STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G745	A. BUILDING 00 B. WING	10/26/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16611 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a pre-determined full annual recertification and state licensure survey. Dates of the Survey: 10/20/20, 10/21/20, 10/22/20, 10/23/20 and 10/26/20. Facility Number: 011663 Provider Number: 15G745 AIM Number: 200902020 These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/6/20.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Governing Body and Management for 1 of 2 sampled clients (#1) and one additional client (#3). The governing body failed to exercise general policy, budget and operating direction over the facility to proactively monitor and prevent abuse toward client #3 by staff choking him, allegedly hitting client #1 in the stomach to intimidate him from reporting that client #3 had been choked and staff having client #3 strip his clothes off to his underwear. Findings include: 1. The governing body failed to exercise general	W 0102	1.Due to COVID19 precautions unannounced random daily observations began at the Facility on 29 October 2020 to ensure plans are being implemented by staff. Observers will question the staff on ANE and ensure documentation is completed as required. Daily observations will remain in effect for 60 days. After 60 days monthly, administrative observations will be conducted. 2.The management team began daily update meetings on October 28, 2020, to ensure compliance and implement changes needed developing a plan and	11/25/2020

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

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	policy, budget and operating direction over the facility to proactively monitor and prevent abuse toward client #3 by staff choking him, allegedly hitting client #1 in the stomach to intimidate him from reporting that client #3 had been choked and staff having client #3 strip his clothes off to his underwear. Please see W104. 2. The governing body failed to ensure the facility met the Condition of Participation: Client Protections for 1 of 2 sampled clients (#1) and one additional client (#3). Please see W122. 9-3-1(a)		implementation of those changes. Meetings will continue until conditions are lifted. 3.The Governing Body will retrain staff in the Facility on the Abuse, Neglect, and Exploitation Policy and disciplinary action will be given if the policy is not followed. Area Supervisor and Residential Manager will ensure that the Abuse, Neglect, and Exploitation Policy is followed. Monitoring of ANE will be done by The Program Manager, Area Supervisor, and Residential Manager to ensure all incidents of possible abuse, neglect, and exploitation are reported to the QA department. 4.The Behavioral Clinician will update client#3 BSP to specify client clothing will not be removed from his person when per BSP other personal items are being removed from his possession. 5.The governing body will ensure all staff is retrained on ANE policy and procedures. 6.The Residential Manager will monitor home activities and client interactions daily to ensure there is no suspected ANE/Mistreatments of clients 7.If there is suspected ANE the RM will immediately report to QA. 8.The Residential Manager will discuss with staff the ANE Policy and Procedures daily. 9.The QIDP will every week discuss with staff the ANE policy	

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			and procedures. 10.The PM will every month confirm there is documented proof the RM, QIDP, and AS have completed the required ANE policy and Procedures discussion with staff. 11.Management will ensure all staff in the Facility are retrained on YSIS the Govern body's approved restraint technique. 12.The Program Manager filed a police report on behalf of Client #1 and Client #3 with the Clark County Sheriffs Department after completion of investigations confirmed the presence of ANE POLICE REPORT # 2020-36912 Persons Responsible: Executive Director, Program Manager, Quality Assurance, Area Supervisor, Behavior Clinician, QIDP, Residential Manager, and DSP.	
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 1 of 2 sampled clients (#1) and 1 additional client (#3), the governing body failed to exercise general policy, budget and operating direction over the facility to proactively monitor and prevent abuse toward client #3 by staff choking him, allegedly hitting client #1 in the stomach to intimidate him from reporting that client #3 had been choked and	W 0104	1. Due to COVID19 precautions unannounced random daily observations began at the Facility on 29 October 2020 to ensure plans are being implemented by staff. Observers will question the staff on ANE and ensure documentation is completed as	11/25/2020

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	staff having client #3 strip his clothes off down to his underwear. Findings include: 1. The governing body failed to exercise general policy, budget and operating direction over the facility to proactively monitor and prevent the staff abuse toward client #3 by choking him, allegedly hitting client #1 in the stomach to intimidate him from reporting that client #3 had been choked and staff having client #3 strip his clothes off down to his underwear. Please see W127. 2. The governing body neglected to implement its policy and procedures for prohibiting Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights for 1) a pattern of staff abuse toward client #3 and staff allegedly hitting client #1 in the stomach in order to ensure he did not report client #3 had been choked and 2) elopement of client #3. Please see W149. 3. The governing body failed to ensure corrective measures were implemented to prevent staff abuse toward client #3 by choking him, allegedly hitting client #1 in the stomach to intimidate him from reporting that client #3 had been choked and staff having client #3 strip his clothes off down to his underwear. Please see W157. 9-3-1(a)		required. Daily observations will remain in effect for 60 days. After 60 days monthly, administrative observations will be conducted. 2. The management team began daily update meetings on October 28, 2020, to ensure compliance and implement changes needed developing a plan and implementation of those changes. Meetings will continue until conditions are lifted. 3. Governing Body members consisting of Program Manager, QIDP, Human Resource Specialist, Area Supervisor, and Residential Manager will be retrained on ANE. 4. The Governing Body will retrain staff in the Facility on the Abuse, Neglect, and Exploitation Policy and disciplinary action will be given if the policy is not followed. Area Supervisor and Residential Manager will ensure that the Abuse, Neglect, and Exploitation Policy is followed. Monitoring of ANE will be done by The Program Manager, Area Supervisor, and Residential Manager to ensure all incidents of possible abuse, neglect, and exploitation are reported to the QA department. 5. The Behavioral Clinician will update client#3 BSP to specify client clothing will not be removed from his person when per BSP other personal items are being removed from his possession.	

