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| W 0000<br><br>Bldg. 00 | This visit was for the investigation of complaints #IN00374335 and #IN00373690.<br><br>Complaint #IN00374335: Unsubstantiated, the allegation did not occur.<br><br>Complaint #IN00373690: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W149 and W157.<br><br>Unrelated deficiencies cited.<br><br>Dates of Survey: 5/23/22, 5/24/22, 5/25/22, 5/26/22 and 5/27/22.<br><br>Facility Number: 001021<br>Provider Number: 15G507<br>AIMS Number: 100245130<br><br>These deficiencies also reflect state findings in accordance with 460 IAC 9.<br>Quality Review of this report completed by #15068 on 6/7/22. | W 0000 | | |
| W 0149<br><br>Bldg. 00 | 483.420(d)(1)<br>STAFF TREATMENT OF CLIENTS<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br>Based on record review and interview for 9 of 21 incident reports affecting clients A, B, C and D, the facility failed to implement its policy and procedures for prohibiting abuse, neglect, exploitation, mistreatment and/or violation of individual's rights to prevent 1) missing controlled medications for clients A and D, 2) elopement of client C, and 3) a pattern of falls for client B. | W 0149 | **W149:** Staff Treatment of Clients<br><br>**Corrective Action:**<br>· All staff retrained on the Abuse and Neglect Policy. **(Attachment A)**<br>· QIDP updated client (C) | 06/19/2022 |

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

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| | Findings include:<br><br>On 5/23/22 at 4:30 PM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following incidents which affected clients A and D:<br><br>1) BDDS incident report dated 1/29/22 indicated, "[Client D] is ordered Lorazepam (anxiety) 1 mg (milligram) bid (twice) at 7 AM and 12 PM. This morning when the staff completed a controlled med (medication) audit count staff discovered there were only 100 pills instead of 101... There is one missing Lorazepam 1 mg tablet".<br><br>Investigation summary dated 1/31/22 through 2/4/22 indicated, "Introduction: [Client D] is ordered Lorazepam 1 mg bid at 7 AM and 12 PM. On 1/29/22 [former staff #1] reported 1 mg missing Lorazepam...<br><br>Summary of Interviews:<br><br>[Staff #1] was interviewed at the group home on 2/1/22. [Staff #1] stated the last time she counted the controlled med was on 1/28/22 at 6 AM with [former staff #2] and the count was correct. [Staff #1] stated the school called around 7 AM about her child and she had to leave. [Staff #1] stated she did not count the meds when she left that day (1/29/22)...<br><br>[Former staff #3] was interviewed at the group home on 2/1/22. [Former staff #3] stated she last counted the Lorazepam on 1/28/22 at 12 AM with [former staff #2] and the count was correct. [Former staff #3] stated the procedure for shift | | behavior plan. **(Attachment B)**<br>· All staff trained on updated behavior plan for client (C). **(Attachment C)**<br>· QIDP completed an addendum to client (B) program plan to add a prn wheelchair due to unsteady gait and falls. **(Attachment D)**<br>· Nurse Manager updated client (B) high risk plans. **(Attachment E)**<br>· All staff trained on updated plans for client (B). **(Attachment C)**<br>· Nurse Manager created a form for oversight of medication administration. **(Attachment F)**<br>· All staff trained on medication administration including the new oversight form created by the Nurse Manager. **(Attachment C)**<br>· Nurse completed weekly audit at the facility which includes oversight of medication audits for controlled medications. **(Attachment G)**<br>· Nurse Manager will complete 3 medication administration observations weekly for no less than 90 days. **(Attachment H)**<br>· Area Supervisor has been hired to solely be assigned to this location and will provide continuous oversight of the facility.<br>· Area Supervisor will complete 3 medication administration observations weekly for no less than 90 days | |

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| | audit counts is staff get out meds, count together on coming and off going staff ... [Former staff #3] stated she honestly didn't know why there have been several recent med errors. [Former staff #3] stated she didn't know why the Lorazepam would be popped out of sequence ... [Former staff #3] stated she did not know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Former staff #2] was interviewed by phone on 2/2/22. [Former staff #2] stated she last counted the Lorazepam with [former staff #1] on 1/28/22 at 6 AM and it was correct. [Former staff #2] stated the procedure for controlled shift count is off going and on coming staff count together... [Former staff #2] stated she believed the missing med was popped out accidentally and no one said anything about it. [Former staff #2] stated she did not know wo (sic) popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Former staff #4] was interviewed at the group home on 2/1/22. [Former staff #4] stated she last counted the Lorazepam on 1/28/22 at 2 PM with [staff #5]. [Former staff #4] stated she and [staff #5] physically counted the med together and count was correct... [Former staff #4] stated she didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Staff #5] was interviewed at the group home on 2/1/22. [Staff #5] stated she last counted the Lorazepam on 1/28/22 at 10 PM and the count was correct. [Staff #5] stated the Lorazepam should have not been touched until the next morning at 7 AM... [Staff #5] stated she did not know why the pill was popped out of sequence unless someone | | and 2 times weekly thereafter. **(Attachment I)**<br>· All BDDS reportable incidents are reviewed by Rescare Management during Peer Review.<br>· QIDP conducts IDT team meetings following a reportable incident to discuss the incident, outcomes and plans for what can be put in place to prevent future incidents.<br>· Quality Assurance Coordinator tracks all incident, BDDS and internal reports into a database. The database will be used to track patterns or trends with incidents and will be utilized during peer reviews and quarterly safety meetings.<br>· Area Supervisor and QIDP will review all ISP and BSP's during monthly staff meetings to ensure we are being proactive to prevent incidents.<br><br>**Monitoring of Corrective Action:**<br>· The Program Manager will review all Individual Support Plans and Behavior Support Plans to ensure plans meet all needs of the individuals served.<br>· Medication Administration observations will be sent to the Program Manager for review and to ensure completion.<br>· QIDP will update program plans and behavior plans annually and as needed.<br>· Nurse weekly audit will be | |

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| | took the pill. [Staff #5] stated she didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Former staff #1] was interviewed by phone on 2/2/22. [Former staff #1] stated she and [staff #5] did not do a shift count on 1/28/22 at 10 PM because [staff #5] had to leave to go pick up [former staff #5] and bring her to work. [Former staff #1] stated she and [former staff #5] went in the med room at 6 AM on 1/29/22 and the Lorazepam 'was all out of whack'. [Former staff #1] stated she is still getting used to doing shift audits stating she 'never had to do before'. [Former staff #1] stated shift audits are supposed to be done at each shift but could be busy or forget and there (sic) not always done. [Former staff #1] stated the med pass the morning of 1/29/22 is the first med pass she had done since coming back to ResCare. [Former staff #1] stated she had not touched the meds prior to that med pass. [Former staff #1] stated she didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Former staff #6] was interviewed by phone on 2/3/22. [Former staff #6] stated she did not work 1/27/22 - 1/29/22.... [Former staff #6] stated she didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Staff #2] was interviewed at the group home on 2/1/22. [Staff #2] stated she did not pass the meds from 1/27/22 - 1/29/22 at 7 AM. [Staff #2] stated [former staff #1] posted on the staff group chat that there was missing Lorazepam. [Staff #2] stated the post came out at 5 AM and when [staff #2] saw the post, she came in to count the meds because she is the weekend med lead. [Staff #2] | | sent to the Program Manager, QIDP and Executive Director for review and to ensure completion.<br>· Your safe I'm Safe Training for behavior intervention is completed upon hire and annually for all staff.<br>· IDT meeting forms are sent to the Program Manager for review.<br>· Abuse and Neglect Policy will be trained annually and reviewed monthly with all staff.<br><br>**Completion Date: 6/19/22** | |

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| | stated when she got there, she counted the Lorazepam about 30 times, shook the pack and looked all over for the pill. [Staff #2] stated she did not know why there has (sic) been recent med errors. [Staff #2] stated she didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Staff #3] was interviewed at the group home on 2/1/22. [Staff #3] stated she did not pass the meds from 1/27/22 - 1/29/22 at 7 AM. [Staff #3] stated she saw [former staff #4] and [staff #5] counting the meds for the shift change on 1/28/22 at 2 PM and assumed it was correct because either (sic) staff did not say there was a problem... [Staff #3] she (sic) didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Staff #4] was interviewed by phone on 2/3/22. [Staff #4] stated she has never passed the meds or did anything with the meds. [Staff #4] stated she was just cleared through the nurse to pass meds on 2/2/22. [Staff #4] stated she completed her on the job training ... [Staff #4] stated she didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Former staff #5] was interviewed by phone on 2/3/22. [Former staff #5] stated she is currently suspended from the med pass and has not did (sic) anything with the meds in about 3 weeks. [Former staff #5] stated she didn't know if [staff #5] and [former staff #1] had did (sic) a shift count on 1/28/21 (sic) at 10 PM. [Former staff #5] stated no one went in the med room the overnight of 1/29/22. [Former staff #5] stated she was standing in the med room with [former staff #1] when she got down the Lorazepam at 5 AM and found the missing pill ... [Former staff #5] stated she didn't | | | |

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| | know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>Conclusion: [Client D's] Lorazepam count on 1/29/22 at 5 AM should have been 101 pills, but there was (sic) only 100 Lorazepam pills. A Lorazepam 1 mg tablet was missing from the medication bubble pack. The missing Lorazepam 1 mg (tablet) was missing out of sequence on the bubble pack. The missing pill was on the last row of the card. All staff deny knowledge of the whereabouts of the missing Lorazepam. Based on these findings the 1 mg Lorazepam is missing, but the whereabouts of the pill cannot be determined...<br><br>Recommendations: Staff meeting has been scheduled to review all administration of medication policy".<br><br>-BDDS incident report dated 2/20/22 indicated, "[Client A] had a dental appointment on 2/14/22 where she was ordered Hydrocodone (pain) 5 ml (milliliters) PRN (as needed) for pain. She was administered the 5 ml Hydrocodone on 2/15/22 at 6 PM but has not required this PRN since that date. [Former staff #2] reported this morning during shift audit of this med that 2 Hydrocodone were signed out as given by [former staff #1] on 3rd shift 2/20/22. Review of the MAR (medication administration record) reads the 2 Hydrocodone were signed out by [former staff #1] and given at 10 PM. Review of buddy checks reads the 2 Hydrocodone where (sic) given at 12 AM. [Former staff #2] states [client A] slept through the night with no concerns and no PRN administered. [Former staff #1] left her shift this morning without completing her buddy check of meds with the on-coming staff. [Former staff #1] has been suspended pending investigation into the | | | |

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| | administration of the 2 Hydrocodone pills".<br><br>Investigation summary dated 2/20/22 through 2/25/22 indicated, "Introduction: On 2/20/22 documentation reads [client A] had received 2 Hydrocodone pills. [Former staff #2] reported the morning of 2/20/22 that during shift audit of this med 2 Hydrocodone were signed out as given by [former staff #1] on 3rd shift 2/20/22... [Former staff #2] states [client A] slept through the night with no concerns and no PRN administered...<br><br>Summary of Interviews:<br><br>[Former staff #6] was interviewed at the group home on 2/23/22. [Former staff #6] stated she came into work Sunday 2/20/22 at 8 AM. [Former staff #6] stated [staff #4] noticed [client A] had been given two pain pills (the Hydrocodone). [Former staff #6] stated [staff #4] checked with [client A] and asked her three different times if she was given the pain medication. [Former staff #6] stated she called [former staff #2] (...the other night shift staff with [former staff #1]). [Former staff #6] stated [former staff #2] told her [client A] hadn't taken any pain medication. [Former staff #6] stated a shift audit for the medications was not done because [former staff #1] left shift before doing a med audit.<br><br>[Staff #4] was interviewed at the group home on 2/23/22. [Staff #4] stated [former staff #1] and [former staff #2] had worked the 3rd shift on Saturday into Sunday morning. [Staff #4] stated when she came in Sunday morning 2/20/22 at 8 AM... she was going through the MARs like she is supposed to. [Staff #4] stated [former staff #1] left before 8 AM and did not complete a shift audit with [staff #4]. [Staff #4] stated when she got to the Hydrocodone, she saw [former staff #1] | | | |

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| | had marked that [former staff #1] had gave (sic) the med to [client A]. [Staff #4] stated [client A] hadn't taken Hydrocodone in 5 days ... [Staff #4] stated she saw on the control count sheet that 2 Hydrocodone had been given. [Staff #4] stated the MAR was documented the med was given at 10 PM and the control sheet read the med was given at 12 AM. [Staff #4] stated [former staff #2] told her [former staff #1] had closed the med door when she gave meds. [Staff #4] stated [client A] told her she never asked for any pain medication.<br><br>[Client A] was interviewed at the group home on 2/23/22. [Client A] stated she didn't know if she took any extra medication. [Client A] stated if she got a pain med or extra med her brother must have given it to her.<br><br>[Former staff #2] was interviewed by phone on 2/25/22. [Former staff #2] stated she worked on Saturday into Sunday morning (sic) 2/20/22 from 8a-8p. [Former staff #2] stated [former staff #1] worked the same time 8a-8p. [Former staff #2] stated [former staff #1] passed the meds that night. [Former staff #2] stated she didn't know if [client A] received the Hydrocodone. [Former staff #2] stated she was in the med room at 12 AM when [former staff #1] passed [client A] her mid night med but did not see her get out the Hydrocodone. [Former staff #2] stated she was not in the med room when [former staff #1] passed her 5 AM meds. [Former staff #2] stated she did not think [former staff #1] was in the medication room at 10 PM passing meds. [Former staff #2] stated she did buddy check [former staff #1] but thought everything was passed correctly. [Former staff #2] stated [client A] did not get up through the night complaining of any pain... [Former staff #2] stated she was not the med passer and did not do the shift audit. [Former staff #2] stated she | | | |

