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	08/17/2020

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

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W 0000 Bldg. 00	This visit was for a post certification revisit (PCR) to the investigation of complaint #IN00323414 completed on 4/9/20. This visit was in conjunction with the investigation of complaint #IN00328228. This visit included the Covid-19 focused infection control survey. Complaint #IN00323414: Not corrected. Survey dates: 7/9/20, 7/10/20, 8/13/20, 8/14/20 and 8/17/20 Facility Number: 011663 Provider Number: 15G745 AIMS Number: 200902020 This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 8/25/20.	W 0000		
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 1 incident report of staff mistreatment affecting client B, the facility failed to conduct a thorough investigation into client B's alleged mistreatment during a behavioral episode. Findings include: On 7/9/20 at 3:48 PM, a review of the Bureau of Developmental Disabilities Services (BDDS)	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 Executive Director on the	09/16/2020

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

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	incident reports and accompanying Investigative Summaries was completed. The reports indicated: BDDS report dated 7/7/20 indicated, "It was reported [client B] told staff that during the use of YSIS (You're Safe, I'm Safe) on July 6, 2020, staff [staff #3] tied his hands and ankles together using the sleeves of his sweatshirt and his sweatpants. [Client B] showed staff a ½ inch bruise on his left forearm and a ½ inch bruise on the top of his right hand". Investigative summary dated 7/7/20 through 7/10/20 indicated, "[Client B] stated, "I had been put in holds before [staff #3] tied me up. [Staff #3], [staff #8] and [staff #7] did holds on me. After the first hold, [staff #7] left the room. Then after a couple more holds, [staff #8] left the room and [staff #3] told me to 'sit down or I will tie you up'. Then he (staff #3) tied me up. [Staff #3] then left the room for 5-10 minutes while I was still tied up on the bed. I was yelling and screaming, 'get me out of it'. Nobody checked on me while I was screaming but [staff #3] yelled 'shut up'. [Staff #3] did come in my room and tell me to shut up and told me not to say a word or else. [Staff #3] then left my room again for about 5 minutes then he (staff #3) came back in and untied me". During the investigation interview with client B, the investigation found detail that would lead to clarifying questions in subsequent interviews. The investigation did not reconcile facts alleged by client B's interview through subsequent interviewing: 1) Client B indicated staff #3 had stated, "sit down or I will tie you up". The facility's investigation did not indicate if anyone had heard staff #3 state to client B "sit down or I will tie you up".		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 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, Area Supervisor, Residential Manager, Quality Assurance, Human Resources Manager, Executive Director.	

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2) Client B indicated he was left in his room for approximately 5-10 minutes while tied up on the bed and then again a second time for an additional 5 minutes. The facility's investigation did not indicate if client B was alone in his room or if anyone had seen staff #3 outside of client B's room during the time client B alleged he had screamed and yelled from his room.

3) Client B indicated he had yelled "get me out of it". The facility's investigation did not indicate if anyone else had heard client B make the statement "get me out of it".

4) Client B indicated staff #3 had stated, "shut up". The facility's investigation did not indicate if anyone else had heard staff #3 make the statement "shut up" to client B.

Staff #3's investigation interview indicated, "When I arrived at work, [client B] was in his room. A short time later, [client B] came out of his room and sounded like he was angry. [Client B] was mad because things were not going his way. [Client B] attempted to elope, and I started YSIS and told [client B] to count to ten. [Staff #8] came to assist in YSIS when [client B] continued to fight. We were in [client B's] room during the use of YSIS and asking him to count to ten. [Staff #7] came in to talk to [client B], but [client B] did not calm down. YSIS was used again and [client B] did calm down and was fine the rest of the night. [Client B] apologized to me and told me he needed help and he wants to change. I did not tie [client B] up. [Client B] was never tied up. YSIS was done a total of 3 times with [client B]".

