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	12/21/2022

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 the investigation of complaints #IN00393849 and #IN00395040. Complaint #IN00393849: Substantiated, Federal and State deficiencies related to the allegation(s) were cited at: W149 and W186. Complaint #IN00395040: Substantiated, Federal and State deficiencies related to the allegation(s) were cited at: W149 and W186. Dates of Survey: December 15, 16, and 21, 2022. Facility Number: 000979 Provider Number: 15G465 AIMs Number: 100244860 These deficiencies also reflect state findings in accordance with 460 IAC 9.	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 (A), the facility failed to implement their policies and procedures to prevent elopements and SIB (Self-Injurious Behavior) incidents involving client A. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/15/22 at 11:50 AM and indicated the following:	W 0149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, or abuse of the client.* Specifically, direct support staff have been retrained on client A's behavior supports, including but not limited to one-to-one supervision protocols. **PREVENTION:**	01/20/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bob Morris	QIDP Manager	01/23/2023

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 BDDS report dated 10/31/22 indicated, "...On the morning of 10/30/22, [client A] told staff he needed to go to the hospital, walked to out of the house and called 911 from his personal phone. Staff followed, but lost line of sight and staff called the supervisor to assist with searching for him. The supervisor located [client A] with police in the at the intersection of [name of road] and [name of road], and police transported [client A] to the [name of hospital] Emergency Department, where he was joined by ResCare staff. Before being evaluated, [client A] ran from the ER (Emergency Room). Staff followed but lost line of sight. Minutes later, [client A] was located at the [name of hospital] Heart Emergency Department. He (client A) refused to leave the Heart Hospital and police transported him to the [name of hospital] Behavioral Health Unit for a psychiatric evaluation. After an assessment, the crisis team released [client A] to ResCare staff with a safety plan and no medication changes. Upon returning home, [client A] called 911 again and ran from the house. Staff followed but lost line of sight and initiated a search. [Client A] was located talking to police, who transported him the the [name of hospital] Crisis Unit for evaluation. The psychiatrist diagnosed [client A] with Suicidal Ideations and released him to ResCare staff with no new orders. Upon returning home, [client A] remained agitated called 911 and walked out of the house. Staff followed, lost line of sight briefly and found him walking in the neighborhood. [Client A] insisted he needed to be seen at the [name of hospital] Emergency Department. Prior to police arrival, staff transported [client A] to the ER per his request...[Client A] does not have approved alone time and was away from staff line of sight for approximately 1 hour. Elopement and frivolous 911 calls will be included in [client A's] initial		A management staff will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assure staff implement clients' Behavior Support Plans, as written. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, QIDPs, Quality Assurance Coordinators, Area Supervisors, and Nurse Manager) will conduct twice weekly administrative monitoring during varied shifts/times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios. After 30 days, administrative monitoring will occur 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. Current Operations Team members received training from the QIDP Manager to assure a clear understanding of administrative monitoring as defined below. · The role of the administrative monitor is not simply to observe & report. · When opportunities for	

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	Behavior Support Plan...". An IS (Investigation Summary) dated 11/4/22 indicated the following: -"Introduction On 10/30/22 Individual [client A] told staff he needed to go to the hospital, walked to out of the house and called 911 from his personal phone. Staff followed, but lost line of sight and staff called the supervisor to assist with searching for him. The supervisor located [client A] with police in the at the intersection of [name of street] and [name of street], and police transported [client A] to the [name of hospital] Emergency Department, where he was joined by ResCare staff. Before being evaluated, [client A] ran from the ER. Staff followed but lost line of sight. Minutes later, [client A] was located at the [name of hospital] Emergency Department. He (client A) refused to leave the [name] Hospital and police transported him to the [name of hospital] Behavioral Health Unit for a psychiatric evaluation. After an assessment, the crisis team released [client A] to ResCare staff with a safety plan and no medication changes. Upon returning home, [client A] called 911 again and ran from the house. Staff followed but lost line of sight and initiated a search. [Client A] was located talking to police, who transported him to [name of hospital] Crisis Unit for evaluation. The psychiatrist diagnosed [client A] with Suicidal Ideations and released him to ResCare staff with no new orders. Upon returning home, [client A] remained agitated called 911 and walked out of the house. Staff followed, lost line of sight briefly and found him walking in the neighborhood. [Client A] insisted he needed to be seen at the [name of hospital] Emergency Department. Prior to police arrival, staff transported [client A] to the ER per his		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 oversight will include assuring staff implement behavior supports as written. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Direct Support Staff, Operations Team, Regional Director	

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	request...The ER Physician diagnosed [client A] with Auditory Hallucinations, Foley Catheter in Place, and Acute Cystitis without Hematuria (sudden inflammation of the urinary bladder) and released him to ResCare staff with a prescription for Keflex (infection). Upon returning home, [client A] walked out into the yard, called 911 and reported he was having a seizure (he was not). Police arrived and transported [client A] to the [name of hospital] Emergency Department. After an initial assessment, [client A] was admitted for psychiatric observation. Scope of Investigation 1. Does [client A's] Initial Behavior Support Plan fail to address Elopement ? 2. Does [client A's] Initial Behavior Support Plan fail to address Frivolous 911 calls? 3. How long was [client A] without staff supervision? 4. Did staff fail to follow ResCare's Policies and Procedures? [Staff #2] [Client A] just opened the front door and left. [Client A] started running, I (staff #2) was trying to follow him (client A). I (staff #2) got in my car; I was looking for him (client A). I (staff #2) found [client A] at [name of street]. I (staff #2) was trying to verbally redirect [client A] and calm him. The police showed up and an ambulance. They (ambulance) took [client A] to the hospital. But [client A] run from the hospital. [Staff #3] This morning when I (staff #3) arrived at the house [client A] was sitting on the couch. He (client A) told me he didn't want to be here			