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			6. The governing body will ensure all staff is retrained on ANE policy and procedures. 7. The governing body will ensure recommendations/corrective measures are implemented through training of Program Manager, Human Resource Specialist, Area Supervisor, BC, Residential Manager, QIDP as recommended from the Peer Review Process. 8. The Residential Manager will monitor home activities and client interactions daily to ensure there is no suspected ANE/Mistreatments of clients 9. If there is suspected ANE the RM will immediately report to QA. 10. The Residential Manager will discuss with staff the ANE Policy and Procedures daily. 11. The QIDP will every week discuss with staff the ANE policy and procedures. 12. The PM will every month confirm there is documented proof the RM, QIDP, and AS have completed the required ANE policy and Procedures discussion with staff. 13. Management will ensure all staff in the Facility are retrained on YSIS the Govern body's approved restraint technique. 14. The Program Manager filed a police report on behalf of Client #1 and Client #3 with the Clark County Sheriffs Department after	

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			an investigation confirmed presence of ANE POLICE REPORT # 2020-36912 Persons Responsible: Executive Director, Program Manager, Quality Assurance, Area Supervisor, Behavior Clinician, QIDP, Human Resource, Residential Manager, and DSP.	
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 1 of 2 sampled clients (#1) and 1 additional client (#3). The facility failed to proactively monitor and prevent the abuse toward client #3 by staff choking him, allegedly hitting client #1 in the stomach to intimidate him from reporting that client #3 had been choked and staff having client #3 strip his clothes off down to his underwear. Findings include: 1. The facility failed to proactively monitor and prevent the abuse toward client #3 by staff choking him, allegedly hitting client #1 in the stomach to intimidate him from reporting that client #3 had been choked and staff having client #3 strip his clothes off down to his underwear. Please see W127. 2. The facility neglected to ensure its policy and procedures for prohibiting abuse, neglect and	W 0122	1.Due to COVID19 precautions unannounced random daily observations began at the Facility on 29 October 2020 to ensure plans are being implemented by staff. Observers will question the staff on ANE and ensure documentation is completed as required. Daily observations will remain in effect for 60 days. After 60 days monthly, administrative observations will be conducted. 2.Governing Body members consisting of Program Manager, QIDP, Human Resource Specialist, Area Supervisor, and Residential Manager will be retrained on ANE. 3.The Governing Body will retrain staff in the Facility on the Abuse, Neglect, and Exploitation Policy and disciplinary action will be given if the policy is not followed. Area Supervisor and	11/25/2020

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	exploitation were implemented which resulted in staff abuse toward client #3 by choking him, allegedly hitting client #1 in the stomach to intimidate him from reporting that client #3 had been choked and staff having client #3 strip his clothes off down to his underwear. Please see W149. 3. The facility failed to ensure corrective measures were implemented to prevent staff abuse toward client #3 by choking him, allegedly hitting client #1 in the stomach to intimidate him from reporting that client #3 had been choked and staff having client #3 strip his clothes off down to his underwear. Please see W157. 9-3-2(a)		Residential Manager will ensure that the Abuse, Neglect, and Exploitation Policy is followed. Monitoring of ANE will be done by The Program Manager, Area Supervisor, and Residential Manager to ensure all incidents of possible abuse, neglect, and exploitation are reported to the QA department. 4.The Behavioral Clinician will update client#3 BSP to specify client clothing will not be removed from his person when per BSP other personal items are being removed from his possession. 5.The governing body will ensure all staff is retrained on ANE policy and procedures. 6.The Residential Manager, QIDP, Area Supervisor, and Program Manager will monitor home activities and client interactions daily to ensure there is no suspected ANE/Mistreatments of clients in the Facility. 7.The governing body will ensure recommendations/corrective measures are implemented through training of Program Manager, Human Resource Specialist, Area Supervisor, BC, Residential Manager, QIDP as recommended from the Peer Review Process. 8.If there is suspected ANE the RM will immediately report to QA. 9.The Residential Manager will discuss with staff the ANE Policy	

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			and Procedures daily. 10.The QIDP will every week discuss with staff the ANE policy and procedures. 11.The PM will every month confirm there is documented proof the RM, QIDP, and AS have completed the required ANE policy and Procedures discussion with staff. 12.Management will ensure all staff in the Facility are retrained on YSIS the Govern body's approved restraint technique. 13.The Program Manager filled a police report on behalf of Client #1 and Client #3 with the Clark County Sheriffs Department after the completion of the investigations confirmed the presence of ANE POLICE REPORT # 2020-36912 Persons Responsible: Executive Director, Program Manager, Quality Assurance, Human Resource, Area Supervisor, Behavior Clinician, QIDP, Residential Manager, and DSP.	
W 0127 Bldg. 00	483.420(a)(5) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment. Based on record review and interview for 4 of 22 incidents affecting clients #1 and #3, the facility failed to ensure staff was not abusive toward	W 0127	1.Upon conclusion of investigations staff found in violation of ANE have been	11/25/2020

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	client #3 by choking him, allegedly hitting client #1 in the stomach to intimidate him from reporting that client #3 had been choked and staff having client #3 strip his clothes. Findings include: On 10/20/20 at 10:54 AM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying investigation summaries was completed. Upon the request, the Quality Assurance Manager (QAM) indicated two investigations were in peer review and being processed for further questions and procedures. The QAM indicated the two investigations would be provided for review once processed by the peer review committee. The reports indicated: -BDDS report dated 10/5/20 indicated, "[Client #1] reported to staff that on 10/4/20 while [client #3] was having behaviors, staff [staff #7] choked [client #3]. [Client #1] reported that [staff #7] told [client #1] not to tell anyone". -BDDS report dated 10/4/20 indicated, "It was reported [client #3] was agitating [client #1] about [client #1's] broken glasses. Staff asked [client #3] to mop the floor to redirect [client #3]. [Client #3] kicked over the mop bucket and attempted to hit staff. Staff initiated one-man YSIS (You're Safe I'm Safe) for 12 minutes with breaks every 3 minutes until [client #3] calmed. [Client #3] began to hit staff again. Staff initiated one-man YSIS for 30 seconds to escort [client #3] to his room. [Client #3] then began to hit staff and staff initiated one-man YSIS for 3 minutes. [Client #3] attempted to leave assigned area and staff verbally redirected [client #3] multiple times. [Client #1] then entered [client #3's] room and hit [client #3] in the eye and was hitting [client #3's] head on the		terminated and marked “not rehireable” in ResCare Human Resource System. 2.The Program Manager filled a police report on behalf of Client #1 and Client #3 with the Clark County Sheriffs Department after investigations confirmed the presence of ANE POLICE REPORT # 2020-36912 3.The Residential Manager, QIDP, Area Supervisor, and Program Manager will monitor home activities and client interactions daily to ensure there is no suspected ANE/Mistreatments of clients in the Facility. 4.The Governing Body will retrain staff in the Facility on the Abuse, Neglect, and Exploitation Policy and disciplinary action will be given if the policy is not followed. Area Supervisor and Residential Manager will ensure that the Abuse, Neglect, and Exploitation Policy is followed. Monitoring of ANE will be done by The Program Manager, Area Supervisor, and Residential Manager to ensure all incidents of possible abuse, neglect, and exploitation are reported to the QA department. Persons Responsible: Executive Director, Program Manager, Human Resource, Quality	