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| | thought [former staff #1] did the shift audit but did not know. [Former staff #2] stated [former staff #1] did not act any differently than any other night. [Former staff #2] stated it was like pulling teeth to get [former staff #1] to do any work".<br><br>[Former staff #1] originally declined interview on 2/24/22 stating she had resigned. [Former staff #1] called back and asked for an interview on 2/25/22. [Former staff #1] stated she did work Saturday into Sunday morning (sic) 2/20/22 and worked with [former staff #2]. [Former staff #1] stated she passed the med that shift. [Former staff #1] stated she believed it was at 12 AM when [client A] came to the office for her 12 AM meds that she gave the Hydrocodone pills. [Former staff #1] stated [client A] had said her mouth hurt and that was why she gave her the Hydrocodone. [Former staff #1] stated she might have given the Hydrocodone when she got her up to use the bathroom. [Former staff #1] stated she wasn't sure when she gave the med but she 'definitely gave 2 Hydrocodone pills to [client A]'. [Former staff #1] stated [former staff #2] had buddy checked her each time she gave meds. [Former staff #1] stated she though (sic) she did a shift audit with on-coming staff Sunday morning.<br><br>Conclusion: The allegation [client A] did not receive 2 Hydrocodone is not substantiated. [Former staff #1] originally declined interview stating she resigned. However, [former staff #1] called back the next day wanting to interview. [Former staff #1] states she definitely gave the 2 Hydrocodone pills to [client A]. [Former staff #1] stated she couldn't remember the time she gave the Hydrocodone but thought she administered at 12 AM. [Former staff #2] stated she did not know if the 2 Hydrocodone were administered. [Former staff #2] stated she did not see [former staff #1] | | | |

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| | give the Hydrocodone... Based on these findings it is not clear if the meds were given to [client A]. [Former staff #1] has previously received corrective action for failing to document med passes correctly and has failed to complete medication shift audits correctly. Peer review concludes [former staff #1] will receive corrective action for failure to document correctly...<br><br>Recommendations: [Former staff #1] return to work CA (corrective action)".<br><br>On 5/24/22 at 1:36 PM, the Nurse was interviewed. The Nurse was asked about medication administration and the missing medications of clients A and D. The Nurse stated, "Yes, I've put forms in place to address the accountability of who is passing medications and who is checking".<br><br>On 5/24/22 at 4:21 PM, staff #3 was interviewed. Staff #3 was asked about clients A and D's missing medications and what was determined. Staff #3 indicated the home recently had experienced a lot of medication administration errors over the weekend shifts. Staff #3 indicated the Nurse had put into place forms to account for who was assigned as the person administering medications and who was assigned as the person to complete the check for errors of administered medicines. Staff #3 stated, "That's faxed to [Nurse] and [Area Supervisor]". Staff #3 was asked if the form had created more accountability and if she believed it was working. Staff #3 stated, "I think so. Med Error Monday has not recently happened". Staff #3 was asked what was determined from client A's missing Hydrocodone and client D's missing Lorazepam. Staff #3 stated, "I remember [client A's]. I want to say she had 2 missing, but I don't recall [client D's]". Staff #3 indicated client A's count for her Hydrocodone | | | |

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| | was off and was determined to be missing 1 tablet. Staff #3 stated, "I don't think there was any way it could be proved [client A] did not take the medications. After that they were destroyed".<br><br>On 5/24/22 at 5:03 PM, staff #4 was interviewed. Staff #4 was asked about clients A and D's missing medications and what was determined. Staff #4 indicated she had just started working and was in training at the time of client D's incident but recalled conversations were occurring about missing medication. Staff #4 indicated she was so new to her position that she did not know any details other than overhearing about medications allegedly missing. Staff #4 indicated the only missing medication she was aware of more details was the incident of client A's missing Hydrocodone that she had reported. Staff #4 stated, "I found and reported over [client A's] Hydrocodone. [Client A] said she never got them. The MAR and count sheet did not match for the time [former staff #1] said she gave them".<br><br>On 5/24/22 at 5:48 PM, staff #5 was interviewed. Staff #5 was asked about clients A and D's missing medications and what was determined. Staff #5 indicated she was not aware of client D's missing medication and stated in regard to client A's missing Hydrocodone, "I don't think so. She tends to forget if she's taken meds. I don't know".<br><br>On 5/25/22 at 10:10 AM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about clients A and D's missing medication. The QIDP stated in regard to client A's incident, "The date in question is the 19th (February 2022). [Former staff #1] signed the MAR that she gave them. [Client A] could not verify and remember. The staff who was working with her (former staff #2), could not say if she | | | |

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| | gave it or not. It was the staff (staff #4) coming on shift at 8 o'clock on Sunday morning that was reporting it. She said the reason she looked at it was because [former staff #1] ran off that morning before they could do the shift audit". The QIDP was asked about client D's missing medication. The QIDP indicated client D's missing 1 mg Lorazepam was not able to be determined as to what had occurred. The QIDP stated, "That was the one where the tablet was punched out of order. No one knew why". The QIDP was asked if the investigations were unable to determine if client A's Hydrocodone and client D's Lorazepam had been administered to them, if it would also be true the alleged exploitation of their controlled medications was not ruled out. The QIDP stated, "That's true". The QIDP was asked if the abuse, neglect and exploitation policy should be implemented at all times. The QIDP stated, "It should".<br><br>2) Confidential Interview (CI #1) was conducted. The CI #1 indicated an attempt to contact ResCare management had been made but was unsuccessful finding correct contact information. CI #1 indicated client C had recently crossed the road and staff were not with him. CI #1 indicated the staff was not known to them, but once aid was being provided (by a community member) the staff did come to assist client C back toward the home. CI #1 indicated concern for client C crossing the road and how staff verbally redirected. CI #1 stated, "The staff speak disrespectful. The client (client C) did end up crossing the road. [Member of the Community] got out to help, the staff then responded".<br><br>Confidential Interview (CI #2) was conducted. The CI #2 stated, "I do not know the client name or staff. It happened the weekend prior. I saw him | | | |

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| | (client C) walk down the driveway. I heard staff say 'you better not cross the road'. He got to the curb. I began to walk over there, and she said something and came over and walked across the street. He wasn't in traffic. I never intervened. She made it down and assisted him before crossing [name of street]. What bothered me more was what I thought was a verbal threat rather than taking action beside verbal prompts".<br><br>On 5/23/22 at 4:30 PM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following incident which affected client C:<br><br>-BDDS incident report dated 1/22/22 indicated, "The home was calm, clients had just finished lunch and were sitting in the living room relaxing and watching TV (television). Staff had took (sic) another client to assist her to use the restroom. As staff was finishing with the client and coming down the hallway staff heard a knock at the door. When staff answered the door there were two gentlemen standing on the porch with [client C]. [Client C] slipped out the door and walked to the gas station where he had purchased a soft drink. The two gentlemen was (sic) bringing him home ...".<br><br>Investigation summary dated 1/28/22 indicated, "On 1/22/22 [client C] eloped from the home. Staff reported the home was calm, clients had just finished lunch and were sitting in the living room relaxing and watching TV. Staff had taken another client to assist her to use the restroom. As staff was finishing with the client and coming down the hallway staff heard a knock at the door. When staff answered the door two gentlemen were standing on the porch with [client C]. The men | | | |

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| | stated they were bringing him home. [Client C] had slipped out the door and walked to the gas station where he had purchased a soft drink ... First reported, [client C] had not received any injuries from this incident.<br><br>On 1/24/22 received additional information during the investigation that [client C] had fell (sic) during the elopement and had small scratches above his left eye and on the left side of his nose. The gentlemen that had returned [client C] to the home stated that [client C] was on the sidewalk and they had helped him up from the ground. [County] Sheriff's office did come to the home on Saturday afternoon to complete a wellness check on [client C]. Officer saw [client C] stating he saw that [client C] made it home and was safe.<br><br>Factual Findings:<br>1.[Client C] does have a BSP (Behavior Support Plan) to address elopement behavior. Staff was aware (sic) [client C] left the house ... He did have scratches on his forehead and nose when he returned home.<br>2.[Client C] has had one other elopement behavior but did not leave the property. He walked to the end of the driveway and stood behind the brush at the side of the driveway. Police were called, they spoke with [client C] and he came back inside the house.<br>3.[Client C] has had recent issues with falls experiencing 3 current falls prior to this fall during the elopement.<br>4. This is the first incident that [client C] has not been mad and snuck out of the house without staff knowledge.<br>5. Skin assessment notes scratches on face on 1/22/22 from a fall.<br>6. No documented behavioral issues on 1/22/22.<br>7. Immediate preventative measures were initiated | | | |

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| | for staff to keep [client C] in eyesight during all waking hours.<br>8. IDT (interdisciplinary team) met on 1/25/22 to discuss further preventative measures. Team agreed to seek approval to place door alarms at each entry way.<br><br>Recommendations:<br>1. Staff have received training to keep [client C] in eyesight during waking hours.<br>2. Team has obtained HRC (human rights committee) approval for door alarms at each entry way door. Maintenance request has been submitted.<br>3. Staff training to report all incidents accurately with detail.<br>4. Fall plan has been updated.<br>5. BSP updated for alarms at doors.<br>6. Add/include outings for a soft drink to the activity schedule".<br><br>On 5/25/22 at 12:44 PM, a focused review of client C's record was conducted. The review indicated the following:<br><br>-Behavioral Support Plan (BSP) dated 2/3/22 indicated, "Area: Challenging Behaviors ... Elopement: Leaving the property of the group home without line of sight of staff, taking off from staff while in the community.<br><br>Proactive Strategies:<br>Advance notice of changes in routine.<br>Door alarms on all entry doors of the home.<br>If the door alarms are not working properly, [client C] is to be in eyesight of staff during waking hours.<br>[Client C] is to be supervised by staff while outside such as being on the porch smoking...<br>Consistent staff interaction... | | | |

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| | Consistent staff redirection...<br>When redirecting [client C] be positive and upbeat...<br>Staff will encourage [client C] to express feelings and emotions<br>Participation in activities of choice<br>Schedule outings on the activity calendar for soft drinks...<br><br>Environmental Strategies:<br>Quiet environment<br>Staff need to know [client C's] likes and dislikes<br>Staff consistency in following BSP<br>Appropriate staff interventions<br><br>Reactive Strategies:<br>If [client C] goes outside of building, staff should keep [client C] in line of sight. Chasing [client C] may make it worse.<br>If [client C] attempts to enter the road staff will initiate 1-2-person escort<br>After [client C] calms, discuss the appropriate way of handling the situation<br>If [client C] does not calm and returns or he gets out of line of sight when at the group home or in the community then staff will follow ResCare policy and procedure for elopement/missing person".<br><br>On 5/23/22 at 7:34 PM, the Program Director was interviewed while working direct care at the group home. The Program Director was asked about client C's incident of elopement. The Program Director shook her head up and down and indicated "yes" and then stated, "He got out of the house, and no one knew anything about it. There was a knock on the door and 2 men that knocked said they found him along the road". The Program Director was asked if the 2 men who assisted client C back to the home were known | | | |

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| | individuals. The Program Director stated, "No, staff did not ask. I am fairly certain law enforcement came and did a welfare check. That's the reason the alarms were added". The Program Director was asked if any other elopements other than the incident on 1/22/22 had occurred. The Program Director stated, "No, his behavior tracking had two incidents of him going out to the driveway in the last two months. The alarms are very much needed". The Program Director was asked how long client C had been gone from the home without staff knowledge. The Program Director stated, "We couldn't get a timeframe for how long he was gone".<br><br>On 5/24/22 at 4:21 PM, staff #3 was interviewed. Staff #3 was asked about client C's incidents of elopement. Staff #3 stated, "Yes, he did. It happened maybe 2 or 3 months ago. It happened over the weekend. [Client C] has behavior when he cannot get what he wants, when he wants. He pretends to leave saying 'bye, bye, bye'. From what I understand we had two staff here and they were taking care of [name of peer]. He was mad because they were assisting [name of peer]. He walked off to [store name] to a gas station to buy a pop. Because that happened we had to get alarms". Staff #3 was asked if client C had been brought back home by two community members. Staff #3 stated, "I think so. That is how it was explained to me. They had to add elopement to his plan after that". Staff #3 was asked if client C had any other additional elopements since the incident reported on 1/22/22. Staff #3 stated, "No, last month someone marked he eloped. I questioned where the elopement incident was. I asked and it was not elopement. We had to in-service the whole staff as to what the definition of elopement is". Staff #3 was asked how it was recorded. Staff #3 stated, "On a tracking sheet". Staff #3 was | | | |