The facility's investigation failed to verify through interview with staff #3 if client B had been left

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	alone in his room and statements made during the behavioral incident. Staff #3 was not asked if he told client B to "sit down or I will tie you up" or if he had told client B to "shut up". Staff #8's investigation interview indicated, "[Client B's] behaviors started before I arrived to work. When I got there, [client B] and [staff #7] were down at the mailbox because [client B] had tried to elope. I tried to calm [client B] down. When we got back to the house, I removed items from [client B's] room per his plan due to behaviors. [Client B] pushed and hit me, and [staff #7] came in to assist in removing items. [Client B] wanted his blankets back, but I told him no. [Staff #3] arrived to work and tried to calm [client B], but [client B] would not calm down. [Staff #3] began one-man YSIS for 2-3 minutes then I assisted, making it two-man YSIS. [Client B] fought the whole time he was in YSIS. We told him to count to 10 and we would let him go and we did let him go. When [client B] calmed and counted to 10, [staff #3] and I let him go. I gave [client B's] glasses back to him. No one tied [client B's] arms and legs. I held [client B's] wrists in an approved move during YSIS. No one tied [client B] up. I did hear client B yell 'get me the [expletive] out of here', but he always says that because he wants out of ResCare". The facility's investigation failed to identify if staff #8 heard staff #3 make the statement "sit down or I will tie you up" or "shut up". Staff #8's interview did not indicate if client B had been left alone during the behavioral incident or if staff #8 had seen staff #3 outside of client B's bedroom during the time when client B alleged he had screamed and yelled with no response. On 7/9/20 at 6:37 PM client B was interviewed.			

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	Client B stated, "On Monday I was being hog tied. We had a staff [staff #3], who was not in a good mood. He had some problem. He said he wanted me to go to my room. I had a problem with that. He said he was going to hog tie me and then done it. He said he was going to wrap a ring around my neck. He put my arms behind my back. I did try to run. He was fighting me. I used all my strength to get back into my room and that's when the hog tie started". Client B was asked where this occurred and stated, "They hog tied me in my room". Client B gestured to show areas where bruising had occurred from the incident, but the marks had faded away and were no longer visible. Client B stated, "He (staff #3) grabbed my arms, threw me on the bed, I kept saying get off me, get off me. He then put me in a hog tie with my shirt. I kept kicking and he used the end of my pants to tie my legs. I don't want to be here". On 7/10/20 at 1:10 PM, the Qualified Intellectual Disability Professional (QIDP) was interviewed. The QIDP indicated client B was the person that initially told him about being tied up. The QIDP indicated staff #3 had been suspended. The QIDP stated, "He (staff #3) has no history (mistreatment of clients). In fact, he was the one that turned in another staff for screaming". On 8/13/20 at 2:40 PM, the investigator was interviewed. The investigator was asked if specific statements client B had identified during interview of being left alone on two occasions had been reconciled through subsequent interviewing. The investigator stated, "I asked other staff and he (client B) said things. He (client B) made it difficult by giving me 3 or 4 different stories. I could not tell if he was going into the past. I would ask and tell him to go with only answering my questions if I was going to be able to help him. He (client B)			

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	was wishy washy. No one saw it (tied up). No one heard him (client B) say to untie him. People did hear him (client B) say get me out of here. No matter what I talk about with him, he always says get me out of here, meaning the ESN (Extensive Support Needs) home". The investigator was asked if staff #3 left client B in his room as client B had alleged and stated, "I think [staff #3] did leave once, but he had calmed down". The investigator indicated she would return to the office on the following day to review the investigative notes and provide more feedback. On 8/14/20 at 10:14 AM, the investigator provided further follow up. The investigator stated, "I looked at my notes, I don't have anything (staff #3 leaving the room while client B screamed and yelled) in my notes. I think we were more focused on if anyone had seen him (client B) tied up". On 8/14/20 at 1:20 PM the Quality Assurance Manager (QAM) was interviewed. The QAM indicated client B's alleged statements of events and being left alone in his room while screaming and yelling should have been reconciled through subsequent interviewing and stated, "We probably made a mistake being too focused on [client B] being tied up". Confidential interview #1 was conducted. When asked if client B provided detail to the alleged incident, confidential interview #1 stated, "Yeah it happened, he told me details with the sweatshirt. Had his arms up. It happened. I believe him on that story. There are times when you can hear a story and not believe any of it. He has told the same story to me as you". This federal tag relates to complaint #IN00323414.			

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	This deficiency was cited on 4/9/20. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-2(a)			