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	wall. Staff initiated one-man YSIS on both clients to separated (sic) the two. [Client #1] was directed to the other side of the house. [Client #3] attempted to leave assigned area again and staff initiated one-man YSIS for 30 seconds to escort [client #3] back to his room. Nurse did skin assessment on [client #3] and found that [client #3] sustained a ½ inch bruise under his right eye, a 2 inch scratch on his right side, a ¾ inch bruise on the right side of the chest, four ½ inch bruises on right arm, a ½ inch bruise on the left arm, a 1 inch bruise on the left side of neck, and swelling and redness on the right ankle. [Staff #7] and [staff #11] have been placed on administrative leave pending investigation". On 10/22/20 at 6:11 PM, the QAM provided the requested investigations for the 10/4/20 and 10/5/20 incidents. The investigation summaries indicated: The investigation summary (10/4/20 incident) dated 10/6/20 through 10/12/20 indicated, "An investigation was initiated when it was reported [staff #7] and [staff #11], DSPs (Direct Support Professionals) watched [client #1] hit [client #3] in the face and hit [client #3's] head against the wall several times. In addition, it was reported [staff #7] placed [client #3] in a choke hold. Conclusion: Substantiated, [staff #7] and [staff #11] watched [client #1] hit [client #3] and hit [client #3's] head against the wall. Substantiated, [staff #7] placed [client #3] in a choke hold. Determined [client #3] sustained injuries to his head/neck when [client #1] hit him in the face and hit [client #3's] head on the wall repeatedly, and [client #3] sustained injuries to his ankle and back when he slipped and fell on pavement. Unable to determine how [client #3] sustained the other injuries but it is likely they occurred during his attempted elopement".		Assurance, Area Supervisor, Behavior Clinician, QIDP, Residential Manager, and DSP.	

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	The investigation summary (10/5/20 incident) dated 10/7/20 through 10/15/20 indicated, "An investigation was initiated when [client #1] reported on 10/6/20, [staff #7] hit him in the stomach after [client #1] told [staff #7] he would tell someone that [staff #7] had choked [client #3]. Factual Findings: Three employees state [client #1] told them [staff #7] hit [client #1] in the stomach when [client #1] said he was going to report an incident. [Staff #7] denies hitting [client #1]. BSP (Behavior Support Plan) for [client #1] dated 7/8/20 does not include fabrication as a behavior. Conclusion: It is unable to be determined if [staff #7] hit [client #1] in the stomach. Recommendations: [Staff #7] termed (termination) for unrelated incident ...". -BDDS report dated 8/26/20 indicated, "It was reported [client #3] was put in safety protocol due to attempting to harm himself. Staff noticed bruising on right upper inner arm. [Client #3] told staff the bruising had been there for a few days. Nurse did skin assessment and noted softball size red/purple dark purple bruise with no swelling. [Client #3] reported to Nurse that he had a lot of behaviors earlier and had been put in a lot of holds. [Client #3] also stated staff [staff #7] had [client #3] by the arms and could not control [client #3], so [staff #7] grabbed [client #3] by the throat to calm [client #3] down. Nurse assessment shows no marks to [client #3's] throat. Staff [staff #7] has been placed on administrative leave pending investigation". Investigation summary dated 8/27/20 through 9/2/20 indicated, "Conclusion: Unsubstantiated [staff #7] placed his hand on [client #3's] throat during YSIS to restrain [client #3]". On 10/23/20 at 8:08 AM, the Quality Assurance			

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	Manager (QAM) forwarded an incident affecting client #3 that was discovered as a missed incident reported to BDDS, but shared to ensure the survey process had all incidents as requested. This incident report was reviewed on 10/23/20 at 9:05 AM and indicated: -BDDS report dated 9/22/20 indicated, "During an unrelated investigation, it was reported [client #3] engages in a behavior of stripping his clothes off to his boxers then states staff makes him do it. It was reported [staff #12], DSP makes [client #3] strip his clothes off to his boxers". Investigation summary reviewed 10/26/20 at 2:15 PM dated 10/7/20 through 10/14/20 indicated, "Introduction: An investigation was initiated when, during an unrelated investigation, reports were made that [client #3] strips down to his underwear. [Staff #12] was placed on administrative leave pending investigation. Conclusion: It is substantiated [staff #12] told [client #3] to take his clothes off. It is substantiated the incident was reported to management (Area Supervisor). Recommendations: Term (termination) [staff #12]. Additional information needed for determination on [Area Supervisor]...". On 10/21/20 at 2:14 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM stated, "It was substantiated. The peer review needed more information". The QAM indicated staff #7 remained suspended as the peer review committee gathered more information in preparation for termination of staff #7's employment and stated, "Yes, the staff (staff #7, staff #11 and staff #12) will be terminated. All staff (will be) retrained on reporting, the BSPs and You're Safe and I'm Safe". The QAM was asked			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	about injuries client #3 had sustained from the alleged client to client incident with client #1 and indicated the investigation could not determine all sources of client #3's injuries. The QAM indicated a pattern of abuse had been determined. On 10/22/20 at 2:17 PM, the Program Manager (PM) was interviewed. The PM was asked about a pattern of abuse toward client #3 and client #1 being hit in order to ensure he would not report staff choking of client #3 and stated, "Staff (staff #7, staff #11 and staff #12) will be terminated. [Staff #7] will be terminated. It has happened, but not official yet (being processed through peer review). It has to go through corporate, the Adjudication process and notified through the HR (Human Resources) department". The PM was asked if the investigation documentation was available for review and stated, "I don't know. They (peer review) have to be close. They had additional questions and why it's taking so long. It did not change the outcome". The PM was asked what corrective measures were put into place and stated, "There will be additional oversight by the Qualified Intellectual Disability Professional, training for ANE (Abuse, Neglect and Exploitation) reporting, the key was more additional oversight". The PM was asked if staff choking client #3 was abuse and stated, "Yes". 9-3-2(a)			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 5 of 22 incidents affecting client #1 and client #3, the facility neglected to implement its policy and	W 0149	1.The Governing Body will retrain staff in the Facility on the Abuse, Neglect, and Exploitation	11/25/2020

