STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G746	A. BUILDING 00 B. WING	10/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE SOUTHEAST INDIANA	16609 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. This visit included a Covid-19 focused infection control survey. Survey dates: 10/18/21, 10/19/21, 10/20/21 and 10/21/21. Facility Number: 011664 Provider Number: 15G746 AIMS Number: 200902010 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/5/21.	W 0000		
W 0104 Bldg. 00	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview for 4 of 4 clients living at the group home (#1, #2, #3 and #4), the governing body failed to exercise general policy, budget, and operating direction over the facility to ensure a full and complete accounting of clients #1, #2, #3 and #4's personal funds entrusted to the facility. Findings include: On 10/18/21 at 4:34 PM a review of the clients' finances was completed. This affected clients #1, #2, #3 and #4. The review indicated the following:	W 0104	To Correct the deficient practice all supervisory staff have been re-trained on ResCare client finances procedures. Client 1,2,3, and 4 have had ledgers created and updated by the supervisory staff. To ensure no others were affected ResCare will Audit the past 3 months of client finances to ensure they are accurate and up to date. Additional monitoring will be achieved through weekly ledger review completed by the QIDP/Area Supervisor. Ongoing	11/20/2021

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

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	1) Client #1 did not have a financial ledger available for review. Client #1 did not have any cash in the home. 2) Client #2 did not have a financial ledger available for review. Client #2 did not have any cash in the home. 3) Client #3 did not have a financial ledger available for review. Client #3's actual cash on hand balance totaled $6.55. ($6.55 unaccounted for). 4) Client #4 did not have a financial ledger available for review. Client #4 did not have any cash in the home. On 10/18/21 at 4:34 PM, the Residential Manager (RM) was asked about clients #1, #2, #3 and #4's October financial ledgers and cash on hand. The RM stated, "I was confused when we went to the P-card (debit card)". The Qualified Intellectual Disabilities Professional (QIDP) stated in response to the RM, "Make sure when you finish the balance and turn it in (left over monies and receipts to the financial department), to do the next ledger with a zero balance. Make sure there is a balance, even if zero". At 4:49 PM, the QIDP instructed the RM to create ledgers for clients #1, #2, #3 and #4. At 4:54 PM, the RM stated, "It difficult. It's really hard to keep up". The RM indicated clients #1, #2, #3 and #4 all received $52.00 a month from the provider placed on a P-card, a home debit card. The RM indicated she tried to ensure all $52.00 was spent early in the month because and stated, "Like, if [staff #2] took someone out and forgot to put the receipts in he (an example client) might spend his $52.00. Then staff comes in the next day and think they still have $52.00". The		monitoring will be completed by monthly ledger review from the AS, and Monthly site reviews completed by ResCare supervisory staff.	

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	RM indicated she tried to ensure the clients $52.00 provided by the provider was spent early in the month to ensure each client spent their $52.00 and turned in the receipts to the office. The RM stated, "I don't want to be on the list" and indicated the business office would contact her if receipts were not received. On 10/19/21 at 3:51 PM, the Assistant Director (AD) was interviewed. The AD was asked about clients #1, #2, #3 and #4's $52.00 a month, missing ledgers, social security deposits and Resident Fund Management Service (RFMS). The AD indicated the $52.00 a month was provided to each client to ensure everyone would have money to spend. The AD indicated the clients' social security monies were not used and the provider deposited monies onto a P-card for the home and each client. The AD stated, "The $52.00 is coming from ResCare. We allotted that budget. It's built into their activities. They should have ledgers in the home. It's basically a community card. The SSI (social security income) goes into the RFMS (personal client accounts)". The AD indicated the SSI monthly deposits were separate and directly into each client's RFMS accounts. The AD was asked how the gifted $52.00 a monthly was accounted for ensuring the money was itemized. The AD stated, "When there is leftover money that should be accounted for. They can have up to $50.00 a month (cash) in the home. We're going to go to an individual card". The AD indicated further follow up was needed. The AD indicated the provider was in the process of obtaining needed information per client to generate individual cards for the $52.00 monthly spend. The AD indicated the SSI monies deposited directly into each client's RFMS account were treated as spend downs. The AD stated, "It's treated as a			

