STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G465	A. BUILDING 00 B. WING	09/17/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	6025 BUCKSKIN CT INDIANAPOLIS, IN 46250

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W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. Dates of Survey: September 9, 10, 11, 12, 13 and 17, 2019. Facility Number: 000979 Provider Number: 15G465 AIMS Number: 100244860 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 9/27/19.	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 (#1), the facility failed to implement its policy and procedures to prevent the neglect of client #1 regarding client #1's undetected elopement for an extended period of time and failed to complete a thorough investigation regarding client #1's undetected elopement for an extended period of time. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 9/10/19 at 10:28 AM. A BDDS report dated 8/16/19 indicated, "... On the night of 8/15/19, at 10:10 PM, direct support staff [staff] #1 discovered that [client] #1 was not in the home. Two staff were	W 0149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically: The QIDP will retrain all facility direct support and supervisory staff toward proper implementation of client #1's Behavior Support Plan. All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and	10/17/2019

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

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	present in the home at the time. The second staff (staff) #2 was in another area of the home attending to the laundry while [staff] #1 was responsible for supervising the individuals who live in the home. Staff contacted the supervisor and initiated a search of the area. When staff could not locate [client] #1 in the immediate vicinity, supervisors and administrative staff arrived to join the search and police were called and a missing person report was filed. ResCare administrative staff located [client] #1 in a wooded area adjacent to the house at 2:00 AM. Staff completed a physical assessment and provided [client] #1 with food and hydration... It should be noted that [client] #1 does not have plan approved alone time... The incident is under investigation and [staff] #1 has been suspended, while investigators determine whether or not appropriate supervision was provided at the time of the incident." An IS (Investigative Summary) form dated 8/15/19 to 8/20/19 indicated the following: -"... Scope of Investigation" -"1. How did [client] #1 leave the house without staff knowing? -"2. Were the door alarms on or off?" -"3. What was staff doing when [client] #1 left the house?" -"4. How did [client] #1 obtain the knife she was found with?" -"5. Did staff follow [client] #1's Behavior Support Plan (BSP)?"		testimonial evidence to identify and clarify discrepancies. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. The investigator assigned responsibility for completing investigations at the facility will receive additional training regarding investigation timelines and components of a thorough investigation. The focus of this training will include emphasis on the need to gather testimony from all potential witnesses at the earliest possible opportunity. This training will include side by side collaborative completion of an investigation with the Quality Assurance Manager. In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigator will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence, development of appropriate scope and conclusions. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. Additionally, the governing body will develop an investigation follow-up checklist to assist with supervisory review and oversight of all investigations. When	

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	-"6. Did staff follow ResCare policy and procedures?...". -"Summary Of Interviews...". -"[Client] #1" -"Could not complete interview due to hospitalization...". -"[RM (Residential Manager] #1" -"They called me at 10:35 pm, so the time sounds off to me." -"I (RM) #1 made sure all the alarms were on before I left." -"I (RM) #1 don't know how they (staff) did not hear the alarm go off when she (client) #1 went out the door." -"I (RM) #1 end (sic) up calling [AS (Area Supervisor] #1 the AS and he had us call the police to assist." -"She (client) #1 was in the woods by the house when ResCare supervisor found her." -"The police did a check on her and left." -"She (client) #1 told me she had the knife when I talked to her." -"[Client] #1 said she got it out of the dishwasher, while helping clean up." -"When she (client) #1 is gone to day services we go through her room and try to check for stuff like that."		deficiencies are noted, The Quality Assurance Manager and/or QIDP Manager will make corrections to investigations to assure they are thorough and meet regulatory requirements. **PREVENTION:** The facility's QIDP will be trained regarding the need to assure aggressive and consistent implementation of active treatment for all clients, including but not limited to implementation of clients' proactive and reactive behavior support strategies. 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 implementation of Behavior Support Plans. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger Assistant Nurse Manager) and the QIDP will conduct administrative monitoring during varied shifts/times, no less than 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	

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	-"[Staff] #2" -"I (staff) #2 was there that night, but I (staff) #2 clocked out at 10 pm, I was not there when she (client) #1 left the house." -"That evening after dinner I (staff) #2 was doing active treatment for the clients that were in the living room." -"We were watching TV (sic) talking and I (staff) #2 remember [client] #1 was on the phone for a while." -"I (staff) #2 left at 10 pm and [client] #1 was in her room at that point." -"[Staff] #1" -"I (staff) #1 was in the med room doing the medications and body checks." -"When I completed all of that, I went to look in on all the people and I saw [client] #1 was not there." -"I (staff) #1 think she (client) #1 turned the alarm off that's why we did not hear the alarm." -"We called the RM (#1), I stayed in the house at first and [staff] #2 went to look for her." -"I (staff) #1 was not there when they found her I was off at 12 AM and the supervisor said I could leave." -"We (staff) keep the sharps in the office." -"I (staff) #1 gave her (client) #1 meds that night		ongoing support needed at the facility, which will occur no less than monthly. 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 Assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring behavior interventions are implemented as written. The QIDP Manager will maintain 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	

