STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G807	A. BUILDING 00 B. WING	12/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY ALTERNATIVES ADEPT	213 W WATER ST CENTERVILLE, IN 47330

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the investigation of complaints #IN00366881, #IN00368229, and #IN00369099. Complaint #IN00366881: Substantiated, federal/state deficiencies related to the allegation(s) are cited at W149 and W156. Complaint #IN00368229: Substantiated, federal/state deficiencies related to the allegation(s) are cited at W149, W153 and W156. Complaint #IN00369099: Unsubstantiated, due to lack of sufficient evidence. Unrelated deficiencies cited. Survey Dates: December 14, 15 and 16, 2021. Facility Number: 012632 Provider Number: 15G807 AIMS Number: 201065000 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/28/21.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on observation, record review and interview for 1 of 2 sampled clients (B), the governing body failed to exercise operating	W 0104	**CORRECTION:** *The governing body must exercise general policy, budget,*	01/15/2022

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

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	direction over the facility by not ensuring client B's recommended physical therapy appointments were scheduled and attended while waiting on approval of payment from client B's health insurance company. Findings include: An observation was conducted at the group home on 12/14/21 from 3:30 PM to 5:05 PM. Throughout the observation, client B walked with an antalgic gait (abnormal pattern of walking). At 4:15 PM, client B was interviewed. Client B indicated she had a PT (physical therapy) evaluation and she was supposed to attend PT due to her right leg being weak when she leaned over. Client B indicated she hasn't attended PT since her evaluation. Client B indicated she had a rolling walker at the group home, but it was stored in the garage. Client B showed the surveyor her rolling walker and indicated it had a specialized back rest due to her scoliosis (sideways curvature of the spine). Client B indicated she needed her walker to help keep her stable and give her a place to sit when her back starts to hurt. On 12/15/21 at 10:00 AM, client B's record was reviewed. Client B's 9/29/21 PT evaluation indicated, "Per patient she was hospitalized last May for 2.5 weeks and diagnosed with scoliosis, back pain and right LE (lower extremity) weakness. Had some PT in hospital. Was using a rollator, has one currently at the facility but is not using it. Pt (patient) complains of pain in right side of neck, low back and each hip.... PT assessment/clinical impression.... Patient is a pleasant [age/gender], presenting to OPPT (out patient physical therapy) today for screening. Pt found to have low back pain, weakness in right		*and operating direction over the facility.* Specifically: Client B has initiated physical therapy as recommended. A review of medical records indicated this deficient practice did not affect additional clients. When clients experience delays in receiving approval from insurance companies, the Area Supervisor, with assistance from the Program Manager, will submit requests to obtain initial funding for recommended medical treatment to avoid interruptions in provision of necessary supports. **PREVENTION:** · The Facility nurse will complete monthly audits of all charts and turn in the audits to the Nurse Manager for review. · The Nurse Manager will review issues revealed in audits, including potential interruptions in treatment due to insurance payment obstacles, with the Executive Director and Department heads weekly for follow-up. · The Executive Director and will follow-up with the Nurse Manager as needed to address issues raised through audits, incident reports or other concerns brought to management attention. Members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP	

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	LE. Pt required assist from therapist x 2 in the clinic to prevent a fall. Patient presents with increase in complaints of pain at rest and with activity, decrease in AROM (active assistive range of motion/how far a joint moves without assistance) of trunk extension, decreased strength and impaired balance. Pt is having difficulty with performing activities at PLOF (prior level of functioning) including normal ADLs (activities of daily living). Pt reports she self limits activity due to pain and right LE weakness. Pt prognosis is fair due to age, motivation, PLOF, PMH (past medical history) and overall co-morbidities. Pt will benefit from skilled physical therapy to address the above mentioned deficits and return patient to their highest functional level. Per caregiver who was present from the facility (Medical Coach), pt has not had any falls at the facility and she has not witnessed any near falls with bending.... Plan of care: [Client B] will return to Physical Therapy 2 time(s)/week for 6 week(s) for 12 total visits within a 90 day plan of care period...." A 12/16/21 PT record of visit form indicated, "2. Results, findings of exam: Low back pain with right lower extremity pain. 3. Diagnosis: low back pain, difficulty walking. 4. Recommendations for treatment: Come to PT and follow HEP (home exercise program) when provided. Recommend walker for sit to stand". On 12/15/21 at 11:25 AM, the LPN (Licensed Practical Nurse) was interviewed. The LPN stated, "She came to facility with it (rolling walker). Her parents said it was all psychological. It's here if she needs it, but she's never used it. She had a PT eval. Stretching exercises were recommended. There was an issue with insurance so she hasn't attended (PT).		Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that necessary medical treatment is not deferred due to delays in insurance company reimbursement approval. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, BDDS Generalist, Regional Director	

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	It is straightened out now and has an appointment coming up. She has not complained about lower back pain until she talked to you (surveyor) yesterday. She does not use the rolling walker. Recommendations for PT should have been followed even though insurance was an issue". On 12/15/21 at 11:35 AM, the MC (Medical Coach) was interviewed. The MC stated, "She came with the walker. She never had an order for it. She went to PT and he said she could use it when needed. The reason she wants it is for storage and because it is comfortable. Starting yesterday she has been complaining about her back. She hasn't complained since she moved in. It wasn't until you (surveyor) talked to her yesterday. She asked her a couple weeks ago if she could use it because it is comfortable and she needs storage. She walks, dances, runs and she has never had an issue or a need for it. She hasn't been going to PT. Her insurance is out of network and we had to get approval". On 12/15/21 at 3:25 PM, the AS (Area Supervisor), QAM (Quality Assurance Manager), QIDPM (Qualified Intellectual Disabilities Professional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed. The AS indicated client B had a rollator walker and it came with her when she moved into the group home. The AS indicated client B hasn't used the walker and she hasn't made any complaints of pain or needing it until the surveyor talked to her on 12/15/21. The QIDPM reviewed the 9/29/21 PT evaluation and indicted PT was recommended. The AS indicated there was an issue with client B's insurance so appointments were not made. The AS indicated she has an appointment Thursday (12/16/21). The QIDPM stated, "If we can't get insurance to			