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	spend down. There will be IDTs (interdisciplinary team meetings) and a list created (purchasable items) and a check cut. When there is left over money that should be accounted for". The AD indicated clients #1, #2, #3 and #4 should have ledgers in the home to track the deposits and expenditures and receipts returned to the office. The AD indicated each client could have up to $50.00 cash in the home. The AD indicated the approach was to ensure all clients had money to spend to reduce maladaptive behavior. The AD indicated it was an attempt to ensure money was available to each client for weekly community outings. The AD indicated staff expenditure at the beginning of the month to use up all $52.00 was not the intention and individual P-cards would better ensure accounting and money available for weekly spending during community outings. The AD indicated staff should maintain itemized ledger in the home for all cash remaining in the home with deposits, expenditures and balances accurately maintained up to the $50.00 cap. The AD indicated further staff training and follow up for the implementation of itemized ledgers was needed. On 10/21/21 at 10:15 AM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the accounting of clients #1, #2, #3 and #4's personal funds. The QAM stated, "Yes, that (lack of ledgers and accounting) has been an ongoing issue". The QAM indicated each client's personal funds should be maintained accurately with a complete accounting. 9-3-1(a)			
W 0140 Bldg. 00	483.420(b)(1)(i) CLIENT FINANCES The facility must establish and maintain a			

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	system that assures a full and complete accounting of clients' personal funds entrusted to the facility on behalf of clients. Based on record review and interview for 4 of 4 clients living at the group home (#1, #2, #3 and #4), the facility failed to ensure a full and complete accounting of clients #1, #2, #3 and #4's personal funds entrusted to the facility. Findings include: On 10/18/21 at 4:34 PM a review of the clients' finances was completed. This affected clients #1, #2, #3 and #4. The review indicated the following: 1) Client #1 did not have a financial ledger available for review. Client #1 did not have any cash in the home. 2) Client #2 did not have a financial ledger available for review. Client #2 did not have any cash in the home. 3) Client #3 did not have a financial ledger available for review. Client #3's actual cash on hand balance totaled $6.55. ($6.55 unaccounted for). 4) Client #4 did not have a financial ledger available for review. Client #4 did not have any cash in the home. On 10/18/21 at 4:34 PM, the Residential Manager (RM) was asked about clients #1, #2, #3 and #4's October financial ledgers and cash on hand. The RM stated, "I was confused when we went to the P-card (debit card)". The Qualified Intellectual Disabilities Professional (QIDP) stated in response to the RM, "Make sure when	W 0140	To Correct the deficient practice all supervisory staff have been re-trained on ResCare client finances procedures. Client 1,2,3, and 4 have had ledgers created and updated by the supervisory staff. To ensure no others were affected ResCare will Audit the past 3 months of client finances to ensure they are accurate and up to date. Additional monitoring will be achieved through weekly ledger review completed by the QIDP/Area Supervisor. Ongoing monitoring will be completed by monthly ledger review from the AS, and Monthly site reviews completed by ResCare supervisory staff.	11/20/2021

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	you finish the balance and turn it in (left over monies and receipts to the financial department), to do the next ledger with a zero balance. Make sure there is a balance, even if zero". At 4:49 PM, the QIDP instructed the RM to create ledgers for clients #1, #2, #3 and #4. At 4:54 PM, the RM stated, "It difficult. It's really hard to keep up". The RM indicated clients #1, #2, #3 and #4 all received $52.00 a month from the provider placed on a P-card, a home debit card. The RM indicated she tried to ensure all $52.00 was spent early in the month because and stated, "Like, if [staff #2] took someone out and forgot to put the receipts in he (an example client) might spend his $52.00. Then staff comes in the next day and think they still have $52.00". The RM indicated she tried to ensure the clients $52.00 provided by the provider was spent early in the month to ensure each client spent their $52.00 and turned in the receipts to the office. The RM stated, "I don't want to be on the list" and indicated the business office would contact her if receipts were not received. On 10/19/21 at 3:51 PM, the Assistant Director (AD) was interviewed. The AD was asked about clients #1, #2, #3 and #4's $52.00 a month, missing ledgers, social security deposits and Resident Fund Management Service (RFMS). The AD indicated the $52.00 a month was provided to each client to ensure everyone would have money to spend. The AD indicated the clients' social security monies were not used and the provider deposited monies onto a P-card for the home and each client. The AD stated, "The $52.00 is coming from ResCare. We allotted that budget. It's built into their activities. They should have ledgers in the home. It's basically a community card. The SSI (social security income) goes into the RFMS (personal client			