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	anymore. I (staff #3) went outside to talk to the other consumers. [Client A] came storming out of the house. [Client A] walked to the street, I was verbally redirecting [client A]. [Client A] was on the phone; he was calling 911 and just kept walking. The other staff (staff #2) followed [client A], but she couldn't keep up. She (staff #2) then got in her car and followed [client A]. [Staff #4] [Client A] called 911, he then run out of the house. I (staff #4) went after [client A]. He (client A) kept saying he wanted to go to the hospital. I (staff #4) took [client A] to the hospital (after locating him in the neighbor during his last elopement) in the van. [Staff #5] [Client A] called 911. [Client A] then left the house. [Staff #4] followed [client A]. He (client A) ended up in at the hospital. The paramedics arrived at the home, but [client A] and already left. [Staff #4] was with him and took [client A] to the emergency room. Factual Findings [Staff #2] states [client A] just left through the front door (first elopement on 10/30/22). I (staff #2) followed him. [Staff #3] states when I (staff #3) arrived [client A] told me he didn't want to be here anymore and he ran out the door. [Staff #4] states [client A] called 911 and then run			

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	out of the house (second elopement on 10/30/22). I (staff #4) followed and then took him to the hospital. [Staff #5] states [client A] called 911 and he left (second elopement on 10/30/22). [Staff #4] followed him. [Client A] has 0 (no) plan approved alone time and was without staff supervision for approximately one hour. [Client A] returned home approximately 1 hour later. [Client A's] initial Behavior Support Plan is currently in development. Conclusion 1. It is not substantiated that [client A's] Initial Behavior Support Plan faiedl (sic) to address elopement, due to the plan not being in place (being developed). 2. It is not substantiated that [client A's] Initial Behavior Support Plan failed to address Frivolous 911 calls, due to the plan not yet being in place (being developed). 3. It was substantiated that [client A] was without staff supervision for approximately one hour. 4. It is not substantiated that staff failed to follow ResCare's Policies and Procedures. Recommendations: Continue to monitor [client A]. Contact [MLBC (Masters Level Behavioral Clinician) #1] for Master level Behavioral Clinician for assistance with assessment and development of initial BSP. Include elopement as Target Behavior in BSP. Include frivolous 911 calls as Target Behavior in BSP." Client A's record was reviewed on 12/16/22 at 9:08 AM.			

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Client A's record indicated an IDT (Interdisciplinary Team) Meeting form dated 10/31/22. The IDT form dated 10/31/22 indicated the following:

-"Meeting Agenda/Topics Discussed/Plan Changes

[Client A] eloped and called 911 on 10/30/22 to be taken to the hospital.
He was promptly released and when he returned home, he eloped a second time and was taken to a second hospital where he was admitted for psychiatric observation.

Action Steps:
Contact [MLBC (Master Level Behavioral Clinician) #1] for assistance with assessment and development of initial BSP.
Include Elopement as Target Behavior in BSP (Behavioral Support Plan)."

2. A BDDS report dated 11/2/22 indicated, "On the morning of 10/30/22 (sic) (11/1/22), [client A] ran out of the home's front door and staff were not able to maintain line of sight. Staff and supervisors initiated a search of the neighborhood. Prior to locating him, a neighbor observed
[client A] lying in the road and called 911. Police transported [client A] to [name of hospital] Emergency Department for a psychiatric evaluation. ResCare staff went to the hospital to meet him...[Client A] is scheduled to initiate behavior therapy through his psychiatric provider and his team has arranged for a Master's level behavioral clinician to assess [client A] and assist with developing appropriate behavior supports. [Client A] will remain on line of sight supervision

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	while awake and 15-minute checks while sleeping and door alarms will be installed pending Human Rights Committee approval...". 3. A BDDS report dated 11/3/22 indicated, "...On 11/2/22, [name of hospital] staff called the residential supervisor and said [client A] was being discharged from emergency psychiatric detention. Before ResCare staff arrived, [client A] eloped from the hospital. ResCare initiated a search and filed a missing person report with the police, who informed staff that [client A] was receiving an additional psychiatric evaluation at [name of hospital]. ResCare staff were not permitted to provide supervision or support during the assessment. Later in the evening, ResCare staff were informed that [client A] was ready for discharge. When staff arrived, [name of hospital] personnel reported that when told he would be released, [client A] swallowed a spoon and a fork, and would be receiving an endoscope to attempt to remove the objects...[Client A] is scheduled to initiate behavior therapy through his psychiatric provider and his team has provided initial assessment information and incident documentation to a Master's level behavioral clinician to assess [client A] and assist with developing appropriate behavior supports. He did not have documented history of swallowing non-food objects prior to his admission to his current home on 10/7/22. When he returns home, [client A] will remain on line of sight supervision while awake and 15-minute checks while sleeping, and door alarms will be installed...". An IS dated 11/7/22 indicated the following: -"Introduction On 11/02/22, [name of hospital] staff called the residential supervisor and said [client A] was			