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	15G745	A. BUILDING 00 B. WING	10/26/2020

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	procedures for prohibiting Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights for 1) a pattern of staff abuse toward client #3 and staff allegedly hitting client #1 in the stomach in order to ensure he did not report client #3 had been choked and 2) elopement of client #3. Findings include: On 10/20/20 at 10:54 AM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying investigation summaries was completed. Upon the request, the Quality Assurance Manager (QAM) indicated two investigations were in peer review and being processed for further questions and procedures. The QAM indicated the two investigations would be provided for review once processed by the peer review committee. The reports indicated: 1)-BDDS report dated 10/5/20 indicated, "[Client #1] reported to staff that on 10/4/20 while [client #3] was having behaviors, staff [staff #7] choked [client #3]. [Client #1] reported that [staff #7] told [client #1] not to tell anyone". -BDDS report dated 10/4/20 indicated, "It was reported [client #3] was agitating [client #1] about [client #1's] broken glasses. Staff asked [client #3] to mop the floor to redirect [client #3]. [Client #3] kicked over the mop bucket and attempted to hit staff. Staff initiated one-man YSIS (You're Safe I'm Safe) for 12 minutes with breaks every 3 minutes until [client #3] calmed. [Client #3] began to hit staff again. Staff initiated one-man YSIS for 30 seconds to escort [client #3] to his room. [Client #3] then began to hit staff and staff initiated one-man YSIS for 3 minutes. [Client #3] attempted to leave assigned area and staff verbally		Policy and disciplinary action will be given if the policy is not followed. Area Supervisor and Residential Manager will ensure that the Abuse, Neglect, and Exploitation Policy is followed. Monitoring of ANE will be done by The Program Manager, Area Supervisor, and Residential Manager to ensure all incidents of possible abuse, neglect, and exploitation are reported to the QA department. 2.The facility will ensure the entry chime feature on the permeant security system is operational, in the event of a malfunction a temporary door chime device will be used until repair will occur. 3.Staff will call 844-RESCARE to schedule a service call with Koorsen Fire and Security to repair the permeant system. 4.In the event of a system malfunction Koorsen Fire and Security will be contacted to inspect and test the Alarm System to ensure the audible alerts were functioning properly. The Program Manager received instructions on reset and testing from Koorsen. 5.Instructions for testing and resetting the security system was developed by Koorsen and staff trained on the procedure, a daily testing schedule was posted in the home by the Program Manager.	

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	redirected [client #3] multiple times. [Client #1] then entered [client #3's] room and hit [client #3] in the eye and was hitting [client #3's] head on the wall. Staff initiated one-man YSIS on both clients to separated (sic) the two. [Client #1] was directed to the other side of the house. [Client #3] attempted to leave assigned area again and staff initiated one-man YSIS for 30 seconds to escort [client #3] back to his room. Nurse did skin assessment on [client #3] and found that [client #3] sustained a ½ inch bruise under his right eye, a 2 inch scratch on his right side, a ¾ inch bruise on the right side of the chest, four ½ inch bruises on right arm, a ½ inch bruise on the left arm, a 1 inch bruise on the left side of neck, and swelling and redness on the right ankle. [Staff #7] and [staff #11] have been placed on administrative leave pending investigation". On 10/22/20 at 6:11 PM, the QAM provided the requested investigations for the 10/4/20 and 10/5/20 incidents. The investigation summaries indicated: The investigation summary (10/4/20 incident) dated 10/6/20 through 10/12/20 indicated, "An investigation was initiated when it was reported [staff #7] and [staff #11], DSPs (Direct Support Professionals) watched [client #1] hit [client #3] in the face and hit [client #3's] head against the wall several times. In addition, it was reported [staff #7] placed [client #3] in a choke hold. Conclusion: Substantiated, [staff #7] and [staff #11] watched [client #1] hit [client #3] and hit [client #3's] head against the wall. Substantiated, [staff #7] placed [client #3] in a choke hold. Determined [client #3] sustained injuries to his head/neck when [client #1] hit him in the face and hit [client #3's] head on the wall repeatedly, and [client #3] sustained injuries to his ankle and back when he slipped and		6.Staff will ensure exterior doors positively latch if there is a malfunction preventing an exterior door from remaining closed staff will contact 844-RESCARE and schedule a work order. Persons Responsible: Executive Director, Program Manager, Koorsen Fire and Security, Quality Assurance, Area Supervisor, Director of Nursing, Nurse, Behavior Clinician, QIDP, Residential Manager, and DSP.	

