STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G440	A. BUILDING 00 B. WING	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00427649. Complaint #IN00427649: Federal and state deficiencies related to the allegation(s) are cited at: W149, W157, W186, W189, W249 and W368. Survey Dates: 3/11/24, 3/12/24, 3/13/24, 3/14/24, 3/15/24, 3/18/24 and 3/19/24. Facility Number: 000954 Provider Number: 15G440 AIM Number: 100244720 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #27547 on 4/3/24.	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 record review and interview for 1 of 3 sampled clients (client A), the facility failed implement its written policies and procedures to prevent neglect of client A regarding elopement incidents. Findings include: The facility's Bureau of Disabilities Services (BDS) reports and investigations were reviewed on 3/12/24 at 3:30 pm. The review included the following:	W 0149	**Client A was previously established with Kestrel Behavioral Health in October of 2023 and behavior plan by Kestrel was being finalized while complaint survey was being conducted.** **New behavior plan for Client A was finalized by Kestrel Behavioral Health on 03/13/24 and all staff were trained on the newly develoed plan as of**	04/17/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Julia Vaughn	QA Manager	04/19/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	1. A BDS report dated 2/3/24 at 4:05 pm indicated, "After waking up from a nap, [client A] forgot to put on her glasses and attempted to take a peer's glasses. Staff separated [client A] and peer. [Client A] told staff she was going to walk down the road. Staff attempted to verbally redirect [client A]. [Client A] left the house and walked down the street. [Client A] was out of line of sight for 20 minutes. Staff lost line of sight of [client A] due to supervising other peers in the home. [Client A] presently does not have alone time in her plan. Area Supervisor and Program Manager notified. Program Manager located [client A] on a neighbor's porch. Program Manger got [client A] into their vehicle and took [client A] home. Upon returning home, [client A] was calm and resumed normal activity. Staff assessed for injuries, and none were observed. Staff will continue to follow [client A's] behavioral plan that addresses elopement. Staff will continue to monitor [client A] and report and changes in her health. An elopement investigation will be initiated." An investigation dated 2/6/24 indicated, "Description of incident: After waking up from a nap, [client A] forgot to put on her glasses and attempted to take a peer's glasses. Staff separated [client A] and peer. [Client A] told staff she was going to walk down the road. Staff attempted to verbally redirect [client A]. [Client A] left the house and walked down the street. [Client A] was out of line of sight for 20 minutes. Staff lost line of sight of [client A] due to supervising other peers in the home. [Client A] presently does not have alone time in her plan. Area Supervisor (AS) and Program Manager (PM) notified. Program Manager located [client A] on a neighbor's porch. Program Manager got [client A] into their vehicle and took [client A] home. Upon returning home,		**03/13/24.** **All staff in home will be retrained on ensuring 5 minute location tracking is being implemented and documented per Client A's plan to address elopement.** **All staff will be retrained on ensuring door alarms in home are sounding appropriately, notifying maintenance of any issues with door alarms, and completing daily documentation appropriately on functionality of alarm system.** **Client A is presently seen by neurologist for diagnosis of dementia. Client A was seen by neurologist following elopement incidents to determine if increased confusion was causing elopement incidents.** **Neurologist determined current medications remained effective. Nursing will continue to monitor for increasing symptoms and discuss concerns with neurologist** **Nursing recently implemented daily administration of Cranberry on 03/20/24 to Client A to help reduce incidents of UTI which can increase symptoms of confusion.** **The facility has policies and procedures in place to train employees who work with clients on skills and**	

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	[client A] was calm and resumed normal activity. Staff assessed for injuries, and none were observed. 1. Witness Statements: [Client C]/client: Did not provide any information relevant to this investigation. [Client F]/client: [Client A] thought that [client B] had her glasses and tried to take them from her and got mad and walked out the door and [AS] brought her back. [Client B]/client: [Client A] tried to take my glasses, was mad and walked outside. [Client H]/client: [Client A] took a nap and when she got up she thought [client B] had taken her glasses and tried to take them and got mad and walked out the door. She was gone for a little while, and then [AS] brought [client A] back home. [Direct Support Professional (DSP) #1]/DSP: After waking up from a nap, [client A] forgot to put on her glasses and attempted to take a peer's glasses. I separated [client A] and peer. [Client A] said she was going to walk down the road. I attempted to verbally redirect [client A]. [Client A] left the house and walked down the street. [Client A] was out of line of sight for 20 minutes. I lost line of sight of [client A] due to supervising other peers in the home. [AS] and [PD] was (sic) able to locate [client A] on a neighbor's porch and got [client A] into their vehicle and took [client A] home. [Client G]/Client: [Client G] did not provide any information relevant to this investigation. [Client A]/client: I was mad and wanted to walk. 2. Where did the elopement occur or happen? [Address]. 3. What was going on prior to the elopement? [Client A] was taking a nap. 4. Was medical treatment needed as a result of the elopement? No. 5. Does this consumer have a history of		**competencies directed towards clients' health needs and programming objectives.** **Area Supervisor and QIDP will be retrained on ensuring all staff are thoroughly consumer specific trained to include their ISP, BSP, reactive strategies, and objectives.** **All staff will be retrained on competency-based consumer specific training to include their ISP, BSP, reactive strategies, and objectives.** **All clients have the potential to be affected by this deficiency.** **Consumer specific training and reviewing client needs remains a prominent component of the agencies all staff monthly meetings.** **Administrative observations have been implemented in the home and will remain in place until the team determines it is appropriate to decrease the number of observations. This will ensure all corrections are implemented per ResCare policy and regulations.** **Ongoing weekly and monthly observations and review will continue with the QIDP and Area Supervisor over the location.**	