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	cover it, we (Rescare) need to pay for it". The QIDPM indicated appointments should have been scheduled and attended while waiting for insurance approval. 9-3-1(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 2 of 2 sampled clients (A and B), the facility failed to implement its written policy and procedures to prevent neglect of client A in regard to two incidents of elopement and two arrests and one incident of elopement and an arrest for client B. The facility failed to report an arrest for client B to BDDS (Bureau of Developmental Disabilities Services) within 24 hours of knowledge. The facility failed to ensure the administrator reviewed the results of investigations within 5 business days. Findings include: On 12/14/21 at 12:00 PM, the facility's BDDS reports, incident reports and investigations were reviewed and indicated the following: 1a. An 11/9/21 BDDS report indicated on 11/8/21 at 5:45 PM the following incident occurred. "...On the evening of 11/8/21, [client A] became agitated after supper and went to her room. Staff followed and observed her breaking her window alarm. Staff redirected her verbally and she entered the living room, (sic) began undressing. She continued to escalate, broke the front door alarm, and exited the house,	W 0149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically: All staff will be retrained toward proper implementation of client A and client B's Behavior Support Plans. Through observation and review of incident documentation, the governing body has determined that this deficient practice did not affect additional clients. The Quality Assurance manager and QIDP Manager will coordinate with designated staff to assure that incidents meeting notification criteria are reported to the State within 24 hours, as required. Moving forward investigation summaries will include documentation of administrator notification of investigation results. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will	01/15/2022

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	accompanied by her housemate [client B]. Staff followed but quickly lost sight. Staff notified the supervisor and called the police and filed a missing person report Additional staff and supervisors arrived to assist with the search, which was coordinated by administrative staff. [Client A] and her housemate (client B) were located by police at approximately 8:00 PM, at the [city] Post Office 0.4 miles from their home. [Client A] hit and spit on police offices (sic) at the scene and she was handcuffed and transported to [name of hospital] for an emergency psychiatric evaluation. [Client A] was assessed, diagnosed with Agitation and Combative Behavior, and released to ResCare staff with no new orders. She returned home without incident. It should be noted that police officers came to the residence while [client A] was at the ER (emergency room) and informed staff that Battery charges would be filed against [client A]. Plan to Resolve: [Client A] is home and receiving emotional support from her team. She was not injured during the incident. No charges have been filed against her at the time of this report. The broken alarms have been replaced. [Client A] has a history of Property Destruction, Physical Aggression and Elopement addressed in her Behavior Support Plan. [Client A] does not have plan approved alone time and was away from staff supervision for two hours and five minutes. Staff will continue to follow the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences. [Client A's] clinician and ResCare nursing are working with [client A's] psychiatric provider to determine if acute Inpatient treatment is indicated". An 11/14/21 Investigative Summary indicated the following:		carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services, and distribute the list to administrative staff (including the Quality Assurance Manager, Program Managers, Quality Assurance Coordinators, Operations Manager, Area Supervisors, QIDP, Nurse Manager and Assistant Nurse Manager) for review and revision, as needed. The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. A tracking spreadsheet for	

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	Factual Findings: "1. Individual [client A] did not sustain injury during this incident. 2. Individual [client A] has a history of Property Destruction, Physical Aggression and Elopement and all are addressed in her Behavior Support Plan. 3. Individual [client A] does not have plan approved alone time and it was determined that she was without staff supervision for 2 hours and 5 minutes". Conclusion: "1. It is substantiated that individual [client A] was without staff supervision after eloping from her home on the night of 11/08/21 for 3 hours (sic/information above indicates 2 hours, 5 minutes). 2. It is not substantiated that individual [client A's] Behavior Support Plan failed to address Elopement. 3. It is not substantiated that staff failed to properly implement individual [client A's] Behavior Support (sic) prior to and in response to his (sic) elopement, on 11/08/21. 4. It is not substantiated that ResCare supervisory and administrative staff failed to respond appropriately once informed of individual [client A's] Elopement, on 11/08/21". A review of the 11/9/21 BDDS report and the 11/14/21 Investigative Summary indicated client A eloped from the group home and was without staff supervision for approximately two hours and five minutes. Client A was handcuffed and transported to the hospital for a psychiatric evaluation then released back to the group home. There was no documentation indicating the investigation was reviewed by the administrator.		incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager. The Quality Assurance Manager will meet with his/her facility Investigator team and the QIDP Manager weekly to review the progress made on all investigations that are open for their homes. Quality Assurance Coordinators or designees will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QIDP Manager will review each investigation to ensure that they indicate the date and time the administrator was notified of investigation results. The QACs will provide weekly updates to the QA Manager on the status of investigations. Failure to report the results of investigations within the allowable five business day timeframe could result in	

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	1b. An 11/10/21 BDDS report indicated on 11/9/21 at 6:00 PM the following incident occurred. "...On the evening of 11/9/21, [client A] had been agitated, threatening and combative at intervals throughout the day. After finishing supper, [client A] was sitting with her assigned one to one staff and said she needed to use the rest room. Staff followed and after using the toilet, [client A] headed toward the front door. Her staff blocked the exit, but [client A] pushed staff out the door and began running. Staff followed and after five minutes, lost line of sight. Staff notified the supervisor and behavioral clinician, and called the police and filed a missing person report. Additional staff and supervisors arrived to assist with the search, which was coordinated by administrative staff. [Client A] and her housemate (client B) were located by police at approximately 7:10 PM. [Client A] was physically aggressive toward police officers, hitting and spitting. Police placed her in handcuffs and the [city] Chief of Police informed staff that [client A] was being arrested for Battery that occurred on 11/8/21 (previously reported Incident #1321794). Police transported [client A] to the [county] jail. Plan to Resolve: [Client A] was not injured prior to her arrest. She remains incarcerated and has been charged with Battery. ResCare has provided the jail with her medication list and medication and will attend court when scheduled. The [County] Sheriff Department has informed ResCare that [client A] is set to be released on 11/12/21, at 8:00 PM. [Client A] has a history of Physical Aggression, and Elopement addressed in her Behavior Support Plan. [Client A] does not have plan approved alone time and was away from staff supervision for one hour and ten minutes.		progressive corrective action to all applicable team members. The Direct Support Lead will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training, including but not limited to assuring behavior supports are implemented as written. . For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will conduct administrative monitoring during varied shifts/times, no less than three times weekly. After 30 Days, administrative monitoring will occur no less than twice weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor	

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	The interdisciplinary team will meet to review the circumstances of the incident to develop additional supports are indicated, and will continue to pursue acute in-patient psychiatric treatment due to her intractable aggression (sic)". An 11/15/21 Investigative Summary indicated the following: Factual Findings: "1. [Client A] was incarcerated at the time of the incident and was not interviewed. 2. Individual [client A] did not sustain injury prior to her being taken into custody. 3. Individual [client A] has a history of Physical Aggression and Elopement and all are addressed in her Behavior Support Plan. 4. Individual [client A] does not have plan approved alone time and it was determined that she was without staff supervision for no more than 45 minutes. Conclusion: 1. It is substantiated that individual [client A] was without staff supervision after eloping from her home on the evening of 11/09/21 for 45 minutes. 2. It is not substantiated that individual [client A's] Behavior Support Plan failed to address Elopement. 3. It is not substantiated that staff failed to properly implement individual [client A's] Behavior Support (sic) prior to and in response to his (sic) elopement, on 11/09/21. 4. It is not substantiated that ResCare supervisory and administrative staff failed to respond appropriately once informed of individual [client A's] Elopement, on 11/09/21". A review of the 11/10/21 BDDS report and the		must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed Administrative support at the home will include but not be limited assuring proper implementation of behavior supports. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, BDDS Generalist, Regional Director	