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	fell on pavement. Unable to determine how [client #3] sustained the other injuries but it is likely they occurred during his attempted elopement". The investigation summary (10/5/20 incident) dated 10/7/20 through 10/15/20 indicated, "An investigation was initiated when [client #1] reported on 10/6/20, [staff #7] hit him in the stomach after [client #1] told [staff #7] he would tell someone that [staff #7] had choked [client #3]. Factual Findings: Three employees state [client #1] told them [staff #7] hit [client #1] in the stomach when [client #1] said he was going to report an incident. [Staff #7] denies hitting [client #1]. BSP (Behavior Support Plan) for [client #1] dated 7/8/20 does not include fabrication as a behavior. Conclusion: It is unable to be determined if [staff #7] hit [client #1] in the stomach. Recommendations: [Staff #7] termed (termination) for unrelated incident ...". -BDDS report dated 8/26/20 indicated, "It was reported [client #3] was put in safety protocol due to attempting to harm himself. Staff noticed bruising on right upper inner arm. [Client #3] told staff the bruising had been there for a few days. Nurse did skin assessment and noted softball size red/purple dark purple bruise with no swelling. [Client #3] reported to Nurse that he had a lot of behaviors earlier and had been put in a lot of holds. [Client #3] also stated staff [staff #7] had [client #3] by the arms and could not control [client #3], so [staff #7] grabbed [client #3] by the throat to calm [client #3] down. Nurse assessment shows no marks to [client #3's] throat. Staff [staff #7] has been placed on administrative leave pending investigation". Investigation summary dated 8/27/20 through 9/2/20 indicated, "Conclusion: Unsubstantiated [staff #7] placed his hand on [client #3's] throat			

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	during YSIS to restrain [client #3]". On 10/23/20 at 8:08 AM, the Quality Assurance Manager (QAM) forwarded an incident affecting client #3 that was discovered as a missed incident reported to BDDS, but shared to ensure the survey process had all incidents as requested. This incident report was reviewed on 10/23/20 at 9:05 AM and indicated: -BDDS report dated 9/22/20 indicated, "During an unrelated investigation, it was reported [client #3] engages in a behavior of stripping his clothes off to his boxers then states staff makes him do it. It was reported [staff #12], DSP makes [client #3] strip his clothes off to his boxers". Investigation summary reviewed 10/26/20 at 2:15 PM dated 10/7/20 through 10/14/20 indicated, "Introduction: An investigation was initiated when, during an unrelated investigation, reports were made that [client #3] strips down to his underwear. [Staff #12] was placed on administrative leave pending investigation. Conclusion: It is substantiated [staff #12] told [client #3] to take his clothes off. It is substantiated the incident was reported to management (Area Supervisor). Recommendations: Term (termination) [staff #12]. Additional information needed for determination on [Area Supervisor]...". 2)-BDDS report dated 8/17/20 indicated, "It was reported [client #3] was in his room when BC (Behavior Clinician) went to check on [client #3] due to [client #3] being agitated over not being able to play basketball due to previous behaviors. [Client #3] could not be located in or around the home. Staff called 911 for police assistance in locating [client #3]. Staff was told by police that a			

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	police officer had [client #3] with him. Staff met police office to transport [client #3] back to the group home. [Client #3] was out of line of sight of staff for 20 minutes ...". Investigation summary dated 8/18/20 through 8/24/20 indicated, "Factual Findings: [Client #3] eloped from the group home at approximately 2:00 PM and was located by police approximately 20 minutes later. Door on office side of the group home is not latching fully and will not sound the alarm if the door is not properly latched. Two staff and BC (Behaviorist) in the office doing paperwork at the time of elopement. One of two staff sitting in the doorway of the office where he could visually monitor [client #3's] bedroom door. Conclusion: It is determined the door alarm was functioning properly at the time [client #3] left the home but did not sound because the door was not fully latched". On 10/21/20 at 2:14 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM stated, "It was substantiated. The peer review needed more information". The QAM indicated staff #7 remained suspended as the peer review committee gathered more information in preparation for termination of staff #7's employment and stated, "Yes, the staff (staff #7, staff #11 and staff #12) will be terminated. All staff (will be) retrained on reporting, the BSPs and You're Safe and I'm Safe". The QAM was asked about injuries client #3 had sustained from the alleged client to client incident with client #1 and the investigation could not determine all sources of client #3's injuries. The QAM indicated a pattern of abuse had been determined. The QAM was then asked about client #3's elopement. The QAM indicated the investigation			

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	determined client #3 had eloped from the home. The QAM was asked to review client #3's interview response from the investigation, "I was sitting outside when I decided to take off running. The staff did not know I was outside because the door alarm did not go off. I got to the end of the street then took off down [highway]. I got a ride from a man that took me about half way to [city] then I got a ride from another man that took me to [restaurant] to get something to drink. I left [restaurant] and walked to the [name] store. I went in and asked to sit in a chair inside the store. I sat there for a little while and the police showed up. I walked outside with the police and stayed with the police until the staff showed up". The QAM was asked if the location where police found client #3 was in the neighboring city client #3 had indicated (8.5 miles by Google maps) and stated, "Correct". The QAM was asked if it would be true client #3 could not walk that distance where police found him in a 20 minute timeframe and stated, "Correct". The QAM was asked if the investigation confirmed client #3's interview statement of traveling by two car rides as a factual finding of the investigation and stated, "You're right, it doesn't state that. That's a reasonable conclusion". The QAM was then asked to review the investigation's reconciliation of fact finding and the relevance of a nonfunctioning door alarm, staff's line of sight of client #3's bedroom in comparison to client #3's interview statement which indicated "I was sitting outside when I decided to take off running". The QAM indicated the factual finding of a staff sitting in the office doorway where client #3's bedroom could be monitored would not be relevant, nor could client #3 go past staff without them seeing client #3 going to the door to elope if client #3 was not			

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	already outside of the home prior to deciding to elope and stated "Right". The QAM was asked about the implementation of the Abuse, Neglect, Exploitation and Violation of an Individual's Rights (ANE) policy. The QAM indicated the policy was in the process of being revised to include staff immediately reporting ANE allegation to the Quality Assurance department rather than the Program Manager. The QAM indicated the change would allow staff more management staff to contact immediately because the department was composed of 3 staff rather than one person to contact. The QAM indicated the ANE policy should be implemented at all times. On 10/22/20 at 2:17 PM, the Program Manager (PM) was interviewed. The PM was asked about a pattern of abuse toward client #3 and client #1 being hit in order to ensure he would not report staff choking of client #3 and stated, "Staff (staff #7, staff #11 and staff #12) will be terminated. [Staff #7] will be terminated. It has happened, but not official yet (being processed through peer review). It has to go through corporate, the Adjudication process and notified through the HR (Human Resources) department". The PM was asked if the investigation documentation was available for review and stated, "I don't know. They (peer review) have to be close. They had additional questions and why it's taking so long. It did not change the outcome". The PM was asked what corrective measures were put into place and stated, "There will be additional oversight by the Qualified Intellectual Disability Professional, training for ANE (Abuse, Neglect and Exploitation) reporting, the key was more additional oversight".			