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	elopement and is it addressed appropriately in the ISP (individual support plan)/BSP (behavior support plan) and Health Care Plan? Yes, and it is addressed appropriately in the BSP. 6. Were there any environmental factors that contributed to the elopement? If yes, please explain what. No. 7. Do any changes need to be made to prevent future occurrences? No. 8. Was there sufficient staff at the time of the incident? No. 9. Conclusion: Substantiated. [Client A] did become upset and leave the grounds. The agency is actively recruiting to fill open shift positions. Area supervisor and program manager to continue efforts to provide double staffing during waking hours at this home. Recommendations: [Client A] has been established with [name] Behavioral Health. She has behavioral supports for elopement which remain appropriate." 2. A BDS report dated 2/23/24 at 7:40 am indicated, "[Client A] became angry when she could not get in the office immediately to get some toiletries. Rather than waiting, [client A] stormed out of the house, yelling and cursing and started walking down the road. A male driver, who recognized [client A], picked her up and took her back to the house. [Client A] had been out of sight for approximately seven minutes because there was only one staff person in the home, and she could not leave the other clients in the home to follow [client A]. She did call her supervisor immediately to request backup. [Client A] does not presently have any alone time in her plan. [Client A] does not presently have any alone time in her plan. [Client A] had calmed down by the time she arrived back at the house. Staff assessed for injuries and there was (sic) none. Staff supervisor and nurse were notified. Plan to Resolve: Staff will			

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	continue to follow [client A's] BSP for Elopement." An investigation dated 2/27/24 indicated, "Description of incident: [Client A] became angry when she could not get in the office immediately to get some toiletries. Rather than waiting, [client A] stormed out of the house, yelling and cursing and started walking down the road. A male driver, who recognized [client A], picked her up and took her back to the house. [Client A] had been out of sight for approximately seven minutes because there was only one staff person in the home, and she could not leave the other clients in the home to follow [client A]. She did call her supervisor immediately to request backup. [Client A] does not presently have any alone time in her plan. [Client A] had calmed down by the time she arrived back at the house. Staff assessed for injuries and there was (sic) none. Staff supervisor and nurse were notified. 1. Witness Statements: [Client C]/client: Did not provide any information relevant to this investigation. [Client F]/client: [Client A] wanted her toothbrush and toothpaste, but staff was passing meds and [client A] got mad and left the house. [Client B]/client: Wanted to brush her teeth, got mad and walked outside. [Client H]/client: Staff was trying to pass meds, but [client A] wanted in the office to get her toothbrush and toothpaste and got mad and left the house when staff couldn't give it to her. [DSP #1]: I was helping other residents when [client A] demanded to be let in the office for toothpaste and toothbrush. I explained to [client A] that I was busy and would let her know when I could open the office for her. [Client A] yelled that she was walking the road and walked out of sight.			

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	I called [AS] the Area Supervisor and [Licensed Practical Nurse (LPN)], agency nurse. [Client A] got in someone's car and the driver drove her back to the house since he has seen her before. I got [client A] back inside where she continued to demand to brush her teeth once again. I asked her to ask nicely, to which she asked in a polite way, then went to brush her teeth. [Client G]/client; Did not provide any information relevant to this investigation. [Client A]/client: I want to brush my teeth. [Client D]/client: Did not provide any information relevant to this investigation. 2. Where did the elopement occur or happen? [Address]. 3. What was going on prior to the elopement? [Client A] was socializing with her peers. 4. Was medical treatment needed as a result of the elopement? No. 5. Does this consumer have a history of elopement and is it addressed appropriately in the ISP/BSP and Health Care Plan? Yes, and it is addressed appropriately in the BSP. She is also established with [name] Behavioral Health. 6. Were there any environmental factors that contributed to the elopement? If yes, please explain what. No. The house is equipped with working door alarms that are on all the doors. 7. Do any changes need to be made to prevent future occurrences? No. 8. Was there sufficient staff at the time of the incident? No. The agency is actively recruiting to fill open shift positions. Area supervisor and program manager to continue efforts to provide double staffing at this home during waking hours. 9. Conclusion: Substantiated. [Client A] did become upset and leave the grounds and got into someone's car and was brought back to the house. She was out of line of sight for approximately 7 minutes. Recommendations:			

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	[Client A] has been established with [name] Behavioral Health. She has behavioral supports for elopement which remain appropriate." Client A's record was reviewed on 3/12/24 at 12:00 pm. The review indicated the following: A Comprehensive Functional Assessment dated 9/23/23 indicated client A required "physical assistance" for pedestrian safety. An ISP dated 9/23/23 indicated client A was "restricted to areas of the building and ground unless supervised by staff." A BSP dated 9/23/23 indicated, "Diagnosis: Mild I/DD, Multiple Sclerosis, osteoporosis, epilepsy, hyperlipidemia, depression, seizures, severe dementia with gait disturbance, hypothyroidism. Area: Elopement. Goal: To decrease elopement [defined by running away, leaving supervision of staff without staff's knowledge...] by increasing involvement in a broader range of meaningful activities, thus increasing independence. Objective: [Client A] will experience no more than 4 episodes of elopement behaviors per month across 6 months by 3/23/24. Replacement Behavior: [Client A] will comply with staff's requests unless she is unable to provide a legitimate reason for not complying... Reactive Strategies: ...follow [client A] and encourage her to return...immediately call the manager...direction will be given at that time... [Client A] will then be on 5 minute tracking after elopement. Staff will monitor [client A's] whereabouts about every 5 minutes. This will remain in place until an IDT (interdisciplinary			