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| | asked how client C's behavior plan addressed walking down the driveway. Staff #3 stated, "I think it says line of sight. When I am here, I am going to follow him. I am not going to let him leave line of sight". Staff #3 was asked if client C's behavior plan indicated how to use physical intervention to prevent him from going into traffic. Staff #3 stated, "Not that I'm aware of".<br><br>On 5/24/22 at 5:03 PM, staff #4 was interviewed. Staff #4 was asked about client C's incident of elopement. Staff #4 stated, "That was my very first day. [Name of peer] was 2 (staff) on 1 (client). The other 2 people (staff) working with me were showing me how to toilet [name of peer]. When we came to check on everyone, two men knocked on the door with [client C]. He went down to [gas station]. He had a [name of soda]". Staff #4 was asked who the other people were working. Staff #4 stated, "[staff #2] and [former staff #5]". Staff #4 was asked what client C's behavior support plan indicated to do for interventions. Staff #4 stated, "To watch him, but not to let him see you. If he sees you, he'll take off. Mostly, watch him". Staff #4 was asked if she ever had to intervene to prevent client C from eloping. Staff #4 stated, "He will walk to the end of the patio. If he sees I am not following he'll come back and sit down". Staff #4 was asked if she felt client C's behavioral interventions worked. Staff #4 stated, "Yes. At first I would follow him. He would keep going. Now if he does not see me following he'll come back. Usually when he gets mad and wanting to smoke (will exhibit elopement behavior)".<br><br>On 5/24/22 at 5:48 PM, staff #5 was interviewed. Staff #5 was asked about client C's incident of elopement. Staff #5 stated, "There have been times where he will go to the end of the driveway or to the stop sign. If you do not go after him or | | | |

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| | chase him he won't go nowhere. If you go after him, it is like a game". Staff #5 was asked what client C's behavior plan indicated for intervention. Staff #5 stated, "To keep him line of sight. Basically. We used to have a thing if he got out of line of sight to call the cops. I do not know if that's a thing or not. If he is in neighbor's yard and you can see him, it's not elopement". Staff #5 was asked if client C's behavioral interventions were keeping him safe. Staff #5 stated, "I've worked with [client C] 7 years. I have learned if you don't feed into it, it's not an issue".<br><br>On 5/25/22 at 12:45 PM, the Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed. The QIDPD was asked about client C's incident of elopement and behavioral interventions. The QIDPD stated, "The previous BSP did talk about his walking down the driveway. He was easily redirected. Staff were to keep him in eyesight. He did not have elopement previously. He has never eloped in the 6 years I've had him. We did put alarms in. That day (1/22/22 incident) they had two staff and you cannot count the person on OJT (on the job training). Part of the revision was adding to the proactive strategies. So, we added soft drinks and opportunities for outings. Alarms on all entry doors. If he leaves the property we are going to follow him". The QIDP was asked if staff should follow client C down the driveway or implement planned ignoring of his behavior. The QIDPD stated, "That's more like the original plan (ignoring)". Shared with the QIDPD was indication from interviews that client C had crossed the road from concerned community members and staff not following client C. The QIDPD was asked at what point would staff need to physically intervene to ensure the safety of client C going toward a road and/or traffic. The | | | |

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| | QIDPD stated, "We don't have a distance (staff positioning) or physical intervention until he goes to enter the road. The team needs to meet to determine at what point the reactive strategies need implemented and to when we physically intervene". The QIDPD indicated based on the information shared from staff interviews for observing from a distance without client C's knowledge and to not follow client C because it would become a game, would therefore place staff out of position to be able to physically intervene and prevent client C from entering a road. As the QIDP entered the conference room at 1:15 PM, the QIDPD began a discussion with the QIDP about new information learned and the need for a team meeting to review client C's reactive strategies for elopement.<br><br>On 5/25/22 at 1:20 PM, the QIDP was interviewed. The QIDP was asked about client C's incident of elopement and behavioral interventions. The QIDP stated, "We're going to have to meet and add interventions". The QIDP indicated she would not delay in addressing client C's behavioral interventions as staff had described the previous behavior plan's reactive strategies and interventions prior to his elopemen<br>t on 1/22/22. The QIDP was asked about the implementation of the abuse, neglect and exploitation policy in relation to client C's elopement on 1/22/22 without staff knowledge and staff interviews describing the previous version of client C's interventions to maintain a line of sight and not to follow him. The QIDP indicated the abuse, neglect and exploitation policy should be implemented at all times and stated, "It | | | |

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| | should".3) On 5/23/22 at 4:30 PM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following incidents which affected client B:-BDDS incident report dated 12/4/21 indicated, "[Client B] was walking back to his recliner from the bathroom. He lost his balance, fell hitting his head. He taken to [hospital] ER (emergency room) for evaluation. At the ER a CT Scan (computerized image) was completed with normal results. He was diagnosed with a scalp hematoma (broken blood vessel). He was released from the ER with orders to follow up with his neurologist".Investigation summary dated 12/4/21 indicated, "Briefly describe the incident and any injury from the fall. [Client B] had been in the bathroom. Walked back to the living room and fell in front of his recliner ... Was medical treatment needed as a result of the fall? Yes, struck head on floor, taken to [hospital]. CT scan of head, no findings and released. Recommendations: [Client B] had his annual physical on 11/30 (2021). Team asked for PT (Physical Therapy) referral ... use of wheelchair to get from room to room until battery (Vagus Nerve Stimulation (VNS) device to limit seizure activity) replacement". -BDDS incident report dated 12/18/21 | | | |

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| | indicated, "[Client B] was sitting in his recliner. He was transferring from the chair to the wheelchair when he fell forward landing on his hands and knees. Staff assisted him into the wheelchair, checked him for injuries finding no visual injuries".Investigation summary dated 12/18/21 indicated, "Briefly describe the incident and any sustained injury from the fall. [Client B] was sitting in the recliner and started to move to the wheelchair and fell to his hands and knees. Was medical treatment needed as a result of the fall? No medical treatment needed, no injuries ... Were there any environmental factors that contributed to the fall? If yes, please explain what. Fall not witnessed. W/C (wheelchair) moved when he started to get in chair...<br>Recommendations: Doctor has ordered labs (blood work). VNS (battery replacement) scheduled for 12/27/21".-BDDS incident report dated 3/14/22 indicated, "This morning staff went (sic) wake [client B] for the day and was laying (sic) on the bedroom floor. [Client B] stated he slipped in his urine when getting out of bed. Staff helped him up and checked for injuries. [Client B] has a small red spot under his left eye, small quarter sized raised bump in the middle of his forehead, 2" (inches) by 1" (inch) red area on his cheek of his face ...".Investigation summary dated 3/17/22 | | | |

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| | indicated, "Briefly describe the incident and any sustained injury from the fall. Staff had completed bed checks at 6 AM. Had went (sic) to bedroom beside [client B's] to start getting clients up for the day (6:20 AM). [Former staff #7] knocked on [client B's] door, entered and he was laying face down next to bed ... Was medical treatment needed as a result of the fall?... quarter sized raised bump in the middle of his forehead, 2" (inches) by 1" (inch) red area on his cheek of his face Recommendations: Possibly get him up through night to avoid urine accident". -BDDS incident report dated 4/6/22 indicated, "[Client B] is diagnosed with seizure disorder and has a VNS. Staff was in the bathroom with [client B]. [Client B] had sit (sic) down on the toilet and staff noticed his depends (incontinent brief) needed changed. Staff left the bathroom to get a depends. [Client B] went into a seizure. He fell off the toilet forward onto his knees. Staff swiped the VNS. He continued to experience seizures following swiping of the VNS. Staff called 911 and he was taken to [hospital] ER for evaluation. At the ER a CT scan was taken. There were no new findings, and he was released from the hospital with orders to follow up with his neurologist".Investigation summary dated 4/5/22 indicated, "Briefly describe the incident and any sustained injury from the | | | |

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| | fall. [Client B] was in the bathroom using the restroom. [Staff #5] noticed his depends was dirty, left bathroom to go to his bedroom to get a depend. [Staff #5] got back, he was going into a seizure. Came forward of (sic) toilet on hands and knees, bit lip and bruised knee. Was medical treatment needed as a result of the fall? Yes, EMS (emergency medical services) called, taken to [hospital] for evaluation... doctor concerned about soft tissue on top/front of head. Referral for follow up with neurology... Recommendations: Training to staff to ensure staff remain in bathroom while [client B] is using the restroom to avoid him falling off toilet should he experience a seizure. F/U (follow up) with neurology".<br>-BDDS incident report dated 4/16/22 indicated, "[Client B] was in the bathroom. When he finished in the bathroom he started to walk out of the bathroom, lost his balance, fell backward into the door frame striking his back. Staff assisted him up and checked him for injuries. There were no visual injuries. Staff assisted him to the living room and to sit down in the chair".Investigation summary dated 4/16/22 indicated, "Briefly describe the incident and any sustained injury from the fall. Staff had helped him in the bathroom. He was finishing and staff went to help another client ... Was medical treatment needed as a result of the | | | |

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| | fall? Staff helped him up, checked him for injuries. No injuries. Staff felt fall (sic) due to being weak from illness. Walked him to living room ...Recommendations: Follow up with Neurology. Cont. (continue) current interventions for safety ... use of w/c (wheelchair) while not feeling well ...".<br>-BDDS incident report dated 5/5/22 indicated, "When staff arrived at the group home [client B] was sitting in the wheelchair near the door. [Client B] stated his ankle hurt. Staff asked what happened that his ankle was hurting and he replied he had fell (sic) down 3 days ago. The Nurse was in the home, she examined his ankle, ankle appeared swollen with slight bruising. His PCP (primary care physician) was called and he ordered to have an x-ray. [Client B] was taken to [hospital] for the x-ray. The x-rays were taken, tech (technician) stated the x-rays would be sent to [client B's] PCP for review and we should receive results tomorrow".Investigation summary dated 5/5/22 through 5/11/22 indicated, "On 5/5/22 when [Area Supervisor] arrived at the group home [client B] was sitting in the wheelchair near the door. [Client B] stated his ankle hurt. Staff asked what happened that his ankle was hurting. [Client B] replied he had fell (sic) down 3 days ago. The Nurse was in the home, she examined his ankle, ankle appeared swollen with slight | | | |

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| | bruising. His PCP was called, PCP ordered to have an x-ray. [Client B] was taken to [hospital] for the x-ray. The x-rays were taken, results sent to PCP on 5/6/22...<br>Scope of the Investigation:1. How did [client B] most likely sustain the fracture to his right foot/ankle?2. Did the team fail to have applicable risk plans in place to prevent injury?3. Did the team fail to have applicable behavior supports in place to prevent injury?4. Did staff fail to implement plans as written?Conclusion: 1. The evidence indicates that although no one saw [client B] sustain the injury, he most likely sustained the fracture of his right foot/ankle as a result of his unsteady balance or sitting on the floor with his legs crisscrossed.2. The evidence does not substantiate that the team failed to have applicable risk plans in place to prevent the injury. Plans were modified for safety needs.3. The evidence does not substantiate that the team failed to have applicable behavior supports in place to prevent the injury. Plan addresses his pseudo seizures.4. The evidence does not substantiate that staff failed to implement plans as written.Recommendations:1. IDT (Interdisciplinary team) to discuss [client B's] mobility and seek referral for OT/PT (Occupational Therapy/Physical Therapy) evaluation.2. Follow orthopedic orders".On 5/25/22 at 12:14 PM, a focused review of | | | |

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| | client B's record was conducted. The record indicated the following:-Individual Support Plan (ISP) Addendum dated 5/13/22 indicated, "Purpose of Meeting: Preventative measures discussed to aid in the prevention of falls. Team agreed on the use of a wheelchair for increased weakness and using a gait belt as a seatbelt when leaning for safety of not leaning/falling out of wheelchair. Team and HRC approval were obtained. A referral for PT has been given and he has an appointment in June scheduled. [Client B] is currently utilizing the wheelchair related to the right ankle fracture. 5/6/22 orthopedic appointment, ace wrap to right ankle for compression and a CAM (controlled ankle movement) boot for mobility placed at this appointment. Weight bearing as tolerated for pivot transfers. Wear boot when he sleeps.Changes To Be Implemented To Current Plan: PRN use of a wheelchair when experiencing increased weakness to aid in the prevention of falls along with continuing helmet, bed alarm, gait belt, and audio monitor in his bedroom".-Medical consult dated 5/5/22 indicated, "Reason for Appointment: X-ray of right ankle. Results/Findings of Examination: Right ankle x-ray completed".-Medical consult dated 5/6/22 indicated, "Diagnosis: Bimalleolar (unstable fracture) ankle fracture ...Recommendations: ace wrap right ankle... | | | |