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	being discharged from emergency psychiatric detention... Before ResCare staff arrived, [client A] eloped from the hospital. ResCare initiated a search and filed a missing person report with the police, who informed staff that [client A] was receiving an additional psychiatric evaluation at [name of hospital]. ResCare staff were not permitted to provide supervision or support during the assessment. Later in the evening, ResCare staff were informed that [client A] was ready for discharge. When staff arrived, [name of hospital] personnel reported that when told he would be released, [client A] swallowed a spoon and a fork, and would be receiving an endoscope to attempt to remove the objects. [Staff #6] [Individual's name] from [name of hospital] called saying [client A] was getting discharged. [Individual from hospital] also stated [client A] left the hospital. We (staff) went to look for [client A] and called the police. [Client A] was found about any hour later at [name of hospital]. [Client A] swollen (sic) a fork and spoon while there (at the hospital) and he was admitted. [Staff #7] We (staff) got a call saying [client A] was being discharged from [name of hospital] and that he (client A) left. We (staff) went to look for him, and called the police. [Client A] was found at [name of hospital]. We (staff) could not go back with [client A]. He (client A) was getting ready to leave and he swollen (sic) a spoon and fork. Factual Findings			

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	[Staff #6] states [name of hospital] called and said [client A] was being discharged and that he had left the hospital. [Staff #7] states [client A] swollen (sic) a spoon and fork and was admitted to [name of hospital]. [Client A] was not receiving ResCare supports at the time of the incident. Efforts to complete [client A's] initial Behavior Support Plan have been hindered due his frequent inpatient hospitalizations. Conclusion 1. It is not substantiated that [client A's] Initial Behavior Support Plan failed to address elopement, due to the plan still being in development. 2. It is not substantiated that [client A's] Initial Behavior Support Plan failed to address swallowing non-food items, due to the plan still being in development. 3. It is not substantiated that staff failed to follow ResCare's Policies and Procedures. Recommendations Provide [MLBC #1] with all incident documentation. Include consuming non-food items as Target Behavior in BSP. Continue 15-minute checks upon return from hospital." Client A's record indicated an IDT Meeting Form dated 11/3/22. The IDT form dated 11/3/22 indicated the following: -"Meeting Agenda/Topics Discussed/Plan Changes [Client A] eloped and made a frivolous 911 call on 11/1/22 and was re-hospitalized.			

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	He eloped from the hospital on 11/2/22 when told he would be discharged and ran to another ER where he swallowed additional non-food items. Action Steps: Provide [MLBC #1] with all incident documentation. Include consuming non-food items as Target Behavior in BSP. Obtain HRC (Human Rights Committee) approval to secure silverware and small objects. Continue 15-minute checks upon return from hospital...". 4. A BDDS report dated 11/12/22 indicated, "...On the evening of 11/11/22, [client A] was pacing in and out of the group home stating he had swallowed a toothbrush. [Client A] then began to run down the street and staff were not able to maintain line of sight. Staff and supervisors initiated a search of the neighborhood. Approximately 20 minutes later, [client A] was located at the corner of [name of road] and [name of road], along with the police and paramedics. EMS (Emergency Medical Services) transported [client A] to [name of hospital] Emergency Department for an evaluation. ResCare staff went to the hospital to meet him. [Client A] was admitted to the hospital with a diagnosis of: Swallowing a Foreign Object. He will be receiving an endoscope to attempt to remove the object...[Client A] is scheduled to initiate behavior therapy through his psychiatric provider and his team has provided initial assessment information and incident documentation to a master's level behavioral clinician to assess [client A] and assist with developing appropriate behavior supports. When he returns home, [client A] will remain in line-of-sight supervision at all times, and door			

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	alarms will be installed...". An IS dated 11/16/22 indicated the following: -"Introduction On 11/11/22, [client A] was pacing in and out of the group home stating he had swallowed a toothbrush. [Client A] then began to run down the street, and staff were not able to maintain line of sight. Staff and supervisors initiated a search of the neighborhood. Approximately 20 minutes later, [client A] was located at the corner of [name of street] and [name of street], along with the police and paramedics. EMS transported [client A] to the [name of hospital] Emergency Department for an evaluation. ResCare staff went to the hospital to meet him. [Client A] was admitted to the hospital with a diagnosis of: Swallowing a Foreign Object. He (client A) will be receiving an endoscope to attempt to remove the object. [Staff #8] [Client A] came home the hospital earlier that day. [Client A] started pacing around the house. He (client A) then said he swollen (sic) a toothbrush. I (staff #8) was calling my supervisor and [client A] left the home. I (staff #8) called 911. We (staff) tried to follow [client A]. The police and paramedics found him. He (client A) was taken to the hospital. [Staff #9] He (client A) just started pacing around. [Client A] then said he had swollen (sic) a toothbrush. We called the supervisor and that is when [client A] left the home. We followed and he was found by the police and			

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	paramedics. The paramedics took him to the hospital. He (client A) was gone for about 20 minutes before he was found. Factual Findings [Staff #8] states he (client A) said he (client A) had swollen (sic) a toothbrush. [Client A] then left the home. [Staff #9] states [client A] just started pacing around the house, he (client A) then said he (client A) had swollen (sic) a toothbrush and left the home. [Client A] has 0 (no) plan approved alone time and was without staff supervision for approximately 20 minutes. At [name of hospital], [client A] was diagnosed with Swallowed Foreign Body. Conclusion 1. It is not substantiated that [client A's] Initial Behavior Support Plan failed to address elopement, due to the plan being in development. 2. It is not substantiated that [client A's] Initial Behavior Support Plan failed to ingest non-food items, due to the plan being in development. 3. It is substantiated that [client A] was without staff supervision for approximately 20 minutes. 4. It is not substantiated that staff failed to follow ResCare's Policies and Procedures. Recommendations: Provide [MLBC #1] with all incident documentation. Initiate 24/7, one to one observation, while plan as a whole is in development. Train all staff on implementation of 1:1 supervision. Discuss Waiver placement to arrange for safer environment."			