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	team) meeting is held to discuss a plan. Measurement Criteria: Frequency recording. Training Schedule: Continuous. Reinforcement Schedule: Continuous...". 5 Minute Location Tracking forms were not available for the timeframe after each of client A's elopements. Direct Support Professional (DSP) #2 was interviewed on 3/12/24 at 4:30 pm. DSP #2 stated client A "has good days but has been having more bad days with her dementia." DSP #2 stated client A, "is very needy, she want attention now no matter what staff is doing." DSP #2 indicated 2 staff are needed during waking hours to implement client A's plans. DSP #3 was interviewed on 3/12/24 at 4:45 pm. DSP #3 stated, "[Client A] ran away on me once. The [Area Supervisor] brought her back. She was gone a good 15 to 30 minutes." DSP #3 stated "I was the only staff here. There needs to be two staff because it was dark out and she's confused." The Qualified Intellectual Disabilities Professional (QIDP) was interviewed 3/13/24 at 2:00 pm. The QIDP indicated client A has had elopement incidents. There QIDP stated, "there was only 1 staff in the home during both elopements." The QIDP indicated 1 staff was not enough to take care of all clients and follow client A's plans. The QIDP stated, "they're trying to get more staff hired." The QIDP stated, "the staff need more training on her plans." The QIDP indicated Rescare had a policy for abuse and neglect. The QIDP stated the policy for abuse and neglect should "always be followed."			

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	The Qualified Intellectual Disabilities Professional Manager (QM) was interviewed 3/19/24 at 2:00 pm. The QM stated, "There was only 1 staff in the home" during client A's elopements. The QM stated, "one staff is not enough" to complete house duties and follow client A's plans. The QM stated "there should be at least 2 staff during waking hours." The QM stated, "staff didn't follow her plan in these incidents although they are trained on the clients' plans every month. More training will never hurt." The QM stated the facility defined abuse/neglect as, "ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights." The QM stated the facility's policy for abuse and neglect define neglect as "the failure to provide services." The QM stated the facility's policy on abuse and neglect should be implemented as written "always." The Quality Assurance Manager (QAM) was interviewed on 3/19/24 at 2:30 pm. The QAM stated the facility had a policy for abuse/neglect and "abuse and neglect is strictly prohibited per the policy." The Abuse Neglect Exploitation policy dated 2/1/24 was reviewed on 3/12/24 at 2:00 pm. The policy indicated, "...Policy: ResCare does not tolerate abuse, neglect, or exploitation of any persons served. All employees are required to report all allegations, or suspected incidents, of abuse, neglect, and/or exploitation. All alleged or suspected incidents of abuse, neglect, and/or exploitation will be immediately investigated; and appropriate corrective action will be taken to ensure prevention of further occurrence. Supervisors, managers, and employees are not permitted to engage in retaliation or retribution, to include any form of harassment directed against			

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	an employee who, in good faith, reports allegations or suspected incidents of abuse, neglect and/or exploitation." This federal tag relates to complaint #IN00427649. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 1 of 3 sampled clients (client A), the facility failed to ensure effective corrective measures were developed and implemented after elopement incidents for client A. Findings include: The facility's Bureau of Disabilities Services (BDS) reports and investigations were reviewed on 3/12/24 at 3:30 pm. The review included the following: 1. A BDS report dated 2/3/24 at 4:05 pm indicated, "After waking up from a nap, [client A] forgot to put on her glasses and attempted to take a peer's glasses. Staff separated [client A] and peer. [Client A] told staff she was going to walk down the road. Staff attempted to verbally redirect [client A]. [Client A] left the house and walked down the street. [Client A] was out of line of sight for 20 minutes. Staff lost line of sight of [client A] due to supervising other peers in the home. [Client A] presently does not have alone time in her plan. Area Supervisor and Program Manager notified. Program Manager located [client A] on a neighbor's porch. Program Manger got [client A] into their vehicle and took [client A] home. Upon	W 0157	**QIDP is responsible for development, coordination, and monitoring of client's active treatment plan to ensure all of client's behavioral and medical needs are met appropriately.** **All QIDPs will be retrained on ensuring Interdisciplinary Team Meetings are held and appropriate corrective measure are implemented pursuant to client behavioral and medical needs when increase in frequency or intensity or new behavioral trends emerge.** **All QIDPs will be retrained on notifying Executive Director when change in behaviors indicates possible need for additional behavioral clinician supports.** **Ongoing, QIDP Manager will conduct a quarterly audit of all client charts to ensure appropriate corrective measure are implemented through convening of Interdisciplinary**	04/17/2024