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| | cam boot for mobility... Patient to sleep in boot...". -Medical consult dated 5/13/22 indicated, "History: Fractured right ankle. Findings: 3 images acquired. Medial and lateral malleolus (bony projection) fractures not significantly changed in alignment. Remaining bones intact. Swelling has decreased".-Fall Risk Plan dated 1/1/22 indicated, " Interventions: A. Staff will provide a safe environment with open space and free from clutter. B. Staff will assist during ambulation in the community on uneven surfaces with hand over hand if needed. C. Staff will keep [client B] in line of sight at all times during ambulation-incase a seizure would happen ... Monitoring: A. Staff will monitor at all times gait/balance". On 5/24/22 at 4:21 PM, staff #3 was interviewed. Staff #3 was asked if client B had any recent falls and about the incident history of falls with injuries. Staff #3 stated, "Recently in the last couple of weeks no. He had some, I have noticed his mobility had decreased. We are waiting on him to get into PT. I personally think a walker could help. I have noticed he likes to lean. That way he is not leaning on household objects. I am not sure if Ortho (Orthopedics) will recommend with him wearing the boot and everything". Staff #3 was asked what happened to client B's foot. Staff #3 stated, "He broke his foot, but I don't know how. No one recalled a | | | |

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| | fall. He has a history of breaking that foot. I wonder if his bone in that foot is compromised or not. He also has a history of not telling us when he falls. I have tried to explain that we can't help you if you don't talk to us. He understands to a certain degree". Staff #3 was asked what was done to address client B's falls. Staff #3 stated, "They have a PRN (as needed) order for his wheelchair. If we notice he is unsteady. We are trying to get him into therapy. I do not want him to get used to a wheelchair if he can walk. He needs something, so maybe the walker would be the next step. He had his gait belt he wears every day. I have seen an improvement in his gait since his boot was placed on his foot. I am going to support him as much as he needs, but I don't want him to lose his mobility. He had a little stomach bug. I think that made him a little weak". Staff #3 was asked if client B had experienced increased seizure activity and the relationship to his falls. Staff #3 stated, "I would say about the same. In December (2021) he was having trouble with his VNS. They changed the battery and have changed his meds (seizure medication). We are trying to find a happy medium between seizure activity and alertness. We do not want him to sleep his life away ... They changed his prescription of Depakote (anticonvulsant) to get it at night so he has more alertness during | | | |

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| | the day. I wonder if the med change and being lethargic is part of his mobility (issue). We are trying to figure it out". Staff #3 indicated when and how client B had fractured his foot/ankle was unable to be determined, however his pattern of falls was suspected as the result of the injury.On 5/24/22 at 5:03 PM, staff #4 was interviewed. Staff #4 was asked if client B had any recent falls and about the incident history of falls with injuries. Staff #4 stated, "He fell once while having a seizure". Staff #4 was asked where client B was at this time. Staff #4 stated, "The bathroom. It was during dinner time. I was making dinner. [Staff #5] took him to the bathroom and took her eye off of him like 2 seconds to get a depend. He had fallen off the toilet". Staff #4 was asked what changes had occurred after this incident. Staff #4 stated, "He got a stomach bug and been off since then. When I first started he was walking with assistance. Now he's in a wheelchair and has a fractured foot". Staff #4 was asked how client B fractured his foot. Staff #4 stated, "First shift said he fell. That morning I put his socks and shoes on and it was not swollen". Staff #4 was asked if anything had been determined to cause client B's fractured foot. Staff #4 stated, "No, they went with what he said. I know he had not fallen on 2nd shift the day prior. I was working and he did not | | | |

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| | fall. He is going downhill".On 5/24/22 at 5:48 PM, staff #5 was interviewed. Staff #5 was asked if client B had any recent falls and about the incident history of falls with injuries. Staff #5 stated, "Not on my watch. Once when he had a seizure. I took him to the bathroom and went into a seizure. I had left to go get a depend and he slumped over". Staff #5 was asked if client B fell to the floor. Staff #5 stated, "No, I want to say that was February (2022)". Staff # 5 was asked how client B fractured his foot. Staff #5 stated, "The day they found the swollen foot and got it checked, I wasn't here". Staff #5 was asked if it was ever determined how client B had fractured his foot. Staff #5 stated, "I don't think so". Staff #5 was asked what changes were made after client B's injury had been discovered. Staff #5 stated, "Staff are to be with him at all times going to the restroom". Staff #5 indicated an in-service had been completed to address staff supports of client B while assisting him in the bathroom.On 5/25/22 at 1:20 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about client B's pattern of falls and injuries. The QIDP stated, "It started in December (2021) maybe late November and associated with seizures. Because of the seizures we talk about Neurology and the VNS. They replaced it, a new battery. We | | | |

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| | then saw some improvements. We think we are on the right track and then he had a couple more falls. [Nurse] contacted Neurology and they changed his meds. We have actually changed his meds a couple of times". The QIDP indicated the team sought and obtained approval for modifications to client B's bed and the use of a wheelchair. The QIDP indicated referral to PT was obtained and scheduled for June 13th or 15th (2022) but did not believe this would occur until after his boot for his fractured foot was removed. The QIDP was asked about the recent falls and determination for how the fractured foot occurred. The QIDP stated, "We had these two falls in April (2022). When I did the investigations they tell me he gets so tired so easily that he will stop and sit down crisscross. Nobody saw any other falls, other than those two in April. I really think when he sat down that is where it makes sense for a fracture like that. He told me he fell in the hallway, but I think it was when he sat down in the hallway. If it happened then, [staff #5] was with him. I did not think there was neglect. He had his gait belt and helmet. He was not in his wheelchair, it was PRN (as needed) and it still is. We want him to walk and not lose that. It maybe in the near future, for wheelchair use all time. We do not want to go there. Staff have said with the changes in | | | |

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| | Depakote he is more alert". The QIDP was asked to clarify the timeline for when she believed the fractured foot occurred. The QIDP stated, "5/5/22 is when he is saying his ankle hurts and he fell 3 days ago. [Staff #5] said she did have him, and he kept sitting down like that (crisscross). He goes for the x-ray and on 5/6/22 the fracture was over the same fracture in 2020. I am sure that ankle is weak and easier to break. [Staff #5] did say he sat down in the hallway, that matched his story of a fall 3 days ago. I think it happened then. I really do". The QIDP was asked if staff indicated client B was weak, why would his weakness not trigger the need to use his PRN wheelchair and if other adaptive devices such a sit and stand walker had been considered rather than allowing client B to sit crisscross during periods of weakness and/or tired during ambulation, if the act of sitting down was believed to be a contributing factor for refracturing an old injury. The QIDP stated, "I had not considered that". On 5/25/22 at 2:15 PM, the Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed. The QIDPD was asked about client B's pattern of falls, injuries and the use of his PRN wheelchair. The QIDPD stated, "Listening to the witnesses they were all reporting he was weak, he was out of breath. That is all indication of the PRN | | | |

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| | wheelchair should have been used. I think it is possible we need to review for how he can walk and possibly after the Physical Therapy to determine his abilities and when to use adaptive supports. We have to get back to a point where he can ambulate".On 5/25/22 at 2:52 PM, the Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of Rights (ANE) policy dated 7/10/19 was reviewed. The ANE policy indicated, "ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights".This federal tag relates to complaint #IN00373690.9-3-2(a) | | | |
| W 0157<br><br>Bldg. 00 | 483.420(d)(4)<br>STAFF TREATMENT OF CLIENTS<br>If the alleged violation is verified, appropriate corrective action must be taken.<br>Based on record review and interview for 2 of 14 incident reports affecting clients A and D, the facility failed to implement corrective measures after incidents of clients A and D's missing controlled medications to include 1) how staff would be monitored to ensure accountability and accurate completion of controlled substances counts at shift changes and 2) an expanded scope of the investigations to include additional clients and a more in-depth review for potential controlled substance exploitation prior to recommending former staff #1 be reinstated back into employment.<br><br>Findings include:<br><br>On 5/23/22 at 4:30 PM, a review of the facility's | W 0157 | **W157: Staff treatment of clients.**<br><br>**Corrective Action:**<br>· Rescare Management met to discuss concerns with medication administration and preventative measures to be put in place to ensure all medications are accounted for and administered properly.<br>· Nurse manager created a form to be used at all medication administrations to ensure all medications were given and accounted for. (**Attachment F)**<br>· All staff trained on | 06/19/2022 |

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| | Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following incidents which affected clients A and D:<br><br>1) BDDS incident report dated 1/29/22 indicated, "[Client D] is ordered Lorazepam (anxiety) 1 mg (milligram) bid (twice) at 7 AM and 12 PM. This morning when the staff completed a controlled med (medication) audit count staff discovered there were only 100 pills instead of 101... There is one missing Lorazepam 1 mg tablet".<br><br>Investigation summary dated 1/31/22 through 2/4/22 indicated, "Introduction: [Client D] is ordered Lorazepam 1 mg bid at 7 AM and 12 PM. On 1/29/22 [former staff #1] reported 1 mg missing Lorazepam...<br><br>Summary of Interviews:<br><br>[Staff #1] was interviewed at the group home on 2/1/22. [Staff #1] stated the last time she counted the controlled med was on 1/28/22 at 6 AM with [former staff #2] and the count was correct. [Staff #1] stated the school called around 7 AM about her child and she had to leave. [Staff #1] stated she did not count the meds when she left that day (1/29/22)...<br><br>[Former staff #3] was interviewed at the group home on 2/1/22. [Former staff #3] stated she last counted the Lorazepam on 1/28/22 at 12 AM with [former staff #2] and the count was correct. [Former staff #3] stated the procedure for shift audit counts is staff get out meds, count together on coming and off going staff ... [Former staff #3] stated she honestly didn't know why there have been several recent med errors. [Former staff #3] | | medication administration oversight form. **(Attachment C)**<br>· Nurse Manager will complete 3 medication administration observations weekly for no less than 90 days. **(Attachment H)**<br>· Area Supervisor will complete 3 medication administration observations weekly for no less than 90 days and 2 times weekly thereafter. **(Attachment I)**<br>· Program Manager will be at the home weekly to observe 2 medication administration passes, a mealtime observation and 2 active treatment observations. **(Attachment J)**<br>· Area Supervisor has been hired to solely be assigned to this location and will provide continuous oversight of the facility.<br>· Rescare has added an additional QIDP in order to provide more oversight at the facility.<br>· Quality Assurance Coordinator will conduct investigations for all BDDS reportable incidents.<br>· Quality Assurance Coordinator trained to ensure a thorough investigation is always completed including involving all consumers in the investigation to ensure we have all needed information. **(Attachment K)**<br>· Rescare policy on progressive discipline is followed when a staff member needs disciplinary action for their | |

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| | stated she didn't know why the Lorazepam would be popped out of sequence ... [Former staff #3] stated she did not know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Former staff #2] was interviewed by phone on 2/2/22. [Former staff #2] stated she last counted the Lorazepam with [former staff #1] on 1/28/22 at 6 AM and it was correct. [Former staff #2] stated the procedure for controlled shift count is off going and on coming staff count together... [Former staff #2] stated she believed the missing med was popped out accidentally and no one said anything about it. [Former staff #2] stated she did not know wo (sic) popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Former staff #4] was interviewed at the group home on 2/1/22. [Former staff #4] stated she last counted the Lorazepam on 1/28/22 at 2 PM with [staff #5]. [Former staff #4] stated she and [staff #5] physically counted the med together and count was correct... [Former staff #4] stated she didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Staff #5] was interviewed at the group home on 2/1/22. [Staff #5] stated she last counted the Lorazepam on 1/28/22 at 10 PM and the count was correct. [Staff #5] stated the Lorazepam should have not been touched until the next morning at 7 AM... [Staff #5] stated she did not know why the pill was popped out of sequence unless someone took the pill. [Staff #5] stated she didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill. | | performance. **(Attachment L)**<br>· Staff #1 received a corrective action for failure to administer medication properly. **(Attachment M)**<br><br>**Monitoring of Corrective Action:**<br>· The Abuse and Neglect Policy will be trained annually and reviewed monthly at house meetings.<br>· IDT meets quarterly and as needed to discuss and update plans annually and as needed.<br>· The Program Manager will review all Individual Support Plans and Behavior Support Plans to ensure plans meet all needs of the individuals served.<br>· QIDP will update all client plans annually and as needed.<br>· All investigations are reviewed by Rescare management within 5 business days and the peer review signed for documentation.<br>· Medication Oversight form will be sent to the Nurse Manager after every medication administration to ensure completion.<br>· Rescare Administration will have monthly meetings to discuss trends and patterns with individuals.<br><br>**Completion Date: 6/19/22** | |