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	and watched her very close (sic)." -"This is new to me about how she would get a knife, she (client) #1 could have got it some time ago and hide (sic) the knife." -"I (staff) #1 made sure she went to her bedroom after meds." -"[Staff] #2" -"I (staff) #2 was in between the laundry room and the garage. -"We keep the laundry baskets in the garage, so I rotate basket from the garage." -"When I got there at 8 pm there were some clients up watching TV in the living room." -"[Client] #1 had gone to her room by that time." -"[Staff] #1 was in the med room doing paperwork, but other than that I don't know what he (staff) #1 was doing." -"When we discovered that [client] #1 was not in the house we started looking for her all over the house." -"We then took turns going outside to look for her with a flashlight, I (staff) #2 checked several areas." -"We called the supervisor and asked should we call the police, and the supervisor [AS] #1 said he would call us right back." -"We were informed to call 911 (Emergency Services) and that ResCare team would be out to		the Quality Assurance Manager, Quality Assurance Coordinators, QIDP Manager, Program Director, Program Managers, Nurse Manager and Assistant Nurse Manager. The QA Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team	

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	help us look for [client] #1." -"[Client] #1 was located in the woods behind the house by a ResCare supervisor, I don't know her name." -"The police asked that if we found her to give them a call." -When the police arrived at the house they did a welfare check to make sure [client] #1 was alright and they left." -"We would keep everything sharp in the office, but she (client) #1 sneak (sic) and get stuff out of the office and hide (sic) it." -"I (staff) #2 did not see her go get a knife that night." "Factual Findings" -"1. The door alarm was turned off by someone, staff could not hear door alarm that someone was walking out the door." -"2. The door alarm was off." -"3. One staff was in the med room, and another staff was in the laundry room and garage." -"4. [Client] #1 found the knife in the dishwasher when helping with clean up after dinner." -"5. Staff member [staff] #1 was suspended pending investigation." -"6. Staff did follow [client] #1's Behavior Support Plan (BSP)."		members. The Quality Assurance Manager will maintain final responsibility for critical review of all investigations and evaluation of the effectiveness of ongoing training. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, BDDS Generalist, Regional Director	

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	-"7. Staff did follow ResCare Policy and Procedures." -"Conclusion" -"1. [Client] #1 turned the alarm off before she left out of the front door." -"2. The door alarm was on, but was turned off by [client] #1." -"3. Suspended staff [staff] #1 was in the med room completing paperwork, and [staff] #2 was completing laundry in the back of the house." -"4. [Client] #1 found the knife in the dishwasher while helping clean up after dinner before the day of her elopement." -"5. It is substantiated that staff followed [client] #1's BSP." -"6. It is substantiated that staff followed ResCare Policy and Procedure." A review of the IS (Investigative Summary) form dated 8/15/19 to 8/20/19 indicated client #1 eloped from the group home on 8/15/19 without staff's knowledge. The review indicated client #1 was out of staff line of sight/supervision for 4 hours. The review indicated client #1 had a knife in her possession when she was located by a supervisor. The review did not substantiate whether client #1 had a sharps restriction. The review did indicate the facility substantiated staff followed client #1's BSP. The review did not indicate client #1 was interviewed for the IS dated 8/15/19 to 8/20/19. Client #1's record was reviewed on 9/11/19 at 9:28			

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	AM. Client #1's BSP dated 3/25/19 indicated, the following: -"...Target Behaviors And Goals:..." -"Suicidal Thoughts/Expressions: Anytime [client] #1 is stating she wants to harm herself, or that she wants to kill herself...". -"Self-Injurious Behaviors: [Client] #1 will hit, slap, poke, stab or try to harm herself by any means available...". -"Reactive Strategy:" -"Staff should remove any sharps, or anything that [client] #1 can use as a weapon, and put in a secure place...". -A review of client #1's BSP indicated sharp objects were to be kept in a secure place due to client #1's history of Self-Injurious Behaviors. Client #2 was interviewed on 9/9/19 at 3:55 PM. Client #2 was asked if client #1 had tried to elope from the group home. Client #2 stated, "Yes, she tried to run away to the woods." Staff #1 was interviewed on 9/9/19 at 5:06 PM. Staff #1 was asked if client #1 had tried to elope from the group home. Staff #1 stated, "Yep, she ran away once. She got away without their notice. She was supposed to be in her room." Staff #1 was asked the amount of time client #1 was without staff supervision. Staff #1 stated, "Probably an hour." Staff #3 was interviewed on 9/9/19 at 5:27 PM. Staff #3 was asked if client #1 had eloped without staff's knowledge. Staff #3 stated, "Yes, more than			