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	returning home, [client A] was calm and resumed normal activity. Staff assessed for injuries, and none were observed. Staff will continue to follow [client A's] behavioral plan that addresses elopement. Staff will continue to monitor [client A] and report and changes in her health. An elopement investigation will be initiated." An investigation dated 2/6/24 indicated, "Conclusion: Substantiated. [Client A] did become upset and leave the grounds...Recommendations: [Client A] has been established with [name] Behavioral Health. She has behavioral supports for elopement which remain appropriate". 2. A BDS report dated 2/23/24 at 7:40 am indicated, "[Client A] became angry when she could not get in the office immediately to get some toiletries. Rather than waiting, [client A] stormed out of the house, yelling and cursing and started walking down the road. A male driver, who recognized [client A], picked her up and took her back to the house. [Client A] had been out of sight for approximately seven minutes because there was only one staff person in the home, and she could not leave the other clients in the home to follow [client A]. She did call her supervisor immediately to request backup. [Client A] does not presently have any alone time in her plan. [Client A] does not presently have any alone time in her plan. [Client A] had calmed down by the time she arrived back at the house. Staff assessed for injuries and there was (sic) none. Staff supervisor and nurse were notified. Plan to Resolve: Staff will continue to follow [client A's] BSP (Behavior Support Plan) for Elopement." An investigation dated 2/27/24 indicated, "Conclusion: Substantiated. [Client A] did		**Team Meetings and effective measures are developed pursuant to client behavioral and medical needs.** **Client A was previously established with Kestrel Behavioral Health in October of 2023 and behavior plan by Kestrel was being finalized while complaint survey was being conducted.** **New behavior plan for Client A was finalized by Kestrel Behavioral Health on 03/13/24 and all staff were trained on the newly developed plan as of 03/13/24.**	

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	become upset and leave the grounds and got into someone's car and was brought back to the house. She was out of line of sight for approximately 7 minutes... Recommendations: [Client A] has been established with [name] Behavioral Health. She has behavioral supports for elopement which remain appropriate.". Client A's record was reviewed on 3/12/24 at 12:00 pm. The review indicated the following: A Comprehensive Functional Assessment dated 9/23/23 indicated client A required "physical assistance" for pedestrian safety. An ISP (Individual Support Plan) dated 9/23/23 indicated client A was "restricted to areas of the building and ground unless supervised by staff." A BSP dated 9/23/23 indicated, "Diagnosis: Mild I/DD, Multiple Sclerosis, osteoporosis, epilepsy, hyperlipidemia, depression, seizures, severe dementia with gait disturbance, hypothyroidism. Area: Elopement. Goal: To decrease elopement [defined by running away, leaving supervision of staff without staff's knowledge...] by increasing involvement in a broader range of meaningful activities, thus increasing independence. Objective: [Client A] will experience no more than 4 episodes of elopement behaviors per month across 6 months by 3/23/24. Replacement Behavior: [Client A] will comply with staff's requests unless she is unable to provide a legitimate reason for not complying... Reactive Strategies: ...follow [client A] and encourage her to return...immediately call the manager...direction will be given at that time...			

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	15G440	A. BUILDING 00 B. WING	03/19/2024

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	[Client A] will then be on 5 minute tracking after elopement. Staff will monitor [client A's] whereabouts about every 5 minutes. This will remain in place until an IDT (interdisciplinary team) meeting is held to discuss a plan. Measurement Criteria: Frequency recording. Training Schedule: Continuous. Reinforcement Schedule: Continuous...". 5 Minute Location Tracking forms were not available for the timeframe after each of client A's elopements thus client A's plans for elopement were not followed by staff. The review indicated recommendations from the investigations did not include training for staff on implementing client A's plans to include pre-cursors, positive programming and reactive strategies. The Qualified Intellectual Disabilities Professional (QIDP) was interviewed 3/13/24 at 2:00 pm. The QIDP indicated client A has had elopement incidents. The QIDP indicated client A had a plan for elopements. The QIDP indicated staff did not follow those plans as written. The QIDP indicated she completed the investigation for client A's elopements. The QIDP stated "recommendations from the investigations should have included staff training." The Qualified Intellectual Disabilities Professional Manager (QM) was interviewed 3/19/24 at 2:00 pm. The QM stated she was "not able to track down any 5 minute tracking forms for...February." The QM stated staff "didn't follow her plan" and they "should have tracked" client A's location every 5 minutes per her plan. The QM stated "recommendations from the investigations should			

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	have included staff training." This federal tag relates to complaint #IN00427649. 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 1 of 3 sampled clients (client A), the facility failed to ensure the group home had sufficient direct care staff to effectively implement client A's plans. Findings include: The facility's Bureau of Disabilities Services (BDS) reports and investigations were reviewed on 3/12/24 at 3:30 pm. The review included the following: 1. A BDS report dated 2/3/24 at 4:05 pm indicated, "After waking up from a nap, [client A] forgot to put on her glasses and attempted to take a peer's glasses. Staff separated [client A] and peer. [Client A] told staff she was going to walk down the road. Staff attempted to verbally redirect [client A]. [Client A] left the house and walked down the street. [Client A] was out of line of sight for 20 minutes. Staff lost line of sight of [client A] due to supervising other peers in the home. [Client A] presently does not have alone time in	W 0186	**The facility will provide sufficient staff to manage and supervise clients in accordance with their individualized plan. The home has recently experienced turnover that has initiated extra recruiting and training efforts to meet the needs of the individuals in the home.** **All staff in the home will be retrained on contacting their chain of command upon noting staffing levels in the home to not be sufficient.** **Program Manager will review all schedules to ensure adequate staffing is in place at all locations and work with Human Resources to recruit to fill staff vacancies in impacted homes.** **The Area Supervisor is**	04/17/2024