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	The PM was asked about client #3's elopement. The PM indicated client #3 had eloped and was gone for 20 minutes. The PM was asked how client #3 had traveled so far in the amount of time and indicated client #3 "had hitch hiked". The PM was asked what corrective measures were put into place and stated, "There was a door alarm or time system that failed. We talked to the provider to fix it. [Client #3] was able to take advantage of the situation. We're also talking with the provider about a second notification on the gate. It would be a second notification". The PM was asked if staff choking client #3 was abuse and stated, "Yes". The PM was then asked if client #3's elopement was considered neglect per the policy and stated, "I think it is. I should verify, but I would think that would be considered neglect under our policy". On 10/23/20 at 9:28 AM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the investigation determination for the 9/22/20 incident. The QAM indicated the investigation had been substantiated and stated, "Yes, we did substantiate [staff #12] did it". The QAM indicated the investigation would recommend termination. The QAM indicated the peer review committee was processing the investigation findings. The QAM was asked about a pattern of abuse and how the lack of corrective measures failed to prevent the abuse from occurring and stated, "Sure, I understand. I can see that and it makes sense". On 10/21/20 at 2:42 PM, the 7/10/19 Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights policy was reviewed. The policy indicated, "ResCare staff actively advocate for the rights and safety of all individuals. All			

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	allegations or occurrences of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare, local, state and federal guidelines ... ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights". 9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 19 incidents affecting client #3, the facility failed to thoroughly investigate client #3's elopement to determine appropriate corrective measures and recommendation to ensure the supervision of client #3. Findings include: On 10/20/20 at 10:54 AM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying investigation summary was completed. The reports indicated: -BDDS report dated 8/17/20 indicated, "It was reported [client #3] was in his room when BC (Behavior Clinician) went to check on [client #3] due to [client #3] being agitated over not being able to play basketball due to previous behaviors. [Client #3] could not be located in or around the home. Staff called 911 for police assistance in locating [client #3]. Staff was told by police that a police officer had [client #3] with him. Staff met	W 0154	1.The Quality Assurance Department will ensure all investigations are completed in accordance with the policies of ResCare, local, state, and federal guidelines. 2.The Quality Assurance Department will be retrained by the Quality Assurance Manager on the local, state, and federal guidelines for investigations of ANE. 3.The Facility will retrain staff on the Abuse, Neglect, and Exploitation Policy and disciplinary action will be given if the policy is not followed. Area Supervisor and Residential Manager will ensure that the Abuse, Neglect, and Exploitation Policy is followed. Monitoring of ANE will be done by The Program Manager, Area Supervisor, and	11/25/2020

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	police office to transport [client #3] back to the group home. [Client #3] was out of line of sight of staff for 20 minutes ...". Investigation summary dated 8/18/20 through 8/24/20 indicated, "Factual Findings: [Client #3] eloped from the group home at approximately 2:00 PM and was located by police approximately 20 minutes later. Door on office side of the group home is not latching fully and will not sound the alarm if the door is not properly latched. Two staff and BC (Behaviorist) in the office doing paperwork at the time of elopement. One of two staff sitting in the doorway of the office where he could visually monitor [client #3's] bedroom door. Conclusion: It is determined the door alarm was functioning properly at the time [client #3] left the home but did not sound because the door was not fully latched". On 10/21/20 at 2:14 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about client #3's elopement. The QAM indicated the investigation determined client #3 had eloped from the home. The QAM was asked to review client #3's interview response from the investigation, "I was sitting outside when I decided to take off running. The staff did not know I was outside because the door alarm did not go off. I got to the end of the street then took off down [highway]. I got a ride from a man that took me about half way to [city] then I got a ride from another man that took me to [restaurant] to get something to drink. I left [restaurant] and walked to the [name] store. I went in and asked to sit in a chair inside the store. I sat there for a little while and the police showed up. I walked outside with the police and stayed with the police until the staff showed up". The QAM was asked if the location where police found client #3 was in the		Residential Manager to ensure all incidents of possible abuse, neglect, and exploitation are reported to the QA department. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, Quality Assurance, Human Resources Manager, Executive Director.	

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	neighboring city client #3 had indicated (8.5 miles by Google maps) and stated, "Correct". The QAM was asked if it would be true client #3 could not walk that distance where police found him in a 20 minute timeframe and stated, "Correct". The QAM was asked if the investigation confirmed client #3's interview statement of traveling by two car rides as a factual finding of the investigation and stated, "You're right it doesn't state that. That's a reasonable conclusion". The QAM was asked to review the investigation's reconciliation of fact finding and the relevance of a nonfunctioning door alarm, staff's line of sight of client #3's bedroom in comparison to client #3's interview statement which indicated "I was sitting outside when I decided to take off running". The QAM indicated the factual finding of a staff sitting in the office doorway where client #3's bedroom could be monitored would not be relevant, nor could client #3 go past staff without them seeing client #3 going to the door to elope if client #3 was not already outside of the home prior to deciding to elope and stated "Right". The QAM indicated incidents should be thoroughly investigated. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 3 of 22 incidents affecting clients #1 and #3, the facility failed to develop and implement effective corrective measures to prevent a pattern of abuse. Findings include:	W 0157	1.Upon conclusion of investigations staff found in violation of ANE have been terminated and marked “not rehireable” in ResCare Human Resource System. 2.The Program Manager filled a	11/25/2020

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	15G745	A. BUILDING 00 B. WING	10/26/2020