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	accounts)". The AD indicated the SSI monthly deposits were separate and directly into each client's RFMS accounts. The AD was asked how the gifted $52.00 a monthly was accounted for ensuring the money was itemized. The AD stated, "When there is leftover money that should be accounted for. They can have up to $50.00 a month (cash) in the home. We're going to go an individual card". The AD indicated further follow up was needed. The AD indicated the provider was in the process of obtaining needed information per client to generate individual cards for the $52.00 monthly spend. The AD indicated the SSI monies deposited directly into each client's RFMS account were treated as spend downs. The AD stated, "It's treated as a spend down. There will be IDTs (interdisciplinary team meetings) and a list created (purchasable items) and a check cut. When there is left over money that should be accounted for". The AD indicated clients #1, #2, #3 and #4 should have ledgers in the home to track the deposits and expenditures and receipts returned to the office. The AD indicated each client could have up to $50.00 cash in the home. The AD indicated the approach was to ensure all clients had money to spend to reduce maladaptive behavior. The AD indicated it was an attempt to ensure money was available to each client for weekly community outings. The AD indicated staff expenditure at the beginning of the month to use up all $52.00 was not the intention and individual P-cards would better ensure accounting and money available for weekly spending during community outings. The AD indicated staff should maintain itemized ledger in the home for all cash remaining in the home with deposits, expenditures and balances accurately maintained up to the $50.00 cap. The AD indicated further staff training and follow up for the			

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	implementation of itemized ledgers was needed. 9-3-2(a)			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 additional client (#4), the facility failed to implement its policy and procedures for prohibiting abuse, neglect, exploitation, mistreatment and/or violation of individual's rights to prevent a pattern of client #4's elopements. Findings include: On 10/19/21 at 9:05 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following which affected client #4: -BDDS incident report dated 8/5/21 indicated, "It was reported [client #4] was in the dining room when he ran out the front door and ran to a neighboring group home. Staff was walking with [client #4] back to his home when he began to run toward the street. Staff followed [client #4], and a staff from a neighboring group home took the van and went to pick [client #4] up. [Client #4] got in the van and was transported to group home. [Client #4] was never out of line of sight. No injuries were reported. Plan to Resolve: Staff will continue to follow plans in place. [Client #4] has a BSP (Behavior Support Plan) that addresses leaving assigned area".	W 0149	To correct the deficient practice all site staff have been re-trained on ResCare ANE policy and procedures. As well as client #4 elopement protocols. The BC and QIDP continue to develop and implement appropriate plans for client #4. The IDT will convene to ensure Client #4 plans are addressing all needs and will update per the IDT recommendations. Additionally, the BC, QIDP, and AS have been trained to ensure the IDT is addressing any patterns of behaviors displayed by the clients. Ongoing monitoring will be achieved through weekly site visits from the BC and QIDP to ensure staff are following ANE policies and all clients plans in place.	11/20/2021

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Investigation Summary dated 8/5/21 indicated, "Briefly describe the incident and any sustained injury if any? Client (client #4) ran from home to [neighboring group home] in order to see nurse [name]. Staff was walking client back to home when he ran away from them and headed for Hwy (highway) 31. Staff got in van and picked client up on edge of Hwy. Client returned to home with staff and staff reviewed safety concerns about being out on the highway ...Recommendations: Client will be monitored at all times. Staff will provide opportunities for client to engage in physical activities on a daily basis ... Medication will be reviewed to determine effectiveness".