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	her plan. Area Supervisor and Program Manager notified. Program Manager located [client A] on a neighbor's porch. Program Manger got [client A] into their vehicle and took [client A] home. Upon returning home, [client A] was calm and resumed normal activity. Staff assessed for injuries, and none were observed. Staff will continue to follow [client A's] behavioral plan that addresses elopement. Staff will continue to monitor [client A] and report and changes in her health. An elopement investigation will be initiated." An investigation dated 2/6/24 indicated, "Description of incident: After waking up from a nap, [client A] forgot to put on her glasses and attempted to take a peer's glasses. Staff separated [client A] and peer. [Client A] told staff she was going to walk down the road. Staff attempted to verbally redirect [client A]. [Client A] left the house and walked down the street. [Client A] was out of line of sight for 20 minutes. Staff lost line of sight of [client A] due to supervising other peers in the home. [Client A] presently does not have alone time in her plan. Area Supervisor (AS) and Program Manager (PM) notified. Program Manager located [client A] on a neighbor's porch. Program Manager got [client A] into their vehicle and took [client A] home. Upon returning home, [client A] was calm and resumed normal activity. Staff assessed for injuries, and none were observed...Witness Statements: [Client A]/client: I was mad and wanted to walk...Was there sufficient staff at the time of the incident? No. Conclusion: Substantiated. [Client A] did become upset and leave the grounds...". 2. A BDS report dated 2/23/24 at 7:40 am indicated, "[Client A] became angry when she could not get in the office immediately to get some toiletries. Rather than waiting, [client A] stormed out of the		**responsible for ensuring that there is sufficient staff in the home at all times. The Area Supervisor is responsible to review and approve the staffing schedule weekly to ensure that adequate staffing is assigned. The staffing schedule has been reviewed for the home and the Area Supervisor will monitor that adequate staff are assigned daily.** **Program Manager will train the Area Supervisor on Job Responsibilities ensuring adequate staffing in the home.** **Administrative observations have been implemented in the home and will remain in place until the team determines it is appropriate to decrease the number of observations. This will ensure all corrections are implemented per ResCare policy and regulations.** **Ongoing weekly and monthly observations and review will continue with the QIDP and Area Supervisor over the location.**	

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	house, yelling and cursing and started walking down the road. A male driver, who recognized [client A], picked her up and took her back to the house. [Client A] had been out of sight for approximately seven minutes because there was only one staff person in the home, and she could not leave the other clients in the home to follow [client A]. She did call her supervisor immediately to request backup. [Client A] does not presently have any alone time in her plan. [Client A] does not presently have any alone time in her plan. [Client A] had calmed down by the time she arrived back at the house. Staff assessed for injuries and there was none. Staff supervisor and nurse were notified. Plan to Resolve: Staff will continue to follow [client A's] BSP (behavior support plan) for Elopement." An investigation dated 2/27/24 indicated, "Description of incident: [Client A] became angry when she could not get in the office immediately to get some toiletries. Rather than waiting, [client A] stormed out of the house, yelling and cursing and started walking down the road. A male driver, who recognized [client A], picked her up and took her back to the house. [Client A] had been out of sight for approximately seven minutes because there was only one staff person in the home, and she could not leave the other clients in the home to follow [client A]. She did call her supervisor immediately to request backup. [Client A] does not presently have any alone time in her plan. [Client A] does not presently have any alone time in her plan. [Client A] had calmed down by the time she arrived back at the house. Staff assessed for injuries and there was none. Staff supervisor and nurse were notified. Witness Statements:..[DSP #1]: I was helping other residents when [Client A] demanded to be let in the office for toothpaste and toothbrush. I explained to [client A] that I was			

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	busy and would let her know when I could open the office for her. [Client A] yelled that she was walking the road and walked out of sight. I called [AS] the Area Supervisor and [Licensed Practical Nurse (LPN)], agency nurse. [Client A] got in someone's car and the driver drove her back to the house since he has seen her before. I got [client A] back inside where she continued to demand to brush her teeth once again. I asked her to ask nicely, to which she asked in a polite way, then went to brush her teeth...[Client A]/client: I want to brush my teeth...Does this consumer have a history of elopement and is it addressed appropriately in the ISP (individual support plan)/BSP and Health Care Plan? Yes, and it is addressed appropriately in the BSP. She is also established with [name] Behavioral Health. Do any changes need to be made to prevent future occurrences? No. Was there sufficient staff at the time of the incident? No...9. Conclusion: Substantiated. [Client A] did become upset and leave the grounds and got into someone's car and was brought back to the house. She was out of line of sight for approximately 7 minutes.". The review indicated client A eloped the home and was out of staff's line of sight twice in less than a month. Client A's record was reviewed on 3/12/24 at 12:00 pm. The review indicated the following: A Comprehensive Functional Assessment dated 9/23/23 indicated client A required "physical assistance" for pedestrian safety. An ISP dated 9/23/23 indicated client A was "restricted to areas of the building and ground unless supervised by staff."			

