STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G127	A. BUILDING 00 B. WING	11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	1031 WEST ST NEW ALBANY, IN 47150

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00328279. This visit included a Covid-19 focused infection control survey. Complaint #IN00328279: Substantiated, Federal and state deficiency related to the allegation(s) is cited at W149. Dates of Survey: 11/19/20, 11/20/20 and 11/23/20. Facility Number: 000664 Provider Number: 15G127 AIMS Number: 100234310 This deficiency also reflects state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 and #39778 on 12/4/20.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 5 of 12 incident reports reviewed affecting client A, the facility failed to implement its policy and procedures for prohibiting abuse, neglect, exploitation, mistreatment or violation of an individual's rights in regard to a pattern of client A's attempted elopements and self-injurious harm. Findings include: Observation was conducted on 11/19/20 from 4:50 PM to 5:51 PM. Client A was not at the home due	W 0149	The Program Manager will ensure the Area Supervisor and Residential Manager 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.	12/23/2020

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

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	to an inpatient placement for behavioral related incidents. The Qualified Intellectual Disabilities Professional (QIDP) indicated client A could return home before the holiday and stated, "He (client A) might be able to come home next week". On 11/19/20 at 3:12 PM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying Investigative Summaries was completed. The reports indicated: -BDDS report dated 5/20/20 indicated, "It was reported [client A] became agitated when his therapy appointment was canceled due to Covid-19 quarantine. Staff was unable to verbally redirect [client A], and [client A] left the property. Police were notified for assistance in locating [client A]. Program Manager was also notified and began trying to locate [client A]. When Program Manager located [client A], Police were with [client A] and (sic) ambulance transported [client A] to [hospital] for ER (emergency room) evaluation. [Client A] was out of line of sight of staff for 25 minutes". Investigation summary dated 5/19/20, reviewed on 11/23/20 at 9:35 AM indicated, "[Client A] was upset that he did not get to go to therapy due to Covid-19 testing results pending. He said he was leaving. Staff tried to redirect but he left the home. He (client A) was out of staffs sight for 25 minutes... Recommendations: Staff will continue to verbally redirect with (sic) [client A] when he is upset and being aggressive. YSIS (You're Safe I'm Safe) is also in his BSP (Behavior Support Plan) and should be used during elopements, if needed". -BDDS report dated 5/22/20 indicated, "It was reported [client A] told staff that he wanted to cut		Monitoring of Corrective Action: The Program Manager, Area Supervisor and Residential Manager will ensure all incidents of possible abuse, neglect and exploitation are reported to the QA department. Follow up will be completed by QIDP. Persons Responsible: Program Manager, Area Supervisor, Residential Manager, DSP and QIDP	

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	himself and that he was having suicidal thoughts. [Client A] was transported to [hospital] for evaluation. No evaluation was completed, as [hospital] refused admittance due to Covid-19. [Client A] returned to the group home where suicide protocol was implemented. [Client A] sustained six 2 inch red marks on his right hand from an x box game case that [client A] used to attempt to cut himself". Investigation summary dated 5/21/20, reviewed on 11/23/20 at 9:35 AM indicated, "[Client A] had small cuts from using an Xbox controller on his right hand...When was the injury was noticed? [Client A] walked up to staff and asked to speak to them alone. [Client A] then told staff he wanted to cut himself. [Former staff #1] and [Former staff #2] noticed cut marks on back of [client A's] right hand". Recommendations indicated, "Staff need to provide enhanced supervision, redirect when necessary and utilize YSIS if needed". -BDDS report dated 8/6/20 indicated, "It was reported [client A] became upset due to his glasses needing fixed due to [client A] breaking them during a previous behavior. [Client A] left the house with staff following. Police were called for assistance. Police arrived and [client A] began to hit and kick the police officers. The officers subdued [client A] on the ground and handcuffed [client A]. Police transported [client A] to [hospital name] ER for evaluation. [Client A] was admitted to [hospital name] until a bed opens at [behavioral hospital] and [client A] can be transferred to [behavioral hospital]. [Client A] was not out of sight of staff until Police transported [client A] to the hospital. No injuries were reported at this time". Investigation summary dated 8/5/20 indicated,			