-BDDS incident report dated 8/6/21 indicated, "It was reported staff was adjusting the tv (television) for [client #4] when he went out the door. Staff followed [client #4] to the street. Staff was able to verbally redirect [client #4] back to the group home. [Client #4] was never out of line of sight. No injuries were reported. Plan to Resolve: Staff will continue to follow plans in place".

Investigation Summary dated 8/6/21 indicated, "Briefly describe the incident and any injury if any? There were no injuries ... What was going on prior to the elopement? Client was eating dinner and got up from table and went into side area of home. Client ran out of side door as staff was adjusting his tv. Staff ran out after client and went all the way to creek and then across Hwy 31 ... Recommendations: Client (client #4) has had several elopements in recent history. Team has met to review those elopements and medications. Additional time playing basketball, going out with preferred staff, and being able to visit with Nurse [name] when she is near, have all been

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	attempted. Staff will continue to follow BSP and report and document all behaviors". -BDDS incident report dated 8/10/21 indicated, "It was reported [client #4] was on his way to the restroom when he left the home with staff following. [Client #4] ran across the street and staff was able to verbally redirect [client #4] back to the group home. No injuries were reported. [Client #4] was never out of line of sight of staff. Plan to Resolve: Staff will continue to follow plans in place". Investigation Summary dated 8/9/21 indicated, "Briefly describe the incident and any sustained injury if any? No injuries were noted ... Where did the elopement occur or happen? Client (client #4) asked to go to the bathroom. Staff provided him that opportunity and client left sight of staff and ran out of the side door ... Interview with staff involved and write their response. [Residential Manager] stated, "We were with him until he went to the restroom and then he just took off. I followed him across 31 and the tracks" ... Was there sufficient staff at the time of the incident? There were only two staff in the home at the time of elopement ... Recommendations: House will maintain ratio. Staff will remain as close to client as possible. BC (Behavior Clinician) and QIDP (Qualified Intellectual Disabilities Professional) will continue to work with client on understanding the need for his safety and the risk of running". -BDDS incident report dated 9/22/21 indicated, "It was reported [client #4] had been calm when he ran out the door toward the street. Staff called police for assistance. [Client #4] then ran to a neighboring group home. [Client #4] was out of line of sight of staff for 10 minutes. No injuries			

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	were reported. Plan to Resolve: Staff will continue to follow plans in place." Investigation Summary dated 9/21/21 indicated, "Briefly describe the incident and any sustained injury if any? Client was calm at the home. He was talking with staff and then he ran out of the door and ran to another home in vicinity. He was out of line of sight for approximately 10 minutes. Police were called to ensure client safety. Was there sufficient staff at the time of the incident? There was one staff with two clients ... Internal incident report dated 9/21/21 indicated, "Consumer involved: [Client #4] ... What happened during the incident? Client ran out (sic) side door to Hwy 31. I was only staff - ESN-1 / [Staff Name] was only staff ESN-2 / ESN-3 on covid lockdown so I called police to get him. He ran back and went to ESN -2 with [staff name]. Out of sight 10 min (minutes) ...". On 10/20/21 at 1:58 PM the Assistant Director (AD) was interviewed. The AD was asked about client #4's pattern of elopements and his knowledge of client #4 going to a major highway described in BDDS reports as a street and a lack of staffing supports during the elopements. The AD stated, "I did not. There is definitely a difference in the level of severity for street compared to highway. We made an Area Supervisor change. That was one of our concerns, was the communication like that". The AD indicated staffing support should be maintained at appropriate levels to implement client #4's program plans to address his target behavior for elopement. The AD was asked about the implementation of the Abuse, Neglect, Exploitation, Mistreatment and/or violation of			