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| | [Former staff #1] was interviewed by phone on 2/2/22. [Former staff #1] stated she and [staff #5] did not do a shift count on 1/28/22 at 10 PM because [staff #5] had to leave to go pick up [former staff #5] and bring her to work. [Former staff #1] stated she and [former staff #5] went in the med room at 6 AM on 1/29/22 and the Lorazepam 'was all out of whack'. [Former staff #1] stated she is still getting used to doing shift audits stating she 'never had to do before'. [Former staff #1] stated shift audits are supposed to be done at each shift but could be busy or forget and there (sic) not always done. [Former staff #1] stated the med pass the morning of 1/29/22 is the first med pass she had done since coming back to ResCare. [Former staff #1] stated she had not touched the meds prior to that med pass. [Former staff #1] stated she didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Former staff #6] was interviewed by phone on 2/3/22. [Former staff #6] stated she did not work 1/27/22 - 1/29/22.... [Former staff #6] stated she didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Staff #2] was interviewed at the group home on 2/1/22. [Staff #2] stated she did not pass the meds from 1/27/22 - 1/29/22 at 7 AM. [Staff #2] stated [former staff #1] posted on the staff group chat that there was missing Lorazepam. [Staff #2] stated the post came out at 5 AM and when [staff #2] saw the post, she came in to count the meds because she is the weekend med lead. [Staff #2] stated when she got there, she counted the Lorazepam about 30 times, shook the pack and looked all over for the pill. [Staff #2] stated she did not know why there has (sic) been recent med | | | |

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| | errors. [Staff #2] stated she didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Staff #3] was interviewed at the group home on 2/1/22. [Staff #3] stated she did not pass the meds from 1/27/22 - 1/29/22 at 7 AM. [Staff #3] stated she saw [former staff #4] and [staff #5] counting the meds for the shift change on 1/28/22 at 2 PM and assumed it was correct because either (sic) staff did not say there was a problem... [Staff #3] she (sic) didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Staff #4] was interviewed by phone on 2/3/22. [Staff #4] stated she has never passed the meds or did anything with the meds. [Staff #4] stated she was just cleared through the nurse to pass meds on 2/2/22. [Staff #4] stated she completed her on the job training ... [Staff #4] stated she didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>[Former staff #5] was interviewed by phone on 2/3/22. [Former staff #5] stated she is currently suspended from the med pass and has not did (sic) anything with the meds in about 3 weeks. [Former staff #5] stated she didn't know if [staff #5] and [former staff #1] had did (sic) a shift count on 1/28/21 (sic) at 10 PM. [Former staff #5] stated no one went in the med room the overnight of 1/29/22. [Former staff #5] stated she was standing in the med room with [former staff #1] when she got down the Lorazepam at 5 AM and found the missing pill ... [Former staff #5] stated she didn't know who popped out the missing Lorazepam (and) why or what happened to the missing pill.<br><br>Conclusion: [Client D's] Lorazepam count on | | | |

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| | 1/29/22 at 5 AM should have been 101 pills, but there was (sic) only 100 Lorazepam pills. A Lorazepam 1 mg tablet was missing from the medication bubble pack. The missing Lorazepam 1 mg (tablet) was missing out of sequence on the bubble pack. The missing pill was on the last row of the card. All staff deny knowledge of the whereabouts of the missing Lorazepam. Based on these findings the 1 mg Lorazepam is missing, but the whereabouts of the pill cannot be determined...<br><br>Recommendations: Staff meeting has been scheduled to review all administration of medication policy".<br><br>2) BDDS incident report dated 2/20/22 indicated, "[Client A] had a dental appointment on 2/14/22 where she was ordered Hydrocodone (pain) 5 ml (milliliters) PRN (as needed) for pain. She was administered the 5 ml Hydrocodone on 2/15/22 at 6 PM but has not required this PRN since that date. [Former staff #2] reported this morning during shift audit of this med that 2 Hydrocodone were signed out as given by [former staff #1] on 3rd shift 2/20/22. Review of the MAR (medication administration record) reads the 2 Hydrocodone were signed out by [former staff #1] and given at 10 PM. Review of buddy checks reads the 2 Hydrocodone where (sic) given at 12 AM. [Former staff #2] states [client A] slept through the night with no concerns and no PRN administered. [Former staff #1] left her shift this morning without completing her buddy check of meds with the on-coming staff. [Former staff #1] has been suspended pending investigation into the administration of the 2 Hydrocodone pills".<br><br>Investigation summary dated 2/20/22 through 2/25/22 indicated, "Introduction: On 2/20/22 | | | |

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| | documentation reads [client A] had received 2 Hydrocodone pills. [Former staff #2] reported the morning of 2/20/22 that during shift audit of this med 2 Hydrocodone were signed out as given by [former staff #1] on 3rd shift 2/20/22... [Former staff #2] states [client A] slept through the night with no concerns and no PRN administered...<br><br>Summary of Interviews:<br><br>[Former staff #6] was interviewed at the group home on 2/23/22. [Former staff #6] stated she came into work Sunday 2/20/22 at 8 AM. [Former staff #6] stated [staff #4] noticed [client A] had been given two pain pills (the Hydrocodone). [Former staff #6] stated [staff #4] checked with [client A] and asked her three different times if she was given the pain medication. [Former staff #6] stated she called [former staff #2] (...the other night shift staff with [former staff #1]). [Former staff #6] stated [former staff #2] told her [client A] hadn't taken any pain medication. [Former staff #6] stated a shift audit for the medications was not done because [former staff #1] left shift before doing a med audit.<br><br>[Staff #4] was interviewed at the group home on 2/23/22. [Staff #4] stated [former staff #1] and [former staff #2] had worked the 3rd shift on Saturday into Sunday morning. [Staff #4] stated when she came in Sunday morning 2/20/22 at 8 AM... she was going through the MARs like she is supposed to. [Staff #4] stated [former staff #1] left before 8 AM and did not complete a shift audit with [staff #4]. [Staff #4] stated when she got to the Hydrocodone, she saw [former staff #1] had marked that [former staff #1] had gave (sic) the med to [client A]. [Staff #4] stated [client A] hadn't taken Hydrocodone in 5 days ... [Staff #4] stated she saw on the control count sheet that 2 | | | |

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| | Hydrocodone had been given. [Staff #4] stated the MAR was documented the med was given at 10 PM and the control sheet read the med was given at 12 AM. [Staff #4] stated [former staff #2] told her [former staff #1] had closed the med door when she gave meds. [Staff #4] stated [client A] told her she never asked for any pain medication.<br><br>[Client A] was interviewed at the group home on 2/23/22. [Client A] stated she didn't know if she took any extra medication. [Client A] stated if she got a pain med or extra med her brother must have given it to her.<br><br>[Former staff #2] was interviewed by phone on 2/25/22. [Former staff #2] stated she worked on Saturday into Sunday morning (sic) 2/20/22 from 8a-8p. [Former staff #2] stated [former staff #1] worked the same time 8a-8p. [Former staff #2] stated [former staff #1] passed the meds that night. [Former staff #2] stated she didn't know if [client A] received the Hydrocodone. [Former staff #2] stated she was in the med room at 12 AM when [former staff #1] passed [client A] her mid night med but did not see her get out the Hydrocodone. [Former staff #2] stated she was not in the med room when [former staff #1] passed her 5 AM meds. [Former staff #2] stated she did not think [former staff #1] was in the medication room at 10 PM passing meds. [Former staff #2] stated she did buddy check [former staff #1] but thought everything was passed correctly. [Former staff #2] stated [client A] did not get up through the night complaining of any pain... [Former staff #2] stated she was not the med passer and did not do the shift audit. [Former staff #2] stated she thought [former staff #1] did the shift audit but did not know. [Former staff #2] stated [former staff #1] did not act any differently than any other night. [Former staff #2] stated it was like pulling | | | |

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| | teeth to get [former staff #1] to do any work".<br><br>[Former staff #1] originally declined interview on 2/24/22 stating she had resigned. [Former staff #1] called back and asked for an interview on 2/25/22. [Former staff #1] stated she did work Saturday into Sunday morning (sic) 2/20/22 and worked with [former staff #2]. [Former staff #1] stated she passed the med that shift. [Former staff #1] stated she believed it was at 12 AM when [client A] came to the office for her 12 AM meds that she gave the Hydrocodone pills. [Former staff #1] stated [client A] had said her mouth hurt and that was why she gave her the Hydrocodone. [Former staff #1] stated she might have given the Hydrocodone when she got her up to use the bathroom. [Former staff #1] stated she wasn't sure when she gave the med but she 'definitely gave 2 Hydrocodone pills to [client A]'. [Former staff #1] stated [former staff #2] had buddy checked her each time she gave meds. [Former staff #1] stated she though (sic) she did a shift audit with on-coming staff Sunday morning.<br><br>Conclusion: The allegation [client A] did not receive 2 Hydrocodone is not substantiated. [Former staff #1] originally declined interview stating she resigned. However, [former staff #1] called back the next day wanting to interview. [Former staff #1] states she definitely gave the 2 Hydrocodone pills to [client A]. [Former staff #1] stated she couldn't remember the time she gave the Hydrocodone but thought she administered at 12 AM. [Former staff #2] stated she did not know if the 2 Hydrocodone were administered. [Former staff #2] stated she did not see [former staff #1] give the Hydrocodone... Based on these findings it is not clear if the meds were given to [client A]. [Former staff #1] has previously received corrective action for failing to document med | | | |

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| | passes correctly and has failed to complete medication shift audits correctly. Peer review concludes [former staff #1] will receive corrective action for failure to document correctly...<br><br>Recommendations: [Former staff #1] return to work CA (corrective action)".<br><br>On 5/24/22 at 1:36 PM, the Nurse was interviewed. The Nurse was asked about medication administration and the missing medications of clients A and D. The Nurse stated, "Yes, I've put forms in place to address the accountability of who is passing medications and who is checking".<br><br>On 5/24/22 at 4:21 PM, staff #3 was interviewed. Staff #3 was asked about clients A and D's missing medications and what was determined. Staff #3 indicated the home recently had experienced a lot of medication administration errors over the weekend shifts. Staff #3 indicated the Nurse had put into place forms to account for who was assigned as the person administering medications and who was assigned as the person to complete the check for errors of administered medicines. Staff #3 stated, "That's faxed to [Nurse] and [Area Supervisor]". Staff #3 was asked if the form had created more accountability and if she believed it was working. Staff #3 stated, "I think so. Med Error Monday has not recently happened". Staff #3 was asked what was determined from client A's missing Hydrocodone and client D's missing Lorazepam. Staff #3 stated, "I remember [client A's]. I want to say she had 2 missing, but I don't recall [client D's]". Staff #3 indicated client A's count for her Hydrocodone was off and was determined to be missing 1 tablet. Staff #3 stated, "I don't think there was any way it could be proved [client A] did not take the medications. After that they were destroyed". | | | |

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| | On 5/24/22 at 5:03 PM, staff #4 was interviewed. Staff #4 was asked about clients A and D's missing medications and what was determined. Staff #4 indicated she had just started working and was in training at the time of client D's incident but recalled conversations were occurring about missing medication. Staff #4 indicated she was so new to her position that she did not know any details other than overhearing about medications allegedly missing. Staff #4 indicated the only missing medication she was aware of more details was the incident of client A's missing Hydrocodone that she had reported. Staff #4 stated, "I found and reported over [client A's] Hydrocodone. [Client A] said she never got them. The MAR and count sheet did not match for the time [former staff #1] said she gave them".<br><br>On 5/24/22 at 5:48 PM, staff #5 was interviewed. Staff #5 was asked about clients A and D's missing medications and what was determined. Staff #5 indicated she was not aware of client D's missing medication and stated in regard to client A's missing Hydrocodone, "I don't think so. She tends to forget if she's taken meds. I don't know".<br><br>On 5/25/22 at 10:10 AM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about clients A and D's missing medication. The QIDP stated in regard to client A's incident, "The date in question is the 19th (February 2022). [Former staff #1] signed the MAR that she gave them. [Client A] could not verify and remember. The staff who was working with her (former staff #2), could not say if she gave it or not. It was the staff (staff #4) coming on shift at 8 o'clock on Sunday morning that was reporting it. She said the reason she looked at it was because [former staff #1] ran off that morning | | | |

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| | before they could do the shift audit". The QIDP was asked about client D's missing medication. The QIDP indicated client D's missing 1 mg Lorazepam was not able to be determined as to what had occurred. The QIDP stated, "That was the one where the tablet was punched out of order. No one knew why". The QIDP was asked if the investigations were unable to determine if client A's Hydrocodone and client D's Lorazepam had been administered to them, if it would also be true the alleged exploitation of their controlled medications was not ruled out. The QIDP stated, "That's true". The QIDP was asked if the abuse, neglect and exploitation policy should be implemented at all times. The QIDP stated, "It should". The QIDP was asked if the investigations into clients A and D's missing medication included additional monitoring, additional clients added to the scope of the investigations and/or reconcile to what extent exploitation might have occurred for all controlled medications. The QIDP stated, "I see what you're saying. There should be monitoring to catch that". The QIDP indicated the investigations into client A and client D's missing medications did not include corrective measures to ensure a review of additional controlled substances for other clients nor was additional monitoring identified to ensure staff completed shift audits for controlled substances consistently with accuracy.<br><br>This federal tag relates to complaint #IN00373690.<br><br>9-3-2(a) | | | |
| W 0193<br><br>Bldg. 00 | 483.430(e)(3)<br>STAFF TRAINING PROGRAM<br>Staff must be able to demonstrate the skills and techniques necessary to administer | | | |

