #19 stated, "I tried to redirect him and he slammed his head back and hit my head. I saw stars after, but I'm, okay". At 4:23 PM, client #3 came back inside with DSP #10, slammed the kitchen door and spit towards his peers. DSP #10 raised her voice and stated, "[Client #3]". The Behavior Technician (BT) was leaning against a window ledge in the day room. Client #3 walked by the television and used the football he was carrying to hit the television (safety box with television inside). At 4:25 PM, client #3 continued spitting towards staff and peers. DSP #10 responded by raising her voice and stating, "[Client #3] stop". Client #3 responded by kicking the couch and continuing to spit. At 4:26 PM, client #3 went into the kitchen and slammed the door shut. DSP #10 stated to client #3, "Quit spitting. Get out". Client #3 picked up a bowl of cooked vegetables and threw it onto the floor. DSP #10 stated with a raised voice, "Room, go. You just threw a whole bowl of food. [Client #3], go to your room". Client #3 continued spitting at his peers and staff in the day room. DSP #14 intervened and client #3 punched him and spit in his face. Client #3 picked up a tablet and threw it then pushed a large trash can over. DSP #11 and DSP #14 physically escorted client #3 to his room. Clients #1, #2 and #4 were in the day room and were not prompted to leave the area. The BT continued to lean against the window and did not intervene. At 4:34 PM, client #3 was in his room with DSP #11 and DSP #14. DSP #14's shirt was torn around the neck.			

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	Client #3 was listening to music. At 4:37 PM, client #3 was in his bedroom continuously yelling "f***" which could be heard in the dayroom. At 4:44 PM, client #3 went to the medication room for a PRN (as needed medication) assessment. DSP #14 indicated client #3's PRN PO (by mouth) medication for behavior control was administered by the Licensed Practical Nurse (LPN) #3. At 4:48 PM, client #3 was in the dayroom without staff. Client #3 sat down to eat dinner. Client #3 took the ham, bread and applesauce off of his plate and handed it to DSP #10. Client #3 ate the potatoes and vegetables. At 4:51 PM, client #3 paced in the dayroom while holding a football and singing. Some of his peers were watching television and talking with staff. Client #3 picked up a carton of milk, finished drinking it then threw the empty carton on the floor. Staff did not prompt him to pick it up. The BT continued leaning against the window ledge in the dayroom. At 4:53 PM, client #3 walked into the kitchen and slammed the door. Staff opened the door back up and client #3 was mumbling as he walked around the kitchen. Client #3 exited the kitchen then walked past the Quality Assurance Manager (QAM) and purposely bumped into him then threw his football at the BT and charged after her. Staff intervened to prevent him from making contact with the BT. Client #3 walked past client #4 and spit in his face. Client #4 wiped the spit off his face and stated, "F****** B****". Client #3 was prompted to go outside. The QAM indicated staff should have done a one person hold which is where staff's arms are wrapped around his arms and the other clients should have been prompted to leave the area. At 5:01 PM, client #3 went in the kitchen and DSP #14 attempted to escort him out the front door in the day room. Client #18 was in the room and stated to client #3, "That's right, throw it			

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	(chair) b****. I don't care. P****". Client #3 threw a chair in the dayroom then went to his room. At 5:06 PM, client #3 went out the front door with DSP #14 and paced around the yard. At 5:09 PM, client #3 punched a window (from outside) in the dayroom several times causing the glass to break from top to bottom. DSP #14 was outside with him and did not intervene. The BT continued leaning on the window ledge inside the dayroom. Client #18 was in the dayroom when client #3 hit the window and stated, "Y'all make me smoke out there with him, I will f*** him up. If I'm out there with him, I'll beat his a**. He f****** p***** all over the place and he doesn't care". At 5:15 PM, DSP #14 remained outside with client #3. DSP #19 came inside the front door with client #11 and client #3 pushed the door closed while DSP #19 was walking through and the door hit her then slammed shut. At 5:21 PM, client #3 came back inside with DSP #14 following him. Client #18 stood up and went to his bedroom and slammed the door. Client #3 paced around the dayroom. DSP #10 stated to client #3, "You need to calm down and focus". Client #3 responded by walking at a fast pace down the hall. At 5:26 PM, client #3 walked by client #20 and pushed him. Client #20 ignored client #3. At 5:28 PM, client #3 walked up to client #10 and wrapped his arms around his neck to hug him. DSP #10 stated in a loud voice, "[Client #3]". At 5:29 PM, client #3 and client #18 were both in the dayroom yelling and threatening peers. Clients #4, #5, #10 and #20 were present in the day room. The BT continued leaning against the window ledge in the dayroom and did not intervene. At 5:38 PM, client #3 started spitting all over the day room. DSP #10 stated in a loud voice, "[Client #3], stop spitting please". Client #3 responded by running down the hall and entering a peer's bedroom. DSP #14 followed client #3 into the room. Client #3 threw			

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	an item out of the bedroom prior to DSP #14 intervening. At 5:41 PM, client #3 paced around the dayroom. Client #3 grabbed client #11's fruit and ate it. DSPs in the area did not intervene. DSP #11 stated, "I'll go get you another one, [client #11]". DSP #11 returned with 2 bags of fruit, one for client #11 and one for client #3. At 5:45 PM, the Executive Director (ED) opened the door at the end of the hallway and prompted the clients to go to the other building (not client #3). Staff assisted with getting most of the clients to the other building away from client #3. Clients #20, #14 and an unknown client did not leave the dayroom. Client #18 was in the front yard with staff present. At 5:47 PM, client #3 was going in and out of his peers bedrooms without redirection from staff. At 5:48 PM, client #3 stood at the back door yelling loudly and staff did not redirect him. As client #3 was walking towards the dayroom, he got in client #14's face and yelled. DSP #10 stated, "Back up" to client #3. At 5:58 PM, client #3 went to the art room where some of his peers were working on activities. Client #3 paced around the room while carrying a basketball. DSP #19 was with him. Client #3 was prompted to color a picture. Client #3 declined. Client #4 stated, "I'm sick of his s***". At 6:04 PM, client #3 was prompted to do a puzzle. Client #3 declined and continued pacing around the room. At 6:07 PM, client #3 charged after the surveyor who was visiting with client #9 as he colored a picture. The surveyor got up and moved to a different area and client #3 followed. Client #3 attacked the Program Manager (PM) by hitting her, grabbing her shirt and pulling her watch off her wrist. The PM got on the walkie talkie and stated, "I need male staff to the art room now". The PM asked the surveyor to leave the art room for safety due to client #3 targeting the surveyor.			

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	The surveyor left the art room and the other clients in the room were prompted to leave the room. At 6:10 PM, client #4 stated, "F*** that b****". Client #3 was in the art room with the PM and the QAM. Client #9 stated to the surveyor, "Is he (client #3) done yet? I want to hang out with you guys". At 6:21 PM, the PM was heard over the walkie-talkie stating, "[DSP #14] or [DSP #11] to the art room now". An unidentified voice on the walkie-talkie stated, "[DSP #11] is on his way". At 6:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) was standing outside the art room and he indicated client #3 received an IM (intramuscular) injection five minutes ago. The QIDP stated, "He's been like this at times, but not often". The observation was ended at 6:43 PM. From 6:43 PM to 6:57 PM, the ED had two of the surveyors isolated in the conference room until it was safe to leave as client #3 was pacing up and down the hallway. The ED stood inside the conference room and observed client #3 by occasionally cracking the door open and looking out. The ED indicated client #3 took off running and pushed the QIDP causing him to fall to the ground and hit his head on the wall. At 6:57 PM, the ED indicated client #3 was cornered in the gym and it was safe for the surveyors to leave the building. The ED walked the surveyors out of the building and to the parking lot. As the surveyors left the conference room, the QIDP was sitting on the floor leaning up against the wall holding a bag of ice on his head. The PM was with him. The QAM came out of the bathroom and indicated he was okay now that he didn't have blood all over him. The QAM indicated he was taking the QIDP to the emergency room to be evaluated. On 6/26/24 at 9:40 AM, the facility's incident			

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	reports for client #3 were reviewed and indicated the following: A BDS (Bureau of Disabilities Services) report dated 6/25/24 indicated, "On 6/24/24 at 3:24pm, [client #3] was (sic) walked behind peer (client #12) and punched him in the back with no precursors. Despite staff attempting to assist [client #3] with his coping skills he was unable to calm himself. The nurse assessed him and administered a behavioral PO (by mouth) PRN (as needed medication for behavior). Staff was able to assist [client #3] with coping skills and he calmed himself down. Nurse assessed [client #3] and noted no injuries. [Client #3] returned to normal programming". A BDS report dated 6/25/24 indicated, "On 6/24/24 at 4:14 pm, [client #3] was walking around the dayroom and walked into the kitchen. Then [client #3] started yelling and hitting the countertops. Staff attempted to redirect [client #3] out of the kitchen and he then threw his head back and hit staff (DSP #19) in head. The nurser (sic) assessed [client #3], no injuries noted, neuro (neurological) check (sic) initiated. [Client #3] returned to normal programming with no further issues". A BDS report dated 6/26/24 indicated, "On 6/24/24 at 6p, [client #3] was physically and verbally aggressive. Staff attempted to de-escalate but was unsuccessful. While in art room, [client #3] hit peer on his right arm and was targeting state surveyor. [Client #3] started throwing objects and hitting staff. At this time, trained staff initiated a guardian and HRC (human rights committee) approved 3 person supine hold (behavioral intervention). Staff attempted to assist [client #3] with his coping skills. The nurse assessed him and administered a behavioral IM (intramuscular)			