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	11/15/21 Investigative Summary indicated client A eloped from the group home and was without staff supervision for approximately 45 minutes. Client A was handcuffed and transported to jail due to being physically aggressive towards and spitting on a police officer. Client A was released from jail on 11/12/21 with a charge of battery against a police officer. There was no documentation indicating the investigation was reviewed by the administrator. 1c. An 11/20/21 BDDS report indicated on 11/19/21 at 8:15 PM the following incident occurred. "...On the evening of 11/19/21, [client A] began pacing through the house, and staring out of the windows. She told staff that she could do anything she wanted without consequences, referencing the fact that all battery charges against her (previously reported incident #1322040) had been dismissed earlier in the day. She ran out of the house, with staff following, yelled at a passing motorist and sat in a neighbor's yard. She re-entered the house and attempted to enter housemates' bedrooms. Staff blocked, provided verbal redirection, and offered coping skills She returned to the porch and began attempting to break items with which to harm herself. Redirection and blocking was (sic) ineffective, and staff called 911 for assistance. [Client A] was physically aggressive toward police officers, hitting and spitting. When she attempted to take an officer's taser (electroshock weapon), police placed her in handcuffs and arrested her. Police transported [client A] to the [County] Jail. Plan to Resolve: [Client A] was not injured prior to her arrest. She remains incarcerated and has been charged with Battery Against a Safety Officer and Battery with Bodily Fluid. ResCare has provided the jail with her medication list and medication and will attend			

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	court when scheduled. [Client A] has a history of Physical Aggression, and Elopement addressed in her Behavior Support Plan. [Client A] does not have plan approved alone time and was away from staff supervision for one hour and ten minutes. The interdisciplinary team will meet to review the circumstances of the incident to develop additional supports are indicated, and will continue to pursue acute in-patient psychiatric treatment due to her intractable aggression (sic)". An 11/23/21 Investigative Summary indicated the following: Interviews: QIDP (Qualified Intellectual Disabilities Professional): "[Staff #3] was with the other clients". Staff #3: "[QIDP] was passing the meds (medications) and I was watching the ladies". Factual Findings: "1. Individual [client A] did not sustain injury prior to her being taken into custody. 2. Individual [client A] has a history of Verbal Aggression, Physical Aggression and Property Destruction/Disruption and all are addressed in her Behavior Support Plan. 3. Individual [client A] does not have plan approved alone time and it was determined that she was never without staff supervision. 4. No evidence was presented suggesting staff did not follow [client A's] plan". Conclusion: "1. The evidence does not substantiate that individual [client A] was ever away from staff supervision after eloping from her home on the			

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	night of 11/19/21. 2. The evidence does not substantiate that individual [client A's] Behavior Support Plan failed to address verbal aggression, physical aggression, and properly disruption/destruction. 3. The evidence does not substantiate that staff failed to properly implement individual [client A's] Behavior Support (sic) prior to and in response to her aggression, on 11/19/21". Recommendations: "1. Maintain staffing redeployment as previously discussed. 2. Arrange meeting with Guardian and BDDS Generalist to make sure the team is in consensus about how to work with [client A]". A review of the 11/20/21 BDDS report and the 11/23/21 Investigative Summary indicated client A had a behavioral episode where she was physically and verbally aggressive, left the property multiple times with staff following and was destroying property. The police were called to assist with keeping client A and staff safe. Client A hit and spit on the officer and attempted to take his taser. Client A was arrested and transported to jail for battery on an officer and battery with bodily fluids. The investigation indicated only two staff were working during the incident. The QIDP was with client A and staff #3 was inside with the other clients. There was no documentation indicating the investigation was reviewed by the administrator. On 12/15/21 at 9:00 AM, client A's record was reviewed and indicated the following. An 11/11/21 [County] Circuit and Superior Courts Appearance Form indicated client A was booked into jail on 11/9/21 and she was released			

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	15G807	A. BUILDING 00 B. WING	12/16/2021

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	on 11/11/21 with a charge of battery and battery against an officer and a court appearance was scheduled for 11/19/21 at 8:30 AM. An 11/21/21 [County] Circuit and Superior Courts Appearance Form indicated client A was booked into jail on 11/19/21 and she was released on 11/21/21 with a charge of battery with bodily fluid and battery against an officer and a court appearance was scheduled for 11/30/21 at 8:30 AM. Client A's 1/8/21 BSP (Behavior Support Plan) indicated client A had target behaviors of self injury behavior, disruptive behavior, task refusal, physical aggression, verbal aggression, emotional manipulation, false allegations/lying, elopement, and property destruction/disruption. "Elopement... Operational Definition: Any occurrence of [client A] leaving an assigned area including including areas within the home or where the group is located without staff acknowledgement and/or permission. Displays of Elopement include occurrences of [client A] climbing out (attempts included) windows (at the residence or elsewhere), walking out of the residence into the front and/or back yard, the garage, across the road to the mailbox, exiting the back gate without having received the explicit permission of a member of staff (residential). Elopement/Leaving Assigned Area also includes occurrences when [client A] enters the personal spaces/areas of the housemates without having received express permission from the individual housemate and/or from a staff member". "Rights restrictions.... Enhanced Supervision (1:1)- elopement (to prevent). To protect [client A] from placing herself at risk of harm and exploitation outside of the residential			

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	environment without supervision of staff". On 12/15/21 at 3:25 PM, the AS (Area Supervisor), QAM (Quality Assurance Manager), QIDPM (Qualified Intellectual Disabilities Professional Manager) and the QIDP were interviewed. The AS indicated client A has been charged with battery on an officer and battery with bodily fluid. The AS indicated client A has a public defender and she returns to court on 12/27/21. The AS indicated client A required 24 hour staff supervision and she eloped on two occasions without staff supervision. The QIDPM indicated client A's BSP was implemented, but it wasn't effective. The QIDP indicated there were two staff working during the behavioral episode on 11/19/21 and there should have been three staff. The AS indicated there should be three staff on first and second shift and two staff on third shift. The QIDPM indicated the plan might have been effective if the required amount of staff had been working on 11/19/21. 2. An 11/9/21 BDDS report indicated on 11/8/21 at 5:45 PM the following incident occurred. "...On the evening of 10/13/21 (sic-11/8/21), [client B] came out of her bedroom and observed her housemate [client A] undressing in an agitated state. [Client B] began removing clothing. Staff redirected her verbally to stop and she complied. Her housemate ran out of the house and [client B] followed behind her. Staff followed but quickly lost sight. Staff notified the supervisor and called the police and filed a missing person report. Additional staff and supervisors arrived to assist with the search, which was coordinated by administrative staff. [Client B] and her housemate were located by police at approximately 8:00 PM, at the [city post office] 0.4 miles from their home. When			

