DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 00 B. WING	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00361161. Complaint #IN00361161. Substantiated, Federal and State deficiencies related to the allegation(s) are cited at W104 and W149. Date of surrey: 9/20/21, 9/21/21, 9/22/21 and 9/23/21. Facility Number: 004615 Provider Number: 15G723 AIMS Number: 200528230 These deficiencies reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #39778 on 10/7/21.	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 1 of 2 sampled clients (former client A), the facility failed to develop a policy and procedures for client safety during heat advisories or high temperatures. Findings include: On 9/20/21 at 3:15 PM, a review of the facility Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated	W 0104	To correct the deficient practice Rescare has created and implemented a policy and procedure in regards to client safety during inclement weather including heat related weather. The policy includes details for when staff should gain permission prior to attending outings and engagements during inclement weather. All site staff have been trained on the	10/23/2021

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

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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	the following which affected former client A: BDDS incident report dated 8/25/21 indicated, "Staff and clients were at [Name] Park when [former client A] sat down on a bench to rest. [Former client A] then lowered himself to the ground and staff told him to continue to rest. Shortly after, [former client A] attempted to get up but appeared too weak to do so. [Former client A] then took staff's hand, then went limp. Staff assessed [former client A] and when no pulse was found, CPR (Cardiopulmonary Resuscitation) was initiated, and EMS (emergency medical services) was called. Police arrived, took over compressions and staff continued giving breaths to [former client A]. EMTs (emergency medical technicians) then arrived and transported [former client A] to [name of hospital] for treatment. At approximately [time] ResCare was notified that [former client A] had passed away. Initial cause of death as (sic) reported to staff by ER (emergency room) personnel was Cardiac Arrest ...". Investigation Summary dated 8/24/21 through 8/29/21 indicated, "... Scope of Investigation: An investigation was initiated into the circumstances surrounding [former client A's] death to determine if [former client A] received quality services while residing in his group home ... Investigative Procedure: ... Autopsy results and official Death Certificate have not been received at this time ... Risk Plans dated 2/15/21 for the following: AIBW/Obesity (adjusted ideal body weight) ... Hypertension (high blood pressure) ... Summary of Interviews: [Former Staff #1] stated ... the clients wanted to go on an outing that day ... I knew it was hot out, but I did not know there was a heat advisory. Everybody had water with them. Former client A had a 2-liter bottle of water with		policy. Rescare administrators will review the policy at least annually to ensure it is accurate and appropriate. Ongoing monitoring will be achieved through monthly supervisory site observations.	

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him ... We parked near the trail and there was a sign that described the trails. [Staff #4] explained the [name of park] trail to the clients. He told them how long the trail was and that there was a steep hill. All clients agreed to go on the [name of park] trail ...

[Staff #3] stated ... [Former client A] said he wanted to go play basketball. [Staff #4] brought up going to a park. [Staff #4] looked up [name of park] on the internet. He told use there was an old amusement park there and the clients all said they wanted to go. I was not aware there was a heat advisory that day. We made sure the clients had water to take with them to drink and [former client A] had a 2-liter bottle of water with him ... We read the description of the trails and explained the [name of park] trail. All the clients said they wanted to go on that trail ...

[Staff #4] stated ... [former client A] and [client B] wanted to play basketball. Due to Covid, I thought it would be better to go to a park. I looked [name of park] up on the internet and we all decided to go there. I was not aware there was a weather advisory. I knew it was going to be hot, but we left early and planned to be back to the group home by noon. We got water for everyone and sunscreen ... When we got to the park, we established which staff would be with which clients. There was a sign that said the hill was steep. The sign also warned to know health concerns and limits. I told the clients the hill was steep, and we could go to a different trail, but they all wanted to go to [name of park] ...

Factual findings: Training documentation for CPR/First-aid certification for [staff #4] indicates he was certified in May 2021. Review of Change of condition procedure was reviewed which states

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any changes in an individual's physical, mental, or psychological status must be reported to a nurse and reviewed timely. The person who has observed the change of condition must first determine, based on training, if emergency services are needed. If so, call 911. Staff contacted 911 on 8/24 (2021) after noticing a change in [former client A] and initiated live saving measures upon observing an emergency. Review of medical records from [name of hospital] shows admit (Admittance) diagnosis was cardiac arrest with secondary diagnosis as Syncope (loss of consciousness) and collapse. Preliminary Cause of Death: Cardiopulmonary Arrest. Conclusion: It is substantiated [former client A] received quality services while residing in his group home".