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	PRN. Staff was able to assist [client #3] with coping skills and he calmed himself down. He was released from the hold. The hold lasted 19 minutes. Nurse assessed [client #3] and noted no injuries. Once released [client #3] ran down the hallway and pushed QIDP and ran to gym. While in gym he became verbally aggressive. Staff were able to calm [client #3] down and he returned to regular programming". A PRN (as needed medication) evaluation form dated 6/24/24 indicated LPN #3 administered PRN Haldol (for behavior) 10 mg (milligrams) and Benadryl 50 mg by mouth at 3:47 PM. A PRN evaluation form dated 6/24/24 indicated LPN #3 administered PRN Haldol 10 mg and Benadryl 50 mg IM (intramuscularly) at 6:47 PM. On 6/26/24 at 1:53 PM, client #3's record was reviewed. Client #3's 6/24/24 Behavior Support Plan (BSP) indicated the following: "Target Behaviors and Goals": "Verbal Aggression: any time he is yelling at others, cursing, threatening others, using profanity, etc. [Client #3] has been observed to yell at no one in particular or to yell threats when no one is in the vicinity. He has also 'punched' the air as if he is fighting another person when there is no other person present". "Property Destruction: any time he is punching items, throwing chairs/items, breaking furniture, kicking items or doors, or causing irreparable damage to objects/items. [Client #3] has a history of becoming frustrated with completing			

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	tasks/chores and throwing items or objects that he is working on". "Physical Aggression: Any occurrence or attempts at hitting people, spitting on them, kicking or scratching at others, using objects as weapons, pulling hair, pinching, or behaviors that produce or have the potential to produce an injury to others. Spitting on others occurred at a high frequency at previous placements. Historically, he has been hysically (sic) aggressive to those who he feels have 'wronged' him. He can also be physically aggressive when he is not getting what he wants from others. He has a history of being very aggressive toward his mother and he has also grabbed the driver during vehicle transports. When highly agitated, he may attempt to engage in several acts of aggression toward peers". "Instigation: Includes attempts to get peers upset or to get peers to engage in target behaviors". "Boundary Violations/Unwelcome Touch: defined as any time [client #3] does not respect the personal space of others by standing less than an arm's reach away from others and not moving away after 1 verbal prompt for personal space. Also includes acts of touching others in a non-threatening way (non-threatening as in does not leave a mark or injury on staff and occurs when [client #3] is not already agitated or demonstrating other forms of aggression). Includes episodes of grabbing/holding staff or peers by the arm in a non-forceful manner (does not leave a mark/injury) or poking staff in a manner that is not forceful". "Replacement Behaviors: Asking/Approaching staff for help: Any time he asks appropriately for staff to help			

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	him get the items or attention that he desires or any time he uses his coping skills instead of engaging in the target behavior. Staff should offer positive social reinforcement to [client #3] anytime that he is attempting to use his replacement behaviors. This can be given through verbal praise, high fives, or other positive statements about his behavior". "Restrictions: If [client #3] is exhibiting agitation, precursors, or has engaged in physical aggression to peers, an assigned staff will be put in place for the protection of other clients. The assigned staff's responsibility is to prevent [client #3] from being able to hit/kick/spit at other clients. The assigned staff should stay between [client #3] and any peers that he may hit. The assigned staff can also encourage [client #3] to go to the gym for activity where he would be away from his peers for their safety". "Preferences Assessment: Likes: music, dancing, singing. Dislikes: Being told what to do by others. When he feels that others are making demands of him". "Precursors: Verbal aggression and instigation could be identified as precursors to other behavioral issues. When he engages in this behavior staff will: See above restriction about implementing an assigned staff for [client #3]. Remain calm in tone and volume, do not react with emotion or irritation. Ignore threats and verbal abuse- do not get into a back-and-forth power struggle. If he is engaging in instigation toward a peer, remain between the two peers. Ask him how you can help. He is more likely to calm down if he feels			

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	supported and liked by his staff. Remind him that we are here to help him so that he can reach his goals of being more independent. If he continues to yell, with as little reaction that you can use, repeat that you want to help him but that you can only do so if he is talking calmly. Once calm, attempt to resolve the problem or come up with a game plan as to how the problem can be resolved. Praise him for his input and compliance when he has calmed (ie: 'I know you're upset but I'm really proud of you for calming down so we can talk about this' etc. If the verbal aggression continues, in a calm and neutral voice, suggest a relaxation technique that he can use to calm down (ie: 'let's take 10 deep breaths together, then if you're calm, we can talk'. A staff will encourage him to go with them (in the opposite direction of his peers) for a walk. If he does not begin to go to a different area and continues being verbally aggressive, staff will redirect peers away from the immediate area. Attempt to find out what is upsetting him and attempt to resolve the problem as best you can with his input. If [client #3] is creating an unsafe environment due to his verbal aggression or instigation of peers, and he is refusing to leave a common area, thus causing him to become a target to his peers, for his own health and safety, he can be physically redirected to a safe area using YOU'RE SAFE I'M SAFE (YSIS) (behavioral intervention) always beginning with the least restrictive measures". "Preventative Procedures/Training: Separate programing should take place in the gym. If [client #3] is engaging in ongoing verbal aggression or instigation, it has been helpful to offer to take him to the life skills building where he can yell or be active without disrupting his peers. See above restriction related to [client #3] having an assigned staff when showing precursors.			

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	Give [client #3] choices whenever possible, he does best when he feels like he has some control over his situation. Speak to him in a calm, neutral-toned voice at all times. Do not take any verbal aggression or physical aggression (or any target behavior) personally. Anytime he is engaging in appropriate behaviors provide abundant specific praise. When giving him instructions/requests they should be: Given in a clear and concise manner/one step at a time. Done in the form of a question and not a demand. Short and to the point. Frequently bring up positive aspects about his day/week or progress. [Client #3] enjoys listening to music and a tablet has been provided for him". "Reactive Procedures: For Physical Aggression/Property Destruction/Self Injurious Behaviors: Immediately ensure the health and safety of everybody in the immediate environment. Redirect him and/or others to a different area of the environment. Tell him to stop the behavior. If he stops the behavior, redirect him to a safe location and problem solve with him and praise him for doing this with us. If the behavior continues block all attempts of aggression and attempt to redirect, if the behavior continues and he is placing himself or others in danger, implement YOU'RE SAFE I'M SAFE (YSIS) beginning with the least restrictive measures.... For Boundary Violations/Unwelcome Touch: In a calm and non-confrontational manner, ask [client #3] to give you/his peer more space, staff can say 'Hi [client #3], can I get a little more personal space?' or 'Don't forget, we keep our hands to ourselves'. Keep the tone light when redirecting. Offer a different activity to [client #3] to distract from the unwelcome touch. Notify administration			

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	staff and document on all appropriate forms". On 6/24/24 at 4:31 PM, the Quality Assurance Manager (QAM) was interviewed in the day room. The QAM indicated client #3 was on normal supervision until he becomes agitated then he becomes assigned staff. The QAM indicated client #3 should get separate programming when his behavior is escalating. The QAM stated, "That (separate programming) ends up in a disaster. They should attempt to get him (client #3) out". The QAM indicated if client #3 refused to leave the area then staff should assist with getting the other clients to a different area. On 6/26/24 at 3:07 PM, the Behavior Consultant (BC) was interviewed. The BC reviewed the target behaviors in client #3's BSP and stated, "We have seen all of these behaviors in [client #3] at least once". The BC indicated client #3's replacement behaviors were to ask for help and to use coping skills instead of target behaviors. The BC was asked about client #3's coping skills. The BC stated, "Being away from whatever the environment is that set him off. Leaving an overstimulated area, go outside, gym to shoot hoops, just to get away from whatever upset him. He has more and more target behaviors when he is still in the same environment. Do something to acknowledge what he wants. Praise him for telling him what he needs, verbal praise, high 5, staff should say tell me what you need". The BC was asked to explain assigned staff. The BC stated, "Typically for [client #3] we are talking about separate programming. Once he hits one client he's probably going to go after someone else. Especially with the spitting. We are probably going to leave the building. It is someone in place to prevent that from happening. It's not typically an escort unless he is creating a situation in the			

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	day room. If he is getting everyone riled up they can escort him to another area. He likes going to other places. They do have in his plan that he can be escorted to his room or a calm area if he is a danger to his peers". The BC indicated client #3's precursors were verbal aggression and instigation. The BC stated, "If they (clients) are starting to escalate and we (staff) escalate, it is going nowhere but up (escalating). Keep the environment calm. Don't respond like you are annoyed. It's not going to help [client #3] if he is in crisis and we too are out of control". The BC was asked how staff should respond if client #3 displayed precursors. The BC stated, "Remain in between him and peer if he is physically aggressive. Remind him we are here to help. Trying to get them to communicate. Like what do you really need? Do you want to go outside? Are you hungry? Have him verbalize what he needs. Staff should model the appropriate response. Offer 10 breaths together. Encourage him to talk. Staff should be thinking, what am I doing throughout the shift to prevent behaviors?" The BC indicated client #3's BSP should be implemented as written and staff needed additional training regarding implementing client #3's BSP. On 6/27/24 at 10:00 AM, the Site Supervisor (SS) was interviewed. The SS was asked to describe client #3's behaviors. The SS stated, "Anything. I would have to look. Honestly, almost anything sets him off. You can look at him and smile or ask him for a smile and you can get a ball thrown at your face and spit at". The SS indicated client #3 had a lot of verbal aggression towards his peers. The SS stated, "If he is in a not so great mood, he will walk up to a peer and tap the arm lightly which will set in motion a whole big set of events. He will randomly spit, at times he will launch his ball			