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	staff arrived [client B] was sitting, handcuffed, in a police cruiser. An office escorted [client B] to the group home van and when he removed the handcuffs, [client B] hit staff in the face. Police then arrested [client B] and transported her to the [county] Jail. Plan to Resolve: [Client A] was not injured prior to her arrest. She remains incarcerated and has been charged with Battery. ResCare has provided the jail with her medication list and medication and will attend court when scheduled. The [county] Sheriff Department has informed ResCare that [client B] is set to be released on 11/10/21, at 8:00 PM. [Client B] has a history of Physical Aggression and Elopement addressed in her Behavior Support Plan. [Client B] does not have plan approved alone time and was away from staff supervision for two hours and five minutes. The interdisciplinary team will meet to review the circumstances of the incident to determine if additional supports are indicated". An 11/14/21 Investigative Summary indicated the following: Factual Findings: "1. Individual [client B] did not sustain injury prior to her being taken into custody. 2. Individual [client B] has a history of Physical Aggression and Elopement and all are addressed in her Behavior Support Plan. 3. Individual [client B] does not have plan approved alone time and it was determined that she was without staff supervision for approximately 3 hours. Conclusion: 1. It is substantiated that [client B] was without staff supervision after eloping from her home on			

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	the night of 11/08/21 for 3 hours. 2. It is not substantiated that individual [client B's] Behavior Support Plan failed to address Elopement. 3. It is not substantiated that staff failed to properly implement individual [client B's] Behavior Support (sic) prior to and in response to his (sic) elopement on 11/08/21. 4. It is not substantiated that ResCare supervisory and administrative staff failed to respond appropriately once informed of individual [client B's] elopement on 11/08/21". A review of the 11/9/21 BDDS report and the 11/14/21 Investigative Summary indicated client B eloped from the group home and was without staff supervision for approximately three hours. Client B was arrested for battery against staff and she was transported to jail. There was no documentation indicating the investigation was reviewed by the administrator. On 12/15/21 at 10:00 AM, client B's record was reviewed and indicated the following. An 11/10/21 [County] Circuit and Superior Courts Appearance Form indicated client B was booked into jail on 11/8/21 and she was released on 11/10/21 with a charge of battery and a court appearance was scheduled for 11/19/21 at 8:30 AM. Client B's Daily Progress Notes for 11/19/21 indicated: 8:00 AM and 10:00 AM: "[Client B] sat with staff til (until) 8:15 AM when she left with the RM (Residential Manager), AS (Area Supervisor), BC (Behavior Clinician), DSP (Direct Support Professional) and housemate (client A)to go to court".			

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	10:00 AM to 12:00 PM: "[Client B] is LOA (leave of absence)". 12:00 PM to 2:00 PM: "[Client B] is LOA". 2:00 PM to 4:00 PM: "[Client B] was picked up from at the jail and released to come home...." A review of client B's Daily Progress Notes indicated client B left the group home on 11/19/21 at 8:15 AM to attend her scheduled court hearing. Client B did not return to the group home until between 2:00 PM and 4:00 PM after she was released from jail. A review of the BDDS reports indicated client B's arrest on 11/19/21 was not reported to BDDS within 24 hours of knowledge. Client B's 11/29/21 BSP indicated client B had target behaviors of self injury behavior, socially offensive behavior, task refusal, physical aggression/physical intimidation, verbal aggression/verbal intimidation, emotional manipulation, withdrawn/isolating behavior and elopement/leaving assigned area. "Elopement/Leaving assigned area... Operational Definition: Any occurrence of [client B] leaving an assigned area (area where she has been directed to remain or is expected to remain) including areas within the home or where the (sic) [client B] accesses without having obtained staff acknowledgement and/or permission. Displays of Elopement or Leaving Assigned Area include occurrences of [client B] climbing or attempting to climb out of windows (at the residence or elsewhere), exiting of the residence and accessing the front and/or back yard(s), accessing the garage, exiting the back gate without having received the explicit permission of a member of staff (residential). Elopement or Leaving Assigned Area also includes			

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	occurrences of [client B] entering the personal spaces/areas of the housemates without having received express permission from the individual housemate and permission from a staff member. Includes Attempts". "Rights restrictions.... 24-Hour Supervision/Freedom of Movement and Unrestricted Access to Community- especially following displays of high intensity behaviors attributed to Self-Injury Behavior; Elopement/Leaving Assigned Area; Physical Aggression or Physical Intimidation (or other novel maladaptive behaviors not included herein). Without continuous supervision and direct oversight of [client B] across environments, there is an increased risk of injury to [client B] or others within the environment or setting due to displays of high intensity and duration behavioral episodes and behaviors. [Client B's] lack of understanding of safe community members or those who may wish to bring him (sic) harm may also increase risks to [client B's] safety and that of others resulting in accidents, injury, or exploitation...." On 12/15/21 at 3:25 PM, the AS, QAM, QIDPM and the QIDP were interviewed. The AS indicated client B attended the scheduled court hearing on 11/19/21. The AS indicated they arrived at the court house on time and they were asked to sit in the lobby to wait for their turn. The AS indicated after a period of time a police officer came to the waiting area and arrested client B after indicating she was late for the court hearing. The AS indicated they were on time and did what they were instructed to do. The AS indicated client B's guardian was contacted and he got an attorney involved and			

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	client B was released from jail around 3:30 PM on 11/19/21. The AS indicated the battery charge for client B was dropped. When asked if the arrest was reported to BDDS, the QIDPM stated, "Shoot, if I didn't send it to you it was not filed. It was an oversight, it was not intentional". The QIDPM and the QAM indicated the facility should prevent neglect of the clients and there was a policy in place to prevent neglect of the clients. The QAM stated, "The admin (administrator) signature has not been part of the investigations. I (QAM) should (sign the investigation) yes, I need to do that". The QIDPM stated, "We need to get a mechanism in place to make that happen". The QAM stated, "The Peer review form needs to be expanded" to include the administrative signature. On 12/16/21 at 11:02 AM, the RD (Regional Director) and the ED (Executive Director) were interviewed. The ED stated, "When there's an allegation made it should be reported immediately to the administrator and to BDDS within 24 hours, suspend (staff) if needed and an investigation is done within 5 days. A peer review and recommendations are completed. Recommendations may include termination or training. There is a spot on the peer review form that includes the administrative signature. Reviews have been done by zoom due to Covid and that is indicated on the forms. When asked who completed the administrative reviews for non ANE (abuse, neglect, exploitation) investigations, the ED stated, "[QAM]". The ED indicated the QAM should should review and sign indicating the investigation was reviewed. The agency's "Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights" Operations			