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	A Comprehensive Functional Assessment dated 9/23/23 indicated client A required "physical assistance" for pedestrian safety. A BSP dated 9/23/23 indicated, "Diagnosis: Mild I/DD, Multiple Sclerosis, osteoporosis, epilepsy, hyperlipidemia, depression, seizures, severe dementia with gait disturbance, hypothyroidism. Area: Elopement. Goal: To decrease elopement [defined by running away, leaving supervision of staff without staff's knowledge...] by increasing involvement in a broader range of meaningful activities, thus increasing independence. Objective: [Client A] will experience no more than 4 episodes of elopement behaviors per month across 6 months by 3/23/24. Replacement Behavior: [Client A] will comply with staff's requests unless she is unable to provide a legitimate reason for not complying... Reactive Strategies: ...follow [client A] and encourage her to return...immediately call the manager...direction will be given at that time... [Client A] will then be on 5 minute tracking after elopement. Staff will monitor [client A's] whereabouts about every 5 minutes. This will remain in place until an IDT (interdisciplinary team) meeting is held to discuss a plan. Measurement Criteria: Frequency recording. Training Schedule: Continuous. Reinforcement Schedule: Continuous...". Direct Support Professional (DSP) #2 was interviewed on 3/12/24 at 4:30 pm. DSP #2 stated client A "has good days but has been having more bad days with her dementia." DSP #2 stated client A, "is very needy, she want attention now no matter what staff is doing." DSP #2 indicated 2 staff are needed during waking hours to implement client A's plans.			

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	DSP #3 was interviewed on 3/12/24 at 4:45 pm. DSP #3 stated, "[Client A] ran away on me once. The [Area Supervisor] brought her back. She was gone a good 15 to 30 minutes." DSP #3 stated "I was the only staff here. There needs to be two staff because it was dark out and she's confused." The Qualified Intellectual Disabilities Professional (QIDP) was interviewed 3/13/24 at 2:00 pm. The QIDP indicated client A has had elopement incidents. The QIDP indicated she completed investigations for the elopements. There QIDP stated, "there was only 1 staff in the home during both elopements." The QIDP indicated 1 staff was not enough to take care of all clients and follow client A's plans. The QIDP stated, "they're trying to get more staff hired." The Qualified Intellectual Disabilities Professional Manager (QM) was interviewed 3/19/24 at 2:00 pm. The QM stated, "There was only 1 staff in the home" during client A's elopements. The QM stated, "one staff is not enough" to complete house duties and follow client A's plans. The QM stated "there should be at least 2 staff during waking hours." This federal tag relates to complaint #IN00427649. 9-3-3(a)			
W 0189 Bldg. 00	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on observation, record review and interview for 1 of 3 sampled clients (client A) the facility failed to ensure staff were trained	W 0189	**The facility has policies and procedures in place to train employees who work with**	04/17/2024

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	regarding client A's plans. Findings include: The facility's Bureau of Disabilities Services (BDS) reports and investigations were reviewed on 3/12/24 at 3:30 pm. The review included the following: 1. A BDS report dated 2/3/24 at 4:05 pm indicated, "After waking up from a nap, [client A] forgot to put on her glasses and attempted to take a peer's glasses. Staff separated [client A] and peer. [Client A] told staff she was going to walk down the road. Staff attempted to verbally redirect [client A]. [Client A] left the house and walked down the street. [Client A] was out of line of sight for 20 minutes. Staff lost line of sight of [client A] due to supervising other peers in the home. [Client A] presently does not have alone time in her plan. Area Supervisor and Program Manager notified. Program Manager located [client A] on a neighbor's porch. Program Manger got [client A] into their vehicle and took [client A] home. Upon returning home, [client A] was calm and resumed normal activity. Staff assessed for injuries, and none were observed. Staff will continue to follow [client A's] behavioral plan that addresses elopement. Staff will continue to monitor [client A] and report and changes in her health. An elopement investigation will be initiated." An investigation dated 2/6/24 indicated, "Description of incident: After waking up from a nap, [client A] forgot to put on her glasses and attempted to take a peer's glasses. Staff separated [client A] and peer. [Client A] told staff she was going to walk down the road. Staff attempted to verbally redirect [client A]. [Client A] left the house and walked down the street. [Client A] was		**clients on skills and competencies directed towards clients' health needs and programming objectives.** **Area Supervisor and QIDP will be retrained on ensuring all staff are thoroughly consumer specific trained to include their ISP, BSP, reactive strategies, and objectives.** **All staff will be retrained on competency-based consumer specific training for all individuals to include their ISP, BSP, reactive strategies, and objectives.** **All clients have the potential to be affected by this deficiency.** **Consumer specific training and reviewing client needs remains a prominent component of the agencies all staff monthly meetings.** **Administrative observations have been implemented in the home and will remain in place until the team determines it is appropriate to decrease the number of observations. This will ensure all corrections are implemented per ResCare policy and regulations.** **Ongoing weekly and monthly observations and review will continue with the QIDP and Area Supervisor over the location.**	

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	out of line of sight for 20 minutes. Staff lost line of sight of [client A] due to supervising other peers in the home. [Client A] presently does not have alone time in her plan. Area Supervisor (AS) and Program Manager (PM) notified. Program Manager located [client A] on a neighbor's porch. Program Manager got [client A] into their vehicle and took [client A] home. Upon returning home, [client A] was calm and resumed normal activity. Staff assessed for injuries, and none were observed...Does this consumer have a history of elopement and is it addressed appropriately in the ISP (individual support plan)/BSP (behavior support plan) and Health Care Plan? Yes, and it is addressed appropriately in the BSP. Conclusion: Substantiated. [Client A] did become upset and leave the grounds. 2. A BDS report dated 2/23/24 at 7:40 am indicated, "[Client A] became angry when she could not get in the office immediately to get some toiletries. Rather than waiting, [client A] stormed out of the house, yelling and cursing and started walking down the road. A male driver, who recognized [client A], picked her up and took her back to the house. [Client A] had been out of sight for approximately seven minutes because there was only one staff person in the home, and she could not leave the other clients in the home to follow [client A]. She did call her supervisor immediately to request backup. [Client A] does not presently have any alone time in her plan. [Client A] does not presently have any alone time in her plan. [Client A] had calmed down by the time she arrived back at the house. Staff assessed for injuries and there was (sic) none. Staff supervisor and nurse were notified. Plan to Resolve: Staff will continue to follow [client A's] BSP for Elopement."			