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	at you out of the blue, randomly knock things over". The SS indicated she wasn't sure if he did those things for attention. The SS stated, "I wonder if [client #3] is fighting through a multitude of personalities. The slightest thing can make him snap". The SS was asked how to address client #3's physical aggression. The SS indicated client #3 should be prompted to leave the area if he displayed target behaviors and his peers were in the same room. The SS indicated if client #3 refused to leave the area, staff should request the other clients to leave the area for their safety. The surveyor reviewed what occurred during the aforementioned observation and asked the SS how staff should have responded. The SS indicated she was not working during the incident, but she would have escorted client #3 out of the area, utilized YSIS if needed then she would have ensured the other clients were encouraged to leave the area. The SS indicated client #3's supervision level changes to assigned supervision when he engages in one of his target behaviors and his assigned staff should encourage him to leave the area. The SS was asked how often the BT was present at the facility. The SS indicated the BT was there on Mondays and Thursdays. The SS indicated the BT brings in-services (trainings) for staff to review, she observes the clients, does the token store for the clients and takes clients for walks to let them vent. The SS indicated the BT does not assist with YSIS but she woul d sometimes redirect the clients. On 6/27/24 at 12:18 PM, DSP #10 was interviewed. DSP #10 indicated she worked 8:00 AM to 8:00 PM with client #3. DSP #10 indicated some of client #3's target behaviors were hitting, kicking and spitting. DSP #10 was			

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	unable to verbalize additional target behaviors. DSP #10 was asked how she should respond to physical aggression. DSP #10 indicated she tries to redirect and preoccupy him with something else. DSP #10 indicated client #3's coping skills were music and carrying balls around. DSP #10 was asked what client #3's precursors were. DSP #10 stated, "He doesn't like being wet. I'm drawing a blank". DSP #10 was asked if there was anything other than redirecting client #3 addressed in his BSP. DSP #10 stated, "The only thing popping in my head is separate programming". DSP #10 was asked about client #3's preventative procedures. DSP #10 stated, "I can turn my phone on. Music will completely distract him". DSP #10 was asked how she should react to client #3's behaviors. DSP #10 stated, "Calm and collective (sic)." DSP #10 stated, "Telling him to stop would not be an effective technique". DSP #10 indicated client #3 should be escorted to his room if he was spitting and flipping tables over. DSP #10 was unable to discuss specific information included in client #3's BSP. 4. On 6/26/24 at 11:02 AM, a review of client #4's record was conducted. The review indicated the following: No quarterly reviews for client #4's program plan progress were available for review. Client #4's record had monthly summaries			

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	with only March, April and May of 2024 available for review.On 6/27/24 at 9:57 AM, the Qualified Intellectual Disabilities Professional (QIDP) and Quality Assurance Manager (QAM) were interviewed. The QAM was asked about client #4's record indicating a lack of quarterly reviews available for review. The QAM stated, "They should be on Teams (electronic system), just not printed for the sample". At 10:48 AM, the QIDP was asked about client #4's progress for goals and the process for monitoring. The QIDP stated, "Yes. I'm in the process of learning the system. The 100's I've learned, the staff have made notes and sometimes indicate a refusal. I've not had extensive training in this. I've learned when I put a goal in it asks how many prompts. When the staff puts in 3 prompts or less the system puts the goal completed (100%), even if the staff noted refused. I've since learned there is drop box and the DSPs (Direct Support Professional) can click non-compliance and the client does not get credit. There was a time when I was checking the box when the goal was 100% and it kicks it out. I did not know that. I'm slowly learning things to do and not to do and it's distorting the data". The QIDP and QAM indicated client #4's progress for his goals should be maintained through quarterly reviews, but the data collection was not			

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	reliable due to the facility learning a new electronic recordkeeping system.5. An observation was conducted on 6/26/24 from 6:55 AM to 8:33 AM. At 7:23 AM, client #6 stopped in the dayroom next to a chair to remove his shoes as he and Certified Nurse Assistant (CNA #1) were taking a mop bucket from the Colts hallway back to the storage location of the mop bucket on Pacer hallway. Client #6 stated to CNA #1, "They're wet" and removed his shoes next to a chair in the dayroom. After removing his shoes, client #6 continued to walk with CNA #1 down the Pacer hallway to return the mop bucket.At 7:25 AM, client #6 returned to the dayroom and sat down in the chair next to his shoes. Client #6 used a dry white washcloth to wipe out the inside of his wet shoes and placed the shoes back onto his feet. At 7:47 AM, client #6 approached the surveyor and stated, "Can I show you something"? The surveyor followed client #6 to his bedroom at the end of the Colts hallway. Client #6 showed the surveyor his bathroom door within his bedroom had a lock and stated, "They locked this, so I can't make it to the bathroom in time". Client #6 was asked why his bathroom door was locked. Client #6 stated, "I have no idea". At 7:48 AM, CNA #1 was asked if client #6 had issues with urinary incontinence. CNA #1 stated, "Yes". CNA #1 was asked			

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	why client #6's bathroom door was required to be locked preventing him access to the bathroom. The CNA #1 stated, "I was told because of sexual behaviors with other clients". CNA #1 was asked when the restriction for locking client #6's bathroom began. CNA #1 stated, "I want to say sometime last week". CNA #1 was asked if there had been an incident which prompted the need for locking client #6's bathroom door. CNA #1 stated, "I want to say so, it happened on days (shift)". CNA #1 was asked what incident occurred that required a restriction to lock client #6's bathroom door and prevent access. CNA #1 stated, "Not totally sure". CNA #1 was asked if she knew which staff members worked during the behavioral incident she had referred to. CNA #1 stated, "No. I know [Program Manager] would know more about the incident though. I would say they put the lock on there in the last week". CNA #1 was asked if client #6 was having urinary incontinence because he could not make it to the Colts hallway bathroom timely. CNA #1 stated, "Yes". CNA #1 was asked why client #6 was on an enhanced supervision level as a one-to-one staffing assignment. CNA #1 stated, "For taking objects and inserting them in his private areas". CNA #1 was asked if this behavior was daily. CNA #1 stated, "Not day to day... I've been here			

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	2 months and he's not done it". At 8:00 AM, CNA #1 completed her shift and went off duty.On 6/26/24 at 8:21 AM, client #6's dayshift one-to-one staff, Direct Support Professional (DSP #15), was interviewed. DSP #15 was asked if client #6 had difficulty making it to the Colts hallway bathroom due to his bathroom door being locked. DSP #15 stated, "For sure. He waits a little too long. He puts it off and puts it off and then it's too late". DSP #15 was asked how long client #6's bathroom door had been locked denying access. DSP #15 stated, "Last week". DSP #15 was asked why a lock had been installed denying access to client #6's bathroom. DSP #15 stated, "Maybe because of a room change. He just changed this month ... I'm not sure. Maybe because of [client #12] so he does not come into his room to hit him. It's a bathroom that connects to [client #12's] room. [Client #12] has been having behaviors. That would be my guess".On 6/26/24 at 1:32 PM, a focused review of client #6's record was conducted. The review indicated the following:Individual Support Plan (ISP) dated 10/11/23 indicated, "Individual Profile:... [Client #6] can take care of his own hygiene independently but needs prompts to complete hygiene tasks such as brushing his teeth, putting on deodorant, and showering...			

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	Needs:... improvement in personal hygiene skills".Behavior Support Plan (BSP) dated 6/24/24 indicated, "Rights Restrictions: Supervision: 1:1 (one-to-one staffing) approximately arm's reach staff supervision when awake due to an extensive history of self-injury with items and ingesting non-food items (see below for shower/restroom supervision). When he is in his bedroom, staff will do a room sweep to look for small items and will then position themselves in the hallway to supervise [client #6] (door open). Staff should not be alone with him in his room due to [client #6's] extensive history of false allegations against his staff. When [client #6] is asleep, staff will be positioned outside his door with the door open. While sleeping/napping, if [client #6] requests that the door be closed, there will be a room sweep and staff can close the door and [client #6] will have 5-minute checks to make sure he is not engaging in self-harming acts...[Client #6's] restroom will be locked, and he will use the hallway restroom only to prevent sexually inappropriate behaviors in the shared restroom. When using the restroom or showering, the 1:1 will do a visual sweep of the restroom/shower to look for any items that can be used for self-harm (these items should be removed). The staff will then position themselves in the hallway outside the restroom/shower while [client			

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	#6] use the restroom/shower. Staff are to handle hygiene products...".Human Rights Committee (HRC) approval dated 6/6/24 indicated, "Restriction/Modification: [Client #6] will not use the passthrough restroom in his bedroom and will instead use the hallway restroom. The restroom will be visually swept by staff prior to use...Reason for Restriction/Modification... [Client #6] has a history of sexually acting out with peers and making sexual suggestions to peers. This modification is being made so that [client #6] can't use his restroom to meet up with peers who are not capable of giving consent to sexual behaviors. The visual sweep of the restroom is being recommended due to [client #6's] history of engaging in self-injury with items found in the restroom...".On 6/27/24 at 9:57 AM, the Program Manager (PM) and Quality Assurance Manager (QAM) were interviewed. The PM and QAM were asked about client #6's restriction to deny access to his bathroom within his bedroom and having urinary incontinence incidents. The PM indicated client #6 had HRC approval for the restriction to deny access to the bathroom in his bedroom. The PM was asked why client #6 required this restriction when he was on a one-to-one staffing level of supervision. The PM indicated client #6 had made false allegations of a sexual nature and for			

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	self-injury due to a history of putting foreign objects in parts of his body and then stated, "The team needs to review that (restriction to bathroom)". The PM was asked to clarify if the interdisciplinary team needed to review client #6's behavioral strategies and the staff knowledge for client #6's purpose of his restrictions. The PM stated, "Yeah, we can have a meeting on that". The PM was asked if there had been an incident which required client #6's bathroom access be locked. The PM stated, "It's (bathroom restriction) probably the false allegations". The QAM was asked if further follow was needed to review client #6's bathroom restriction and staff knowledge for behavioral restrictions. The QAM stated, "Right. I have to follow up with [Behavior Clinician]". On 6/26/24 at 3:07 PM, the Behavior Consultant (BC) was interviewed. The BC indicated client #6 had a BSP (Behavior Support Plan) to manage client #6's targeted behaviors which included but were not limited to self-harm, inappropriate sexual behavior towards his peers and false reporting of allegations against staff. The BC indicated client #6 was on 1:1 (one to one staffing ratio) during wake hours. The BC indicated staff should complete room sweeps when client #6 was inside of his bedroom while positioning themselves in the hallway and not alone in the room with client #6. The BC indicated			