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	Standard dated 1/9/15 (7/10/19 revision) was reviewed on 12/16/21 at 11:15 AM and indicated the agency strictly prohibited abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights. "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." The Operation Standard indicated, in part, the following: "ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights. These include but are not limited to any of the following: corporal punishment i.e. forced physical activity, prone restraints, contingent exercise, hitting, pinching, the application of pain or noxious stimuli, the use of electric shock, the infliction of physical pain, seclusion in an area which exit is prohibited, an example of seclusion is locking an individual in their bedroom and not allowing them to leave, negative practice or overcorrection, visual or facial screening, verbal abuse including screaming, swearing, name-calling, belittling, damaging an individual's selfrespect (sic) or dignity, failure to follow physician's orders, denial of sleep, shelter, food, drink, physical movement for prolonged periods of time, Medical treatment or care or use of bathroom facilities. The use of mechanical restraints except for when ordered as a medical			

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	restraint by a licensed physician or dentist is strictly prohibited. ResCare strictly prohibits the use of any other technique that incorporates the use of painful or noxious stimuli; incorporates denial of any health-related necessity; or degrades the dignity of an individual. Abuse, neglect, exploitation, mistreatment or violation of an Individual's rights may also be defined as forcing an individual to complete chores benefiting others without pay unless: (A) The Provider has obtained a certificate from the US Department of Labor to authorize employment; (B) The services are being performed in the individual's own home as a normal and customary part of housekeeping duties; or (C) Individual desires to perform volunteer work in the community. This includes that the individual should not be compelled to provide services for a provider, either by request of the provider, enticements or aversive techniques...." This federal tag relates to complaints #IN00366881 and #IN00368229. 9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on record review and interview for 1 of 2 sampled clients (B), the facility failed to report an arrest for client B to BDDS (Bureau of Developmental Disabilities Services) within 24 hours of knowledge.	W 0153	**CORRECTION:** *The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the*	01/15/2022

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	Findings include: On 12/14/21 at 12:00 PM, the facility's BDDS reports, incident reports and investigations were reviewed. An 11/9/21 BDDS report indicated on 11/8/21 at 5:45 PM the following incident occurred. "...On the evening of 10/13/21 (sic-11/8/21), [client B] came out of her bedroom and observed her housemate [client A] undressing in an agitated state. [Client B] began removing clothing. Staff redirected her verbally to stop and she complied. Her housemate ran out of the house and [client B] followed behind her. Staff followed but quickly lost sight. Staff notified the supervisor and called the police and filed a missing person report. Additional staff and supervisors arrived to assist with the search, which was coordinated by administrative staff. [Client B] and her housemate were located by police at approximately 8:00 PM, at the [city post office] 0.4 miles from their home. When staff arrived [client B] was sitting, handcuffed, in a police cruiser. An office escorted [client B] to the group home van and when he removed the handcuffs, [client B] hit staff in the face. Police then arrested [client B] and transported her to the [county] Jail. Plan to Resolve: [Client A] was not injured prior to her arrest. She remains incarcerated and has been charged with Battery. ResCare has provided the jail with her medication list and medication and will attend court when scheduled. The [county] Sheriff Department has informed ResCare that [client B] is set to be released on 11/10/21, at 8:00 PM. [Client B] has a history of Physical Aggression and Elopement addressed in her Behavior Support Plan. [Client B] does not		*administrator or to other officials in accordance with State law through established procedures.* Specifically, the Quality Assurance manager and QIDP Manager will coordinate with designated staff to assure that incidents meeting notification criteria are reported to the State within 24 hours, as required. **PREVENTION:** The Quality Assurance Manager and the QIDP Manager will carefully review all incidents reported by the facility and outside entities, to assure that allegations and other required incidents are reported to the Bureau of Developmental Disabilities Services as required by state law. Each day, QIDP Manager or designee will compile a list of incidents requiring reports to the Bureau of Developmental Disabilities Services, and distribute the list to administrative staff (including the Quality Assurance Manager, Program Managers, Quality Assurance Coordinators, Operations Manager, Area Supervisors, QIDP, Nurse Manager and Assistant Nurse Manager) for review and revision, as needed. The QIDP Manager or designee will assign reporting responsibilities daily. Supervisory staff will review all facility documentation to assure incidents are reported as	

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	have plan approved alone time and was away from staff supervision for two hours and five minutes. The interdisciplinary team will meet to review the circumstances of the incident to determine if additional supports are indicated". An 11/14/21 Investigative Summary indicated the following: Factual Findings: "1. Individual [client B] did not sustain injury prior to her being taken into custody. 2. Individual [client B] has a history of Physical Aggression and Elopement and all are addressed in her Behavior Support Plan. 3. Individual [client B] does not have plan approved alone time and it was determined that she was without staff supervision for approximately 3 hours. Conclusion: 1. It is substantiated that [client B] was without staff supervision after eloping from her home on the night of 11/08/21 for 3 hours. 2. It is not substantiated that individual [client B's] Behavior Support Plan failed to address Elopement. 3. It is not substantiated that staff failed to properly implement individual [client B's] Behavior Support (sic) prior to and in response to his (sic) elopement on 11/08/21. 4. It is not substantiated that ResCare supervisory and administrative staff failed to respond appropriately once informed of individual [client B's] elopement on 11/08/21". A review of the 11/9/21 BDDS report and the 11/14/21 Investigative Summary indicated client B eloped from the group home and was without staff supervision for approximately three hours.		required. Additionally, internal and day service incident reports will be sent via electronic fax directly to administrative staff. The Quality Assurance Manager and the QIDP Manager will coordinate and follow-up with the Quality Assurance Coordinators, QIDPs and other staff responsible for reporting to outside agencies, to assure incidents are reported to state agencies as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	Client B was arrested for battery against staff and she was transported to jail. There was no documentation indicating the investigation was reviewed by the administrator. On 12/15/21 at 10:00 AM, client B's record was reviewed and indicated the following. An 11/10/21 [County] Circuit and Superior Courts Appearance Form indicated client B was booked into jail on 11/8/21 and she was released on 11/10/21 with a charge of battery and a court appearance was scheduled for 11/19/21 at 8:30 AM. Client B's Daily Progress Notes for 11/19/21 indicated: 8:00 AM and 10:00 AM: "[Client B] sat with staff til (until) 8:15 AM when she left with the RM (Residential Manager), AS (Area Supervisor), BC (Behavior Clinician), DSP (Direct Support Professional) and housemate (client A)to go to court". 10:00 AM to 12:00 PM: "[Client B] is LOA (leave of absence)". 12:00 PM to 2:00 PM: "[Client B] is LOA". 2:00 PM to 4:00 PM: "[Client B] was picked up from at the jail and released to come home...." A review of client B's Daily Progress Notes indicated client B left the group home on 11/19/21 at 8:15 AM to attend her scheduled court hearing. Client B did not return to the group home until between 2:00 PM and 4:00 PM after she was released from jail. A review of the BDDS reports indicated client B's arrest on 11/19/21 was not reported to BDDS within 24 hours of knowledge.			