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	Individual's Rights (ANE) policy. The AD indicated staffing supports should be maintained to implement client #4's program plans. The AD was asked if the ANE policy should be implemented at all times. The AD stated, "Yes". On 10/21/21 at 10:15 AM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the pattern of client #4's elopements and lack of staffing supports to ensure the implementation of his program plans. The QAM indicated staffing supports should be maintained to implement client #4's program plans. The QAM was asked about the implementation of the ANE policy. The QAM stated, "Right, correct. There had been some communication issues. The one common denominator was having multiple Area Supervisor". The QAM indicated changes with the Area Supervisors role had been made. The change would ensure better communication for staffing supports that would enable consistent implementation of program plans like client #4's elopement strategies. The consistence with one Area Supervisor with improved communication for staffing support would better ensure implementation of the ANE policy to address patterns like elopements. On 10/20/21 at 2:48 PM, the ANE policy dated 5/5/21 was reviewed. The ANE indicated, "ResCare staff actively advocate for the rights and safety of all individuals ... ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights". 9-3-2(a)			

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RES CARE SOUTHEAST INDIANA	16609 SIMA GRAY RD HENRYVILLE, IN 47126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on record review and interview for 2 of 2 sampled clients (#1 and #2), and 2 additional clients (#3 and #4), the facility failed to ensure there was sufficient direct care staff to manage and supervise clients #1, #2, #3 and #4 according to their program plans. Findings include: On 10/19/21 at 9:05 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following which affected clients #1, #2, #3 and #4: -BDDS incident report dated 8/10/21 indicated, "It was reported [client #4] was on his way to the restroom when he left the home with staff following. [Client #4] ran across the street and staff was able to verbally redirect [client #4] back to the group home. No injuries were reported. [Client #4] was never out of line of sight of staff. Plan to Resolve: Staff will continue to follow plans in place". Investigation Summary dated 8/9/21 indicated, "Briefly describe the incident and any sustained injury if any? No injuries were noted ... Where	W 0186	To correct the deficient practice all staff responsible for scheduling have been re-trained on ensuring appropriate ratios at all times. Additionally, a dedicated Area Supervisor has been placed at all ESN locations to ensure continuity of care is achieved. The PM and AS will review the schedule weekly to ensure appropriate staffing is in place. Weekly observations will be conducted by the BC/QIDP to ensure appropriate staffing levels are in place. Ongoing monitoring will be achieved by at least monthly random drop ins by the AED to ensure staffing levels are in place.	11/20/2021

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	did the elopement occur or happen? Client (client #4) asked to go to the bathroom. Staff provided him that opportunity and client left sight of staff and ran out of the side door ... Interview with staff involved and write their response. [Residential Manager] stated, "We were with him until he went to the restroom and then he just took off. I followed him across 31 and the tracks" ... Was there sufficient staff at the time of the incident? There were only two staff in the home at the time of elopement ... Recommendations: House will maintain ratio. Staff will remain as close to client as possible. BC (Behavior Clinician) and QIDP (Qualified Intellectual Disabilities Professional) will continue to work with client on understanding the need for his safety and the risk of running". -BDDS incident report dated 9/22/21 indicated, "It was reported [client #4] had been calm when he ran out the door toward the street. Staff called police for assistance. [Client #4] then ran to a neighboring group home. [Client #4] was out of line of sight of staff for 10 minutes. No injuries were reported. Plan to Resolve: Staff will continue to follow plans in place." Investigation Summary dated 9/21/21 indicated, "Briefly describe the incident and any sustained injury if any? Client was calm at the home. He was talking with staff and then he ran out of the door and ran to another home in vicinity. He was out of line of sight for approximately 10 minutes. Police were called to ensure client safety ... Internal incident report dated 9/21/21 indicated, "Consumer involved: [Client #4] ... What happened during the incident? Client ran out (sic) side door to Hwy 31. I was only staff - ESN-1 /			