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	once. Two times ago, she left after 10 PM and they found her after 2 AM." Staff #4 was interviewed on 9/10/19 at 6:11 AM. Staff #4 was asked if client #1 had ever eloped on the overnight shift. Staff #4 stated, "Not on my shift. I keep her with me. When she's in her bedroom I check on her constantly." Staff #2 was interviewed on 9/10/19 at 6:21 PM. Staff #2 was asked if client #1 had eloped without staff's knowledge. Staff #2 stated, "Yes, it was the 15th of August. It was around 10:15 to 10:30 PM. I was in the laundry room. The other staff was checking on meds." Staff #2 was asked how client #1 got out of the group home. Staff #2 stated, "I don't know how she got out. Once we started looking for her, after about 30 minutes we called the manager. Then we still couldn't find her (and) then we called 911. At around past 2 AM they found her (client) #1." Staff #2 was asked where client #1 was found. Staff #2 stated, "They told me beside the lake or something." Staff #5 was interviewed on 9/10/19 at 6:45 AM. Staff #5 was asked if client #1 had eloped while she was working. Staff #5 stated, "Yes, maybe three times." Staff #5 was asked if staff followed client #1. Staff #5 stated, "Yes." Staff #5 was asked why the knives and forks were locked in the medication room. Staff #5 stated, "Because of [client] #5, self-injury." RM #1 was interviewed on 9/10/19 at 6:57 AM. RM #1 was asked if client #1 had eloped from the group home on 8/15/19 without staff's knowledge. RM #1 stated, "Yes." RM #1 was asked for how long client #1 was out of staff's line of sight/supervision. RM #1 stated, "Probably about 4 hours. She was back in these woods. [OM			

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	[Operations Manager] #1 found her." OM #1 was interviewed on 9/11/19 at 1:09 PM. OM #1 was asked at what time in the AM on 8/16/19 did he locate client #1. OM #1 stated, "Between 1:30 AM and 2 AM." OM #1 was asked where client #1 was found. OM #1 stated, "About 4 blocks from the group home underneath the bridge." OM #1 was asked what client #1 was wearing when he found her. OM #1 stated, "A pink shirt, blue jean shorts and no shoes." OM #1 was asked if client #1 had a knife in her possession. OM #1 stated, "Yes, it was a steak knife with ridges on it, about 6 or 7 inches (long)." OM #1 was asked if client #1 was allowed to have sharp objects/knives in her possession. OM #1 stated, "No, for her safety. She has suicidal ideation and self-harm as well." QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 9/11/19 at 1:27 PM. QIDPM #1 was asked if the facility substantiated client #1 left the group home with staff supervision/knowledge on 8/15/19. QIDPM #1 stated, "Yes." QIDPM #1 was asked how client #1 was able to elope from the group home with staff's knowledge. QIDPM #1 stated, "We determined that she disabled the home's front door alarm and walked out the front door." QIDPM #1 was asked for how long client #1 was without staff supervision. QIDPM #1 stated, "Approximately 4 hours." QIDPM #1 was asked how client #1 was able to have a steak knife in her possession. QIDPM #1 stated, "It was in the dishwasher and she removed it." QIDPM #1 was asked if staff should have allowed client #1 to have access to a sharp object/knife. QIDPM #1 stated, "No, because she could injure herself or others in an agitated state." QIDPM #1 was asked if client #1 was interviewed for the Investigation			

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	dated 8/15/19 to 8/20/19. QIDPM #1 stated, "No." QIDPM #1 was asked if client #1 should have been interviewed for the Investigation dated 8/15/19 to 8/20/19. QIDPM #1 stated, "Yes, she should have been interviewed." QIDPM #1 indicated the facility's policy on the prevention of abuse, neglect and mistreatment should be implemented as written. QIDPM #1 indicated all allegations of abuse, neglect and mistreatment should be thoroughly investigated all witnesses or potential witnessed should be interviewed. The Facility's policy and procedures were reviewed on 9/11/19 at 3:00 PM. The facility's Abuse, Neglect, Exploitation policy revised on 2/26/18 indicated, "Policy: Adept staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and exploitation shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ADEPT, ResCare and local, state and federal guidelines..."Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment." "Program intervention neglect: ...Failure to implement a support plan, inappropriate application of intervention with out (sic) a qualified person notification/review...". "6. A full investigation will be conducted by ADEPT personnel...".			