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	client #6 could request his door to be shut and staff could complete a room sweep and allow client #6 to have his door shut for 5 minutes at a time. The BC indicated the restroom located inside of client #6's bedroom was a shared restroom with client #12 and should be locked. The BC indicated client #6 should utilize the hallway restroom. The BC indicated when client #6 utilized the hallway restroom staff should complete a sweep of the environment and then position themselves in the hallway to monitor client #6. The BC indicated staff working with client #6 should know his BSP and supervision protocols. 5-1.3			
W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, record review and interview for 1 of 4 sampled clients (#1), the facility failed to ensure a plan was developed to address client #1's smoking schedule. Findings include: An observation was conducted on 6/24/24 from 12:40 PM until 5:30 PM. At 2:45 PM client #1 was in the recreational building. At 2:45 PM DSP (Direct Support Professional) #16 took clients #1, #4 and #18 outside to vape/smoke. Client #1 was observed to be vaping. At 2:55 PM clients #1, #4 and 18 returned to the residential living unit. An observation was conducted on 6/25/24 at 6:05	W 0240	To correct the deficient practice, the QIDP and BC have been trained to ensure appropriate and client specific plans are in place. A smoking schedule has been developed for #1. To ensure no others were affected, /BC will review all client plans to ensure appropriate plans are in place. Additional monitoring will be achieved by the QAM conducting weekly QIDP meetings to discuss all current plans and client issues. Ongoing monitoring will be achieved by the QIDP, BC reviewing each specific needs at	08/04/2024

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	AM until 8:26 AM. At 8:24 AM client #1 exited the residential living unit to the front porch. Client #1 was observed to be vaping. Client #1's record review was completed on 6/26/24 at 9:35 AM. Client #1's BSP (Behavior Support Plan) dated 6/24/24 indicated, "Preventative Procedures/Training: [Client #1] is a smoker. The following smoking guidelines should be followed: The client must be dressed appropriately for the weather (no shorts in winter, etc) The client should not receive a smoke break immediately following a behavior that he has engaged in (wait about 20 minutes or until they are calm) There are no other important tasks taking place at the time such as meal clean-up/prep, etc. that the staff and client need to complete first. The smoke break doesn't conflict with his smoking schedule." The BSP did not address client #1's smoking schedule. On 6/27/24 at 9:57 AM, the Program Manager (PM), QIDP (Qualified Intellectual Disability Professional), and Quality Assurance Manager (QAM) were interviewed. The QIDP stated, "[Client #1] him specifically we start at 8:30 then every 2 hours after that. We adjusted the whole day there is a group that goes out at 8:15 and then the second group at 8:30. We split into groups for supervision." The PM stated, "the schedule is documented in the BSP." The PM stated, "the plan should be specific."		least quarterly and as needed.	
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient			

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	number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 2 of 4 sampled clients (#2 and #3) and 2 additional clients (#8 and #9), the facility failed to implement client #3's Behavior Support Plan (BSP) and clients #2, #8 and #9's Individual Support Plan (ISP) objectives during formal and informal opportunities. Findings include: 1. An observation was conducted at the facility on 6/24/24 from 3:07 PM to 6:43 PM. At 3:32 PM, client #3 was singing in the day room. At 3:34 PM, client #3 walked down the hall and slammed a bedroom door then went to the day room, picked a tablet up off the table and moved it to a different table. At 3:42 PM, client #3 walked throughout the building spitting towards staff and his peers. Direct Support Professional (DSP) #10 prompted him to stop spitting. At 3:44 PM, client #3 ran down the hall to the bathroom then slammed the bathroom door. At 3:50 PM, client #3 walked around in the dayroom while holding a football and yelling. DSP #10 raised her voice and prompted client #3 to go outside. At 3:53 PM, client #3 pounded on the outside of the dayroom windows. At 4:09 PM, client #3 walked around the dayroom with DSP #19. Client #3 was carrying a football while pacing, yelling and spitting at the surveyors, staff and his peers. At 4:11 PM, client #3 ran into the kitchen and DSP #19 followed him. Yelling was heard coming from the kitchen. DSP #19 fell out of the doorway to the kitchen and landed on the ground. DSP #19 had her hand covering her left eye and forehead. DSP #10 stated to client #3, "[Client #3] stop, [client #3]". DSP #10 took client #3 out the front door while	W 0249	To correct the deficient practice, all staff have been trained on each BSP, ISP, and dining plan. has been trained intervening, coaching, and modeling. Additional monitoring will be achieved by daily administrative observations to ensure staff are implementing all policies, procedures, documentation, and plans as written. The administrative team will evaluate the observation frequency monthly to determine if the observations should continue, decrease, or increase. The administrative team will meet daily to discuss any needs or incident follow up in the facility. The lead BC will meet weekly with the BC completing observations to discuss any client's needs, staff training, and any training the BC may need. Ongoing monitoring will be achieved by the administrative team completing monthly facility site reviews, record reviews, and quarterly quality and safety reviews for incident patterns, follow up, and thoroughness.	08/04/2024

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	other staff assisted DSP #19 with getting ice for her head. At 4:17 PM, client #3 was outside punching the day room windows. At 4:20 PM, DSP #19 indicated when client #3 was in the kitchen he picked up a bucket of soapy water and was going to throw it. DSP #19 stated, "I tried to redirect him and he slammed his head back and hit my head. I saw stars after, but I'm, okay". At 4:23 PM, client #3 came back inside with DSP #10, slammed the kitchen door and spit towards his peers. DSP #10 raised her voice and stated, "[Client #3]". The Behavior Technician (BT) was leaning against a window ledge in the day room. Client #3 walked by the television and used the football he was carrying to hit the television (safety box with television inside). At 4:25 PM, client #3 continued spitting towards staff and peers. DSP #10 responded by raising her voice and stating, "[Client #3] stop". Client #3 responded by kicking the couch and continuing to spit. At 4:26 PM, client #3 went into the kitchen and slammed the door shut. DSP #10 stated to client #3, "Quit spitting. Get out". Client #3 picked up a bowl of cooked vegetables and threw it onto the floor. DSP #10 stated with a raised voice, "Room, go. You just threw a whole bowl of food. [Client #3], go to your room". Client #3 continued spitting at his peers and staff in the day room. DSP #14 intervened and client #3 punched him and spit in his face. Client #3 picked up a tablet and threw it then pushed a large trash can over. DSP #11 and DSP #14 physically escorted client #3 to his room. Clients #1, #2 and #4 were in the day room and were not prompted to leave the area. The BT continued to lean against the window and did not intervene. At 4:34 PM, client #3 was in his room with DSP #11 and DSP #14. DSP #14's shirt was torn around the neck. Client #3 was listening to music. At 4:37 PM, client #3 was in his bedroom continuously yelling			

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	"f***" which could be heard in the dayroom. At 4:44 PM, client #3 went to the medication room for a PRN (as needed medication) assessment. DSP #14 indicated client #3's PRN PO (by mouth) medication for behavior control was administered by the Licensed Practical Nurse (LPN) #3. At 4:48 PM, client #3 was in the dayroom without staff. Client #3 sat down to eat dinner. Client #3 took the ham, bread and applesauce off of his plate and handed it to DSP #10. Client #3 ate the potatoes and vegetables. At 4:51 PM, client #3 paced in the dayroom while holding a football and singing. Some of his peers were watching television and talking with staff. Client #3 picked up a carton of milk, finished drinking it then threw the empty carton on the floor. Staff did not prompt him to pick it up. The BT continued leaning against the window ledge in the dayroom. At 4:53 PM, client #3 walked into the kitchen and slammed the door. Staff opened the door back up and client #3 was mumbling as he walked around the kitchen. Client #3 exited the kitchen then walked past the Quality Assurance Manager (QAM) and purposely bumped into him then threw his football at the BT and charged after her. Staff intervened to prevent him from making contact with the BT. Client #3 walked past client #4 and spit in his face. Client #4 wiped the spit off his face and stated, "F****** B****". Client #3 was prompted to go outside. The QAM indicated staff should have done a one person hold which is where staff's arms are wrapped around his arms and the other clients should have been prompted to leave the area. At 5:01 PM, client #3 went in the kitchen and DSP #14 attempted to escort him out the front door in the day room. Client #18 was in the room and stated to client #3, "That's right, throw it (chair) b****. I don't care. P****". Client #3 threw a chair in the dayroom then went to his			

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	room. At 5:06 PM, client #3 went out the front door with DSP #14 and paced around the yard. At 5:09 PM, client #3 punched a window (from outside) in the dayroom several times causing the glass to break from top to bottom. DSP #14 was outside with him and did not intervene. The BT continued leaning on the window ledge inside the dayroom. Client #18 was in the dayroom when client #3 hit the window and stated, "Y'all make me smoke out there with him, I will f*** him up. If I'm out there with him, I'll beat his a**. He f****** p***** all over the place and he doesn't care". At 5:15 PM, DSP #14 remained outside with client #3. DSP #19 came inside the front door with client #11 and client #3 pushed the door closed while DSP #19 was walking through and the door hit her then slammed shut. At 5:21 PM, client #3 came back inside with DSP #14 following him. Client #18 stood up and went to his bedroom and slammed the door. Client #3 paced around the dayroom. DSP #10 stated to client #3, "You need to calm down and focus". Client #3 responded by walking at a fast pace down the hall. At 5:26 PM, client #3 walked by client #20 and pushed him. Client #20 ignored client #3. At 5:28 PM, client #3 walked up to client #10 and wrapped his arms around his neck to hug him. DSP #10 stated in a loud voice, "[Client #3]". At 5:29 PM, client #3 and client #18 were both in the dayroom yelling and threatening peers. Clients #4, #5, #10 and #20 were present in the day room. The BT continued leaning against the window ledge in the dayroom and did not intervene. At 5:38 PM, client #3 started spitting all over the day room. DSP #10 stated in a loud voice, "[Client #3], stop spitting please". Client #3 responded by running down the hall and entering a peer's bedroom. DSP #14 followed client #3 into the room. Client #3 threw an item out of the bedroom prior to DSP #14 intervening. At 5:41 PM, client #3 paced around			