On 9/20/21 at 5:55 PM, staff #3 was interviewed. Staff #3 was asked about the activity where former client A experienced a medical emergency and his concerns about the trip. Staff #3 indicated all clients were excited to go. Staff #3 was asked to describe the events of the activity and any of his concerns. Staff #3 stated, "At the time, no. There was a sign before we went down the hill. We asked all of them twice and they were fine with going down the hill, so we went". Staff #3 was asked if he had concerns before going down the hill. Staff #3 stated, "Yeah. We had 2 liters of water for [former client A] and [client C]. [Client C] did not have his knee brace. For [former client A], we knew he had breathing problems. We were not sure about him going down, but he was perfectly fine. Staff #3 was asked if everything going down hill went well. Staff #3 stated, "Everything went well". Staff #3 was asked how long the trip was from the start of going down the hill to coming back up. Staff #3 stated, "I would say we stayed about an hour". Staff #3 was asked how much walking the group had completed. Staff #3 stated,

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	"We walked a little bit, drank water, walked. We sat down at the picnic table and asked how everyone was. Then we went down hill to a bridge, took pictures. The trail was shaded and mostly flat. Staff #3 was asked if everyone in the group was doing well at this point in the activity. Staff #3 stated, "Yep". Staff #3 was asked about coming back. Staff #3 stated, "Yeah, it was getting close to lunch time and some of the guys have meds (medications) and we decided to come back. Before we got to the bridge or at the bridge, [former client A] said he was tired. We sat. We asked him if he was ok. He wanted to continue. He made it to the picnic tables. We were there for about 20 minutes. We asked if he was ok. He said yes. Maybe 5 minutes going up (the hill) he said he was tired. He sat down. That hill is paved. He sat on the pavement. We told him to take his time. I was in the middle in case I needed to fall back or go up to the front. In case [client B] or anyone decided to run (elope)". Staff #3 was asked who was with [former client A]. Staff #3 stated, "[Staff #4] was with him the whole time. I went back and [staff #4] said to take the guys up to the van and get them out of the sun. After about 20 minutes I went back. He (former client A) made it about halfway. He was on the ground laying down. Staff #3 was asked if former client A was still conscious at that time. Staff #3 shook his head no and stated, "I got to him, and his words were not coming out. We asked if he could sit up. He was a big guy. He shook his head yes and helped us. I asked him if he wanted water and he shook his head no. He was just grunting at us. He laid back down. We asked if he could help us sit him up. I immediately checked for a pulse on his wrist and [staff #4] checked his neck. I called 911 and [staff #4] did the CPR. I ran up (the) hill because I was the only one with service and left my phone with [staff #4] and went up hill to tell [former staff #1].			

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	I guess I didn't notice the police until after I came back. He (police) was already there". Staff #3 was asked about the temperature during the activity. Staff #3 stated, "It wasn't hot when we left, but the sun was out. We took sunscreen". Staff #3 was asked what the temperature was during the activity. Staff #3 stated, "I think it was around 79 degrees (Fahrenheit)". Staff #3 was asked if any of the direct care staff contacted anyone in management before the activity. Staff #3 stated, "No". Staff #3 was asked if the Qualified Intellectual Disabilities Professional or Nurse were contacted prior to the activity. Staff #3 stated, "No, it was just an idea that popped up and we didn't tell anybody we were going". Staff #3 was asked if former client A had any risk plans which would have prevented him from participating in this activity. Staff #3 stated, "No". Staff #3 was asked if former client A had medical conditions which would have prevented him participating in this type of activity. Staff #3 stated, "Not that I can remember ...". On 9/21/21 at 11:30 AM, former client A's record was reviewed. The record indicated the following: -Individual Support Plan (ISP) dated 1/11/21 indicated diagnoses, but not limited to, "Traumatic Brian Injury ... Obesity. Individual Profile:.. [Former client A] is an attention seeking individual who likes to be praised for his behaviors. He has many barriers to overcome with limited intellectual development, limited education, difficulty understanding how his behavior affects others, limited focus and difficulty retaining information. [Former client A's] strengths are his abilities to cooperate, friends to friend's involvement, outgoing, overall peasant, vocational employment ... and being helpful to staff and other clients ... Needs: Needs help with			

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community access ... Needs help to work on decision making skills ... Needs help with showering and wearing appropriate clothing due to weather conditions".