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W 0154 Bldg. 00	9-3-2(a) 483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 1 of 37 allegations of abuse, neglect and mistreatment reviewed, the facility failed to complete a thorough investigation regarding client #1's undetected elopement for an extended period of time. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 9/10/19 at 10:28 AM. A BDDS report dated 8/16/19 indicated, "... On the night of 8/15/19, at 10:10 PM, direct support staff [staff] #1 discovered that [client] #1 was not in the home. Two staff were present in the home at the time. The second staff (staff) #2 was in another area of the home attending to the laundry while [staff] #1 was responsible for supervising the individuals who live in the home. Staff contacted the supervisor and initiated a search of the area. When staff could not locate [client] #1 in the immediate vicinity, supervisors and administrative staff arrived to join the search and police were called and a missing person report was filed. ResCare administrative staff located [client] #1 in a wooded area adjacent to the house at 2:00 AM. Staff completed a physical assessment and provided [client] #1 with food and hydration... It should be noted that [client] #1 does not have plan approved alone time... The incident is under investigation and staff [staff] #1 has been suspended, while investigators determine whether or not appropriate supervision was provided at	W 0154	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically: All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. The investigator assigned responsibility for completing investigations at the facility will receive additional training regarding investigation timelines and components of a thorough investigation. The focus of this training will include emphasis on the need to gather testimony from all potential witnesses at the earliest possible opportunity. This training will include side by side collaborative completion of an investigation with the Quality Assurance Manager. In addition to weekly face to face training and follow-up with the	10/17/2019

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	the time of the incident." An IS (Investigative Summary) form dated 8/15/19 to 8/20/19 indicated the following: -"... Scope of Investigation" -"1. How did [client] #1 leave the house without staff knowing? -"2. Were the door alarms on or off?" -"3. What was staff doing when [client] #1 left the house?" -"4. How did [client] #1 obtain the knife she was found with?" -"5. Did staff follow [client] #1's Behavior Support Plan (BSP)?" -"6. Did staff follow ResCare policy and procedures?...". -"Summary Of Interviews...". -"[Client] #1" -"Could not complete interview due to hospitalization...". -"[RM (Residential Manager] #1" -"They called me at 10:35 pm, so the time sounds off to me." -"I (RM) #1 made sure all the alarms were on before I left." -"I (RM) #1 don't know how they (staff) did not		Quality Assurance Manager, the investigator will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence, development of appropriate scope and conclusions. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. Additionally, the governing body will develop an investigation follow-up checklist to assist with supervisory review and oversight of all investigations. When deficiencies are noted, The Quality Assurance Manager and/or QIDP Manager will make corrections to investigations to assure they are thorough and meet regulatory requirements. **PREVENTION:** The QIDP Manager will maintain 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 Quality Assurance Manager, Quality Assurance Coordinators, QIDP Manager, Program Director, Program Managers, Nurse Manager and Assistant Nurse Manager. The QA Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the	

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	hear the alarm go off when she (client) #1 went out the door." -"I (RM) #1 end (sic) up calling [AS (Area Supervisor] #1 the AS and he had us call the police to assist." -"She (client) #1 was in the woods by the house when ResCare supervisor found her." -"The police did a check on her and left." -"She (client) #1 told me she had the knife when I talked to her." -"[Client] #1 said she got it out of the dishwasher, while helping clean up." -"When she (client) #1 is gone to day services we go through her room and try to check for stuff like that." -"[Staff] #2" -"I (staff) #2 was there that night, but I (staff) #2 clocked out at 10 pm, I was not there when she (client) #1 left the house." -"That evening after dinner I (staff) #2 was doing active treatment for the clients that were in the living room." -"We were watching TV (sic) talking and I (staff) #2 remember [client] #1 was on the phone for a while." -"I (staff) #2 left at 10 pm and [client] #1 was in her room at that point." -"[Staff] #1"		progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. The Quality Assurance Manager will maintain final responsibility for critical review of all investigations and evaluation of the effectiveness of ongoing training. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff,	

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	-"I (staff) #1 was in the med room doing the medications and body checks." -"When I completed all of that, I went to look in on all the people and I saw [client] #1 was not there." -"I (staff) #1 think she (client) #1 turned the alarm off that's why we did not hear the alarm." -"We called the RM (#1), I stayed in the house at first and [staff] #2 went to look for her." -"I (staff) #1 was not there when they found her I was off at 12 AM and the supervisor said I could leave." -"We (staff) keep the sharps in the office." -"I (staff) #1 gave her (client) #1 meds that night and watched her very close (sic)." -"This is new to me about how she would get a knife, she (client) #1 could have got it some time ago and hide (sic) the knife." -"I (staff) #1 made sure she went to her bedroom after meds." -"[Staff] #2" -"I (staff) #2 was in between the laundry room and the garage. -"We keep the laundry baskets in the garage, so I rotate basket from the garage." -"When I got there at 8 pm there were some clients up watching TV in the living room."		Operations Team, Regional Director	

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	-"[Client] #1 had gone to her room by that time." -"[Staff] #1 was in the med room doing paperwork, but other than that I don't know what he (staff) #1 was doing." -"When we discovered that [client] #1 was not in the house we started looking for her all over the house." -"We then took turns going outside to look for her with a flashlight, I (staff) #2 checked several areas." -"We called the supervisor and asked should we call the police, and the supervisor [AS] #1 said he would call us right back." -"We were informed to call 911 (Emergency Services) and that ResCare team would be out to help us look for [client] #1." -"[Client] #1 was located in the woods behind the house by a ResCare supervisor, I don't know her name." -"The police asked that if we found her to give them a call." -When the police arrived at the house they did a welfare check to make sure [client] #1 was alright and they left." -"We would keep everything sharp in the office, but she (client) #1 sneak (sic) and get stuff out of the office and hide (sic) it." -"I (staff) #2 did not see her go get a knife that night."			