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	the dayroom. Client #3 grabbed client #11's fruit and ate it. DSPs in the area did not intervene. DSP #11 stated, "I'll go get you another one, [client #11]". DSP #11 returned with 2 bags of fruit, one for client #11 and one for client #3. At 5:45 PM, the Executive Director (ED) opened the door at the end of the hallway and prompted the clients to go to the other building (not client #3). Staff assisted with getting most of the clients to the other building away from client #3. Clients #20, #14 and an unknown client did not leave the dayroom. Client #18 was in the front yard with staff present. At 5:47 PM, client #3 was going in and out of his peers bedrooms without redirection from staff. At 5:48 PM, client #3 stood at the back door yelling loudly and staff did not redirect him. As client #3 was walking towards the dayroom, he got in client #14's face and yelled. DSP #10 stated, "Back up" to client #3. At 5:58 PM, client #3 went to the art room where some of his peers were working on activities. Client #3 paced around the room while carrying a basketball. DSP #19 was with him. Client #3 was prompted to color a picture. Client #3 declined. Client #4 stated, "I'm sick of his s***". At 6:04 PM, client #3 was prompted to do a puzzle. Client #3 declined and continued pacing around the room. At 6:07 PM, client #3 charged after the surveyor who was visiting with client #9 as he colored a picture. The surveyor got up and moved to a different area and client #3 followed. Client #3 attacked the Program Manager (PM) by hitting her, grabbing her shirt and pulling her watch off her wrist. The PM got on the walkie talkie and stated, "I need male staff to the art room now". The PM asked the surveyor to leave the art room for safety due to client #3 targeting the surveyor. The surveyor left the art room and the other clients in the room were prompted to leave the			

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	room. At 6:10 PM, client #4 stated, "F*** that b****". Client #3 was in the art room with the PM and the QAM. Client #9 stated to the surveyor, "Is he (client #3) done yet? I want to hang out with you guys". At 6:21 PM, the PM was heard over the walkie-talkie stating, "[DSP #14] or [DSP #11] to the art room now". An unidentified voice on the walkie-talkie stated, "[DSP #11] is on his way". At 6:38 PM, the Qualified Intellectual Disabilities Professional (QIDP) was standing outside the art room and he indicated client #3 received an IM (intramuscular) injection five minutes ago. The QIDP stated, "He's been like this at times, but not often". The observation was ended at 6:43 PM. From 6:43 PM to 6:57 PM, the ED had two of the surveyors isolated in the conference room until it was safe to leave as client #3 was pacing up and down the hallway. The ED stood inside the conference room and observed client #3 by occasionally cracking the door open and looking out. The ED indicated client #3 took off running and pushed the QIDP causing him to fall to the ground and hit his head on the wall. At 6:57 PM, the ED indicated client #3 was cornered in the gym and it was safe for the surveyors to leave the building. The ED walked the surveyors out of the building and to the parking lot. As the surveyors left the conference room, the QIDP was sitting on the floor leaning up against the wall holding a bag of ice on his head. The PM was with him. The QAM came out of the bathroom and indicated he was okay now that he didn't have blood all over him. The QAM indicated he was taking the QIDP to the emergency room to be evaluated. On 6/26/24 at 9:40 AM, the facility's incident reports for client #3 were reviewed and indicated the following:			

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A BDS (Bureau of Disabilities Services) report dated 6/25/24 indicated, "On 6/24/24 at 3:24pm, [client #3] was (sic) walked behind peer (client #12) and punched him in the back with no precursors. Despite staff attempting to assist [client #3] with his coping skills he was unable to calm himself. The nurse assessed him and administered a behavioral PO (by mouth) PRN (as needed medication for behavior). Staff was able to assist [client #3] with coping skills and he calmed himself down. Nurse assessed [client #3] and noted no injuries. [Client #3] returned to normal programming".

A BDS report dated 6/25/24 indicated, "On 6/24/24 at 4:14 pm, [client #3] was walking around the dayroom and walked into the kitchen. Then [client #3] started yelling and hitting the countertops. Staff attempted to redirect [client #3] out of the kitchen and he then threw his head back and hit staff (DSP #19) in head. The nurser (sic) assessed [client #3], no injuries noted, neuro (neurological) check (sic) initiated. [Client #3] returned to normal programming with no further issues".

A BDS report dated 6/26/24 indicated, "On 6/24/24 at 6p, [client #3] was physically and verbally aggressive. Staff attempted to de-escalate but was unsuccessful. While in art room, [client #3] hit peer on his right arm and was targeting state surveyor. [Client #3] started throwing objects and hitting staff. At this time, trained staff initiated a guardian and HRC (human rights committee) approved 3 person supine hold (behavioral intervention). Staff attempted to assist [client #3] with his coping skills. The nurse assessed him and administered a behavioral IM (intramuscular) PRN. Staff was able to assist [client #3] with coping skills and he calmed himself down. He was

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	released from the hold. The hold lasted 19 minutes. Nurse assessed [client #3] and noted no injuries. Once released [client #3] ran down the hallway and pushed QIDP and ran to gym. While in gym he became verbally aggressive. Staff were able to calm [client #3] down and he returned to regular programming". A PRN (as needed medication) evaluation form dated 6/24/24 indicated LPN #3 administered PRN Haldol (for behavior) 10 mg (milligrams) and Benadryl 50 mg by mouth at 3:47 PM. A PRN evaluation form dated 6/24/24 indicated LPN #3 administered PRN Haldol 10 mg and Benadryl 50 mg IM (intramuscularly) at 6:47 PM. On 6/26/24 at 1:53 PM, client #3's record was reviewed. Client #3's 6/24/24 Behavior Support Plan (BSP) indicated the following: "Target Behaviors and Goals": "Verbal Aggression: any time he is yelling at others, cursing, threatening others, using profanity, etc. [Client #3] has been observed to yell at no one in particular or to yell threats when no one is in the vicinity. He has also 'punched' the air as if he is fighting another person when there is no other person present". "Property Destruction: any time he is punching items, throwing chairs/items, breaking furniture, kicking items or doors, or causing irreparable damage to objects/items. [Client #3] has a history of becoming frustrated with completing tasks/chores and throwing items or objects that he is working on".			

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	"Physical Aggression: Any occurrence or attempts at hitting people, spitting on them, kicking or scratching at others, using objects as weapons, pulling hair, pinching, or behaviors that produce or have the potential to produce an injury to others. Spitting on others occurred at a high frequency at previous placements. Historically, he has been hysically (sic) aggressive to those who he feels have 'wronged' him. He can also be physically aggressive when he is not getting what he wants from others. He has a history of being very aggressive toward his mother and he has also grabbed the driver during vehicle transports. When highly agitated, he may attempt to engage in several acts of aggression toward peers". "Instigation: Includes attempts to get peers upset or to get peers to engage in target behaviors". "Boundary Violations/Unwelcome Touch: defined as any time [client #3] does not respect the personal space of others by standing less than an arm's reach away from others and not moving away after 1 verbal prompt for personal space. Also includes acts of touching others in a non-threatening way (non-threatening as in does not leave a mark or injury on staff and occurs when [client #3] is not already agitated or demonstrating other forms of aggression). Includes episodes of grabbing/holding staff or peers by the arm in a non-forceful manner (does not leave a mark/injury) or poking staff in a manner that is not forceful". "Replacement Behaviors: Asking/Approaching staff for help: Any time he asks appropriately for staff to help him get the items or attention that he desires or any time he uses his coping skills instead of			

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	engaging in the target behavior. Staff should offer positive social reinforcement to [client #3] anytime that he is attempting to use his replacement behaviors. This can be given through verbal praise, high fives, or other positive statements about his behavior". "Restrictions: If [client #3] is exhibiting agitation, precursors, or has engaged in physical aggression to peers, an assigned staff will be put in place for the protection of other clients. The assigned staff's responsibility is to prevent [client #3] from being able to hit/kick/spit at other clients. The assigned staff should stay between [client #3] and any peers that he may hit. The assigned staff can also encourage [client #3] to go to the gym for activity where he would be away from his peers for their safety". "Preferences Assessment: Likes: music, dancing, singing. Dislikes: Being told what to do by others. When he feels that others are making demands of him". "Precursors: Verbal aggression and instigation could be identified as precursors to other behavioral issues. When he engages in this behavior staff will: See above restriction about implementing an assigned staff for [client #3]. Remain calm in tone and volume, do not react with emotion or irritation. Ignore threats and verbal abuse- do not get into a back-and-forth power struggle. If he is engaging in instigation toward a peer, remain between the two peers. Ask him how you can help. He is more likely to calm down if he feels supported and liked by his staff. Remind him that we are here to help him so that he can reach his			