-Health Risk Plan dated 2/19/21 indicated, "Consumer: [former client A]. Problem: Obesity. Approach: ... 13) Staff will provide education to [former client A] regarding his condition as needed to ensure that he has information to make informed decisions about his care".

-Health Risk Plan dated 2/19/21 indicated, "Consumer: [former client A]. Problem: Hypertension ... Approach:.. 2) Staff will encourage [former client A] to maintain a calm life style, provide extra rest should blood pressure become elevated, and exercise as tolerated ... 8. Staff will provide education to [former client A] regarding his condition as needed to ensure the (sic) he has information to make informed decisions about his care. Risk of Support: Hypotension (low blood pressure), dizziness, headache, light-headiness, flushing, weakness. Risk of Nonsupport: Elevation of blood pressure, stroke. Staff Responsible: Direct Support Staff, Nurse, RM (Residential Manager)".

-Medical Consult dated 8/24/21 indicated, "Narrative notes: [age] male to [name] ER emergency room at 1327 (1:27PM) found down at local [city] state park. Per EMS PT (patient) was out walking the trails ambulating up a large hill when he just collapsed. Bystander did start CPR. EMS on scene at 12:54 (PM) AED (automatic external defibrillator) applied with no shock advised".

On 9/21/21 at 11:51 AM, the Nurse was interviewed. The Nurse was asked if she was

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	involved with the activity planning and her understanding of former client A's medical emergency. The Nurse stated, "Not before going. When I received the call, we were at lunch. My first call was from [former staff #1]. I thought not [name of park]". The Nurse described frustration after receiving the call from former staff #1 and stated, "What made you guys go there and they told me they went early". The Nurse was asked about the temperature during the activity where former client A experienced a medical emergency. The Nurse stated, "I know it was a hot day. I don't know what the temperature was. The staff typically don't call me unless meds are involved. It's not that I give permission. [Former client A] did have noon meds. [Staff #4] said [former client A] wanted to play ball, but [staff #4] said it was going to be to hot and they decided to do something early in the morning. When I heard from [former staff #1], I asked where they were and thought please tell me not [name of park]. I don't know if you've been there, but it's a hard hike". The Nurse was asked if former client A was able to make informed decisions for himself pertaining to the weather and the difficulty of the trail considering his health conditions. The Nurse stated, "I would have to say [former client A] had impaired decision making. I can hear [former client A] saying I'm fine. I don't see him being able to associate medical like his weight to heart attack". The Nurse was asked if staff had contacted her as part of the activity planning. The Nurse stated, "They did not". The Nurse was asked if there was a policy regarding heat advisories/high temperature and/or rigorous activities requiring informed decision making and/or consent. The Nurse stated, "I know there is a power outage or a winter advisory policy for really cold days, so they don't get out to go to workshop. The Nurse was asked if the weather conditions combined			

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with the degree of difficulty of the activity where former client A experienced a medical emergency was an informed decision. The Nurse shook her head no and stated, "Not for [former client A]". The Nurse explained the staff and other clients participating were young men and former client A's weight, the degree of difficulty for the activity and weather may not have been considered. The Nurse stated, "May not have factored in the weight issues for [former client A]".

On 9/21/21 at 2:45 PM, the Behavior Clinician (BC) was interviewed. The BC was asked if she was involved with the activity planning and her understanding of former client A's medical emergency. The BC stated, "Staff did not speak with me before leaving. They never do unless it's crossing state lines". The BC was asked if a policy for hot weather or heat advisory protocol could be provided for review. The BC stated, "The only policy I'm aware of is cold weather. Not hot weather".