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	Client A's record indicated hospital discharge documentation dated 11/11/22. The after visit summary form dated 11/11/22 indicated the following: -"Reason for Hospitalization Your (client A's) primary diagnosis was Swallowed Foreign Body Initial Encounter... Swallowed Foreign Body Based on your (client A's) evaluation, no treatment is needed at this time. The swallowed object is expected to move through your digestive tract and pass out the body in the stool with no problems...". Client A's record indicated an IDT Meeting Form dated 11/12/22. The IDT form dated 11/12/22 indicated the following: -"Meeting Agenda/Topics Discussed/Plan Changes Approximately an hour and a half after returning from inpatient hospitalization on 11/11/22, [client A] said he had swallowed a toothbrush and eloped. Once located, he was taken to [name of hospital] by EMS and Admitted. Due to his time in the hospital, his BC (Behavioral Clinician) has not been able to complete a face-to-face assessment. Action Steps: Provide [MLBC #1] with all incident documentation. Install door alarms. Initiate 24/7 (24 hours a day/7 days per week) one to one observation. Train all staff on implementation of 1:1			

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	supervision. Discuss Waiver placement to arrange for safer environment...". 5. A BDDS report dated 11/23/22 indicated, "...On the morning 11/22/22, [client A] ran out of his home's front door and staff lost line of sight. Staff contacted the residential supervisor who located [client A] three blocks from the home. [Client A] willingly rode back to the house with the supervisor...[Client A] has a history of elopement addressed in his Behavior Support Plan. He does not have plan approved alone time and was away from staff supervision for approximately five minutes. [Client A] will receive one-to-one supervision to help reduce and prevent further occurrences, and all staff will be trained toward proper implementation of the enhanced supervision protocols...". An IS dated 11/30/22 indicated the following: -"Introduction On the morning 11/23/22, [client A] ran out of his home's front door and staff lost line of sight. Staff contacted the residential supervisor who located [client A] three blocks from the home. [Client A] willingly rode back to the house with the supervisor. [Staff #10] I (staff #10) was getting the other consumers medications ready in the medication room. [Client A] sneaked (sic) out of house. I (staff #10) didn't know he (client A) left. At first, he (client A) was in the medication room with me. He (client A) went to the bathroom. That is when he (client A) sneaked (sic) out. I (staff #10) went to look for [client A].			

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	We (staff) found him a couple of blocks away. [Client A] returned home with me. Factual Findings [Staff #10] states [client A] was in the medication room with me, he (client A) said he (client A) was going to the bathroom, and he (client A) left. [Staff #10] did not follow [client A] to the bathroom, per the plan (BSP). Conclusion 1. It is not substantiated that [client A's] Behavior Support Plan failed to address Elopement. 2. It is substantiated that [client A] was without staff supervision. 3. It is substantiated that [client A] was without staff supervision for approximately 5 minutes. 4. It is substantiated that staff failed to follow [client A's] Behavior Support Plan. 5. It is not substantiated that staff failed to follow ResCare's Policies and Procedures. Recommendations Continue to follow [client A's] Behavior Support Plan. [Client A] will receive 24/7 one to one staffing. Retrain [staff #10] on the one to one protocols...". 6. A BDDS report dated 11/29/22 indicated, "...On 11/28/22, [client A] was at home with his one-to-one staff. The other staff on duty was transporting [client A's] housemates to their day activities. [Client A's] one-to-one staff used the bathroom and once finished [client A] told him he had swallowed a toothbrush. Staff notified the supervisor and nurse and transported him to the [name of hospital] Emergency Department per nurse instructions. After an initial assessment, the attending physician admitted [client A] to the hospital for observation...[Client			

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	A] has a history of swallowing non-food items addressed in his Behavior Support Plan. ResCare supervisory staff will assure sufficient staff are present to maintain [client A's] one-to-one supervision when staff take care of personal needs...". Client A's record indicated an IDT Meeting Form dated 11/29/22. The IDT form dated 11/29/22 indicated the following: -"Meeting Agenda/Topics Discussed/Plan Changes On 11/28/22, [client A] was home alone with his 1:1 staff. While his 1:1 staff used the bathroom, [client A] swallowed a toothbrush. [Client A] was hospitalized and the toothbrush was removed successfully via endoscope. Action Steps: Provide [MLBC #1] with all incident documentation. Assure two staff are present wherever [client A] is so that one-to-one supervision can be supported when staff must take care of personal needs...". 7. A BDDS report dated 12/8/22 indicated, "...On 12/7/22, [client A] complained to staff of abdominal pain and staff contacted the nurse and supervisor. At the ER, [client A] disclosed that he had swallowed a razor which was confirmed by an abdominal CT (computerized topography) scan. The ER physician admitted [client A] to the hospital to arrange for removal of the object and he will be transferred to the facility's behavioral unit. It is currently unclear how [client A] obtained a razor because they are not currently used in his home...[Client A] has a history of swallowing non-food items addressed in his			