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	[Staff Name] was only staff ESN-2 / ESN-3 on covid lockdown so I called police to get him. He wan back and went to ESN -2 with [staff name]. Out of sight 10 min (minutes) ...". -BDDS incident report dated 10/13/21 indicated, "It was reported ESN group home at [address] was out of ratio from 9:00 AM to 10:00 AM when staff arrived putting home in ratio". Internal incident report dated 10/13/21 indicated, " ...What was happening before the incident? House 1 clients (clients #1, #2, #3 and #4) were present at house 2 with only 3 staff present. What happened during the incident? 3 staff present with 7 clients". On 10/19/21 at 2:30 PM, client #2's record was reviewed. The record indicated the following: -Individual Support Plan (ISP) dated 7/16/21 indicated, "[Client #2] requires supervision to ensure basic ADL's (Adult Daily Living Skills) are completed. He is currently healthy and requires 24- hour supervision and care... The interdisciplinary team recommends that [client #2] have supervision while participating in community activities because of his ... inappropriate behaviors as well as health and safety issues. He chooses leisure activities independently, but still requires structure for completing leisure time activities and participating in group activities. The interdisciplinary team has reviewed the comprehensive assessments and determined that at this time, due to the level of needs and training required and inability to transfer some skills to other environments or settings, [client #2] is in need of continued ... placement and active treatment services".			

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	On 10/19/21 at 3:21 PM, client #1's record was reviewed. The record indicated the following: -Individual Support Plan (ISP) dated 7/23/21 indicated, "(SIC) (Client #1) requires supervision in attending to his daily living skills ... level of care and active treatment is need so as health/safety and nutrition cannot be done without training and staff support". On 10/19/21 at 3:40 PM, client #3's record was reviewed. The record indicated the following: -Individual Support Plan (ISP) dated 3/24/21 indicated, "[Client #3] requires supervision to ensure basic ADL's are completed. He currently is in good health but requires 24- hour supervision and care ... The interdisciplinary team recommends that [client #3] have supervision while participating in community activities ... The interdisciplinary team has reviewed the comprehensive assessments and determined that at this time, due to the level of needs and training required and inability to transfer some skills ... [client #3] is in need of continued ... placement and active treatment services". On 10/19/21 at 3:45 PM, client #4's record was reviewed. The record indicated the following: -Individual Support Plan (ISP) dated 2/25/21 indicated, "[Client #4] requires supervision to ensure basic ADL's are completed. He is currently healthy requires 24- hour supervision and care ... The interdisciplinary team recommends that [client #4] have supervision while participating in community activities ... The interdisciplinary team has reviewed the			

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	comprehensive assessments and determined that at this time, due to the level of needs and training required and inability to transfer some skills to other environments or settings, [client #4] is in need of continued ... placement and active treatment services". Confidential Interview (CI #1) indicated the home had reoccurring staffing issues to implement clients #1, #2, #3 and #4 program plans. The CI #1 stated, "The big thing is the staffing issues. You can't make people come to work. The previous Area Supervisor was so unsupportive". Confidential Interview (CI #2) indicated the home had staffing issues. The CI #2 stated, "One day they had to move to another home. They didn't have enough staff coverage". On 10/20//21 at 1:20 PM, the BDDS Service Coordinator for clients #1, #2, #3 and #4 was interviewed. The BDDS Service Coordinator was asked about the incident that occurred on 10/13/21. The BDDS Service Coordinator stated, "I can tell you what happened. I arrived at ESN 2. The home you're surveying, the 4 clients with 1 staff was walking up the road to a neighboring home. I did a pre-check for someone moving in. We have a ratio of 3-3-2. When they brought the others in (clients #1, #2, #3 and #4), 3 staff were with 7 clients...". On 10/20/21 at 1:58 PM the Assistant Director (AD) was interviewed. The AD was asked about client #4's pattern of elopements with a lack of staffing supports. The AD indicated staffing support should be maintained at appropriate levels to implement client #4's program plans to address his target behavior for elopement. The			