On 9/21/21 at 2:50 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the weather conditions during the activity where former client A experienced a medical emergency. The QIDP stated, "I found records that the temperature on the 24th (8/24/21) was 96 degrees (Fahrenheit). The day before was 97 degrees ... The advisory began at 2 PM and went until 9 PM. [City] and [City] was not in the advisory, I don't know why, but they weren't". The QIDP was asked during the day of former client A's activity if it was hot outside. The QIDP stated, "Sure it was, absolutely". The QIDP was asked if direct support staff contacted her prior to participating in the activity. The QIDP stated, "No". The QIDP was asked if a protocol for activity choice making,

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	such as activities requiring informed decision making, consent and/or weather-related protocols could be provided for review. The QIDP stated, "I don't think so for heat. We have stuff (protocol) that gets faxed (sent to group homes) out for cold weather. Staff are guided in that situation not to go out in those certain (cold) temperatures. I'm not sure what it's called, Inclement Weather maybe. I'm aware of that policy. I'm not aware of a heat policy. I've never seen a notification for heat being sent out. The QIDP was asked about the warning sign at the beginning of the trail explaining the type of trail and if former client A could make informed decisions about his physical abilities. The QIDP stated, "I've never seen that sign". The QIDP was asked about former client A's decision-making skills and ability to understand the physical demands the trail required. The QIDP stated, "I was not aware of the sign. I knew they had a conversation about going back up the hill. I was told they talked about bringing the van back down. All of the guys agreed they were going up the hill and wanted to do it". The QIDP was asked if former client A could make the decision for himself. The QIDP stated, "I've never questioned it in the past. Like how if it's raining, he wants to go on his walk". The QIDP stated an example with former client A's and described client A to say "I want to go on my walk! It might storm today? I'm going on my walk. He's insistent on going on his walk. At [park #2] [former client A] passed me up on those hills, so I guess I would not question his ability to do it. Those staff are always with him and play basketball. He (former client A) can move up and down that court. He (former client A) plays it to the best of his ability. I'm not sure they (staff) would question his ability". The QIDP was asked if she was contacted prior to the activity. The QIDP shook her head no and then stated, "I			

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	cannot disagree with you on calling. We left it up to 19 and 20-year old's to make decisions on a hot day. They had not seen him have trouble and played basketball. That's a lot of responsibility for anybody. We train them to do activities and not force someone to do something they don't want to. If he says he can make it, I want to do it, their (staff) training kicks in to allow him". The QIDP then stated, "If we expect them to, we, ResCare, as a whole should". The QIDP was asked to clarify and if she meant protocol for hot weather was needed. The QIDP stated, "Absolutely, if we have cold weather, we should have it for hot ... It makes no sense to have a policy for cold weather and not hot. We failed them (staff) by not providing them guidance. Those boys (staff) will have to live with this the rest of their lives. Obviously that was a strenuous activity, but I've seen him (former client A) at workshop, he had water, but I can see where they (staff) would not double guess it. It's a tragic loss for everyone". On 9/21/21 at 3:45 PM, the Quality Assurance Coordinator (QAC) was interviewed. The QAC was asked if a policy for hot weather and or activity planning for informed decision making / consent could be provided for review. The QAC stated, "We don't have a policy for weather. We have cold". The QAC was asked about activity planning to process informed decision making and consents for activities with warnings, waivers and strenuous activities. The QAC stated, "That would be more individual based on diagnosis or case by case basis". The QAC was asked to clarify individual planning and if she meant through a team review process. The QAC stated, "I don't think there is a policy defining activity planning". The QAC indicated agreement the provider did have a policy for out of state activity planning, but not within the state for activities			

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	requiring informed decision making and or consent to participate in activities with higher degree of risk. The QAC stated, "Maybe that is one of those things where trips like that need reviewed by the IDT (Interdisciplinary Team). Maybe we should look at planning before going". This federal tag relates to complaint #IN00361161. 9-3-1(a)			
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 2 sampled clients (Former Client A and client B), the facility failed to implement its policy and procedures prohibiting abuse, neglect, and exploitation to prevent 1) former client A's lack of Interdisciplinary Team involvement with the planning of a rigorous activity on a hot summer day and 2) a pattern of client B's elopement to ensure safety prior to an elopement incident involving the neighbor's tractor. Findings include: On 9/20/21 at 3:15 PM, a review of the facility Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following, which affected former client A and client B: 1) BDDS incident report dated 8/25/21 indicated, "Staff and clients were at [Name] Park when [former client A] sat down on a bench to rest. [Former client A] then lowered himself to the	W 0149	To correct the deficient practice Rescare has created and implemented a policy and procedure in regards to client safety during inclement weather including heat related weather. The policy includes details for when staff should gain permission prior to attending outings and engagements during inclement weather. Additionally, the alarm system in the home has been replaced with a continuous sounding alarm for when clients are eloping to alert staff. The QIDP and supervisory staff have been trained to ensure the IDT meets regularly to discuss all aspects of the individual's healthcare and behavioral needs. To ensure no others were affected the QIDP will review ABC tracking, and health notes for the last 6 months	10/23/2021