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	On 12/15/21 at 3:25 PM, the AS (Area Supervisor), QAM (Quality Assurance Manager), QIDPM (Qualified Intellectual Disabilities Professional Manager) and the QIDP (Qualified Intellectual Disabilities Professional) were interviewed. The AS indicated client B attended the scheduled court hearing on 11/19/21. The AS indicated they arrived at the court house on time and they were asked to sit in the lobby to wait for their turn. The AS indicated after a period of time a police officer came to the waiting area and arrested client B after indicating she was late for the court hearing. The AS indicated they were on time and did what they were instructed to do. The AS indicated client B's guardian was contacted and he got an attorney involved and client B was released from jail around 3:30 PM on 11/19/21. The AS indicated the battery charge for client B was dropped. When asked if the arrest was reported to BDDS, the QIDPM stated, "Shoot, if I didn't send it to you it was not filed. It was an oversight, it was not intentional". This federal tag relates to complaint #IN00368229. 9-3-2(a)			
W 0156 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 4 of 7 investigation reports reviewed for client A, the facility failed to ensure the administrator reviewed the results of investigations within 5	W 0156	**CORRECTION:** *The results of all investigations must be reported to the administrator or designated*	01/15/2022

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	business days. Findings include: On 12/14/21 at 12:00 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports, incident reports and investigations were reviewed and indicated the following: 1a. An 11/9/21 BDDS report indicated on 11/8/21 at 5:45 PM the following incident occurred. "...On the evening of 11/8/21, [client A] became agitated after supper and went to her room. Staff followed and observed her breaking her window alarm. Staff redirected her verbally and she entered the living room, (sic) began undressing. She continued to escalate, broke the front door alarm, and exited the house, accompanied by her housemate [client B]. Staff followed but quickly lost sight. Staff notified the supervisor and called the police and filed a missing person report Additional staff and supervisors arrived to assist with the search, which was coordinated by administrative staff. [Client A] and her housemate (client B) were located by police at approximately 8:00 PM, at the [city] Post Office 0.4 miles from their home. [Client A] hit and spit on police offices (sic) at the scene and she was handcuffed and transported to [name of hospital] for an emergency psychiatric evaluation. [Client A] was assessed, diagnosed with Agitation and Combative Behavior, and released to ResCare staff with no new orders. She returned home without incident. It should be noted that police officers came to the residence while [client A] was at the ER (emergency room) and informed staff that Battery charges would be filed against [client A]. Plan to Resolve: [Client A] is home and receiving		*representative or to other officials in accordance with State law within five working days of the incident.* Specifically, moving forward investigation summaries will include documentation of administrator notification of investigation results. **PREVENTION:** A tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team comprised of the Executive Director, Operations Managers, Program Managers, Area Supervisors, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager. The Quality Assurance Manager will meet with his/her facility Investigator team and the QIDP Manager weekly to review the progress made on all investigations that are open for their homes. Quality Assurance Coordinators or designees will be required to attend and sign an in-service at these meetings stating that they are aware of which investigations with which they are required to assist, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QIDP Manager will review each	

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	emotional support from her team. She was not injured during the incident. No charges have been filed against her at the time of this report. The broken alarms have been replaced. [Client A] has a history of Property Destruction, Physical Aggression and Elopement addressed in her Behavior Support Plan. [Client A] does not have plan approved alone time and was away from staff supervision for two hours and five minutes. Staff will continue to follow the proactive and reactive strategies in [client A's] plan to help reduce and prevent further occurrences. [Client A's] clinician and ResCare nursing are working with [client A's] psychiatric provider to determine if acute Inpatient treatment is indicated". An 11/14/21 Investigative Summary indicated the following: Factual Findings: "1. Individual [client A] did not sustain injury during this incident. 2. Individual [client A] has a history of Property Destruction, Physical Aggression and Elopement and all are addressed in her Behavior Support Plan. 3. Individual [client A] does not have plan approved alone time and it was determined that she was without staff supervision for 2 hours and 5 minutes". Conclusion: "1. It is substantiated that individual [client A] was without staff supervision after eloping from her home on the night of 11/08/21 for 3 hours (sic/information above indicates 2 hours, 5 minutes). 2. It is not substantiated that individual [client A's] Behavior Support Plan failed to address Elopement.		investigation to ensure that they indicate the date and time the administrator was notified of investigation results. The QACs will provide weekly updates to the QA Manager on the status of investigations. Failure to report the results of investigations within the allowable five business day timeframe could result in progressive corrective action to all applicable team members. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Operations Team	

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	3. It is not substantiated that staff flailed to properly implement individual [client A's] Behavior Support (sic) prior to and in response to his (sic) elopement, on 11/08/21. 4. It is not substantiated that ResCare supervisory and administrative staff failed to respond appropriately once informed of individual [client A's] Elopement, on 11/08/21". A review of the 11/14/21 Investigative Summary indicated there was no documentation the administrator reviewed the investigation. 1b. An 11/10/21 BDDS report indicated on 11/9/21 at 6:00 PM the following incident occurred. "...On the evening of 11/9/21, [client A] had been agitated, threatening and combative at intervals throughout the day. After finishing supper, [client A] was sitting with her assigned one to one staff and said she needed to use the rest room. Staff followed and after using the toilet, [client A] headed toward the front door. Her staff blocked the exit, but [client A] pushed staff out the door and began running. Staff followed and after five minutes, lost line of sight. Staff notified the supervisor and behavioral clinician, and called the police and filed a missing person report. Additional staff and supervisors arrived to assist with the search, which was coordinated by administrative staff. [Client A] and her housemate (client B) were located by police at approximately 7:10 PM. [Client A] was physically aggressive toward police officers, hitting and spitting. Police placed her in handcuffs and the [city] Chief of Police informed staff that [client A] was being arrested for Battery that occurred on 11/8/21 (previously reported Incident #1321794). Police transported [client A] to the [county] jail.			