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	"Factual Findings" -"1. The door alarm was turned off by someone, staff could not hear door alarm that someone was walking out the door." -"2. The door alarm was off." -"3. One staff was in the med room, and another staff was in the laundry room and garage." -"4. [Client] #1 found the knife in the dishwasher when helping with clean up after dinner." -"5. Staff member [staff] #1 was suspended pending investigation." -"6. Staff did follow [client] #1's Behavior Support Plan (BSP)." -"7. Staff did follow ResCare Policy and Procedures." -"Conclusion" -"1. [Client] #1 turned the alarm off before she left out of the front door." -"2. The door alarm was on, but was turned off by [client] #1." -"3. Suspended staff [staff] #1 was in the med room completing paperwork, and [staff] #2 was completing laundry in the back of the house." -"4. [Client] #1 found the knife in the dishwasher while helping clean up after dinner before the day of her elopement."			

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	-"5. It is substantiated that staff followed [client] #1's BSP." -"6. It is substantiated that staff followed ResCare Policy and Procedure." A review of the IS (Investigative Summary) form dated 8/15/19 to 8/20/19 indicated client #1 eloped from the group home on 8/15/19 without staff's knowledge. The review indicated client #1 was out of staff line of sight/supervision for 4 hours. The review did not indicate client #1 was interviewed for the IS dated 8/15/19 to 8/20/19. -A review of client #1's BSP indicated sharp objects were to be kept in a secure place due to client #1's history of Self-Injurious Behaviors. Client #2 was interviewed on 9/9/19 at 3:55 PM. Client #2 was asked if client #1 had tried to elope from the group home. Client #2 stated, "Yes, she tried to run away to the woods." Staff #1 was interviewed on 9/9/19 at 5:06 PM. Staff #1 was asked if client #1 had tried to elope from the group home. Staff #1 stated, "Yep, she ran away once. She got away without their notice. She was supposed to be in her room." Staff #1 was asked the amount of time client #1 was without staff supervision. Staff #1 stated, "Probably an hour." Staff #3 was interviewed on 9/9/19 at 5:27 PM. Staff #3 was asked if client #1 had eloped without staff's knowledge. Staff #3 stated, "Yes, more than once. Two times ago, she left after 10 PM and they found her after 2 AM." Staff #4 was interviewed on 9/10/19 at 6:11 AM. Staff #4 was asked if client #1 had ever eloped on			

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	the overnight shift. Staff #4 stated, "Not on my shift. I keep her with me. When she's in her bedroom I check on her constantly." Staff #2 was interviewed on 9/10/19 at 6:21 PM. Staff #2 was asked if client #1 had eloped without staff's knowledge. Staff #2 stated, "Yes, it was the 15th of August. It was around 10:15 to 10:30 PM. I was in the laundry room. The other staff was checking on meds." Staff #2 was asked how client #1 got out of the group home. Staff #2 stated, "I don't know how she got out. Once we started looking for her, after about 30 minutes we called the manager. Then we still couldn't find her (and) then we called 911. At around past 2 AM they found her (client) #1." Staff #2 was asked where client #1 was found. Staff #2 stated, "They told me beside the lake or something." Staff #5 was interviewed on 9/10/19 at 6:45 AM. Staff #5 was asked if client #1 had eloped while she was working. Staff #5 stated, "Yes, maybe three times." Staff #5 was asked if staff followed client #1. Staff #5 stated, "Yes." Staff #5 was asked why the knives and forks were locked in the medication room. Staff #5 stated, "Because of [client] #5, self-injury." RM #1 was interviewed on 9/10/19 at 6:57 AM. RM #1 was asked if client #1 had eloped from the group home on 8/15/19 without staff's knowledge. RM #1 stated, "Yes." RM #1 was asked for how long client #1 was out of staff's line of sight/supervision. RM #1 stated, "Probably about 4 hours. She was back in these woods. [OM [Operations Manager] #1 found her." OM #1 was interviewed on 9/11/19 at 1:09 PM. OM #1 was asked at what time in the AM on 8/16/19 did he locate client #1. OM #1 stated,			