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	ground and staff told him to continue to rest. Shortly after, [former client A] attempted to get up but appeared too weak to do so. [Former client A] then took staff's hand, then went limp. Staff assessed [former client A] and when no pulse was found, CPR (Cardiopulmonary Resuscitation) was initiated, and EMS (emergency medical services) was called. Police arrived, took over compressions and staff continued giving breaths to [former client A]. EMTs (emergency medical technicians) then arrived and transported [former client A] to [name of hospital] for treatment. At approximately [time] ResCare was notified that [former client A] had passed away. Initial cause of death as (sic) reported to staff by ER (emergency room) personnel was Cardiac Arrest ...". Investigation Summary dated 8/24/21 through 8/29/21 indicated, "... Scope of Investigation: An investigation was initiated into the circumstances surrounding [former client A's] death to determine if [former client A] received quality services while residing in his group home ... Investigative Procedure: ... Autopsy results and official Death Certificate have not been received at this time ... Risk Plans dated 2/15/21 for the following: AIBW/Obesity (adjusted ideal body weight) ... Hypertension (high blood pressure) ... Summary of Interviews: [Former Staff #1] stated ... the clients wanted to go on an outing that day ... I knew it was hot out, but I did not know there was a heat advisory. Everybody had water with them. Former client A had a 2-liter bottle of water with him ... We parked near the trail and there was a sign that described the trails. [Staff #4] explained the [name of park] trail to the clients. He told them how long the trail was and that there was a steep hill. All clients agreed to go on the [name of park] trail ...		to ensure the IDT met the client's needs. Ongoing monitoring will be achieved by the QIDP Manager reviewing all incidents monthly to ensure the IDT is meeting the needs of the individual.	

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[Staff #3] stated ... [Former client A] said he wanted to go play basketball. [Staff #4] brought up going to a park. [Staff #4] looked up [name of park] on the internet. He told use there was an old amusement park there and the clients all said they wanted to go. I was not aware there was a heat advisory that day. We made sure the clients had water to take with them to drink and [former client A] had a 2-liter bottle of water with him ... We read the description of the trails and explained the [name of park] trail. All the clients said they wanted to go on that trail ...

[Staff #4] stated ... [former client A] and [client B] wanted to play basketball. Due to Covid, I thought it would be better to go to a park. I looked [name of park] up on the internet and we all decided to go there. I was not aware there was a weather advisory. I knew it was going to be hot, but we left early and planned to be back to the group home by noon. We got water for everyone and sunscreen ... When we got to the park, we established which staff would be with which clients. There was a sign that said the hill was steep. The sign also warned to know health concerns and limits. I told the clients the hill was steep, and we could go to a different trail, but they all wanted to go to [name of park] ...

Factual findings: Training documentation for CPR/First-aid certification for [staff #4] indicates he was certified in May 2021. Review of Change of condition procedure was reviewed which states any changes in an individual's physical, mental, or psychological status must be reported to a nurse and reviewed timely. The person who has observed the change of condition must first determine, based on training, if emergency services are needed. If so, call 911. Staff contacted