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	AD was asked about the incident of 1 staff with 4 clients that occurred on 10/13/21. The AD stated, "That happened, yes. That was actually the reason we pulled the Area Supervisor". The AD indicated clients #1, #2, #3 and #4's BDDS Service Coordinator was visiting the neighboring home when one staff escorted clients #1, #2, #3 and #4 into that home due to a lack of staffing. The AD stated, "They should have had appropriate staffing levels. It was not communicated by the Area Supervisor". The AD indicated the BDDS Service Coordinator contacted management to inform 7 clients were being supervised by 3 staff once clients #1, #2 #3 and #4 had entered the neighboring home. The AD indicated the home's staffing levels should be maintained to implement clients #1, #2, #3 and #4's program plans. On 10/21/21 at 10:15 AM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the pattern of client #4's elopements and lack of staffing supports to ensure the implementation of his program plans. The QAM indicated staffing supports should be maintained to implement client #4's program plans. The QAM stated, "Right, correct. There had been some communication issues. The one common denominator was having multiple Area Supervisors". The QAM indicated changes with the Area Supervisors role had been made. The change would ensure better communication for staffing supports that would enable consistent implementation of program plans like client #4's elopement strategies. The consistency with one Area Supervisor with improved communication for staffing support would better ensure implementation of the plans to address patterns like elopements.			

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	On 10/20/21 at 2:51 PM, the undated Reimbursement Guidelines for the 24 hour Extensive Support Needs Residences were reviewed. The record indicated, "Individuals living in residences under this category must be supervised at all times and the staffing pattern at full capacity should be a minimum of: three (3) staff on the day shift; three (3) staff on the evening shift; and two (2) staff on the night shift". 9-3-3(a)			
W 0317 Bldg. 00	483.450(e)(4)(ii) DRUG USAGE Drugs used for control of inappropriate behavior must be gradually withdrawn at least annually in a carefully monitored program conducted in conjunction with the interdisciplinary team, unless clinical evidence justifies that this is contraindicated. Based on record review and interview for 1 of 2 sampled clients (#2), the facility failed to review the rate of client #2's targeted behaviors outlined within his medication reduction plan and follow up with his prescribing physician to determine appropriate course of action for the prescribed medications listed within client #2's medication reduction plan. Findings include: On 10/19/21 at 2:30 PM, client #2's record was reviewed. The record indicated the following: -Individual Support Plan (ISP) dated 7/16/21 indicated, "Discharge plan: ... Alternative placement may be a reasonable consideration at a later time upon meeting discharge criteria of 6 consecutive months of progress and an average of 4 occurrences per month in the following	W 0317	To correct the deficient practice the QIDP/BC have been trained on ensure the IDT meets when a client has met the criteria for medication reduction and the medication reduction plan is updated as needed. Additionally the QIDP/BC will work closely with the prescribing physician to ensure documentation is obtained when a client is in therapeutic range. To ensure no others were affected the BC will review ABC tracking for all clients for a period of 3 months and compare to the medication reduction plans. Ongoing monitoring will be achieved through monthly behavioral data review and quarterly psychiatric	11/20/2021

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	areas of physical aggression and elopement". -Behavior Support Plan (BSP) dated 1/13/21 indicated, "Target Behaviors: Physical Aggression ...Goal: [Client #2] will have 5 or fewer occurrences of physical aggression for three consecutive months ... Property Destruction ... Goal: [Client #2] will have 5 or fewer occurrences of property destruction for three consecutive months ... Noncompliance ... Goal: [Client #2] will have 5 or fewer occurrences of noncompliance for three consecutive months ... Elopement ... Goal: [Client #2] will have 0 or fewer occurrences of elopement for three consecutive months ... Leaving Assigned Area ... Goal: [Client #2] will have 5 or fewer occurrences of leaving assigned area for three consecutive months ...". Client #2's BSP indicated "The Psychiatric Diagnoses and Drug Reduction Plan" the following criteria: Depakote (manic episodes) ... When the goals for physical aggression and property destruction have been met, the IDT (interdisciplinary team) will meet to discuss a reduction ... Fluoxetine (antidepressant) ... When the goal for physical aggression is met, the IDT will meet to discuss a reduction ... Olanzapine (antipsychotic) ... When the goal for physical aggression and property destruction have been meet, the IDT will meet to discuss a reduction ... Propranolol (beta-blocker) ... When the goals for physical aggression have been met, the IDT will meet to discuss a reduction ...". -Behavior Tracking dated September 2021 indicated, 2 incidents of Physical Aggression, 2 incidents of Property Destruction, 0 incidents of Noncompliance, 0 incidents of Elopement and 1 incident of Leaving Assigned Area.		appointments.	