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	"Between 1:30 AM and 2 AM." OM #1 was asked where client #1 was found. OM #1 stated, "About 4 blocks from the group home underneath the bridge." OM #1 was asked what client #1 was wearing when he found her. OM #1 stated, "A pink shirt, blue jean shorts and no shoes." OM #1 was asked if client #1 had a knife in her possession. OM #1 stated, "Yes, it was a steak knife with ridges on it, about 6 or 7 inches (long)." OM #1 was asked if client #1 was allowed to have sharp objects/knives in her possession. OM #1 stated, "No, for her safety. She has suicidal ideation and self-harm as well." QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 9/11/19 at 1:27 PM. QIDPM #1 was asked if the facility substantiated client #1 left the group home with staff supervision/knowledge on 8/15/19. QIDPM #1 stated, "Yes." QIDPM #1 was asked how client #1 was able to elope from the group home with staff's knowledge. QIDPM #1 stated, "We determined that she disabled the home's front door alarm and walked out the front door." QIDPM #1 was asked for how long client #1 was without staff supervision. QIDPM #1 stated, "Approximately 4 hours." QIDPM #1 was asked if client #1 was interviewed for the Investigation dated 8/15/19 to 8/20/19. QIDPM #1 stated, "No." QIDPM #1 was asked if client #1 should have been interviewed for the Investigation dated 8/15/19 to 8/20/19. QIDPM #1 stated, "Yes, she should have been interviewed." 9-3-2(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,			

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	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 record review and interview for 1 of 3 sampled clients (#1), the facility failed to ensure staff implemented client #1's BSP (Behavior Support Plan). Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports were reviewed on 9/10/19 at 10:28 AM. A BDDS report dated 8/16/19 indicated, "... On the night of 8/15/19, at 10:10 PM, direct support staff [staff] #1 discovered that [client] #1 was not in the home. Two staff were present in the home at the time. The second staff (staff) #2 was in another area of the home attending to the laundry while [staff] #1 was responsible for supervising the individuals who live in the home. Staff contacted the supervisor and initiated a search of the area. When staff could not locate [client] #1 in the immediate vicinity, supervisors and administrative staff arrived to join the search and police were called and a missing person report was filed. ResCare administrative staff located [client] #1 in a wooded area adjacent to the house at 2:00 AM. Staff completed a physical assessment and provided [client] #1 with food and hydration... It should be noted that [client] #1 does not have plan approved alone time... The incident is under investigation and staff [staff] #1 has been suspended, while investigators determine whether or not appropriate supervision was provided at the time of the incident."	W 0249	**CORRECTION:** *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.* Specifically, the QIDP will retrain all facility direct support and supervisory staff toward proper implementation of client #1's Behavior Support Plan. A review of facility documentation indicated this deficient practice did not affect other clients. **PREVENTION:** The facility's QIDP will be trained regarding the need to assure aggressive and consistent implementation of active treatment for all clients, including but not limited to implementation of clients' proactive and reactive behavior support strategies. 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	10/17/2019

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	An IS (Investigative Summary) form dated 8/15/19 to 8/20/19 indicated the following: -"... Scope of Investigation" -"1. How did [client] #1 leave the house without staff knowing? -"2. Were the door alarms on or off?" -"3. What was staff doing when [client] #1 left the house?" -"4. How did [client] #1 obtain the knife she was found with?" -"5. Did staff follow [client] #1's Behavior Support Plan (BSP)?" -"6. Did staff follow ResCare policy and procedures?...". -"Summary Of Interviews...". -"[Client] #1" -"Could not complete interview due to hospitalization...". -"[RM (Residential Manager] #1" -"They called me at 10:35 pm, so the time sounds off to me." -"I (RM) #1 made sure all the alarms were on before I left." -"I (RM) #1 don't know how they (staff) did not hear the alarm go off when she (client) #1 went out the door."		implementation of Behavior Support Plans. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger Assistant Nurse Manager) and the QIDP will conduct administrative monitoring during varied shifts/times, no less than 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, which will occur no less than monthly. 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.	

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	-"I (RM) #1 end (sic) up calling [AS (Area Supervisor] #1 the AS and he had us call the police to assist." -"She (client) #1 was in the woods by the house when ResCare supervisor found her." -"The police did a check on her and left." -"She (client) #1 told me she had the knife when I talked to her." -"[Client] #1 said she got it out of the dishwasher, while helping clean up." -"When she (client) #1 is gone to day services we go through her room and try to check for stuff like that." -"[Staff] #2" -"I (staff) #2 was there that night, but I (staff) #2 clocked out at 10 pm, I was not there when she (client) #1 left the house." -"That evening after dinner I (staff) #2 was doing active treatment for the clients that were in the living room." -"We were watching TV (sic) talking and I (staff) #2 remember [client] #1 was on the phone for a while." -"I (staff) #2 left at 10 pm and [client] #1 was in her room at that point." -"[Staff] #1" -"I (staff) #1 was in the med room doing the		· Review all relevant documentation, providing documented coaching and training as needed Administrative support at the home will include Assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring behavior interventions are implemented as written. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	medications and body checks." -"When I completed all of that, I went to look in on all the people and I saw [client] #1 was not there." -"I (staff) #1 think she (client) #1 turned the alarm off, that's why we did not hear the alarm." -"We called the RM (#1), I stayed in the house at first and [staff] #2 went to look for her." -"I (staff) #1 was not there when they found her I was off at 12 AM and the supervisor said I could leave." -"We (staff) keep the sharps in the office." -"I (staff) #1 gave her (client) #1 meds that night and watched her very close (sic)." -"This is new to me about how she would get a knife, she (client) #1 could have got it some time ago and hide (sic) the knife." -"I (staff) #1 made sure she went to her bedroom after meds." -"[Staff] #2" -"I (staff) #2 was in between the laundry room and the garage. -"We keep the laundry baskets in the garage, so I rotate basket from the garage.: -"When I got there at 8 pm there were some clients up watching TV in the living room." -"[Client] #1 had gone to her room by that time."			