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| | interventions to manage the inappropriate behavior of clients.<br>Based on record review and interview for 1 of 3 sampled clients (C), the facility failed to ensure staff were competent with the implementation of client C's proactive and reactive strategies for elopement to ensure his safety when near streets and/or roads.<br><br>Findings include:<br><br>Confidential Interview (CI #1) was conducted. The CI #1 indicated an attempt to contact ResCare management had been made but was unsuccessful finding correct contact information. CI #1 indicated client C had recently crossed the road and staff were not with him. CI #1 indicated the staff was not known to them, but once aid was being provided (by a community member) the staff did come to assist client C back toward the home. CI #1 indicated concern for client C crossing the road and how staff verbally redirected. CI #1 stated, "The staff speak disrespectful. The client (client C) did end up crossing the road. [Member of the Community] got out to help, the staff then responded".<br><br>Confidential Interview (CI #2) was conducted. The CI #2 stated, "I do not know the client name or staff. It happened the weekend prior. I saw him (client C) walk down the driveway. I heard staff say 'you better not cross the road'. He got to the curb. I began to walk over there, and she said something and came over and walked across the street. He wasn't in traffic. I never intervened. She made it down and assisted him before crossing [name of street]. What bothered me more was what I thought was a verbal threat rather than taking action beside verbal prompts". | W 0193 | **W193:** Staff Training Program<br><br>**Corrective Action:**<br>· QIDP updated client (C) behavior plan. (**Attachment B**)<br>· All staff trained updated behavior plan for client (C).**(Attachment C)**<br>· All staff trained on the elopement policy. **(Attachment C)**<br>· Program Manager submitted a work order for alarms to be placed on all exit doors. **(Attachment N)**<br>· Rescare has added an additional QIDP in order to provide more oversight at the facility.<br>· The QIDP will provide continuous training to staff on all behavior and Program Plans annually and as needed.<br>· Area Supervisor has been hired to solely be assigned to this location and will provide continuous oversight of the facility.<br>·Program Manager will be at the home weekly to observe 2 medication administration passes, a mealtime observation and 2 active treatment observations. **(Attachment J)**<br><br>**Monitoring of Corrective Action:**<br>· Area Supervisor will | 06/19/2022 |

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| | On 5/23/22 at 4:30 PM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following incident which affected client C:<br><br>-BDDS incident report dated 1/22/22 indicated, "The home was calm, clients had just finished lunch and were sitting in the living room relaxing and watching TV (television). Staff had took (sic) another client to assist her to use the restroom. As staff was finishing with the client and coming down the hallway staff heard a knock at the door. When staff answered the door there were two gentlemen standing on the porch with [client C]. [Client C] slipped out the door and walked to the gas station where he had purchased a soft drink. The two gentlemen was (sic) bringing him home ...".<br><br>Investigation summary dated 1/28/22 indicated, "On 1/22/22 [client C] eloped from the home. Staff reported the home was calm, clients had just finished lunch and were sitting in the living room relaxing and watching TV. Staff had taken another client to assist her to use the restroom. As staff was finishing with the client and coming down the hallway staff heard a knock at the door. When staff answered the door two gentlemen were standing on the porch with [client C]. The men stated they were bringing him home. [Client C] had slipped out the door and walked to the gas station where he had purchased a soft drink ... First reported, [client C] had not received any injuries from this incident.<br><br>On 1/24/22 received additional information during the investigation that [client C] had fell (sic) during the elopement and had small scratches above his left eye and on the left side of his nose. | | complete weekly checks to ensure completion of goal training and medication administration.<br>· Program Manager will review Area Supervisor weekly check for monitoring and completion.<br>· Your safe I'm Safe Training for behavior intervention is completed upon hire and annually for all staff.<br>· All oversight observations will be submitted to Rescare management team for review.<br>· Maintenance Technician placed alarms on all exit doors.<br><br>**Completion Date: 6/19/22** | |

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| | The gentlemen that had returned [client C] to the home stated that [client C] was on the sidewalk and they had helped him up from the ground. [County] Sheriff's office did come to the home on Saturday afternoon to complete a wellness check on [client C]. Officer saw [client C] stating he saw that [client C] made it home and was safe.<br><br>Factual Findings:<br>1. [Client C] does have a BSP (Behavior Support Plan) to address elopement behavior. Staff was aware (sic) [client C] left the house ... He did have scratches on his forehead and nose when he returned home.<br>2. [Client C] has had one other elopement behavior but did not leave the property. He walked to the end of the driveway and stood behind the brush at the side of the driveway. Police were called, they spoke with [client C] and he came back inside the house.<br>3. [Client C] has had recent issues with falls experiencing 3 current falls prior to this fall during the elopement.<br>4. This is the first incident that [client C] has not been mad and snuck out of the house without staff knowledge.<br>5. Skin assessment notes scratches on face on 1/22/22 from a fall.<br>6. No documented behavioral issues on 1/22/22.<br>7. Immediate preventative measures were initiated for staff to keep [client C] in eyesight during all waking hours.<br>8. IDT (interdisciplinary team) met on 1/25/22 to discuss further preventative measures. Team agreed to seek approval to place door alarms at each entry way.<br><br>Recommendations:<br>1. Staff have received training to keep [client C] in eyesight during waking hours. | | | |

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| | 2. Team has obtained HRC (human rights committee) approval for door alarms at each entry way door. Maintenance request has been submitted.<br>3. Staff training to report all incidents accurately with detail.<br>4. Fall plan has been updated.<br>5. BSP updated for alarms at doors.<br>6. Add/include outings for a soft drink to the activity schedule".<br><br>On 5/25/22 at 12:44 PM, a focused review of client C's record was conducted. The review indicated the following:<br><br>-Behavioral Support Plan (BSP) dated 2/3/22 indicated, "Area: Challenging Behaviors ... Elopement: Leaving the property of the group home without line of sight of staff, taking off from staff while in the community.<br><br>Proactive Strategies:<br>Advance notice of changes in routine.<br>Door alarms on all entry doors of the home.<br>If the door alarms are not working properly, [client C] is to be in eyesight of staff during waking hours.<br>[Client C] is to be supervised by staff while outside such as being on the porch smoking...<br>Consistent staff interaction...<br>Consistent staff redirection...<br>When redirecting [client C] be positive and upbeat...<br>Staff will encourage [client C] to express feelings and emotions<br>Participation in activities of choice<br>Schedule outings on the activity calendar for soft drinks...<br><br>Environmental Strategies: | | | |

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| | Quiet environment<br>Staff need to know [client C's] likes and dislikes<br>Staff consistency in following BSP<br>Appropriate staff interventions<br><br>Reactive Strategies:<br>If [client C] goes outside of building, staff should keep [client C] in line of sight. Chasing [client C] may make it worse.<br>If [client C] attempts to enter the road staff will initiate 1-2-person escort<br>After [client C] calms, discuss the appropriate way of handling the situation<br>If [client C] does not calm and returns or he gets out of line of sight when at the group home or in the community then staff will follow ResCare policy and procedure for elopement/missing person".<br><br>On 5/23/22 at 7:34 PM, the Program Director was interviewed while working direct care at the group home. The Program Director was asked about client C's incident of elopement. The Program Director shook her head up and down and indicated "yes" and then stated, "He got out of the house, and no one knew anything about it. There was a knock on the door and 2 men that knocked said they found him along the road". The Program Director was asked if the 2 men who assisted client C back to the home were known individuals. The Program Director stated, "No, staff did not ask. I am fairly certain law enforcement came and did a welfare check. That's the reason the alarms were added". The Program Director was asked if any other elopements other than the incident on 1/22/22 had occurred. The Program Director stated, "No, his behavior tracking had two incidents of him going out to the driveway in the last two months. The alarms are very much needed". The Program Director was | | | |

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| | asked how long client C had been gone from the home without staff knowledge. The Program Director stated, "We couldn't get a timeframe for how long he was gone".<br><br>On 5/24/22 at 4:21 PM, staff #3 was interviewed. Staff #3 was asked about client C's incidents of elopement. Staff #3 stated, "Yes, he did. It happened maybe 2 or 3 months ago. It happened over the weekend. [Client C] has behavior when he cannot get what he wants, when he wants. He pretends to leave saying 'bye, bye, bye'. From what I understand we had two staff here and they were taking care of [name of peer]. He was mad because they were assisting [name of peer]. He walked off to [store name] to a gas station to buy a pop. Because that happened we had to get alarms". Staff #3 was asked if client C had been brought back home by two community members. Staff #3 stated, "I think so. That is how it was explained to me. They had to add elopement to his plan after that". Staff #3 was asked if client C had any other additional elopements since the incident reported on 1/22/22. Staff #3 stated, "No, last month someone marked he eloped. I questioned where the elopement incident was. I asked and it was not elopement. We had to in-service the whole staff as to what the definition of elopement is". Staff #3 was asked how it was recorded. Staff #3 stated, "On a tracking sheet". Staff #3 was asked how client C's behavior plan addressed walking down the driveway. Staff #3 stated, "I think it says line of sight. When I am here, I am going to follow him. I am not going to let him leave line of sight". Staff #3 was asked if client C's behavior plan indicated how to use physical intervention to prevent him from going into traffic. Staff #3 stated, "Not that I'm aware of".<br><br>On 5/24/22 at 5:03 PM, staff #4 was interviewed. | | | |

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| | Staff #4 was asked about client C's incident of elopement. Staff #4 stated, "That was my very first day. [Name of peer] was 2 (staff) on 1 (client). The other 2 people (staff) working with me were showing me how to toilet [name of peer]. When we came to check on everyone, two men knocked on the door with [client C]. He went down to [gas station]. He had a [name of soda]". Staff #4 was asked who the other people were working. Staff #4 stated, "[staff #2] and [former staff #5]". Staff #4 was asked what client C's behavior support plan indicated to do for interventions. Staff #4 stated, "To watch him, but not to let him see you. If he sees you, he'll take off. Mostly, watch him". Staff #4 was asked if she ever had to intervene to prevent client C from eloping. Staff #4 stated, "He will walk to the end of the patio. If he sees I am not following he'll come back and sit down". Staff #4 was asked if she felt client C's behavioral interventions worked. Staff #4 stated, "Yes. At first I would follow him. He would keep going. Now if he does not see me following he'll come back. Usually when he gets mad and wanting to smoke (will exhibit elopement behavior)".<br><br>On 5/24/22 at 5:48 PM, staff #5 was interviewed. Staff #5 was asked about client C's incident of elopement. Staff #5 stated, "There have been times where he will go to the end of the driveway or to the stop sign. If you do not go after him or chase him he won't go nowhere. If you go after him, it is like a game". Staff #5 was asked what client C's behavior plan indicated for intervention. Staff #5 stated, "To keep him line of sight. Basically. We used to have a thing if he got out of line of sight to call the cops. I do not know if that's a thing or not. If he is in neighbor's yard and you can see him, it's not elopement". Staff #5 was asked if client C's behavioral interventions were keeping him safe. Staff #5 stated, "I've worked | | | |

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| | with [client C] 7 years. I have learned if you don't feed into it, it's not an issue".<br><br>On 5/25/22 at 12:45 PM, the Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed. The QIDPD was asked about client C's incident of elopement and behavioral interventions. The QIDPD stated, "The previous BSP did talk about his walking down the driveway. He was easily redirected. Staff were to keep him in eyesight. He did not have elopement previously. He has never eloped in the 6 years I've had him. We did put alarms in. That day (1/22/22 incident) they had two staff and you cannot count the person on OJT (on the job training). Part of the revision was adding to the proactive strategies. So, we added soft drinks and opportunities for outings. Alarms on all entry doors. If he leaves the property we are going to follow him". The QIDP was asked if staff should follow client C down the driveway or implement planned ignoring of his behavior. The QIDPD stated, "That's more like the original plan (ignoring)". Shared with the QIDPD was indication from interviews that client C had crossed the road from concerned community members and staff not following client C. The QIDPD was asked at what point would staff need to physically intervene to ensure the safety of client C going toward a road and/or traffic. The QIDPD stated, "We don't have a distance (staff positioning) or physical intervention until he goes to enter the road. The team needs to meet to determine at what point the reactive strategies need implemented and to when we physically intervene". The QIDPD indicated based on the information shared from staff interviews for observing from a distance without client C's knowledge and to not follow client C because it would become a game, would therefore place staff | | | |