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	On 10/20/20 at 10:54 AM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying investigation summaries was completed. Upon the request, the Quality Assurance Manager (QAM) indicated two investigations were in peer review and being processed for further questions and procedures. The QAM indicated the two investigations would be provided for review once processed by the peer review committee. The reports indicated: -BDDS report dated 10/5/20 indicated, "[Client #1] reported to staff that on 10/4/20 while [client #3] was having behaviors, staff [staff #7] choked [client #3]. [Client #1] reported that [staff #7] told [client #1] not to tell anyone". -BDDS report dated 10/4/20 indicated, "It was reported [client #3] was agitating [client #1] about [client #1's] broken glasses. Staff asked [client #3] to mop the floor to redirect [client #3]. [Client #3] kicked over the mop bucket and attempted to hit staff. Staff initiated one-man YSIS (You're Safe I'm Safe) for 12 minutes with breaks every 3 minutes until [client #3] calmed. [Client #3] began to hit staff again. Staff initiated one-man YSIS for 30 seconds to escort [client #3] to his room. [Client #3] then began to hit staff and staff initiated one-man YSIS for 3 minutes. [Client #3] attempted to leave assigned area and staff verbally redirected [client #3] multiple times. [Client #1] then entered [client #3's] room and hit [client #3] in the eye and was hitting [client #3's] head on the wall. Staff initiated one-man YSIS on both clients to separated (sic) the two. [Client #1] was directed to the other side of the house. [Client #3] attempted to leave assigned area again and staff initiated one-man YSIS for 30 seconds to escort [client #3] back to his room. Nurse did skin assessment on [client #3] and found that [client		police report on behalf of Client #1 and Client #3 with the Clark County Sheriffs Department after investigations confirmed the presence of ANE POLICE REPORT # 2020-36912 3.The Residential Manager, QIDP, Area Supervisor, and Program Manager will monitor home activities and client interactions daily to ensure there are no suspected ANE/Mistreatments of clients in the Facility. 4.The Governing Body will retrain staff in the Facility on the Abuse, Neglect, and Exploitation Policy and disciplinary action will be given if the policy is not followed. Area Supervisor and Residential Manager will ensure that the Abuse, Neglect, and Exploitation Policy is followed. Monitoring of ANE will be done by The Program Manager, Area Supervisor, and Residential Manager to ensure all incidents of possible abuse, neglect, and exploitation are reported to the QA department. 5.The governing body will ensure recommendations/corrective measures are implemented through training of Program Manager, Human Resource Specialist, Area Supervisor, BC, Residential Manager, QIDP as recommended from the Peer Review Process.	

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	#3] sustained a ½ inch bruise under his right eye, a 2 inch scratch on his right side, a ¾ inch bruise on the right side of the chest, four ½ inch bruises on right arm, a ½ inch bruise on the left arm, a 1 inch bruise on the left side of neck, and swelling and redness on the right ankle. [Staff #7] and [staff #11] have been placed on administrative leave pending investigation". On 10/22/20 at 6:11 PM, the QAM provided the investigations for the 10/4/20 and 10/5/20 incidents. The investigation summaries indicated: The investigation summary (10/4/20 incident) dated 10/6/20 through 10/12/20 indicated, "An investigation was initiated when it was reported [staff #7] and [staff #11], DSPs (Direct Support Professionals) watched [client #1] hit [client #3] in the face and hit [client #3's] head against the wall several times. In addition, it was reported [staff #7] placed [client #3] in a choke hold. Conclusion: Substantiated, [staff #7] and [staff #11] watched [client #1] hit [client #3] and hit [client #3's] head against the wall. Substantiated, [staff #7] placed [client #3] in a choke hold. Determined [client #3] sustained injuries to his head/neck when [client #1] hit him in the face and hit [client #3's] head on the wall repeatedly, and [client #3] sustained injuries to his ankle and back when he slipped and fell on pavement. Unable to determine how [client #3] sustained the other injuries but it is likely they occurred during his attempted elopement". The investigation summary (10/5/20 incident) dated 10/7/20 through 10/15/20 indicated, "An investigation was initiated when [client #1] reported on 10/6/20, [staff #7] hit him in the stomach after [client #1] told [staff #7] he would tell someone that [staff #7] had choked [client #3]. Factual Findings: Three employees state [client		Persons Responsible: Executive Director, Program Manager, Human Resource, Quality Assurance, Area Supervisor, Behavior Clinician, QIDP, Residential Manager, and DSP.	

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	#1] told them [staff #7] hit [client #1] in the stomach when [client #1] said he was going to report an incident. [Staff #7] denies hitting [client #1]. BSP (Behavior Support Plan) for [client #1] dated 7/8/20 does not include fabrication as a behavior. Conclusion: It is unable to be determined if [staff #7] hit [client #1] in the stomach. Recommendations: [Staff #7] termed (termination) for unrelated incident ...". -BDDS report dated 8/26/20 indicated, "It was reported [client #3] was put in safety protocol due to attempting to harm himself. Staff noticed bruising on right upper inner arm. [Client #3] told staff the bruising had been there for a few days. Nurse did skin assessment and noted softball size red/purple dark purple bruise with no swelling. [Client #3] reported to Nurse that he had a lot of behaviors earlier and had been put in a lot of holds. [Client #3] also stated staff [staff #7] had [client #3] by the arms and could not control [client #3], so [staff #7] grabbed [client #3] by the throat to calm [client #3] down. Nurse assessment shows no marks to [client #3's] throat. Staff [staff #7] has been placed on administrative leave pending investigation". Investigation summary dated 8/27/20 through 9/2/20 indicated, "Conclusion: Unsubstantiated [staff #7] placed his hand on [client #3's] throat during YSIS to restrain [client #3]". On 10/23/20 at 8:08 AM, the Quality Assurance Manager (QAM) forwarded an incident affecting client #3 that was discovered as a missed incident reported to BDDS, but shared to ensure the survey process had all incidents as requested. This incident report was reviewed on 10/23/20 at 9:05 AM and indicated:			