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	goals of being more independent. If he continues to yell, with as little reaction that you can use, repeat that you want to help him but that you can only do so if he is talking calmly. Once calm, attempt to resolve the problem or come up with a game plan as to how the problem can be resolved. Praise him for his input and compliance when he has calmed (ie: 'I know you're upset but I'm really proud of you for calming down so we can talk about this' etc. If the verbal aggression continues, in a calm and neutral voice, suggest a relaxation technique that he can use to calm down (ie: 'let's take 10 deep breaths together, then if you're calm, we can talk'. A staff will encourage him to go with them (in the opposite direction of his peers) for a walk. If he does not begin to go to a different area and continues being verbally aggressive, staff will redirect peers away from the immediate area. Attempt to find out what is upsetting him and attempt to resolve the problem as best you can with his input. If [client #3] is creating an unsafe environment due to his verbal aggression or instigation of peers, and he is refusing to leave a common area, thus causing him to become a target to his peers, for his own health and safety, he can be physically redirected to a safe area using YOU'RE SAFE I'M SAFE (YSIS) (behavioral intervention) always beginning with the least restrictive measures". "Preventative Procedures/Training: Separate programing should take place in the gym. If [client #3] is engaging in ongoing verbal aggression or instigation, it has been helpful to offer to take him to the life skills building where he can yell or be active without disrupting his peers. See above restriction related to [client #3] having an assigned staff when showing precursors. Give [client #3] choices whenever possible, he does best when he feels like he has some control			

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	over his situation. Speak to him in a calm, neutral-toned voice at all times. Do not take any verbal aggression or physical aggression (or any target behavior) personally. Anytime he is engaging in appropriate behaviors provide abundant specific praise. When giving him instructions/requests they should be: Given in a clear and concise manner/one step at a time. Done in the form of a question and not a demand. Short and to the point. Frequently bring up positive aspects about his day/week or progress. [Client #3] enjoys listening to music and a tablet has been provided for him". "Reactive Procedures: For Physical Aggression/Property Destruction/Self Injurious Behaviors: Immediately ensure the health and safety of everybody in the immediate environment. Redirect him and/or others to a different area of the environment. Tell him to stop the behavior. If he stops the behavior, redirect him to a safe location and problem solve with him and praise him for doing this with us. If the behavior continues block all attempts of aggression and attempt to redirect, if the behavior continues and he is placing himself or others in danger, implement YOU'RE SAFE I'M SAFE (YSIS) beginning with the least restrictive measures.... For Boundary Violations/Unwelcome Touch: In a calm and non-confrontational manner, ask [client #3] to give you/his peer more space, staff can say 'Hi [client #3], can I get a little more personal space?' or 'Don't forget, we keep our hands to ourselves'. Keep the tone light when redirecting. Offer a different activity to [client #3] to distract from the unwelcome touch. Notify administration staff and document on all appropriate forms".			

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	On 6/24/24 at 4:31 PM, the Quality Assurance Manager (QAM) was interviewed in the day room. The QAM indicated client #3 was on normal supervision until he becomes agitated then he becomes assigned staff. The QAM indicated client #3 should get separate programming when his behavior is escalating. The QAM stated, "That (separate programming) ends up in a disaster. They should attempt to get him (client #3) out". The QAM indicated if client #3 refused to leave the area then staff should assist with getting the other clients to a different area. On 6/26/24 at 3:07 PM, the Behavior Consultant (BC) was interviewed. The BC reviewed the target behaviors in client #3's BSP and stated, "We have seen all of these behaviors in [client #3] at least once". The BC indicated client #3's replacement behaviors were to ask for help and to use coping skills instead of target behaviors. The BC was asked about client #3's coping skills. The BC stated, "Being away from whatever the environment is that set him off. Leaving an overstimulated area, go outside, gym to shoot hoops, just to get away from whatever upset him. He has more and more target behaviors when he is still in the same environment. Do something to acknowledge what he wants. Praise him for telling him what he needs, verbal praise, high 5, staff should say tell me what you need". The BC was asked to explain assigned staff. The BC stated, "Typically for [client #3] we are talking about separate programming. Once he hits one client he's probably going to go after someone else. Especially with the spitting. We are probably going to leave the building. It is someone in place to prevent that from happening. It's not typically an escort unless he is creating a situation in the day room. If he is getting everyone riled up they can escort him to another area. He likes going to			

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	other places. They do have in his plan that he can be escorted to his room or a calm area if he is a danger to his peers". The BC indicated client #3's precursors were verbal aggression and instigation. The BC stated, "If they (clients) are starting to escalate and we (staff) escalate, it is going nowhere but up (escalating). Keep the environment calm. Don't respond like you are annoyed. It's not going to help [client #3] if he is in crisis and we too are out of control". The BC was asked how staff should respond if client #3 displayed precursors. The BC stated, "Remain in between him and peer if he is physically aggressive. Remind him we are here to help. Trying to get them to communicate. Like what do you really need? Do you want to go outside? Are you hungry? Have him verbalize what he needs. Staff should model the appropriate response. Offer 10 breaths together. Encourage him to talk. Staff should be thinking, what am I doing throughout the shift to prevent behaviors?" The BC indicated client #3's BSP should be implemented as written and staff needed additional training regarding implementing client #3's BSP. On 6/27/24 at 10:00 AM, the Site Supervisor (SS) was interviewed. The SS was asked to describe client #3's behaviors. The SS stated, "Anything. I would have to look. Honestly, almost anything sets him off. You can look at him and smile or ask him for a smile and you can get a ball thrown at your face and spit at". The SS indicated client #3 had a lot of verbal aggression towards his peers. The SS stated, "If he is in a not so great mood, he will walk up to a peer and tap the arm lightly which will set in motion a whole big set of events. He will randomly spit, at times he will launch his ball at you out of the blue, randomly knock things over". The SS indicated she wasn't sure if he did			

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	those things for attention. The SS stated, "I wonder if [client #3] is fighting through a multitude of personalities. The slightest thing can make him snap". The SS was asked how to address client #3's physical aggression. The SS indicated client #3 should be prompted to leave the area if he displayed target behaviors and his peers were in the same room. The SS indicated if client #3 refused to leave the area, staff should request the other clients to leave the area for their safety. The surveyor reviewed what occurred during the aforementioned observation and asked the SS how staff should have responded. The SS indicated she was not working during the incident, but she would have escorted client #3 out of the area, utilized YSIS if needed then she would have ensured the other clients were encouraged to leave the area. The SS indicated client #3's supervision level changes to assigned supervision when he engages in one of his target behaviors and his assigned staff should encourage him to leave the area. The SS was asked how often the BT was present at the facility. The SS indicated the BT was there on Mondays and Thursdays. The SS indicated the BT brings in-services (trainings) for staff to review, she observes the clients, does the token store for the clients and takes clients for walks to let them vent. The SS indicated the BT does not assist with YSIS but she would sometimes redirect the clients. On 6/27/24 at 12:18 PM, DSP #10 was interviewed. DSP #10 indicated she worked 8:00 AM to 8:00 PM with client #3. DSP #10 indicated some of client #3's target behaviors were hitting, kicking and spitting. DSP #10 was unable to verbalize additional target behaviors. DSP #10 was asked how she should respond to physical aggression. DSP #10 indicated she tries to redirect and			

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	preoccupy him with something else. DSP #10 indicated client #3's coping skills were music and carrying balls around. DSP #10 was asked what client #3's precursors were. DSP #10 stated, "He doesn't like being wet. I'm drawing a blank". DSP #10 was asked if there was anything other than redirecting client #3 addressed in his BSP. DSP #10 stated, "The only thing popping in my head is separate programming". DSP #10 was asked about client #3's preventative procedures. DSP #10 stated, "I can turn my phone on. Music will completely distract him". DSP #10 was asked how she should react to client #3's behaviors. DSP #10 stated, "Calm and collective (sic)." DSP #10 stated, "Telling him to stop would not be an effective technique". DSP #10 indicated client #3 should be escorted to his room if he was spitting and flipping tables over. DSP #10 was unable to discuss specific information included in client #3's BSP. 4. Observations were conducted at the facility on 6/24/24 from 1:00 PM to 3:29 PM and on 6/25/24 from 5:50 AM to 9:15 AM and 10:46 AM to 11:42 AM. On 6/24/24 at 2:28 PM client #2 sat at the table with a whole banana. Client #2 ate a few big bites of the banana, then threw part of the banana and peel on the floor. On 6/25/24 at 9:02 AM SS (Site Supervisor) #2 placed a container of dry cereal and a carton of milk on the table in front of client #2. SS #2 opened a muffin and placed the muffin on the table laying it on top of the plastic wrapper. Client #2 picked up the whole muffin and crumbled it with his fingers putting a few pieces in his mouth while the rest of the muffin fell into his lap and onto the floor. Client #2 used his fingers to grab a handful of dry cereal. He brought his hand to his			

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	mouth getting a few pieces of cereal in his mouth while the rest of the cereal fell into his lap and onto the floor. Client #2 stood up and walked around the day room. SS #2 asked client #2 to come back to the table. Client #2 walked over to the table and grabbed a handful of dry cereal and ate while walking around the day room. At 9:09 AM client #2 sat on the couch in the day room. Client #2 stood up and went over to the table and grabbed a handful of dry cereal and ate it. SS #2 asked client #2 to sit down. Client #2 continued to walk around while eating his dry cereal. At 10:51 AM client #2 went into the kitchen. DSP #14 came out of the kitchen with client #2 emptying a sandwich size bag of cut cantaloupe in 1 inch by 2 inch pieces and whole strawberries into a bowl. DSP #14 left to assist another client. Client #2 sat at the table unsupervised eating cantaloupe with his fingers. At 10:53 AM client #2 stood up and went to his room and got into bed. Client #2's record was reviewed on 6/26/24 at 11:29 AM. Client #2's Dining Plan dated 10/2023 indicated the following: "...Food Texture: ¼ inch chopped Food should be moist and tender Specific Skills to Maintain/Acquire: Prompt to assist with meal prep and cleanup. Provide prompts and reminders to eat and drink at a slow pace. Food to be cut into ¼ inch pieces. Sit upright at table for meals. Monitor for regurgitation and prompt him to stop...."			

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Client #2's High Risk Plan for Choking or Aspiration dated 10/23/23 indicated the following: "...Potential for Choking or Aspiration and Illness due to SIB (Self-Injurious Behaviors) of Causing Self to Regurgitate After Eating and then Consuming the Emesis.