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| | out of position to be able to physically intervene and prevent client C from entering a road. As the QIDP entered the conference room at 1:15 PM, the QIDPD began a discussion with the QIDP about new information learned and the need for a team meeting to review client C's reactive strategies for elopement.<br><br>On 5/25/22 at 1:20 PM, the QIDP was interviewed. The QIDP was asked about client C's incident of elopement and behavioral interventions. The QIDP stated, "We're going to have to meet and add interventions". The QIDP indicated she would not delay in addressing client C's behavioral interventions as staff had described the previous behavior plan's reactive strategies and interventions prior to his elopement on 1/22/22.<br><br>9-3-3(a) | | | |
| W 0240<br><br>Bldg. 00 | 483.440(c)(6)(i)<br>INDIVIDUAL PROGRAM PLAN<br>The individual program plan must describe relevant interventions to support the individual toward independence.<br>Based on record review and interview for 1 of 3 sampled clients (C), the facility failed to ensure client C's behavioral interventions for elopement included techniques from least intrusive to most intrusive interventions such as verbal redirection techniques, positioning techniques of staff if client C attempted to leave his assigned area, and physical interventions techniques for how and when to physical intervene to ensure client C's safety when in proximity to roads and/or streets.<br><br>Findings include:<br><br>Confidential Interview (CI #1) was conducted. The | W 0240 | **W240:** The individual program plan must describe relevant interventions to support the individual toward independence.<br><br>**Corrective action:**<br>· QIDP updated client (C) behavior plan. (**Attachment B**)<br>· All staff trained updated behavior plan for client (C).**(Attachment C)**<br>· All staff trained on the elopement policy. **(Attachment C)**<br>· QIDP will conduct IDT | 06/19/2022 |

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| | CI #1 indicated an attempt to contact ResCare management had been made but was unsuccessful finding correct contact information. CI #1 indicated client C had recently crossed the road and staff were not with him. CI #1 indicated the staff was not known to them, but once aid was being provided (by a community member) the staff did come to assist client C back toward the home. CI #1 indicated concern for client C crossing the road and how staff verbally redirected. CI #1 stated, "The staff speak disrespectful. The client (client C) did end up crossing the road. [Member of the Community] got out to help, the staff then responded".<br><br>Confidential Interview (CI #2) was conducted. The CI #2 stated, "I do not know the client name or staff. It happened the weekend prior. I saw him (client C) walk down the driveway. I heard staff say 'you better not cross the road'. He got to the curb. I began to walk over there, and she said something and came over and walked across the street. He wasn't in traffic. I never intervened. She made it down and assisted him before crossing [name of street]. What bothered me more was what I thought was a verbal threat rather than taking action beside verbal prompts".<br><br>On 5/23/22 at 4:30 PM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following incident which affected client C:<br><br>-BDDS incident report dated 1/22/22 indicated, "The home was calm, clients had just finished lunch and were sitting in the living room relaxing and watching TV (television). Staff had took (sic) another client to assist her to use the restroom. As staff was finishing with the client and coming | | meetings to discuss proactive and reactive strategies for behavior concerns with all team members quarterly and as needed.<br>· Program Manager submitted a work order for alarms to be placed on all exit doors. **(Attachment N)**<br>· Rescare has added an additional QIDP in order to provide more oversight at the facility.<br>· The QIDP will provide continuous training to staff on all behavior and Program Plans annually and as needed.<br>· Area Supervisor has been hired to solely be assigned to this location and will provide continuous oversight of the facility.<br>·Program Manager will be at the home weekly to observe 2 medication administration passes, a mealtime observation and 2 active treatment observations. **(Attachment J)**<br><br>**·Monitoring of Corrective Action**:<br>· QIDP will update the Individual Support Plan and Behavior plans annually and as needed.<br>· All trainings are sent to the HR department for tracking.<br>· IDT Meetings are held quarterly to discuss any concerns with individuals plans and | |

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| | down the hallway staff heard a knock at the door. When staff answered the door there were two gentlemen standing on the porch with [client C]. [Client C] slipped out the door and walked to the gas station where he had purchased a soft drink. The two gentlemen was (sic) bringing him home ...".<br><br>Investigation summary dated 1/28/22 indicated, "On 1/22/22 [client C] eloped from the home. Staff reported the home was calm, clients had just finished lunch and were sitting in the living room relaxing and watching TV. Staff had taken another client to assist her to use the restroom. As staff was finishing with the client and coming down the hallway staff heard a knock at the door. When staff answered the door two gentlemen were standing on the porch with [client C]. The men stated they were bringing him home. [Client C] had slipped out the door and walked to the gas station where he had purchased a soft drink ... First reported, [client C] had not received any injuries from this incident.<br><br>On 1/24/22 received additional information during the investigation that [client C] had fell (sic) during the elopement and had small scratches above his left eye and on the left side of his nose. The gentlemen that had returned [client C] to the home stated that [client C] was on the sidewalk and they had helped him up from the ground. [County] Sheriff's office did come to the home on Saturday afternoon to complete a wellness check on [client C]. Officer saw [client C] stating he saw that [client C] made it home and was safe.<br><br>Factual Findings:<br>1.[Client C] does have a BSP (Behavior Support Plan) to address elopement behavior. Staff was aware (sic) [client C] left the house ... He did have | | programming, monthly summaries will be reviewed at this time which includes goal percentages progress.<br>· All oversight observations will be submitted to Rescare management team for review.<br>· Maintenance technician placed alarms on all exits.<br><br>**Completion Date: 6/19/22** | |

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| | scratches on his forehead and nose when he returned home.<br>2.[Client C] has had one other elopement behavior but did not leave the property. He walked to the end of the driveway and stood behind the brush at the side of the driveway. Police were called, they spoke with [client C] and he came back inside the house.<br>3.[Client C] has had recent issues with falls experiencing 3 current falls prior to this fall during the elopement.<br>4. This is the first incident that [client C] has not been mad and snuck out of the house without staff knowledge.<br>5. Skin assessment notes scratches on face on 1/22/22 from a fall.<br>6. No documented behavioral issues on 1/22/22.<br>7. Immediate preventative measures were initiated for staff to keep [client C] in eyesight during all waking hours.<br>8. IDT (interdisciplinary team) met on 1/25/22 to discuss further preventative measures. Team agreed to seek approval to place door alarms at each entry way.<br><br>Recommendations:<br>1. Staff have received training to keep [client C] in eyesight during waking hours.<br>2. Team has obtained HRC (human rights committee) approval for door alarms at each entry way door. Maintenance request has been submitted.<br>3. Staff training to report all incidents accurately with detail.<br>4. Fall plan has been updated.<br>5. BSP updated for alarms at doors.<br>6. Add/include outings for a soft drink to the activity schedule".<br><br>On 5/25/22 at 12:44 PM, a focused review of client | | | |

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| | C's record was conducted. The review indicated the following:<br><br>-Behavioral Support Plan (BSP) dated 2/3/22 indicated, "Area: Challenging Behaviors ... Elopement: Leaving the property of the group home without line of sight of staff, taking off from staff while in the community.<br><br>Proactive Strategies:<br>Advance notice of changes in routine.<br>Door alarms on all entry doors of the home.<br>If the door alarms are not working properly, [client C] is to be in eyesight of staff during waking hours.<br>[Client C] is to be supervised by staff while outside such as being on the porch smoking...<br>Consistent staff interaction...<br>Consistent staff redirection...<br>When redirecting [client C] be positive and upbeat...<br>Staff will encourage [client C] to express feelings and emotions<br>Participation in activities of choice<br>Schedule outings on the activity calendar for soft drinks...<br><br>Environmental Strategies:<br>Quiet environment<br>Staff need to know [client C's] likes and dislikes<br>Staff consistency in following BSP<br>Appropriate staff interventions<br><br>Reactive Strategies:<br>If [client C] goes outside of building, staff should keep [client C] in line of sight. Chasing [client C] may make it worse.<br>If [client C] attempts to enter the road staff will initiate 1-2-person escort<br>After [client C] calms, discuss the appropriate way | | | |

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| | of handling the situation<br>If [client C] does not calm and returns or he gets out of line of sight when at the group home or in the community then staff will follow ResCare policy and procedure for elopement/missing person".<br><br>On 5/23/22 at 7:34 PM, the Program Director was interviewed while working direct care at the group home. The Program Director was asked about client C's incident of elopement. The Program Director shook her head up and down and indicated "yes" and then stated, "He got out of the house, and no one knew anything about it. There was a knock on the door and 2 men that knocked said they found him along the road". The Program Director was asked if the 2 men who assisted client C back to the home were known individuals. The Program Director stated, "No, staff did not ask. I am fairly certain law enforcement came and did a welfare check. That's the reason the alarms were added". The Program Director was asked if any other elopements other than the incident on 1/22/22 had occurred. The Program Director stated, "No, his behavior tracking had two incidents of him going out to the driveway in the last two months. The alarms are very much needed". The Program Director was asked how long client C had been gone from the home without staff knowledge. The Program Director stated, "We couldn't get a timeframe for how long he was gone".<br><br>On 5/24/22 at 4:21 PM, staff #3 was interviewed. Staff #3 was asked about client C's incidents of elopement. Staff #3 stated, "Yes, he did. It happened maybe 2 or 3 months ago. It happened over the weekend. [Client C] has behavior when he cannot get what he wants, when he wants. He pretends to leave saying 'bye, bye, bye'. From | | | |

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| | what I understand we had two staff here and they were taking care of [name of peer]. He was mad because they were assisting [name of peer]. He walked off to [store name] to a gas station to buy a pop. Because that happened we had to get alarms". Staff #3 was asked if client C had been brought back home by two community members. Staff #3 stated, "I think so. That is how it was explained to me. They had to add elopement to his plan after that". Staff #3 was asked if client C had any other additional elopements since the incident reported on 1/22/22. Staff #3 stated, "No, last month someone marked he eloped. I questioned where the elopement incident was. I asked and it was not elopement. We had to in-service the whole staff as to what the definition of elopement is". Staff #3 was asked how it was recorded. Staff #3 stated, "On a tracking sheet". Staff #3 was asked how client C's behavior plan addressed walking down the driveway. Staff #3 stated, "I think it says line of sight. When I am here, I am going to follow him. I am not going to let him leave line of sight". Staff #3 was asked if client C's behavior plan indicated how to use physical intervention to prevent him from going into traffic. Staff #3 stated, "Not that I'm aware of".<br><br>On 5/24/22 at 5:03 PM, staff #4 was interviewed. Staff #4 was asked about client C's incident of elopement. Staff #4 stated, "That was my very first day. [Name of peer] was 2 (staff) on 1 (client). The other 2 people (staff) working with me were showing me how to toilet [name of peer]. When we came to check on everyone, two men knocked on the door with [client C]. He went down to [gas station]. He had a [name of soda]". Staff #4 was asked who the other people were working. Staff #4 stated, "[staff #2] and [former staff #5]". Staff #4 was asked what client C's behavior support plan indicated to do for interventions. Staff #4 stated, | | | |

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| | "To watch him, but not to let him see you. If he sees you, he'll take off. Mostly, watch him". Staff #4 was asked if she ever had to intervene to prevent client C from eloping. Staff #4 stated, "He will walk to the end of the patio. If he sees I am not following he'll come back and sit down". Staff #4 was asked if she felt client C's behavioral interventions worked. Staff #4 stated, "Yes. At first I would follow him. He would keep going. Now if he does not see me following he'll come back. Usually when he gets mad and wanting to smoke (will exhibit elopement behavior)".<br><br>On 5/24/22 at 5:48 PM, staff #5 was interviewed. Staff #5 was asked about client C's incident of elopement. Staff #5 stated, "There have been times where he will go to the end of the driveway or to the stop sign. If you do not go after him or chase him he won't go nowhere. If you go after him, it is like a game". Staff #5 was asked what client C's behavior plan indicated for intervention. Staff #5 stated, "To keep him line of sight. Basically. We used to have a thing if he got out of line of sight to call the cops. I do not know if that's a thing or not. If he is in neighbor's yard and you can see him, it's not elopement". Staff #5 was asked if client C's behavioral interventions were keeping him safe. Staff #5 stated, "I've worked with [client C] 7 years. I have learned if you don't feed into it, it's not an issue".<br><br>On 5/25/22 at 12:45 PM, the Qualified Intellectual Disabilities Professional Designee (QIDPD) was interviewed. The QIDPD was asked about client C's incident of elopement and behavioral interventions. The QIDPD stated, "The previous BSP did talk about his walking down the driveway. He was easily redirected. Staff were to keep him in eyesight. He did not have elopement previously. He has never eloped in the 6 years I've | | | |

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| | had him. We did put alarms in. That day (1/22/22 incident) they had two staff and you cannot count the person on OJT (on the job training). Part of the revision was adding to the proactive strategies. So, we added soft drinks and opportunities for outings. Alarms on all entry doors. If he leaves the property we are going to follow him". The QIDP was asked if staff should follow client C down the driveway or implement planned ignoring of his behavior. The QIDPD stated, "That's more like the original plan (ignoring)". Shared with the QIDPD was indication from interviews that client C had crossed the road from concerned community members and staff not following client C. The QIDPD was asked at what point would staff need to physically intervene to ensure the safety of client C going toward a road and/or traffic. The QIDPD stated, "We don't have a distance (staff positioning) or physical intervention until he goes to enter the road. The team needs to meet to determine at what point the reactive strategies need implemented and to when we physically intervene". The QIDPD indicated based on the information shared from staff interviews for observing from a distance without client C's knowledge and to not follow client C because it would become a game, would therefore place staff out of position to be able to physically intervene and prevent client C from entering a road. As the QIDP entered the conference room at 1:15 PM, the QIDPD began a discussion with the QIDP about new information learned and the need for a team meeting to review client C's reactive strategies for elopement.<br><br>On 5/25/22 at 1:20 PM, the QIDP was interviewed. The QIDP was asked about client C's incident of elopement and behavioral interventions. The QIDP stated, "We're going to have to meet and | | | |