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-Behavior Tracking dated August 2021 indicated, 0 incidents of Physical Aggression, 0 incidents of Property Destruction, 0 incidents of Noncompliance, 0 incidents of Elopement and 0 incidents of Leaving Assigned Area.

-Behavior Tracking dated July 2021 indicated, 1 incident of Physical Aggression, 1 incident of Property Destruction, 0 incidents of Noncompliance, 0 incidents of Elopement and 0 incident of Leaving Assigned Area.

-Behavior Tracking dated June 2021 indicated, 0 incidents of Physical Aggression, 0 incidents of Property Destruction, 0 incidents of Noncompliance, 0 incidents of Elopement and 0 incident of Leaving Assigned Area.

Based on client #2's medication reduction plan, the IDT should review the rate of client #2's targeted behaviors and have a discussion with the prescribing physician to determine if a reduction and/or change would be deemed appropriate. No documentation of a team review for the rate of client #2's targeted behaviors and/or discussion with a prescribing physician was available for review.

On 10/19/21 at 4:45 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about client #2's behavior data and criteria of meeting his reduction plan. The QIDP stated, "[Behavior Clinician] and I talked about needing a team meeting to review his goals". The QIDP indicated further follow up was needed as client #2 had meet his goals, but the goals were being discussed as needing revision. The QIDP was asked if documentation of the teams review

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	and/or documentation from the prescribing physician finding client #2's medication supports to be therapeutic could be provided for review. The QIDP indicated no documentation of the teams review and/or therapeutic levels determined by the team and prescribing physician could be provided for review. On 10/20/21 at 1:00 PM, the Behavior Clinician (BC) was interviewed. The BC was asked about client #2's behavior data and criteria of meeting his reduction plan. The BC stated, "I need to change his goals to 0. We were going to do that at the annual. I spoke with [nurse] about making sure we talk about therapeutic levels. It was a past discussion". The BC was asked if documentation of the teams review and/or documentation from the prescribing physician finding client #2's medication supports to be therapeutic could be provided for review. The BC indicated no documentation of the teams review and/or therapeutic levels determined by the team and prescribing physician could be provided for review. 9-3-5(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, record review and interview for 1 additional client (#4), the facility failed to maintain drug security while preparing for client #4's medication administration. Findings include: An observation was completed on 10/19/21 from	W 0382	To correct the deficient practice all site staff have been re-trained on appropriate medication pass procedures and medication security. Additionally, monitoring will be achieved by twice weekly medication pass observation from the Supervisory team responsible	11/20/2021

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	6:47 AM to 8:22 AM. The observation indicated the following: -At 7:14 AM, staff #1 began preparing for the morning medication administration routine. -At 7:21 AM, staff #1 stated to client #4, "Get your water and wash your hands". Staff #1 then followed client #4 to the kitchen. Staff #1 left the medication cabinet unlocked and open with client #4's medications sitting out on a countertop. Client #4's medications were left unattended and unsecured with the medication administration room's door open. -At 7:23 AM, staff #1 returned to medication administration room with client #4 and completed his medication administration routine. On 10/19/21 at 12:01 PM, staff #1 was interviewed. Staff #1 was asked about client #4's medication administration routine and the security of his medication when left unattended. Staff #1 stated, "I knew when I walked out I messed up leaving his meds (medications) out". Staff #1 indicated she had been trained on medication security. Staff #1 was asked a follow up question and if medications should be secured and not left unattended. Staff #1 stated, "Yes sir". On 10/19/21 at 12:53 PM, the Nurse was interviewed. The Nurse was asked about staff #1 leaving client #4's medications out on a countertop with the medication cabinet unlocked and open while assisting client #4 with washing his hands and gathering his water to take his medications. The Nurse stated, "Yeah, I'll need to in-service on that". The Nurse was asked if medications should be securely maintained. The Nurse stated, "Yeah".		for the home. Ongoing monitoring will be achieved though monthly med audits and site reviews by ResCare Administration staff.	

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