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	Plan to Resolve: [Client A] was not injured prior to her arrest. She remains incarcerated and has been charged with Battery. ResCare has provided the jail with her medication list and medication and will attend court when scheduled. The [County] Sheriff Department has informed ResCare that [client A] is set to be released on 11/12/21, at 8:00 PM. [Client A] has a history of Physical Aggression, and Elopement addressed in her Behavior Support Plan. [Client A] does not have plan approved alone time and was away from staff supervision for one hour and ten minutes. The interdisciplinary team will meet to review the circumstances of the incident to develop additional supports are indicated, and will continue to pursue acute in-patient psychiatric treatment due to her intractable aggression (sic)". An 11/15/21 Investigative Summary indicated the following: Factual Findings: "1. [Client A] was incarcerated at the time of the incident and was not interviewed. 2. Individual [client A] did not sustain injury prior to her being taken into custody. 3. Individual [client A] has a history of Physical Aggression and Elopement and all are addressed in her Behavior Support Plan. 4. Individual [client A] does not have plan approved alone time and it was determined that she was without staff supervision for no more than 45 minutes. Conclusion: 1. It is substantiated that individual [client A] was without staff supervision after eloping from her home on the evening of 11/09/21 for 45 minutes. 2. It is not substantiated that individual [client			

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	A's] Behavior Support Plan failed to address Elopement. 3. It is not substantiated that staff failed to properly implement individual [client A's] Behavior Support (sic) prior to and in response to his (sic) elopement, on 11/09/21. 4. It is not substantiated that ResCare supervisory and administrative staff failed to respond appropriately once informed of individual [client A's] Elopement, on 11/09/21". A review of the 11/15/21 Investigative Summary indicated there was no documentation the administrator reviewed the investigation. 1c. An 11/20/21 BDDS report indicated on 11/19/21 at 8:15 PM the following incident occurred. "...On the evening of 11/19/21, [client A] began pacing through the house, and staring out of the windows. She told staff that she could do anything she wanted without consequences, referencing the fact that all battery charges against her (previously reported incident #1322040) had been dismissed earlier in the day. She ran out of the house, with staff following, yelled at a passing motorist and sat in a neighbor's yard. She re-entered the house and attempted to enter housemates' bedrooms. Staff blocked, provided verbal redirection, and offered coping skills She returned to the porch and began attempting to break items with which to harm herself. Redirection and blocking was (sic) ineffective, and staff called 911 for assistance. [Client A] was physically aggressive toward police officers, hitting and spitting. When she attempted to take an officer's taser (electroshock weapon), police placed her in handcuffs and arrested her. Police transported [client A] to the [County] Jail. Plan to Resolve: [Client A] was not injured prior to her arrest. She remains			

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	incarcerated and has been charged with Battery Against a Safety Officer and Battery with Bodily Fluid. ResCare has provided the jail with her medication list and medication and will attend court when scheduled. [Client A] has a history of Physical Aggression, and Elopement addressed in her Behavior Support Plan. [Client A] does not have plan approved alone time and was away from staff supervision for one hour and ten minutes. The interdisciplinary team will meet to review the circumstances of the incident to develop additional supports are indicated, and will continue to pursue acute in-patient psychiatric treatment due to her intractable aggression (sic)". An 11/23/21 Investigative Summary indicated the following: Interviews: QIDP (Qualified Intellectual Disabilities Professional): "[Staff #3] was with the other clients". Staff #3: "[QIDP] was passing the meds (medications) and I was watching the ladies". Factual Findings: "1. Individual [client A] did not sustain injury prior to her being taken into custody. 2. Individual [client A] has a history of Verbal Aggression, Physical Aggression and Property Destruction/Disruption and all are addressed in her Behavior Support Plan. 3. Individual [client A] does not have plan approved alone time and it was determined that she was never without staff supervision. 4. No evidence was presented suggesting staff did not follow [client A's] plan".			

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	Conclusion: "1. The evidence does not substantiate that individual [client A] was ever away from staff supervision after eloping from her home on the night of 11/19/21. 2. The evidence does not substantiate that individual [client A's] Behavior Support Plan failed to address verbal aggression, physical aggression, and properly disruption/destruction. 3. The evidence does not substantiate that staff failed to properly implement individual [client A's] Behavior Support (sic) prior to and in response to her aggression, on 11/19/21". Recommendations: "1. Maintain staffing redeployment as previously discussed. 2. Arrange meeting with Guardian and BDDS Generalist to make sure the team is in consensus about how to work with [client A]". A review of the 11/23/21 Investigative Summary indicated there was no documentation the administrator reviewed the investigation. 2. An 11/9/21 BDDS report indicated on 11/8/21 at 5:45 PM the following incident occurred. "...On the evening of 10/13/21 (sic-11/8/21), [client B] came out of her bedroom and observed her housemate [client A] undressing in an agitated state. [Client B] began removing clothing. Staff redirected her verbally to stop and she complied. Her housemate ran out of the house and [client B] followed behind her. Staff followed but quickly lost sight. Staff notified the supervisor and called the police and filed a missing person report. Additional staff and supervisors arrived to assist with the search, which was coordinated by administrative staff. [Client B] and her housemate were located by			

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	police at approximately 8:00 PM, at the [city post office] 0.4 miles from their home. When staff arrived [client B] was sitting, handcuffed, in a police cruiser. An office escorted [client B] to the group home van and when he removed the handcuffs, [client B] hit staff in the face. Police then arrested [client B] and transported her to the [county] Jail. Plan to Resolve: [Client A] was not injured prior to her arrest. She remains incarcerated and has been charged with Battery. ResCare has provided the jail with her medication list and medication and will attend court when scheduled. The [county] Sheriff Department has informed ResCare that [client B] is set to be released on 11/10/21, at 8:00 PM. [Client B] has a history of Physical Aggression and Elopement addressed in her Behavior Support Plan. [Client B] does not have plan approved alone time and was away from staff supervision for two hours and five minutes. The interdisciplinary team will meet to review the circumstances of the incident to determine if additional supports are indicated". An 11/14/21 Investigative Summary indicated the following: Factual Findings: "1. Individual [client B] did not sustain injury prior to her being taken into custody. 2. Individual [client B] has a history of Physical Aggression and Elopement and all are addressed in her Behavior Support Plan. 3. Individual [client B] does not have plan approved alone time and it was determined that she was without staff supervision for approximately 3 hours. Conclusion:			