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| | add interventions". The QIDP indicated she would not delay in addressing client C's behavioral interventions as staff had described the previous behavior plan's reactive strategies and interventions prior to his elopement on 1/22/22.<br><br>9-3-4(a) | | | |
| W 0368<br><br>Bldg. 00 | 483.460(k)(1)<br>DRUG ADMINISTRATION<br>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br>Based on record review and interview for 19 of 41 incident reports affecting clients A, B, D, E and G, the facility failed to ensure clients A, B, D, E and G received their medication according to their physician orders without error.<br><br>Findings include:<br><br>On 5/23/22 at 4:30 PM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following incidents which affected clients A, B, D, E and G:<br><br>1) BDDS incident report dated 12/27/21 indicated, "This morning when the staff began passing meds she noticed a med (medication) error on [client E]. [Client E] is ordered Clonazepam (schizophrenia) 1 mg (milligram) BID (twice) for Schizophrenia ... On 12/26/21 at 6 AM he did not receive the Clonazepam 1 mg ...".<br><br>2) BDDS incident report dated 12/27/21 indicated, "[Client G] is ordered vitamin E as a supplement. This morning when the staff was passing | W 0368 | **W368:** The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.<br><br>**Corrective action:**<br>·Nurse manager created a form to be used at all medication administrations to ensure all medications were given and accounted for. (**Attachment F)**<br>·All staff trained on medication administration oversight form. **(Attachment C)**<br>·Nurse Manager will complete 3 medication administration observations weekly for no less than 90 days. **(Attachment H)**<br>·Area Supervisor will complete 3 medication administration observations weekly for no less than 90 days and 2 times weekly thereafter. **(Attachment I)**<br>·Program Manager will be at the home weekly to observe 2 | 06/19/2022 |

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| | medications she noticed a med error ... On 12/26/21 at the 7 PM med pass [client G] did not receive the vitamin E ...".<br><br>3) BDDS incident report dated 12/27/21 indicated, "This morning when the staff was passing medications she noticed medication errors. [Client B] is ordered Pregabalin (seizure) 150 mg TID (three times) for seizures and Divalproex (seizure) 500 mg (2 tbs) BID for seizures ... On 12/26/21 at the 8 PM med pass [client B] did not receive the Pregabalin 150 mg or the Divalproex 500 mg (2 tabs) at the 8 PM med pass on 12/26/21 ...".<br><br>4) BDDS incident report dated 12/27/21 indicated, "This morning when the staff began to pass [client D's] medication she noticed there were med errors. Med errors are: [Client D] is ordered Chlorpromazine (Schizophrenia) 100 mg BID for Schizophrenia, on 12/7/21 he did not receive the Chlorpromazine 100 mg at the 8 AM med pass. [Client D] is ordered Lorazepam (anxiety) 1 mg BID and 2 mg at 8 PM for anxiety, on 12/26/21 at the 7 AM med pass he was given Lorazepam 2 mg instead of the 1 mg that is ordered for a 1 mg extra dose. [Client D] is ordered Levothyroxine (thyroid hormone) 100 mcg (microgram) daily for Hypothyroidism (underactive thyroid), on 12/26/21 and 12/27/21 at the 5 AM med pass he was given 100 mcg (2 tabs) instead of 100 mcg (1 tab) ...".<br><br>5) BDDS incident report dated 1/3/22 indicated, "[Client D] is ordered Lorazepam 1 mg for anxiety at 7 AM and 12 PM ... On 1/2/22 at 7 AM [client D] did not receive the Lorazepam 1 mg ...".<br><br>6) BDDS incident report dated 1/24/22 indicated, "[Client D] is ordered Divalproex TID. This morning when the staff was passing meds staff | | medication administration passes, a mealtime observation and 2 active treatment observations. **(Attachment J)**<br>·Area Supervisor has been hired to solely be assigned to this location and will provide continuous oversight of the facility.<br>·Rescare has added an additional QIDP in order to provide more oversight at the facility.<br>·Medication lead completes weekly audit of medications to ensure the needed medications/ treatments are present in the home.<br><br>**Monitoring of Corrective Action:**<br>· All training sent to the Rescare trainer for filing in staff files.<br>· All oversight observations will be sent to the Program Manager for monitoring and to ensure completion.<br>· Nurse Manager will send medication administration observations to the Program Manager for tracking and review.<br>· Area Supervisor observations will be sent to the Program Manager upon completion for review and to ensure completion.<br>· All oversight observations will be submitted to Rescare management team for review.<br>· Nurse updates High Risk Plans and trains staff and sends | |

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| | found a med error. The med error is Divalproex 250 mg at 7 AM on 1/23/22, [client D] received 2 pills instead on (sic) 1 pill for 500 mg at 7 AM ...".<br><br>7) BDDS incident report dated 1/31/22 indicated, "[Client B] is ordered Divalproex 500 mg 2 tablets twice daily at 7 AM and 7 PM ... On 1/30/22 at 7 AM [client B] received only 1 tablet of the Divalproex 500 mg instead of the 2 tablets that are ordered ...".<br><br>8) BDDS incident report dated 1/31/22 indicated, "[Client B] is ordered Divalproex 500 mg 2 tablets twice daily at 7 AM and 7 PM ... On 1/29/22 at 7 AM [client B] received only 1 tablet of the Divalproex 50mmg (sic) instead of the 2 tablets that are ordered ...".<br><br>9) BDDS incident report dated 2/3/22 indicated, "[Client A] is ordered Synthroid (thyroid hormone) 50 mcg at 5 AM daily ... On 2/3/22 [client A] received 175 MCG at 5 AM instead of 50 mcg pill. Another client living in the home receives Synthroid 175 mcg and his med packet was in [client A's] med basket and [client A] received his ...".<br><br>10) BDDS incident report dated 2/7/22 indicated, "[Client D] is ordered Levothyroxine 100 mcg 1 tab ... at 5 AM ... On 2/6/22 at 5 AM [client D] received 2 tab of Levothyroxine 100 mcg instead of the 1 tab ordered ..."<br><br>11) BDDS incident report dated 2/7/22 indicated, "[Client B] is ordered Tamsulosin (enlarged prostate) 0.4 mg ... and Zyprexa (schizophrenia) 7.5 mg ... On 2/6/22 at the 7 AM med pass [client B] did not receive the Tamsulosin 0.4 mg at 7 AM and did not receive the Zyprexa 7.5 mg at 7 AM ...". | | out to the IDT for team review.<br><br>**Completion Date-6/19/22** | |

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| | 12) BDDS incident report dated 2/7/22 indicated, "[Client G] is ordered Abilify (depression) 15 mg at 7 AM ... On 2/6/22 at 7 AM [client G] did not receive her Abilify 15 mg ...".<br><br>13) [Client A] is ordered Simethicone (gas relief) 80 mg 1 tab qid (four times) ... On 2/19/22 at 12 AM [client A] did not receive the Simethicone 80 mg ...".<br><br>14) BDDS incident report dated 4/4/22 indicated, "[Client D] is ordered Clozapine (schizophrenia) 200 mg at 6 AM ... On 4/3/22 at 6 AM [client D] was given Clozapine 400 mg, 200 mg extra ..."<br><br>15) BDDS incident report dated 4/5/22 indicated, "[Client G] is ordered vitamin E 400 mg 1 cap (capsule) at 7 AM ... On 4/3/22 [client G] was given vitamin E 400 mg 2 caps instead of the 1 cap that is ordered ...".<br><br>On 5/25/22 at 1:18 PM, a focused review of client E's record was conducted. The record indicated the following:<br><br>-Physician Orders dated 3/14/22 indicated, "Clonazepam TAB (tablet) 1 mg ... Give one tablet by mouth twice daily ...".<br><br>On 5/25/22 at 3:19 PM, a focused review of client G's record was conducted. The record indicated the following:<br><br>-Physician Orders dated 3/14/22 indicated, "Vitamin E 400 IU (International Units) CAP. Give one capsule by mouth twice daily ... Aripiprazole (Abilify) Tab 15 mg. Give one tablet by mouth once daily". | | | |

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|---|---|---|---|
| | 15G507 | A. BUILDING 00<br>B. WING | 05/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
|---|---|
| VOCA CORPORATION OF INDIANA | 2900 KENTUCKY AVE<br>MADISON, IN 47250 |

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| | On 5/25/22 at 12:14 PM, a focused review of client B's record was conducted. The record indicated the following:<br><br>-Physician Orders dated 3/24/22 indicated, "Pregabalin CAP 150 mg ... Give once capsule by mouth three times daily ... Divalproex TAB 500 mg ... Give two (2) Tablets (=1000 mg) by mouth twice daily ... Tamsulosin CAP 0.4 mg ... Give one capsule by mouth once daily ... Olanzapine (Zyprexa ) Tab 7.5 mg ... Give one tablet by mouth once daily ...".<br><br>On 5/25/22 at 11:19 AM, a focused review of client D's record was conducted. The record indicated the following:<br><br>-Physician Orders dated 3/24/22 indicated, "Chlorpromazine 100 mg Tab ... Give one tablet by mouth twice daily ... Lorazepam Tab 1 mg ... Give one tablet by mouth twice daily ... Lorazepam Tab 2 mg ... Give one tablet by mouth at bedtime ... Levothyroxine Tab 100 mcg ... Give one tablet by mouth once daily ... Divalproex Tab 250 mg ... Give one tablet by mouth three times daily ... Divalproex Tab 500 mg ... Give one tablet by mouth three times daily ... Clozapine Tab 200 mg ... Give one tablet by mouth twice daily ...".<br><br>On 5/25/22 at 10:05 AM, a focused review of client A's record was conducted. The record indicated the following:<br><br>-Physician Orders dated 3/14/22 indicated, "Levothyroxine (Synthroid) SOD (sodium) 50 mcg Tab ... Give one tablet by mouth every morning. Take on empty stomach with a glass of water, one hour before eating, drinking or taking any other medications ... Gas Relief (Simethicone) CHW (chewable) 80 mg ... Chew one tablet by mouth | | | |

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|---|---|---|---|
| | 15G507 | A. BUILDING 00<br>B. WING | 05/27/2022 |

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| | after meals and at bedtime as needed for gas pain ...".<br><br>On 5/24/22 at 4:21 PM, staff #3 was interviewed. Staff #3 indicated the home recently had experienced a lot of medication administration errors over the weekend shifts. Staff #3 indicated the Nurse had put into place forms to account for who was assigned as the person administering medications and who was assigned as the person to complete the check for errors of administered medicines. Staff #3 stated, "That's faxed to [Nurse] and [Area Supervisor]". Staff #3 was asked if the form had created more accountability and if she believe it was working. Staff #3 stated, "I think so. Med Error Monday has not recently happened".<br><br>On 5/24/22 at 5:03 PM, staff #4 was interviewed. Staff #4 was asked if she administered medications. Staff #4 stated, "Yes". Staff #4 was asked what she believe to be contributing factors to create a pattern of medication administration errors. Staff #4 indicated many medication administration issues occurred during weekends and stated, "The only one I know about is [former staff #1], but she no longer works here".<br><br>On 5/24/22 at 5:48 PM, staff #5 was interviewed. Staff #5 was asked a pattern of medication administration errors. Staff #5 stated, "I had one last week working 3rd (shift). Honestly, I worked an excessive amount of hours. Someone came in and I got distracted".<br><br>On 5/25/22 at 12:24 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the pattern of medication administration errors for the above listed incidents. The QIDP stated, "Usually it's | | | |

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| | they (staff) give the wrong dose or to the wrong person or they didn't give it". The QIDP was asked about missed medication errors. The QIDP stated, "Like 7 AM and they didn't give them". The QIDP indicated a pattern of medication errors had been identified. The QIDP indicated trainings had been completed throughout the period of time for medication errors in question and the nurse put into place a form for accountability to identify who would be responsible for medication administration and who would be responsible for completing a buddy check to limit errors. The QIDP was asked if medications administered to clients A, B, D, E and G should have been according to their physicians orders and without errors. The QIDP stated, "Yes".<br><br>On 5/25/22 at 12:29 PM, the Nurse was interviewed. The Nurse was asked about the pattern of medication administration errors for the above listed incidents. The Nurse stated, "We've done multiple retrainings. I came up with a form to hold them more accountable than we already do". The Nurse indicated the form for accountability included the identification of which staff on shift who would be responsible for administering medication and the identification of who would be responsible for checking to ensure that staff had not made a medication administration error. The Nurse indicated all medications should be administered to clients A, B, D, E and G according to their physicians orders and without errors.<br><br>9-3-6(a) | | | |