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	"[Client A] was upset about his glasses being broken. He left the home with staff following. Police were called to assist and the police (sic) [client A] and he became physically aggressive with the police. The police handcuffed him and took him to [hospital name] for a psych (psychiatric) assessment. No injuries were noted". -BDDS report dated 8/21/20 indicated, "It was reported [client A] was on the front porch when staff informed [client A] that it was time for medication administration. Staff noticed smoke coming from the astray and went to get water to extinguish the smoke. [Client A] told staff to leave the ashtray alone because that was his fire. [Client A] then told staff he was leaving to find drugs from a drug dealer. [Client A] began to walk down the street with staff following. [Client A] began to throw rocks and sticks at staff and (sic) running in and out of traffic. A second staff arrived in staff's car, [client A] began to hit the car with stick causing a dent in the car. Police arrived, and [client A] resisted police and hit the police car. Police officer stated that police were transporting [client A] to [hospital name] for evaluation and advised staff not to go to the hospital due to the threats [client A] was making toward staff. [Client A] has been transferred to [hospital name] for treatment. No injuries were reported from this incident. [Client A] was never out of sight of staff". Investigation summary dated 8/20/20, reviewed on 11/23/20 at 9:35 AM indicated, "[Client A] was on the back porch smoking with the other clients, he told staff that he wanted some drugs and just started walking towards the road. Staff was right behind him as he was walking down the [name] street towards [name] street south. [Client A] was picking up limbs (sic) throwing them. [Former staff			

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	#3] was walking behind him. [Staff #2] was calling 911 and [staff #1] had pulled up for shift change and was following him. He hit her car with a rock and tree limbs. The police arrived and took [client A] to [hospital name] for evaluation". Recommendations indicated, "YSIS per behavior plan HRC (Human Rights Committee) approved. Redirection. Staff present when smoking". -BDDS report dated 10/6/20 indicated, "It was reported [client A] showed staff two 3/8 inch burn marks on his right hand. The burn marks appear to be healed. [Client A] told staff that he had burned himself with a cigarette, and it had happened as a result of a suicide attempt. [Client A] cleaned the burn marks with soap and water". Investigation summary dated 10/6/20, reviewed on 11/23/20 at 9:35 AM indicated, "There are burn marks on [client A's] right hand. They are on the top of his hand". Recommendations indicated, "Staff need to continue to do an assessment of [client A] upon return from his home visits for any other SIB (Self-injurious behavior) attempts". On 11/20/20 at 11:34 AM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the pattern of client A's elopement, self-harm and the lack of implementation for the abuse, neglect, mistreatment and violation of individual rights (ANE) policy and stated, "Right, right". The QAM indicated the ANE policy should be implemented at all times and stated, "yes". On 11/20/20 at 11:52 AM, client A's record was reviewed. The record indicated the following target behaviors listed in client A's behavior support plan dated 1/30/20, "Verbal Aggression, Noncompliance, Physical Aggression, Property			

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	Destruction, Elopement, Leaving Assigned Area, Self-Injurious Behavior/Suicidal Ideation and Stealing". The target behavior Elopement for was defined as, "Any occurrence of leaving the area without staff supervision at home or in community". The target behavior Leaving the Assigned Area was defined as, "Any occurrence of leaving the area without staff permission but staff still have him (client A) within eye view". On 11/20/20 at 12:00 PM, the Program Manager (PM) was interviewed. The PM was asked about the pattern of client A's elopement, self-harm and the lack of implementation for the ANE policy and stated, "sure". The PM was asked if the ANE policy should be implemented at all times and stated, "yeah". On 11/23/20 at 9:35 AM, the Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual Rights (ANE) policy dated 7/10/19 was reviewed. The ANE policy indicated, "ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare, local, state and federal guidelines ... ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights". This federal tag relates to complaint #IN00328279. 9-3-2(a)			