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	Behavior Support Plan. The interdisciplinary team met and determined that in addition to [client A's] one-to-one supervision, staff will complete sweeps of the home every half-hour to remove objects that [client A] could potentially swallow, and that staff will complete a body check each time [client A] returns from outside of the home. Administrative team members will train all staff on implementation of [client A's] revised safety protocols...". Client A's record was reviewed on 12/16/22 at 9:08 AM. Client A's record indicated an IDT Meeting Form dated 12/7/22. The IDT form dated 12/7/22 indicated the following: Meeting Agenda/Topics Discussed/Plan Changes During the overnight hours of 12/7/22, [client A] complained of severe abdominal pain and was taken to the ER. 1:1 staffing was in place. At the ER, [client A] told staff he swallowed a razor. [Client A] was hospitalized. Action Steps: Provide [MLBC #1] with all incident documentation. Implement every ½ hour house sweeps, completed by non-1 to 1 staff to not draw attention to the task. Complete Body checks each time [client A] returns from being away from the home. Administrative team members to provide all house staff and supervisor with retraining on 1:1 protocols and training on new house sweep protocol...". Client A's BSP dated 12/7/22 indicated the following:			

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	-"Plan Date: 11/17/22, revised 12/7/22 Behavioral History: Target Behavioral History: The target behaviors identified and displayed since Consumer's transition to the residential placement are: Physical Aggression/Physical Intimidation; Verbal Aggression; Frivolous 911 calls and Elopement/Leaving Assigned Area and Medication Seeking (opiates). Additional behaviors to be added and monitor as they have been observed to be engaged in/displayed by Consumer since his transition to the residence are: Swallowing non-food items (spoons, forks straws, etc.), Noncompliance with Dietary/Health; and Suicidal ideations (running into busy roadways/Traffic) - these two behaviors to watch have typically been observed to occur at the same time and warrant to be listed as new target behaviors to be decreased but were not previously an issue before his transitions into the home. ENHANCED SUPERVISION: Due to a recent pattern of elopement and swallowing non-food items that has led to psychiatric hospitalization and inpatient medical procedures, [client A] will receive 1:1 supervision 24/7. This supervision is defined as within line of sight at all times, close enough to react if he picks up an item to swallow. When [client A] is in bed, staff will position themselves outside of the door with the door cracked so that line of sight is maintained. If [client A] gets out of bed, staff must enter the room to prevent him from picking up an item to swallow. A specific staff will be assigned to provide [client A] with one-to-one supervision at all times. If for			

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	any reason the assigned staff needs to be relieved from 1:1 responsibilities for any reason, another staff must take over the 1:1 observation duties. For no reason is [client A] to be out of staff line of sight. If [client A] moves around, the 1:1 staff is expected to move with him. It is unacceptable for [client A] to be in one room, and his assigned staff to be in another. (As stated above, when [client A] is in bed staff may be in the hallway, with his door slightly open, in order to maintain line of sight. Privacy may be maintained in the bathroom, with the door shut, but the assigned 1:1 staff must remain outside the bathroom door. Prior to [client A] entering the bathroom, staff must sweep the room and remove anything he could potentially swallow. The 1:1 staff must maintain line of sight in the bathroom when [client A] completes oral hygiene or shaves and must remove any item he attempts to swallow. Staff are to monitor all activities, conversations, sudden movements of [client A] always. If you are assigned to be 1:1, the expectation is that you are engaging with [client A], and encouraging him to participate in functional learning activities as much as possible. If, for any reason, there is not enough staff in the home to accommodate a 1:1, the supervisor must be called immediately. However, the assigned staff with the 1:1 is expected to stay with [client A] until a supervisor has provided coverage for him. 12/7/22: due to today's incident of swallowing a disposable razor, despite one-to-one supervision, the interdisciplinary team consensually agrees that additional protective measures are required. Staff will implement house sweeps every half hour to secure potentially swallowable items. A staff not assigned as [client A's] one-to-one will complete the sweep so as not to draw attention to			

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	it. Additionally, any time [client A] has been away from the home, staff will complete a body check, including watching him empty his pockets to assure he has not picked up any item he could swallow. Consumer's current Identified Maladaptive Behaviors: ...3. Non-Compliance with Health and Safety/Swallowing non food items. 4. Elopement. 5. Suicidal Ideations... Target Behaviors for Reduction Defined: (Primary) ...Non Compliance with Health and Safety/ Swallowing non food items/Self-harming: Includes but not limited to periods of behaviors that directly and deliberately cause harm or injury to any area of his body with objects and or swallowing non-food items with the intention of self-harming. Elopement: Deliberately leaving supervision or assigned area/residence without permission; Individual leaves the immediate area or supervision as a direct result of anger and or with the intention of running away. Frivolous 911 Calls: Deliberately making unnecessary calls to 911 for non-emergency issues and making false allegations/reports to gain attention from medical services. Medication seeking/Opiates: Deliberately causing harm to self/and or making false allegations about health issues that do no exist to gain access to opiate medications. Suicidal Ideations: Having thoughts of self harm, with deliberate consideration or planning of			

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	possible techniques of causing his own death (examples: Running into traffic, swallowing harmful objects etc.)... Restrictions: Rights Restrictions: The team has reviewed the risks for each of the below stated rights restrictions and agrees that the restrictions should be implemented as stated to ensure health and safety for all person in the environment... Enhanced Supervision/ Secured Residential environment: To protect client from placing himself at risk of harm and exploitation outside of the residential environment without supervision of staff. Every 3 months (quarterly), progress will be monitored and discussed with the IDT in order to restore rights. Modified Enhanced Supervision Protocols: When Consumer demonstrates he may be a threat to himself (through the expression of suicidal ideations or other high intensity displays of behaviors), supervision will move from Modified Enhanced Supervision to Enhanced Supervision protocols. During these displays, Consumer needs the support and heightened supervision protocols that Enhanced Supervision provide; these specific measures are to be implemented when Consumer is potentially a threat to himself or others while at home and in the community... Consumer should not be unsupervised during this period and the staff should record Consumer's movements/activities on the 15-minute Check sheet/paperwork which should be maintained in Consumer's documentation binder...			