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	911 on 8/24 (2021) after noticing a change in [former client A] and initiated live saving measures upon observing an emergency. Review of medical records from [name of hospital] shows admit (Admittance) diagnosis was cardiac arrest with secondary diagnosis as Syncope (loss of consciousness) and collapse. Preliminary Cause of Death: Cardiopulmonary Arrest. Conclusion: It is substantiated [former client A] received quality services while residing in his group home". On 9/20/21 at 5:55 PM, staff #3 was interviewed. Staff #3 was asked about the activity where former client A experienced a medical emergency and his concerns about the trip. Staff #3 indicated all clients were excited to go. Staff #3 was asked to describe the events of the activity and any of his concerns. Staff #3 stated, "At the time, no. There was a sign before we went down the hill. We asked all of them twice and they were fine with going down the hill, so we went". Staff #3 was asked if he had concerns before going down the hill. Staff #3 stated, "Yeah. We had 2 liters of water for [former client A] and [client C]. [Client C] did not have his knee brace. For [former client A], we knew he had breathing problems. We were not sure about him going down, but he was perfectly fine. Staff #3 was asked if everything going down hill went well. Staff #3 stated, "Everything went well". Staff #3 was asked how long the trip was from the start of going down the hill to coming back up. Staff #3 stated, "I would say we stayed about an hour". Staff #3 was asked how much walking the group had completed. Staff #3 stated, "We walked a little bit, drank water, walked. We sat down at the picnic table and asked how everyone was. Then we went down hill to a bridge, took pictures. The trail was shaded and mostly flat. Staff #3 was asked if everyone in the group was doing well at this point in the activity.			

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	Staff #3 stated, "Yep". Staff #3 was asked about coming back. Staff #3 stated, "Yeah, it was getting close to lunch time and some of the guys have meds (medications) and we decided to come back. Before we got to the bridge or at the bridge, [former client A] said he was tired. We sat. We asked him if he was ok. He wanted to continue. He made it to the picnic tables. We were there for about 20 minutes. We asked if he was ok. He said yes. Maybe 5 minutes going up (the hill) he said he was tired. He sat down. That hill is paved. He sat on the pavement. We told him to take his time. I was in the middle in case I needed to fall back or go up to the front. In case [client B] or anyone decided to run (elope)". Staff #3 was asked who was with [former client A]. Staff #3 stated, "[Staff #4] was with him the whole time. I went back and [staff #4] said to take the guys up to the van and get them out of the sun. After about 20 minutes I went back. He (former client A) made it about halfway. He was on the ground laying down. Staff #3 was asked if former client A was still conscious at that time. Staff #3 shook his head no and stated, "I got to him, and his words were not coming out. We asked if he could sit up. He was a big guy. He shook his head yes and helped us. I asked him if he wanted water and he shook his head no. He was just grunting at us. He laid back down. We asked if he could help us sit him up. I immediately checked for a pulse on his wrist and [staff #4] checked his neck. I called 911 and [staff #4] did the CPR. I ran up (the) hill because I was the only one with service and left my phone with [staff #4] and went up hill to tell [former staff #1]. I guess I didn't notice the police until after I came back. He (police) was already there". Staff #3 was asked about the temperature during the activity. Staff #3 stated, "It wasn't hot when we left, but the sun was out. We took sunscreen". Staff #3 was asked what the temperature was during the			

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activity. Staff #3 stated, "I think it was around 79 degrees (Fahrenheit)". Staff #3 was asked if any of the direct care staff contacted anyone in management before the activity. Staff #3 stated, "No". Staff #3 was asked if the Qualified Intellectual Disabilities Professional or Nurse were contacted prior to the activity. Staff #3 stated, "No, it was just an idea that popped up and we didn't tell anybody we were going". Staff #3 was asked if former client A had any risk plans that would have prevented him from participating in this activity. Staff #3 stated, "No". Staff #3 was asked if former client A had medical conditions that would have prevented him participating in this type of activity. Staff #3 stated, "Not that I can remember ...".

On 9/21/21 at 11:30 AM, former client A's record was reviewed. The record indicated the following:

-Individual Support Plan (ISP) dated 1/11/21 indicated diagnoses, but not limited to, "Traumatic Brian Injury ... Obesity. Individual Profile:.. [Former client A] is an attention seeking individual who likes to be praised for his behaviors. He has many barriers to overcome with limited intellectual development, limited education, difficulty understanding how his behavior affects others, limited focus and difficulty retaining information. [Former client A's] strengths are his abilities to cooperate, friends to friend's involvement, outgoing, overall peasant, vocational employment ... and being helpful to staff and other clients ... Needs: Needs help with community access ... Needs help to work on decision making skills ... Needs help with showering and wearing appropriate clothing due to weather conditions".