Expected Outcome: [Client #2] will not choke, aspirate or consume any non-food substances causing same through 10/2024.

Ensure [client #2's] SAFETY first.

1. [Client #2] will have 1 on 1 staffing assigned for meals who will cut up his food into ¼ inch pieces and will prevent him from eating too fast or too much in one setting.
2. Staff are to monitor for indication he is trying to cause himself to regurgitate and redirect him to stop behavior...."

Client #2's BSP (Behavior Support Plan) dated 6/21/24 indicated, "...Restrictions: meal/snack supervision...All of [client #2's] food must be cut into ¼ inch pieces due to his choking risk and his tendency to gorge himself. He is on thin liquids. Clothing protectors will be available to help keep [client #2's] clothing clean...."

The BC (Behavior Clinician) was interviewed on 6/26/24 at 3:08 PM. The BC indicated client #2 has an assigned staff across all shifts. The BC indicated staff should cut up client #2's food and be in line of sight when he is eating.

The PM (Program Manager) was interviewed on 6/27/24 at 9:54 AM. The PM indicated client #2's dining plan instructed for his food to be cut into 1/4 inch pieces. The PM indicated staff should

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	follow client #2's plan as written. SS #2 was interviewed on 6/27/24 at 10 AM. SS #2 indicated client #2's food should be cut into 1/4 inch pieces including fresh fruit. DSP #10 was interviewed on 6/27/24 at 12:18 PM. DSP #10 indicated client #2's sandwiches should be cut into four pieces. DSP #10 was asked if other foods needed to be cut up.			
W 0268 Bldg. 00	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview for 2 of 4 sampled clients (#1 and #2) and 3 additional clients (#10, #11 and #12), the facility failed to ensure client #1's clothing was clean, client #2's feet were clean, client #11 wore a clean shirt, client #12 wore clean shirts and and his face was clean after eating and client #10 did not have his shorts on backwards or food around his mouth after eating. Findings include: 1. Observations were conducted at the facility on 6/24/24 from 1:00 PM to 3:29 PM, on 6/25/24 from 5:50 AM to 9:15 AM and 10:46 AM to 11:42 AM and on 6/27/24 from 11:52 AM to 12:18 PM. a. On 6/24/24 at 2:42 PM client #2 took his pants off in the hall. The BC (Behavior Technician) and DSP #10 assisted him into his room to change his clothes. Client #2 came out of his room without shoes or socks. Client #2 walked on his tip toes. The balls of his feet were black. On 6/25/24 at 8:40 PM client #2 was assisted in	W 0268	To correct the deficient practice, all staff have been trained client dignity. The following has been put in place to prevent recurrence: A will be assigned daily to inspect and ensure each client is maintaining their dignity. The PM will review daily and rectify any issues noted. Additional monitoring will be achieved by daily administrative observations to ensure staff are implementing all policies, procedures, documentation, and plans as written. The administrative team will evaluate the observation frequency monthly to determine if the observations should continue, decrease, or increase. The administrative team will meet daily to discuss any or incident follow up in the facility. Ongoing monitoring will be achieved by the administrative team completing	08/04/2024

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	15G811	A. BUILDING 00 B. WING	07/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES-CARE INC	1306 S BLOOMINGTON STREET GREENCASTLE, IN 46135

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	taking a shower after smearing feces on his body. At 9:00 AM client #2 returned to the day room without shoes or socks on. The balls of client #2's were black following his shower. b. On 6/24/24 at 2:51 PM client #11 entered the day room. Client #11 had long brown stains on the front of his shirt. DSP (Direct Support Professional) #2 indicated client #11 had ice cream in the activities room. DSP #2 assisted client #11 in washing his hands. Client #11 was wearing the stained shirt when the observation ended at 3:29 PM. c. On 6/24/24 at 3:10 PM client #12 walked into the day room wearing a gray sweatshirt with food stains and wet areas on the front of his sweatshirt. Client #12 was wearing the stained shirt when the observation ended at 3:29 PM. On 6/25/24 at 7:25 AM client #12 ate his breakfast at the dining room table. Client #12 had bits of cereal and milk in his beard. At 7:28 PM client #12 stood in the day room with cereal and milk in his beard and was drooling onto his shirt. At 7:40 PM SS (Site Supervisor) #1 asked DSP #7 to help client #12 wipe his mouth. At 8:08 AM client #12 sat in a chair in the day room watching a video on his phone. He was drooling and his shirt was wet. At 8:43 AM client #12 continued to drool while watching the video. d. On 6/25/24 at 7:30 AM client #10 was in the day room with his shorts on backwards. On 6/27/24 at 11:57 AM client #10 ate his lunch of chicken salad. At 12:12 PM client #10 was in the day room with chicken salad around the corners of his mouth. The QAM (Quality Assurance Manager) was interviewed on 6/27/24 at 9:57 AM. The QAM		monthly facility site reviews, record reviews, and quarterly quality and safety reviews for incident patterns, follow up, and thoroughness.	

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	indicated clothing should be changed right after the clothes become soiled. The QAM indicated client should be prompted to change their clothing and be offered assistance if needed. 2. An observation was conducted on 6/24/24 from 1:00 PM to 3:29 PM. During the observation client #2 paced throughout the dayroom and dining room. Upon entering the residential area, client #2 was outside on the porch with Direct Support Professional (DSP #16). At 1:23 PM, client #2 and DSP #16 returned from the front porch to the dining room. At 1:39 PM, client #2 was observed to be wearing his shorts on backwards with the button and zipper to his shorts located on his backside. At 2:00 PM, client #2 returned from his bedroom to the dayroom. Client #2's shorts had been reversed and he was now wearing them correctly. At 2:02 PM, client #2 returned to the front porch with DSP #16. At 2:09 PM, client #2 returned inside to the dayroom and DSP #16 stated, "No, we need to leave your pants on". Client #2 and DSP #16 returned to client #2's bedroom and shut the door. At 2:22 PM, client #2 and DSP #16 came out of client #2's bedroom and returned to the dayroom. At 2:29 PM, client #2 walked down the Pacer hallway with Direct Support Professional (DSP #18) and returned to the dayroom. Client #2 sat briefly in a chair in the dayroom before getting up and entering the kitchen at 2:35 PM. Client #2 grabbed some fruit from the kitchen. DSP #19 assisted client #2 with eating pieces of an orange and a banana.			

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	At 2:42 PM, client #2 ran down the Colts hallway and the Behavior Tech (BT) followed and redirected client #2 back toward the dayroom. At 2:43 PM, client #2's shorts fell down from his waist exposing himself in the Pacer hallway. Direct Support Staff (DSP #10) ran down the hallway and stated, "I'll get some clothes". DSP #10 returned with clothing and handed the BT a pair of black athletic long pants and a grey shirt. Client #2 was not wearing socks or shoes. At 2:49 PM, client #2 ran down the Pacer hallway and DSP #10 stated, "[Client #2] no" and ran after client #2 down the hallway. Client #2 returned to the dayroom and sat down on a sofa next to client #18. Client #18 stated, "Man, look at the bottom of his feet. I don't know why you guys don't have him wear socks". The bottoms of client #2's feet were black and soiled. At 2:52 PM, client #2 paced throughout the dayroom and DSP #18 stated, "Ok buddy, sit down". The bottoms of client #2's feet were black and soiled. At 2:54 PM, client #2 walked down the Pacer hallway. DSP #18 stated, "Where are you going buddy? No leave your shirt on". At 2:55 PM, client #2 took his shirt off and pulled his pants off. At 2:56 PM, DSP #18 unlocked the laundry room door and stated, "Come in here, let's put some shorts on". Client #2 was not wearing socks or shoes. Client #2 was not prompted to clean the bottoms of his feet. On 6/27/24 at 9:57 AM, the Program Manager (PM) and Quality Assurance Manager (QAM) were interviewed. The PM and QAM were provided an example of the observation of client			

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	#2's clothing being worn backwards and the bottom of his feet black from being soiled and asked if client #2's dignity should be maintained. The PM stated, "Yes". The PM and QAM were asked how staff should ensure client #2's dignity was maintained. The QAM stated, "Prompting and providing hands on assistance if needed". 3. Observations were conducted on 6/25/24 from 6:05 AM until 8:26 AM at the residential living unit and from 8:35 AM until 9:10 AM at the outside agency owned workshop. At 8:23 AM client #1 went to his bedroom and returned with a blue hooded sweatshirt that had white substances down the front of the sweatshirt. At 8:24 AM client #1 exited the building with staff for the outside agency workshop. At 8:42 AM client #1 was at the outside agency workshop working on assembling products for a local car part factory. Client #1 was wearing the dirty blue hooded sweatshirt. An interview was conducted on 6/25/24 at 9:10 AM with the DSC (Day Service Coordinator). The DSC stated, "they usually come in wearing the same clothing they had on the previous day." On 6/27/24 at 9:57 AM, the Program Manager (PM) and Quality Assurance Manager (QAM) were interviewed. The PM and QAM were provided an example of the observation of client #1's clothing being dirty and asked if client #1's dignity should be maintained. The PM stated, "Yes." The PM and QAM were asked how staff should ensure client #1's dignity was maintained. The QAM stated, "Prompting and providing hands on assistance if needed".			
W 0436 Bldg. 00	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good			