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	Sharps/Chemicals/Lighters (Access Restricted): To protect individual from accessing items which can be used to harm himself and/or others within the environment. Every 3 months (quarterly), progress will be monitored and discussed with the IDT to restore rights. Consumer has a history of collecting lighters, flints, magnifying glasses and other fire-starting devices which requires frequent room checks and the removal of these devices from his possession to ensure his safety as well as his housemates' safety... Self-Injury/S wallowing non food items:The direct, deliberate destruction of one's own body tissues without suicidal intent (e.g. includes striking his head against an object or striking his head with an object; hits (a) solid object, typically a door or wall or floor, table, window; scratch self that leaves a mark with own fingernails; scratch/cut/stab self with self-made weapon that leaves a mark; pinch self, choke self with object) or tries swallow harmful non food items...Door and window alarms: The use of window and door alarms to ensure safety of Consumer as well as housemates who have the risk of elopement. The usage of door alarms will be reviewed and discussed in IDT meetings...".Staff #1 was interviewed on 12/16/22 at 7:05 AM. Staff #1 stated, "I am the 1:1 staff for [client A]. Wherever he goes I have to go. He (client A) cannot go anywhere without staff supervision. Staff #1 was asked if client A should be able to elope from the home or			

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	ingest any non-food items. Staff #1 stated, "No he should not, not without staff at least there preventing it from happening."HM (House Manager) #1 was interviewed on 12/16/22 at 7:48 AM. HM #1 stated, "[Client A] has a 1:1 staff with him at all times. Staff are to complete body checks anytime he leaves the house, and we do room sweeps every 30 minutes to check for anything he (client A) could potentially swallow. Staff should also be documenting every 15 minutes on 15 minute check forms." HM #1 was asked how long these measures have been in place. HM #1 stated, "Since he started eloping and swallowing things." HM #1 was asked about client A swallowing non-food items. HM #1 indicated client A had not presented the behavior prior to the first incident on 11/2/22. HM #1 stated, "The swallowing things is new. Something he started doing in the hospital to stay in the hospital when they would tell him they were going to discharge him. That's why he swallowed the spoon at the hospital (on 11/2/22). He wanted to stay at the hospital. Then he started doing it at home because he knew he would go to the hospital." HM #1 was asked about client #1 swallowing a toothbrush on 11/11/22. HM #1 stated, "He had just returned home from a hospital stay and I guess wanted to go back." HM #1 was asked about the incident			

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	on 11/28/22 where client A swallowed a toothbrush while with his 1:1 staff. HM #1 stated, "He (client A) was with his one on one staff and when that staff went to the bathroom, he found one of his toothbrushes and swallowed it. I think he was doing this behavior because he just wanted to go to the hospital. He went to the hospital and they got it (the toothbrush) out." HM #1 indicated since the incident they had obtained lock boxes for all of the clients and their small items and he hasn't had access to them unless using them and staff supervising. HM #1 was asked about the incident on 12/7/22 involving client A complaining of abdominal pain and telling the hospital he had swallowed a razor. HM #1 stated, "We think he must of gotten it (razor) during one of his hospital stays. We don't have razors in the home. He broke the razor in half, took the handle off, and swallowed it. This is one of the reasons the body checks are now being completed." HM #1 was asked if client A should have been able to continue to elope and swallow non-food items if the supervision levels were being met. HM #1 indicated there have been times the supervision level was not followed as expected and a couple incidents occurred but, "It has gotten better."QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 12/16/22			

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	at 1:30 PM. QIDPM #1 was asked about client A's supervision level when client A moved into the group home on 10/6/22. QIDPM #1 stated, "15 minute checks which is the expected supervision level for new admissions for the first 30 days." QIDPM #1 indicated client A was moved to line of sight supervision during waking hours and 15 minute checks during the night after his first elopements on 10/30/22. QIDPM #1 was asked if client A should have been able to elope from the home multiple times on the evening of 10/30/22. QIDPM #1 stated, "No." QIDPM #1 indicated client A's supervision level was changed to 24/7 1:1 supervision and sharps and small items were secured following his discharge from the hospital on 11/11/22 (after he had eloped and then swallowed a non-food item). QIDPM #1 indicated client A should not have been able to continue to elope or swallow non-food items following the implementation of the enhanced supervision levels. QIDPM #1 stated, "The expected (supervision) levels were not implemented."The facility's policy and procedures were reviewed on 12/16/22 at 12:45 PM. The facility's Abuse, Neglect, Exploitation policy revised on 2/26/18 indicated, "ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect,			

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	exploitation, mistreatment or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare, local, state and federal guidelines...ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights...3. Any staff person who is suspected of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights toward an individual will be immediately suspended until the allegation can be fully investigated. After the investigation, if the allegation is not substantiated, the employee will be paid for missed scheduled hours...7. If the allegation is substantiated, the staff person accused will follow progressive corrective action up to and including termination...".This federal tag relates to complaints #IN00393849 and #IN00395040.9-3-2(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 (A), the facility failed to deploy	W 0186	**CORRECTION:** *The facility must provide sufficient*	01/20/2023

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	15G465	A. BUILDING 00 B. WING	12/21/2022