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	hyperlipidemia, depression, seizures, severe dementia with gait disturbance, hypothyroidism. Area: Elopement. Goal: To decrease elopement [defined by running away, leaving supervision of staff without staff's knowledge...] by increasing involvement in a broader range of meaningful activities, thus increasing independence. Objective: [Client A] will experience no more than 4 episodes of elopement behaviors per month across 6 months by 3/23/24. Replacement Behavior: [Client A] will comply with staff's requests unless she is unable to provide a legitimate reason for not complying... Reactive Strategies: ...follow [client A] and encourage her to return...immediately call the manager...direction will be given at that time... [Client A] will then be on 5 minute tracking after elopement. Staff will monitor [client A's] whereabouts about every 5 minutes. This will remain in place until an IDT (interdisciplinary team) meeting is held to discuss a plan. Measurement Criteria: Frequency recording. Training Schedule: Continuous. Reinforcement Schedule: Continuous...". 5 Minute Location Tracking forms were not available for the timeframe after each of client A's elopements. The Qualified Intellectual Disabilities Professional (QIDP) was interviewed 3/13/24 at 2:00 pm. The QIDP indicated client A has had elopement incidents. The QIDP stated, "the staff need more training on her plans." The Qualified Intellectual Disabilities Professional			

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	Manager (QM) was interviewed 3/19/24 at 2:00 pm. The QM indicated client A had elopement incidents. The QM stated, "staff didn't follow her plan in these incidents although they are trained on the clients' plans every month. More training will never hurt." This federal tag relates to complaint #IN00427649. 9-3-3(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on interview and record review for 1 of 3 sampled clients (client A) the facility failed to ensure staff followed client A's plans. Findings include: The facility's Bureau of Disabilities Services (BDS) reports and investigations were reviewed on 3/12/24 at 3:30 pm. The review included the following: 1. A BDS report dated 2/3/24 at 4:05 pm indicated, "After waking up from a nap, [client A] forgot to put on her glasses and attempted to take a peer's glasses. Staff separated [client A] and peer. [Client A] told staff she was going to walk down the road. Staff attempted to verbally redirect [client A]. [Client A] left the house and walked down the street. [Client A] was out of line of sight	W 0249	**Client A was previously established with Kestrel Behavioral Health in October of 2023 and behavior plan by Kestrel was being finalized while complaint survey was being conducted.** **New behavior plan for Client A was finalized by Kestrel Behavioral Health on 03/13/24 and all staff were trained on the newly developed plan as of 03/13/24.** **All staff in home will be retrained on ensuring 5 minute location tracking is being implemented and documented per Client A's plan to address elopement.**	04/17/2024

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	15G440	A. BUILDING 00 B. WING	03/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORMAL LIFE OF INDIANA	1970 E 45 1/2 CT TERRE HAUTE, IN 47802

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	for 20 minutes. Staff lost line of sight of [client A] due to supervising other peers in the home. [Client A] presently does not have alone time in her plan. Area Supervisor and Program Manager notified. Program Manager located [client A] on a neighbor's porch. Program Manger got [client A] into their vehicle and took [client A] home. Upon returning home, [client A] was calm and resumed normal activity. Staff assessed for injuries, and none were observed. Staff will continue to follow [client A's] behavioral plan that addresses elopement. Staff will continue to monitor [client A] and report and changes in her health. An elopement investigation will be initiated." An investigation dated 2/6/24 indicated, "Conclusion: Substantiated. [Client A] did become upset and leave the grounds...". 2. A BDS report dated 2/23/24 at 7:40 am indicated, "[Client A] became angry when she could not get in the office immediately to get some toiletries. Rather than waiting, [client A] stormed out of the house, yelling and cursing and started walking down the road. A male driver, who recognized [client A], picked her up and took her back to the house. [Client A] had been out of sight for approximately seven minutes because there was only one staff person in the home, and she could not leave the other clients in the home to follow [client A]. She did call her supervisor immediately to request backup. [Client A] does not presently have any alone time in her plan. [Client A] does not presently have any alone time in her plan. [Client A] had calmed down by the time she arrived back at the house. Staff assessed for injuries and there was none. Staff supervisor and nurse were notified. Plan to Resolve: Staff will continue to follow [client A's] BSP for Elopement."		**All staff will be retrained on ensuring door alarms in home are sounding appropriately, notifying maintenance of any issues with door alarms, and completing daily documentation appropriately on functionality of alarm system.** **All staff will be retrained on competency-based consumer specific training for all individuals in the home to include their ISP, BSP, reactive strategies, and objectives.** **All clients have the potential to be affected by this deficiency. Consumer specific training and reviewing client needs remains a prominent component of the agencies all staff monthly meetings.** **Administrative observations have been implemented in the home and will remain in place until the team determines it is appropriate to decrease the number of observations. This will ensure all corrections are implemented per ResCare policy and regulations.** **Ongoing weekly and monthly observations and review will continue with the QIDP and Area Supervisor over the location.**	