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	1. It is substantiated that [client B] was without staff supervision after eloping from her home on the night of 11/08/21 for 3 hours. 2. It is not substantiated that individual [client B's] Behavior Support Plan failed to address Elopement. 3. It is not substantiated that staff failed to properly implement individual [client B's] Behavior Support (sic) prior to and in response to his (sic) elopement on 11/08/21. 4. It is not substantiated that ResCare supervisory and administrative staff failed to respond appropriately once informed of individual [client B's] elopement on 11/08/21". A review of the 11/14/21 Investigative Summary indicated there was no documentation the administrator reviewed the investigation. On 12/15/21 at 3:25 PM, the AS (Area Supervisor), QAM (Quality Assurance Manager), QIDPM (Qualified Intellectual Disabilities Professional Manager) and the QIDP were interviewed. The QAM stated, "The admin (administrator) signature has not been part of the investigations. I (QAM) should (sign the investigation) yes, I need to do that". The QIDPM stated, "We need to get a mechanism in place to make that happen". The QAM stated, "The Peer review form needs to be expanded" to include the administrative signature. On 12/16/21 at 11:02 AM, the RD (Regional Director) and the ED (Executive Director) were interviewed. The ED stated, "When there's an allegation made it should be reported immediately to the administrator and to BDDS within 24 hours, suspend (staff) if needed and an investigation is done within 5 days. A peer review and recommendations are completed.			

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	Recommendations may include termination or training. There is a spot on the peer review form that includes the administrative signature. Reviews have been done by zoom due to Covid and that is indicated on the forms. When asked who completed the administrative reviews for non ANE (abuse, neglect, exploitation) investigations, the ED stated, "[QAM]". The ED indicated the QAM should should review and sign indicating the investigation was reviewed. This federal tag relates to complaints #IN00366881 and #IN00368229. 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 record review and interview for 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the facility failed to provide a sufficient amount of direct care staff in order to manage and supervise the clients according to their program plans and to ensure the Extensive Support Needs Reimbursement Guidelines were followed at a minimum. Findings include: On 12/14/21 at 12:00 PM, the facility's BDDS (Bureau of Developmental Disabilities Services)	W 0186	**CORRECTION:** *The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.* Specifically, the Governing Body has directed the facility to modify the staffing matrix to assure that there are no less than two staff on duty during the overnight shift and three staff on duty between 8:00 AM and 10:00 PM to provide active	01/15/2022

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	reports, incident reports and investigations were reviewed and indicated the following: An 11/20/21 BDDS report indicated on 11/19/21 at 8:15 PM the following incident occurred. "...On the evening of 11/19/21, [client A] began pacing through the house, and staring out of the windows. She told staff that she could do anything she wanted without consequences, referencing the fact that all battery charges against her (previously reported incident #1322040) had been dismissed earlier in the day. She ran out of the house, with staff following, yelled at a passing motorist and sat in a neighbor's yard. She re-entered the house and attempted to enter housemates' bedrooms. Staff blocked, provided verbal redirection, and offered coping skills She returned to the porch and began attempting to break items with which to harm herself. Redirection and blocking was ineffective, and staff called 911 for assistance. [Client A] was physically aggressive toward police officers, hitting and spitting. When she attempted to take an officer's taser (electroshock weapon), police placed her in handcuffs and arrested her. Police transported [client A] to the [County] Jail. Plan to Resolve: [Client A] was not injured prior to her arrest. She remains incarcerated and has been charged with Battery Against a Safety Officer and Battery with Bodily Fluid. ResCare has provided the jail with her medication list and medication and will attend court when scheduled. [Client A] has a history of Physical Aggression, and Elopement addressed in her Behavior Support Plan. [Client A] does not have plan approved alone time and was away from staff supervision for one hour and ten minutes. The interdisciplinary team will meet to review the		treatment and ensure the ability to safely intervene with aggressive behavior during times of peak activity. When sufficient staff assigned to the facility are not available staff will be pulled from other agency facilities, including from facilities outside of Wayne County, when needed. All fill-in staff will receive client specific training prior to working in the facility. **PREVENTION:** The Residential Manager and Area Supervisor will submit schedule revisions to Program Manager for approval prior to implementation. The Program Manager will monitor time and attendance records to assure required staffing levels are met. The Program Manager will assist with procuring staff from outside of the facility as needed. An Area Supervisor or Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training, including but not limited to assuring required staffing levels are in place. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDP, Quality	

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	15G807	A. BUILDING 00 B. WING	12/16/2021

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	circumstances of the incident to develop additional supports are indicated, and will continue to pursue acute in-patient psychiatric treatment due to her intractable aggression (sic)". An 11/23/21 Investigative Summary indicated the following: Interviews: QIDP (Qualified Intellectual Disabilities Professional): "[Staff #3] was with the other clients". Staff #3: "[QIDP] was passing the meds (medications) and I was watching the ladies". Factual Findings: "1. Individual [client A] did not sustain injury prior to her being taken into custody. 2. Individual [client A] has a history of Verbal Aggression, Physical Aggression and Property Destruction/Disruption and all are addressed in her Behavior Support Plan. 3. Individual [client A] does not have plan approved alone time and it was determined that she was never without staff supervision. 4. No evidence was presented suggesting staff did not follow [client A's] plan". Conclusion: "1. The evidence does not substantiate that individual [client A] was ever away from staff supervision after eloping from her home on the night of 11/19/21. 2. The evidence does not substantiate that individual [client A's] Behavior Support Plan failed to address verbal aggression, physical aggression, and properly disruption/destruction. 3. The evidence does not substantiate that staff		Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will conduct administrative monitoring during varied shifts/times, no less than three times weekly. After 30 Days, administrative monitoring will occur no less than twice weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed Administrative support at the home will include but not be limited to assuring required staffing levels	

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	failed to properly implement individual [client A's] Behavior Support (sic) prior to and in response to her aggression, on 11/19/21". Recommendations: "1. Maintain staffing redeployment as previously discussed. 2. Arrange meeting with Guardian and BDDS Generalist to make sure the team is in consensus about how to work with [client A]". A review of the 11/20/21 BDDS report and the 11/23/21 Investigative Summary indicated only two staff were working during the 11/19/21 behavioral episode. The QIDP was with client A and staff #3 was inside with the other clients. On 12/15/21 at 3:25 PM, the AS (Area Supervisor), QAM (Quality Assurance Manager), QIDPM (Qualified Intellectual Disabilities Professional Manager) and the QIDP were interviewed. The QIDP indicated there were two staff working during the behavioral episode on 11/19/21 and there should have been three staff. The AS indicated there should be three staff on first and second shift and two staff on third shift. The QIDPM indicated the plan might have been effective if the required amount of staff had been working on 11/19/21. The undated Reimbursement Guidelines for the 24 hour Extensive Support Needs/ESN Residences were reviewed on 12/16/21 at 1:00 PM. The guidelines indicated ESN homes "...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."		are in place. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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