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	15G465	A. BUILDING 00 B. WING	09/17/2019

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	-"[Staff] #1 was in the med room doing paperwork, but other than that I don't know what he (staff) #1 was doing." -"When we discovered that [client] #1 was not in the house we started looking for her all over the house." -"We then took turns going outside to look for her with a flashlight, I (staff) #2 checked several areas." -"We called the supervisor and asked should we call the police, and the supervisor [AS] #1 said he would call us right back." -"We were informed to call 911 (Emergency Services) and that ResCare team would be out to help us look for [client] #1." -"[Client] #1 was located in the woods behind the house by a ResCare supervisor, I don't know her name." -"The police asked that if we found her to give them a call." -When the police arrived at the house they did a welfare check to make sure [client] #1 was alright and they left." -"We would keep everything sharp in the office, but she (client) #1 sneak (sic) and get stuff out of the office and hide (sic) it." -"I (staff) #2 did not see her go get a knife that night." "Factual Findings"			

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	-"1. The door alarm was turned off by someone, staff could not hear door alarm that someone was walking out the door." -"2. The door alarm was off." -"3. One staff was in the med room, and another staff was in the laundry room and garage." -"4. [Client] #1 found the knife in the dishwasher when helping with clean up after dinner." -"5. Staff member [staff] #1 was suspended pending investigation." -"6. Staff did follow [client] #1's Behavior Support Plan (BSP)." -"7. Staff did follow ResCare Policy and Procedures." -"Conclusion" -"1. [Client] #1 turned the alarm off before she left out of the front door." -"2. The door alarm was on, but was turned off by [client] #1." -"3. Suspended staff [staff] #1 was in the med room completing paperwork, and [staff] #2 was completing laundry in the back of the house." -"4. [Client] #1 found the knife in the dishwasher while helping clean up after dinner before the day of her elopement." -"5. It is substantiated that staff followed [client] #1's BSP."			

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-"6. It is substantiated that staff followed ResCare Policy and Procedure."

A review of the IS (Investigative Summary) form dated 8/15/19 to 8/20/19 indicated client #1 eloped from the group home on 8/15/19 without staff's knowledge. The review indicated client #1 had a knife in her possession when she was located by a supervisor. The review did not substantiate whether client #1 had a sharps restriction. The review did indicate the facility substantiated staff followed client #1's BSP.

Client #1's record was reviewed on 9/11/19 at 9:28 AM. Client #1's BSP dated 3/25/19 indicated, the following:

-"...Target Behaviors And Goals:..."

-"Suicidal Thoughts/Expressions: Anytime [client] #1 is stating she wants to harm herself, or that she wants to kill herself...".

-"Self-Injurious Behaviors: [Client] #1 will hit, slap, poke, stab or try to harm herself by any means available...".

-"Reactive Strategy:"

-"Staff should remove any sharps, or anything that [client] #1 can use as a weapon, and put in a secure place...".

-A review of client #1's BSP indicated sharp objects were to be kept in a secure place due to client #1's history of Self-Injurious Behaviors.

Client #2 was interviewed on 9/9/19 at 3:55 PM. Client #2 was asked if client #1 had tried to elope

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	from the group home. Client #2 stated, "Yes, she tried to run away to the woods." Staff #1 was interviewed on 9/9/19 at 5:06 PM. Staff #1 was asked if client #1 had tried to elope from the group home. Staff #1 stated, "Yep, she ran away once. She got away without their notice. She was supposed to be in her room." Staff #1 was asked the amount of time client #1 was without staff supervision. Staff #1 stated, "Probably an hour." Staff #3 was interviewed on 9/9/19 at 5:27 PM. Staff #3 was asked if client #1 had eloped without staff's knowledge. Staff #3 stated, "Yes, more than once. Two times ago, she left after 10 PM and they found her after 2 AM." Staff #4 was interviewed on 9/10/19 at 6:11 AM. Staff #4 was asked if client #1 had ever eloped on the overnight shift. Staff #4 stated, "Not on my shift. I keep her with me. When she's in her bedroom I check on her constantly." Staff #2 was interviewed on 9/10/19 at 6:21 PM. Staff #2 was asked if client #1 had eloped without staff's knowledge. Staff #2 stated, "Yes, it was the 15th of August. It was around 10:15 to 10:30 PM. I was in the laundry room. The other staff was checking on meds." Staff #2 was asked how client #1 got out of the group home. Staff #2 stated, "I don't know how she got out. Once we started looking for her, after about 30 minutes we called the manager. Then we still couldn't find her then we called 911. At around past 2 AM they found her (client) #1." Staff #2 was asked where client #1 was found. Staff #2 stated, "They told me beside the lake or something." Staff #5 was interviewed on 9/10/19 at 6:45 AM.			