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	An investigation dated 2/27/24 indicated, "Conclusion: Substantiated. [Client A] did become upset and leave the grounds and got into someone's car and was brought back to the house. She was out of line of sight for approximately 7 minutes...". Client A's record was reviewed on 3/12/24 at 12:00 pm. The review indicated the following: A Comprehensive Functional Assessment dated 9/23/23 indicated client A required "physical assistance" for pedestrian safety. An ISP dated 9/23/23 indicated client A was "restricted to areas of the building and ground unless supervised by staff." A BSP dated 9/23/23 indicated, "Diagnosis: Mild I/DD, Multiple Sclerosis, osteoporosis, epilepsy, hyperlipidemia, depression, seizures, severe dementia with gait disturbance, hypothyroidism. Area: Elopement. Goal: To decrease elopement [defined by running away, leaving supervision of staff without staff's knowledge...] by increasing involvement in a broader range of meaningful activities, thus increasing independence. Objective: [Client A] will experience no more than 4 episodes of elopement behaviors per month across 6 months by 3/23/24. Replacement Behavior: [Client A] will comply with staff's requests unless she is unable to provide a legitimate reason for not complying... Reactive Strategies: ...follow [client A] and encourage her to return...immediately call the manager...direction will be given at that time...			

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	[Client A] will then be on 5 minute tracking after elopement. Staff will monitor [client A's] whereabouts about every 5 minutes. This will remain in place until an IDT (interdisciplinary team) meeting is held to discuss a plan. Measurement Criteria: Frequency recording. Training Schedule: Continuous. Reinforcement Schedule: Continuous...". 5 Minute Location Tracking forms were not available for the timeframe after each of client A's elopements thus client A's plans for elopement were not followed by staff. The Qualified Intellectual Disabilities Professional (QIDP) was interviewed 3/13/24 at 2:00 pm. The QIDP indicated client A has had elopement incidents. The QIDP indicated client A had a plan for elopements. The QIDP indicated staff did not follow those plans as written. The QIDP stated staff "should have" followed client A's plans as written. The Qualified Intellectual Disabilities Professional Manager (QM) was interviewed 3/19/24 at 2:00 pm. The QM stated she was "not able to track down any 5 minute tracking forms for...February." The QM stated staff "didn't follow her plan" and they "should have tracked" client A's location every 5 minutes per her plan. This federal tag relates to complaint #IN00427649. 9-3-4(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in			

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	compliance with the physician's orders. Based on record review and interview for 1 of 3 sampled clients (client A), the facility failed to ensure staff administered client A's medications per physician's orders. Findings include: Client A's record was reviewed on 3/12/24 at 12:00 pm. The review indicated the following: A physician's order sheet dated January 2024 indicated client A had an order for "rivastigmine 13.3/24 patch. Apply 1 patch topically as directed once daily for dementia...glatiramer inject 20 mg under the skin once daily for multiple sclerosis...alendronate 70 mg tablet, give one table every week...for osteoporosis..." A Medication Administration Record (MAR) for January 2024 indicated client a did not receive her rivastigmine 13.3/24 patch for dementia on 1/29, 1/30 and 1/31/24, did not receive her glatiramer injection on 1/27 and 1/28 and did not receive her alendronate 70 mg tablet on 1/11 and 1/18/24. The Licensed Practical Nurse (LPN) was interviewed on 3/13/24 at 1:30 pm. The LPN stated "it is mandatory that all staff are Core A and Core B trained before entering the home." The LPN stated "I do all the med training upon hire and as needed." The LPN stated "yes, orders should be followed". The Qualified Intellectual Disabilities Professional (QIDP) was interviewed 3/13/24 at 2:00 pm. The QIDP stated, "meds should be given per the MAR (medication administration record)." The Qualified Intellectual Disabilities Professional Manager (QM) was interviewed 3/19/24 at 2:00	W 0368	**The facility recently implemented QuickMar for electronic recording and monitoring of medication administration. All staff have been trained on the use of QuickMar, including medication administration, ordering and documentation requirements.** **Area Supervisors and Nursing have received training on verifying medication orders per physician orders, ordering medications and monitoring medication administration in real-time using the QuickMar program.** **All staff in the home will receive retraining on medication administration procedure to include following Physician Orders as noted in QuickMar.** **Area Supervisors and Nurses will continue to review the QuickMar documentation daily to ensure medication administration, treatments and supplies are completed and available, without issue, per agency polices and physician orders.** **Administrative observations have been implemented in the home and will remain in place until the team determines it is appropriate to decrease the number of observations. This**	04/17/2024

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	pm. The QM indicated all staff in the home are Core A and Core B trained. The QM stated, "staff should give meds as ordered on the MAR." The Quality Assurance Manager (QAM) was interviewed on 3/19/24 at 2:30 pm. The QAM stated physician's orders should be followed "at all times." This federal tag relates to complaint #IN00427649. 9-3-6(a)		**will ensure all corrections are implemented per ResCare policy and regulations. Ongoing weekly and monthly observations and review will continue with the QIDP and Area Supervisor over the location.**	