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	-BDDS report dated 9/22/20 indicated, "During an unrelated investigation, it was reported [client #3] engages in a behavior of stripping his clothes off to his boxers then states staff makes him do it. It was reported [staff #12], DSP makes [client #3] strip his clothes off to his boxers". Investigation summary reviewed 10/26/20 at 2:15 PM dated 10/7/20 through 10/14/20 indicated, "Introduction: An investigation was initiated when, during an unrelated investigation, reports were made that [client #3] strips down to his underwear. [Staff #12] was placed on administrative leave pending investigation. Conclusion: It is substantiated [staff #12] told [client #3] to take his clothes off. It is substantiated the incident was reported to management (Area Supervisor). Recommendations: Term (termination) [staff #12]. Additional information needed for determination on [Area Supervisor]...". On 10/21/20 at 2:14 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the investigation determination for the 10/4/20 and 10/5/20 incidents. The QAM stated, "It was substantiated. The peer review needed more information". The QAM indicated staff #7 remained suspended as the peer review committee gathered more information in preparation of employment and stated, "Yes, the staff (staff #7, staff #11 and staff #12) will be terminated. All staff (will be) retrained on reporting, the BSPs and You're Safe and I'm Safe". The QAM was asked about injuries client #3 had sustained from the alleged client to client incident with client #1 and the investigation could not determine all sources of client #3's injuries. The QAM indicated corrective measures to ensure a pattern of abuse between 8/26/20 when client #3			

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	first alleged he had been grabbed by the throat by staff #7 to 10/4/20 incident reported by client #1 had not occurred. The QAM indicated the 8/26/20 alleged incident could not be substantiated. On 10/23/20 at 9:28 AM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the investigation determination for the 9/22/20 incident. The QAM indicated the investigation had been substantiated and stated, "Yes, we did substantiate [staff #12] did it". The QAM indicated the investigation would recommend termination. The QAM indicated the peer review committee was processing the investigation findings. The QAM was asked about a pattern of abuse and how the lack of corrective measures failed to prevent the abuse from occurring and stated, "Sure, I understand. I can see that and it makes sense". 9-3-2(a)			
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, interview and record review for 4 of 4 clients living in the group home (#1, #2, #3 and #4), the facility failed to ensure there was a sufficient number of direct care staff working each shift in order to manage and supervise the clients.	W 0186	1.The Program Manager will conduct a daily meeting to project needs and plan coverage for open shifts. All Area Supervisors in the New Albany Program and All ESN Residential Managers will attend if	11/25/2020

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	Findings include: Observation was completed on 10/20/20 from 7:30 AM to 9:21 AM. The observation indicated the following: -At 7:30 AM, staff #4 answered the door. Staff #4 completed the infection control questionnaire and took the surveyor's temperature upon entry to the home. Staff #1 was working in the kitchen. Client #1 was in his bedroom, client #2 was in the living area watching television, client #3 was in the dining room area and client #4 was in his bedroom with music playing and the door shut. Both staff #1 and staff #4 were wearing facial coverings. -At 7:50 AM, staff #4 was assisting client #3 with his morning routine. Client #3 was eating a bowl of cereal when staff #4 stated to him, "Make sure you weigh yourself after breakfast". Staff #4 was asked how things were going and indicated the clients were doing good. Staff #4 was asked how staffing was going and stated, "It would help if the staff would come in (when scheduled to work)". -At 7:54 AM, client #2 was riding an exercise bike. Staff #1 had assisted client #2 with working of the pedals and standing near client #2 as he exercised. -At 7:56 AM, staff #1 was asked how things were going at the home. Staff #1 indicated no one had been sick and stated, "No one has been sick since that covid thing". Staff #1 was asked what the staffing schedule was and indicated they do 12 hours and 16 hour shifts. Staff #1 was asked if the clients were awake when would the day shift schedule began and indicated 6 AM and stated, "There should be 3 on shift. The roster at night is 2. That is for 10 PM to 6 AM. I think [Nurse] is on		available. 2.ResCare New Albany Operation has brought in staff from out of town and, increased wages for DSPs outside of the ESN System including paid travel time bonuses, and mileage. 3.Human Resources has made filling ESN Open shifts a priority, this will continue until vacancies are filled. 4.The Area Supervisor will coordinate with ESN Residential Managers to ensure shift coverage. The unfilled shift will be reported to the Program Manager. Persons Responsible: Program Manager, Human Resource, Quality Assurance, Area Supervisor, Behavior Clinician, QIDP, Residential Manager, and DSP.	

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	her way. She should be here any minute". -At 8:06 AM, the Nurse arrived at the home. -At 8:19 AM, staff #1 knocked on client #1's door and provided verbal prompting to do chores. -At 8:21 AM, client #1 came out the dining area and wiped off the dining room table. Staff #1 assisted client #1 by spraying disinfectant on the table and client #1 would wipe the table surface with a rag. -At 8:24 AM, staff #8 entered the home. Staff #8 was asked if she worked at the home and stated, "I came in to get some paper. I work at house #1 (neighboring home)". Staff #8 took her temperature and was wearing a facial covering. Staff #8 remained at the home assisting clients #1, #2, #3 and #4 along with staff #1 and staff #4 for the remained of the observation period. On 10/23/20 at 11:57 AM, the undated Reimbursement Guidelines for the 24 hour Extensive Support Needs Residences were reviewed. The record indicated, "Individuals living in residences under this category must be supervised at all times and the staffing pattern at full capacity should be a minimum of: three (3) staff on the day shift; three (3) staff on the evening shift; and two (2) staff on the night shift". During observation the home was staffed by staff #1 and staff #4 from 7:30 AM to 8:24 AM when staff #8 arrived. On 10/22/20 at 12:07 PM, the Program Manager (PM) was interviewed. The PM was asked for 30 days of staff time sheet records to review. The PM indicated he would contact Human Resources to gather the requested information and would			

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	require further follow up. On 10/22/20 at 7:10 PM, the Program Manager provided further follow up and indicated no time sheet documentation would be available for review. The PM stated, "I failed to get the time sheet for you. We failed and have been. I don't have it and won't before [Human Resource Contact] gets back. We're in a staffing crisis from staffing suspension". The PM indicated the time sheets would indicate a lack of staffing coverage if the documentation was able to be provided for review. 9-3-3(a)			