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	group home staff in a manner to implement client A's plan for supervision. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 12/15/22 at 11:50 AM and indicated the following: 1. A BDDS report dated 11/23/22 indicated, "...On the morning 11/22/22, [client A] ran out of his home's front door and staff lost line of sight. Staff contacted the residential supervisor who located [client A] three blocks from the home. [Client A] willingly rode back to the house with the supervisor...[Client A] has a history of elopement addressed in his Behavior Support Plan. He does not have plan approved alone time and was away from staff supervision for approximately five minutes. [Client A] will receive 24/7 (24 hours/7 days a week) one-to-one supervision to help reduce and prevent further occurrences, and all staff will be trained toward proper implementation of the enhanced supervision protocols...". An IS dated 11/30/22 indicated the following: -"Introduction On the morning 11/23/22, [client A] ran out of his home's front door and staff lost line of sight. Staff contacted the residential supervisor who located [client A] three blocks from the home. [Client A] willingly rode back to the house with the supervisor. [Staff #10] I (staff #10) was getting the other consumers medications ready in the medication room.		*direct care staff to manage and supervise clients in accordance with their individual program plans.* Specifically, supervisory staff have been retrained to assure adequate staffing is in place at the facility and in the community to assure client A's one-to-one supervision is supported and all staff have been retrained that at least two staff must be present at all times at the facility and in the community with client A to prevent gaps in one-to-one supervision. **PREVENTION:** A management staff will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assure appropriate staffing is in place for implementation of clients' 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, QIDP, Quality Assurance Coordinators, Area Supervisors, Nurse Manager and Assistant Nurse Manager) will conduct twice weekly administrative monitoring at the day service facility at varied times, to assure interaction with multiple staff, involved in a full range of active treatment scenarios. After 30 days, administrative monitoring	

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	[Client A] sneaked (sic) out of house. I (staff #10) didn't know he (client A) left. At first, he (client A) was in the medication room with me. He (client A) went to the bathroom. That is when he (client A) sneaked (sic) out. I (staff #10) went to look for [client A]. We (staff) found him a couple of blocks away. [Client A] returned home with me. Factual Findings [Staff #10] states [client A] was in the medication room with me, he (client A) said he (client A) was going to the bathroom, and he (client A) left. [Staff #10] did not follow [client A] to the bathroom, per the plan (BSP). Conclusion 1. It is not substantiated that [client A's] Behavior Support Plan failed to address Elopement. 2. It is substantiated that [client A] was without staff supervision. 3. It is substantiated that [client A] was without staff supervision for approximately 5 minutes. 4. It is substantiated that staff failed to follow [client A's] Behavior Support Plan. 5. It is not substantiated that staff failed to follow ResCare's Policies and Procedures. Recommendations Continue to follow [client A's] Behavior Support Plan. [Client A] will receive 24/7 one to one staffing...". 2. A BDDS report dated 11/29/22 indicated, "...On 11/28/22, [client A] was at home with his one-to-one staff. The other staff on duty was transporting [client A's] housemates to their day activities. [Client A's] one-to-one staff used the bathroom and once finished [client A]		will occur 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. Current Operations Team members received training from the QIDP Manager to assure a clear understanding of administrative monitoring as defined below. · 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 day service facility will include but not be limited to assuring sufficient staff are present to implement behavior supports. **RESPONSIBLE PARTIES:** QIDP,	

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	told him he had swallowed a toothbrush. Staff notified the supervisor and nurse and transported him to the [name of hospital] Emergency Department per nurse instructions. After an initial assessment, the attending physician admitted [client A] to the hospital for observation...[Client A] has a history of swallowing non-food items addressed in his Behavior Support Plan. ResCare supervisory staff will assure sufficient staff are present to maintain [client A's] one-to-one supervision when staff take care of personal needs...". Client A's record indicated an IDT Meeting Form dated 11/29/22. The IDT form dated 11/29/22 indicated the following: -"Meeting Agenda/Topics Discussed/Plan Changes On 11/28/22, [client A] was home alone with his 1:1 staff. While his 1:1 staff used the bathroom, [client A] swallowed a toothbrush. [Client A] was hospitalized and the toothbrush was removed successfully via endoscope. Action Steps: Provide [MLBC #1] with all incident documentation. Assure two staff are present wherever [client A] is so that one-to-one supervision can be supported when staff must take care of personal needs...". 3. A BDDS report dated 12/8/22 indicated, "...On 12/7/22, [client A] complained to staff of abdominal pain and staff contacted the nurse and supervisor. At the ER, [client A] disclosed that he had swallowed a razor which was confirmed by an abdominal CT (computerized topography) scan. The ER physician admitted [client A] to the		Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	hospital to arrange for removal of the object and he will be transferred to the facility's behavioral unit. It is currently unclear how [client A] obtained a razor because they are not currently used in his home...[Client A] has a history of swallowing non-food items addressed in his Behavior Support Plan. The interdisciplinary team met and determined that in addition to [client A's] one-to-one supervision, staff will complete sweeps of the home every half-hour to remove objects that [client A] could potentially swallow, and that staff will complete a body check each time [client A] returns from outside of the home. Administrative team members will train all staff on implementation of [client A's] revised safety protocols...". Client A's record was reviewed on 12/16/22 at 9:08 AM. Client A's record indicated an IDT Meeting Form dated 12/7/22. The IDT form dated 12/7/22 indicated the following: Meeting Agenda/Topics Discussed/Plan Changes During the overnight hours of 12/7/22, [client A] complained of severe abdominal pain and was taken to the ER. 1:1 staffing was in place. At the ER, [client A] told staff he swallowed a razor. [Client A] was hospitalized. Action Steps: Provide [MLBC #1] with all incident documentation. Implement every ½ hour house sweeps, completed by non-1 to 1 staff to not draw attention to the task. Complete Body checks each time [client A] returns from being away from the home. Administrative team members to provide all house			