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	repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview for 1 of 4 sampled clients (#1), plus 1 additional client (#9), the facility failed to ensure client #1's adaptive supports for hearing aids were worn and to ensure client #9's adaptive supports for knee pads and a helmet to prevent injury during a fall were worn while he ambulated during his morning routine. Findings include: 1. Observations were conducted on 6/24/24 from 1:00 PM until 5:30 PM at the residential living area. At 1:30 PM client #1 was sitting on the front porch of the residential living area. Client #1 was observed to not be wearing hearing aids. At 4:49 PM client #1 was in the recreational building eating his dinner. Client #1 was observed to not be wearing hearing aids. Observations were conducted on 6/25/24 from 6:05 AM until 8:26 AM at the residential living unit and from 8:35 AM until 9:10 AM at the outside agency owned workshop. At 7:17 AM client #1 was in the common area of the residential living unit. Client #1 was observed to not be wearing hearing aids. At 7:20 AM client #1 went into the nurses station to receive his morning medications. Client #1 was observed to not be wearing hearing aids. At 8:25 AM client #1 exited the building and left with staff for the outside agency workshop. Client #1 was observed to not be wearing hearing aids. At 8:42 AM client #1 was at the outside agency workshop working on	W 0436	To correct the deficient practice, all staff have been trained in All clients adaptive equipment needs and procedures. The nursing staff has been trained ensuring all doctor recommendations are completed. Client #1 has an appointment scheduled with a hearing specialist on 8-6-24. The RN will ensure all recommendations are . To ensure no others were affected the RN will review all client charts to ensure all recommendations are completed, as well as all client adaptive equipment to ensure they are utilized appropriately. Additional monitoring will be achieved by daily administrative observations to ensure staff are implementing all policies, procedures, documentation, and plans as written. The administrative team will evaluate the observation frequency monthly to determine if the observations should continue, decrease, or increase.	08/04/2024

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	assembling products for a local car part factory. Client #1 was observed to not be wearing hearing aids. At 12:23 PM client #1 returned to the residential living unit. Client #1 was observed to not be wearing hearing aids. Client #1's record review was completed on 6/26/24 at 9:35 AM. The ISP (Individualized Support Plan) dated 5/15/24 indicated, "Adaptive Equipment...None." Client #1's Medical Consult Record dated 5/25/23 indicated, "Patient is a candidate for hearing aids." An interview was conducted with the QIDP (Qualified Intellectual Disabilities Professional) and QAM (Quality Assurance Manager). The QIDP stated, "[Client #1] does not have hearing aids that I can think of". The QAM stated, "to my knowledge that hearing instrument has not been followed up." 2, Observations were conducted on 6/25/24 from 6:31 AM to 8:01 AM and on 6/26/24 from 6:55 AM to 8:00 AM. During these morning observations client #9 would awake for his morning routine and come out of his bedroom to the dayroom carrying his knee pads and helmet with him. Client #9 would sit down at the dining room table and remove his helmet during his morning meals. Client #9 would stand and ambulate during his morning meals to throw away trash and return his plate and utensils to the kitchen without wearing his helmet. During the first observation on 6/25/24 at 6:47 AM, client #9 attempted to ambulate from his dining table toward the trash can and fell onto a dining room table hitting the left side of his torso against a table. Client #9 was not wearing his knee pads or helmet. The Executive Director used a verbal prompt with client #9 to put on and wear his adaptive support devices. At 6:49 AM,			

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	Direct Support Professional (DSP #7) assisted client #9 in the dayroom with placing on his knee pads and helmet to wear while he ambulated. During the second morning observation on 6/26/24 at 7:21 AM, client #9 carried his knee pads and helmet in his hands from his bedroom out to the dayroom as he began his morning routine. Direct Support Professional (DSP #6) used a verbal prompt with client #9 to sit down in the dayroom to assist him with placing his knee pads and helmet on. At 7:28 AM, client #9 was seated at a dining room table eating his morning meal when he removed his helmet. At 7:34 AM, client #9 stood from the table and ambulated to the kitchen with some of his dishes and returned. Client #9 was not wearing his helmet as he ambulated to and from the kitchen. At 7:36 AM, client #9 gathered his napkin and wrappers from his morning meal and went to the trash can and back to the table. Client #9 was not wearing his helmet as he ambulated to throw away his trash. At 7:37 AM, DSP #6 used a verbal prompt with client #9 to indicate he needed to use a cleaning rag to clean the table where he had eat his morning meal. Client #9 stood and wiped the table with the rag. Client #9 was not wearing his helmet while he cleaned the table with the rag. At 7:38 AM, the Program Manager (PM) was passing through the dayroom and used a verbal prompt stating to client #9, "Get your helmet on please". Client #9 returned to the dining room table to get his helmet and the PM assisted him with placing it on his head. On 6/27/24 at 9:16 AM, a focused review of client #9's record was conducted. The review indicated the following: Individual Support Plan (ISP) dated 10/25/23 indicated, "Strength:... Dresses and undresses self			

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	independently... Ambulates independently (losses balance at times)...". Fall Risk Plan dated 5/15/24 indicated, "Expected Outcome: [Client #9's] safety will be maintained through 5/2025... Actions: 1) Staff to provide assistance or support with ambulation (walking) and activities of daily living as needed... 4)... Staff to also make sure that he is wearing his soft helmet and bilateral knee pads during waking hours...". On 6/27/24 at 9:57 AM, the Program Manger (PM) was interviewed. The PM was asked about client #9's adaptive support devices and when he should wear his knee pads and helmet. The PM stated, "At all times. He can take it (helmet) off when he is sitting down". The PM was asked if client #9's adaptive devices should be worn when he was ambulating. The PM stated, "Yes. He can typically put them on but may need help with the knee pads".			
W 0454 Bldg. 00	483.470(l)(1) INFECTION CONTROL The facility must provide a sanitary environment to avoid sources and transmission of infections. Based on observation and interview for 4 of 4 sampled clients (#1, #2, #3 and #4) and 16 additional clients (#5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20), the facility failed to ensure the facility was clean and sanitary in order to avoid sources and transmission of infections. Findings include: 1) An observation was conducted at the facility on 6/24/24 from 3:07 PM to 6:43 PM. Throughout	W 0454	To correct the deficient practice, all staff have been trained on infection control and cleanliness of the facility. The administrative team will conduct twice daily walk throughs of the facility to ensure cleanliness and infection control. Additional monitoring will be achieved by daily administrative observations to ensure staff are implementing all policies, procedures, documentation, and	08/04/2024

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	the observation, client #3 engaged in spitting on the floor, on the furniture and towards staff and peers numerous times. The spit landed on the floor, on the furniture and on staff and peers. Staff did not clean or encourage client #3 to clean the area he spit on. This affected clients #1, #2, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19 and #20. 2. An observation was conducted on 6/26/24 from 6:55 AM to 8:33 AM. At 7:23 AM, client #6 stopped in the dayroom next to a chair to remove his shoes as he and Certified Nurse Assistant (CNA #1) were taking a mop bucket from the Colts hallway back to the storage location of the mop bucket on Pacer hallway. Client #6 stated to CNA #1, "They're wet" and removed his shoes next to a chair in the dayroom. After removing his shoes, client #6 continued to walk with CNA #1 down the Pacer hallway to return the mop bucket. At 7:25 AM, client #6 returned to the dayroom and sat down in the chair next to his shoes. Client #6 used a dry white washcloth to wipe out the inside of his wet shoes and placed the shoes back onto his feet. At 7:47 AM, client #6 approached the surveyor and stated, "Can I show you something"? The surveyor followed client #6 to his bedroom at the end of the Colts hallway. Client #6 showed the surveyor his bathroom door within his bedroom had a lock and stated, "They locked this, so I can't make it to the bathroom in time". At 7:48 AM, CNA #1 was asked if client #6 had issues with urinary incontinence. CNA #1 stated, "Yes". CNA #1 was asked about prevention of client #6's urinary incontinence and need to mop up accidents due to his bathroom door being		plans as written. The administrative team will evaluate the observation frequency monthly to determine if the observations should continue, decrease, or increase. Ongoing monitoring will be achieved by the administrative team completing monthly facility site reviews	

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	locked. CNA #1 stated, "I would say we prompt him more to use the bathroom. It's really in the morning when he first gets up. This was the first time I was his one to one. It's not every morning". On 6/26/24 at 1:32 PM, a focused review of client #6's record was conducted. The review indicated the following: Individual Support Plan (ISP) dated 10/11/23 indicated, "Individual Profile: ... [Client #6] can take care of his own hygiene independently but needs prompts to complete hygiene tasks such as brushing his teeth, putting on deodorant, and showering ... Needs: ... Needs improvement in personal hygiene skills". On 6/27/24 at 9:57 AM, the Program Manager (PM) and Quality Assurance Manager (QAM) were interviewed. The PM and QAM were asked about sanitation practices of client #6's shoes being wet from mop water used to clean urine, the mop bucket being returned to the storage closet in the Pacer hallway, and client #6's use of a dry white washcloth to clean the wetness from the inside of his shoes and placing them back on his feet. The PM stated, "The [shoes] should be cleaned with a disinfectant cleaner". The PM and QAM were asked who should assist to ensure sanitation practices had occurred. The PM stated, "Staff, they should have offered". The PM and QAM were asked why staff should have intervened. The QAM stated, "For the safety of the clients". The PM stated, "It's a biohazard". 3. Observations were conducted at the facility on 6/24/24 from 1:00 PM to 3:29 PM. On 6/24/24 at 1:28 PM the QIDP (Qualified Intellectual Disability Professional) unlocked a closet at the end of the Pacers hallway. There			

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	were two mop buckets with a mop inside each bucket. The water in the mop bucket was a dark brown color. The QIDP indicated sometimes there is an odor in the Pacers hallway due to the mop water. At 2:28 PM client #2 sat at the table and staff placed a peeled banana directly on the table without a plate or napkin under the banana. The table was not sanitized prior to staff placing the banana on the table. The PM (Program Manager) and QAM (Quality Assurance Manager) were interviewed on 6/27/24 at 9:57 AM. The PM indicated food should be on a plate or napkin not placed directly on the table. The PM indicated the infection control practices should be implemented. The QAM indicated effective infection control practices should be implemented to protect the clients from infection.			