-Health Risk Plan dated 2/19/21 indicated,

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	"Consumer: [former client A]. Problem: Obesity. Approach: ... 13) Staff will provide education to [former client A] regarding his condition as needed to ensure that he has information to make informed decisions about his care". -Health Risk Plan dated 2/19/21 indicated, "Consumer: [former client A]. Problem: Hypertension ... Approach:.. 2) Staff will encourage [former client A] to maintain a calm life style, provide extra rest should blood pressure become elevated, and exercise as tolerated ... 8. Staff will provide education to [former client A] regarding his condition as needed to ensure the (sic) he has information to make informed decisions about his care. Risk of Support: Hypotension (low blood pressure), dizziness, headache, light-headiness, flushing, weakness. Risk of Nonsupport: Elevation of blood pressure, stroke. Staff Responsible: Direct Support Staff, Nurse, RM (Residential Manager)". -Medical Consult dated 8/24/21 indicated, "Narrative notes: [age] male to [name] ER emergency room at 1327 (1:27PM) found down at local [city] state park. Per EMS PT (patient) was out walking the trails ambulating up a large hill when he just collapsed. Bystander did start CPR. EMS on scene at 12:54 (PM) AED (automatic external defibrillator) applied with no shock advised". On 9/21/21 at 11:51 AM, the Nurse was interviewed. The Nurse was asked if she was involved with the activity planning and her understanding of former client A's medical emergency. The Nurse stated, "Not before going. When I received the call, we were at lunch. My first call was from [former staff #1]. I thought not [name of park]". The Nurse described frustration			

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	after receiving the call from former staff #1 and stated, "What made you guys go there and they told me they went early". The Nurse was asked about the temperature during the activity where former client A experienced a medical emergency. The Nurse stated, "I know it was a hot day. I don't know what the temperature was. The staff typically don't call me unless meds are involved. It's not that I give permission. [Former client A] did have noon meds. [Staff #4] said [former client A] wanted to play ball, but [staff #4] said it was going to be to hot and they decided to do something early in the morning. When I heard from [former staff #1], I asked where they were and thought please tell me not [name of park]. I don't know if you've been there, but it's a hard hike". The Nurse was asked if former client A was able to make informed decisions for himself pertaining to the weather and the difficulty of the trail considering his health conditions. The Nurse stated, "I would have to say [former client A] had impaired decision making. I can hear [former client A] saying I'm fine. I don't see him being able to associate medical like his weight to heart attack". The Nurse was asked if staff had contacted her as part of the activity planning. The Nurse stated, "They did not". The Nurse was asked if there was a policy regarding heat advisories/high temperature and/or rigorous activities requiring informed decision making and/or consent. The Nurse stated, "I know there is a power outage or a winter advisory policy for really cold days, so they don't get out to go to workshop. The Nurse was asked if the weather conditions combined with the degree of difficulty for the activity where former client A experienced a medical emergency was an informed decision. The Nurse shook her head no and stated, "Not for [former client A]". The Nurse explained the staff and other clients participating were young men and former client			

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	A's weight, the degree of difficulty for the activity and weather may not have been considered. The Nurse stated, "May not have factored in the weight issues for [former client A]". On 9/21/21 at 2:45 PM, the Behavior Clinician (BC) was interviewed. The BC was asked if she was involved with the activity planning and her understanding of former client A's medical emergency. The BC stated, "Staff did not speak with me before leaving. They never do unless it's crossing state lines". The BC was asked if a policy for hot weather or heat advisory protocol could be provided for review. The BC stated, "The only policy I'm aware of is cold weather. Not hot weather". On 9/21/21 at 2:50 PM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about the weather conditions during the activity where former client A experienced a medical emergency. The QIDP stated, "I found records that the temperature on the 24th (8/24/21) was 96 degrees (Fahrenheit). The day before was 97 degrees ... The advisory began at 2 PM and went until 9 PM. [City] and [City] was not in the advisory, I don't know why, but they weren't". The QIDP was asked during the day of former client A's activity if it was hot outside. The QIDP stated, "Sure it was, absolutely". The QIDP was asked if direct support staff contacted her prior to participating in the activity. The QIDP stated, "No". The QIDP was asked if a protocol for activity choice making, such as activities requiring informed decision making, consent and/or weather-related protocols could be provided for review. The QIDP stated, "I don't think so for heat. We have stuff (protocol) that gets faxed (sent to group homes) out for cold weather. Staff are guided in that situation not to			