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	staff and supervisor with retraining on 1:1 protocols and training on new house sweep protocol...". Client A's BSP dated 12/7/22 indicated the following: -"Plan Date: 11/17/22, revised 12/7/22 Behavioral History: Target Behavioral History: The target behaviors identified and displayed since Consumer's transition to the residential placement are: Physical Aggression/Physical Intimidation; Verbal Aggression; Frivolous 911 calls and Elopement/Leaving Assigned Area and Medication Seeking (opiates). Additional behaviors to be added and monitor as they have been observed to be engaged in/displayed by Consumer since his transition to the residence are: Swallowing non-food items (spoons, forks straws, etc.), Noncompliance with Dietary/Health; and Suicidal ideations (running into busy roadways/Traffic) - these two behaviors to watch have typically been observed to occur at the same time and warrant to be listed as new target behaviors to be decreased but were not previously an issue before his transitions into the home. ENHANCED SUPERVISION: Due to a recent pattern of elopement and swallowing non-food items that has led to psychiatric hospitalization and inpatient medical procedures, [client A] will receive 1:1 supervision 24/7. This supervision is defined as within line of sight at all times, close enough to react if he picks up an item to swallow. When [client A] is in bed, staff will position themselves outside of the door			

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	with the door cracked so that line of sight is maintained. If [client A] gets out of bed, staff must enter the room to prevent him from picking up an item to swallow. A specific staff will be assigned to provide [client A] with one-to-one supervision at all times. If for any reason the assigned staff needs to be relieved from 1:1 responsibilities for any reason, another staff must take over the 1:1 observation duties. For no reason is [client A] to be out of staff line of sight. If [client A] moves around, the 1:1 staff is expected to move with him. It is unacceptable for [client A] to be in one room, and his assigned staff to be in another. (As stated above, when [client A] is in bed staff may be in the hallway, with his door slightly open, in order to maintain line of sight. Privacy may be maintained in the bathroom, with the door shut, but the assigned 1:1 staff must remain outside the bathroom door. Prior to [client A] entering the bathroom, staff must sweep the room and remove anything he could potentially swallow. The 1:1 staff must maintain line of sight in the bathroom when [client A] completes oral hygiene or shaves and must remove any item he attempts to swallow. Staff are to monitor all activities, conversations, sudden movements of [client A] always. If you are assigned to be 1:1, the expectation is that you are engaging with [client A], and encouraging him to participate in functional learning activities as much as possible. If, for any reason, there is not enough staff in the home to accommodate a 1:1, the supervisor must be called immediately. However, the assigned staff with the 1:1 is expected to stay with [client A] until a supervisor has provided coverage for him. 12/7/22: due to today's incident of swallowing a disposable razor, despite one-to-one supervision,			

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	the interdisciplinary team consensually agrees that additional protective measures are required. Staff will implement house sweeps every half hour to secure potentially swallowable items. A staff not assigned as [client A's] one-to-one will complete the sweep so as not to draw attention to it. Additionally, any time [client A] has been away from the home, staff will complete a body check, including watching him empty his pockets to assure he has not picked up any item he could swallow. Staff #1 was interviewed on 12/16/22 at 7:05 AM. Staff #1 stated, "I am the 1:1 staff for [client A]. Wherever he goes I have to go. He (client A) cannot go anywhere without staff supervision. Staff #1 was asked if client A should be able to elope from the home or ingest any non-food items. Staff #1 stated, "No he should not, not without staff at least there preventing it from happening." HM (House Manager) #1 was interviewed on 12/16/22 at 7:48 AM. HM #1 stated, "[Client A] has a 1:1 staff with him at all times. Staff are to complete body checks anytime he leaves the house, and we do room sweeps every 30 minutes to check for anything he (client A) could potentially swallow. Staff should also be documenting every 15 minutes on 15-minute check forms." HM #1 was asked how long these measures have been in place. HM #1 stated, "Since he started eloping and swallowing things." HM #1 was asked if client A should have been able to continue to elope and swallow non-food items if the supervision levels were being met. HM #1 indicated there have been times the supervision level was not followed as expected and a couple incidents occurred but, "It has gotten better."			

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	QIDPM (Qualified Intellectual Disabilities Professional Manager) #1 was interviewed on 12/16/22 at 1:30 PM. QIDPM #1 was asked about client A's supervision level when client A moved into the group home on 10/6/22. QIDPM #1 stated, "15 minute checks which is the expected supervision level for new admissions for the first 30 days." QIDPM #1 indicated client A was moved to line of sight supervision during waking hours and 15 minute checks during the night after his first elopements on 10/30/22. QIDPM #1 was asked if client A should have been able to elope from the home multiple times on the evening of 10/30/22. QIDPM #1 stated, "No." QIDPM #1 indicated client A's supervision level was changed to 24/7 1:1 supervision and sharps and small items were secured following his discharge from the hospital on 11/11/22 (after he had eloped and then swallowed a non-food item). QIDPM #1 indicated client A should not have been able to continue to elope or swallow non-food items following the implementation of the enhanced supervision levels. QIDPM #1 stated, "The expected (supervision) levels were not implemented." This federal tag relates to complaints #IN00393849 and #IN00395040. 9-3-3(a)			