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	Staff #5 was asked if client #1 had eloped while she was working. Staff #5 stated, "Yes, maybe three times." Staff #5 was asked if staff followed client #1. Staff #5 stated, "Yes." Staff #5 was asked why the knives and forks were locked in the medication room. Staff #5 stated, "Because of [client] #5, self-injury." RM #1 was interviewed on 9/10/19 at 6:57 AM. RM #1 was asked if client #1 had eloped from the group home on 8/15/19 without staff's knowledge. RM #1 stated, "Yes." RM #1 was asked for how long client #1 was out of staff's line of sight/supervision. RM #1 stated, "Probably about 4 hours. She was back in these woods. [OM (Operations Manager] #1 found her." OM #1 was interviewed on 9/11/19 at 1:09 PM. OM #1 was asked at what time in the AM on 8/16/19 did he locate client #1. OM #1 stated, "Between 1:30 AM and 2 AM." OM #1 was asked where client #1 was found. OM #1 stated, "About 4 blocks from the group home underneath the bridge." OM #1 was asked what client #1 was wearing when he found her. OM #1 stated, "A pink shirt, blue jean shorts and no shoes." OM #1 was asked if client #1 had a knife in her possession. OM #1 stated, "Yes, it was a steak knife with ridges on it, about 6 or 7 inches (long)." OM #1 was asked if client #1 was allowed to have sharp objects/knives in her possession. OM #1 stated, "No, for her safety. She has suicidal ideation and self-harm as well." QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 9/11/19 at 1:27 PM. QIDPM #1 was asked if the facility substantiated client #1 left the group home with staff supervision/knowledge on 8/15/19. QIDPM #1 stated, "Yes." QIDPM #1 was asked			

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	how client #1 was able to elope from the group home with staff's knowledge. QIDPM #1 stated, "We determined that she disabled the home's front door alarm and walked out the front door." QIDPM #1 was asked for how long client #1 was without staff supervision. QIDPM #1 stated, "Approximately 4 hours." QIDPM #1 was asked how client #1 was able to have a steak knife in her possession. QIDPM #1 stated, "It was in the dishwasher and she removed it." QIDPM #1 was asked if staff should have allowed client #1 to have access to a sharp object/knife. QIDPM #1 stated, "No, because she could injure herself or others in an agitated state. 9-3-4(a)			
W 0382 Bldg. 00	483.460(l)(2) DRUG STORAGE AND RECORDKEEPING The facility must keep all drugs and biologicals locked except when being prepared for administration. Based on observation and interview for 3 of 3 sampled clients (#1, #2 and #3) plus 5 additional clients (#4, #5, #6, #7 and #8), the facility failed to ensure the clients' medications were secured. Findings include: Observations were conducted at the group home on 9/9/19 from 3:32 PM through 6:00 PM and on 9/10/19 from 6:08 AM through 8:04 AM. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were observed throughout the observation period. On 9/10/19 at 6:45 AM staff #5 administered AM medications. At 6:48 AM, staff #5 left the medication room and walked toward the dining room area. Staff #5 left both medication cabinets unlocked and left the door to the medication room unlocked and open. Clients #1, #2, #3, #4, #5, #6, #7 and #8 were	W 0382	**CORRECTION:** *The facility must keep all drugs and biologicals locked except when being prepared for administration.* Specifically, all staff will be retrained to assure that medication is secured at all times. **PREVENTION:** 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 medications are secured at all times. For the	10/17/2019

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	walking past the medication room from the living room to the bedrooms. QIDP (Qualified Intellectual Disabilities Professional) #1 was interviewed on 9/11/19 at 1:27 PM. QIDPM #1 was asked if staff should secure/lock the clients' medications at all times. QIDP #1 stated, "Yes, in order to order to prevent the medications to be misused." 9-3-6(a)		next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Directors, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger) and the QIDP will conduct administrative monitoring no less than weekly during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios, 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	

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			documented coaching and training as needed Administrative support at the home will include but not be limited to assuring medications are secured at all times. **RESPONSIBLE PARTIES:** QIDP, Residential Manager, Direct Support Staff, Health Services Team, Operations Team, Regional Director	