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	go out in those certain (cold) temperatures. I'm not sure what it's called, Inclement Weather maybe. I'm aware of that policy. I'm not aware of a heat policy. I've never seen a notification for heat being sent out. The QIDP was asked about the warning sign at the beginning of the trail explaining the type of trail and if former client A could make informed decisions about his physical abilities. The QIDP stated, "I've never seen that sign". The QIDP was asked about former client A's decision-making skills and ability to understand the physical demands the trail required. The QIDP stated, "I was not aware of the sign. I knew they had a conversation about going back up the hill. I was told they talked about bringing the van back down. All of the guys agreed they were going up the hill and wanted to do it". The QIDP was asked if former client A could make the decision for himself. The QIDP stated, "I've never questioned it in the past. Like how if it's raining, he wants to go on his walk". The QIDP stated an example with former client A's and described client A to say "I want to go on my walk! It might storm today? I'm going on my walk. He's insistent on going on his walk. At [park #2] [former client A] passed me up on those hills, so I guess I would not question his ability to do it. Those staff are always with him and play basketball. He (former client A) can move up and down that court. He (former client A) plays it to the best of his ability. I'm not sure they (staff) would question his ability". The QIDP was asked if she was contacted prior to the activity. The QIDP shook her head no and then stated, "I cannot disagree with you on calling. We left it up to 19- and 20-year old's to make decisions on a hot day. They had not seen him have trouble and played basketball. That's a lot of responsibility for anybody. We train them to do activities and not force someone to do something they don't want			

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	to. If he says he can make it, I want to do it, their (staff) training kicks in to allow him". The QIDP then stated, "If we expect them to, we, ResCare, as a whole should". The QIDP was asked to clarify and if she meant protocol for hot weather was needed. The QIDP stated, "Absolutely, if we have cold weather, we should have it for hot ... It makes no sense to have a policy for cold weather and not hot. We failed them (staff), by not providing them guidance. Those boys (staff) will have to live with this the rest of their lives. Obviously that was a strenuous activity, but I've seen him (former client A) at workshop, he had water, but I can see where they (staff) would not double guess it. It's a tragic loss for everyone". On 9/21/21 at 3:45 PM, the Quality Assurance Coordinator (QAC) was interviewed. The QAC was asked if a policy for hot weather and or activity planning for informed decision making / consent could be provided for review. The QAC stated, "We don't have a policy for weather. We have cold". The QAC was asked about activity planning to process informed decision making and consents for activities with warnings, waivers and strenuous activities. The QAC stated, "That would be more individual based on diagnosis or case by case basis". The QAC was asked to clarify individual planning and if she meant through a team review process. The QAC stated, "I don't think there is a policy defining activity planning". The QAC indicated agreement the provider did have a policy for out of state activity planning, but not within the state for activities requiring informed decision making and or consent to participate in activities with higher degree of risk. The QAC stated, "Maybe that is one of those things where trips like that need reviewed by the IDT (Interdisciplinary Team). Maybe we should look at planning before going".			

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	2) BDDS incident report dated 7/31/21 indicated, "Staff reported they were completing a medication pass while another staff was in the restroom, and [client B] was in the kitchen. [Client B] exited the home, jumped the fence and went across the street, to look at the trucks that were in a barn. [Client B] was out of line of sight for approximately 20 minutes, then returned home. Plan to Resolve: [Client B] has a BSP (Behavior Support Plan) in place that addresses leaving the assigned area. There were no injuries reported as a result of this incident". Investigation Summary dated 7/30/21 indicated, "Briefly describe the incident and any sustained injury if any. Staff noticed client returning to home. When they asked him where he had been he stated, 'Just to look at the tractors' ... What was going on prior to the elopement? Staff were passing medications and using the restroom. Client was in his new room. This was clients first day in new placement at ESN (Extensive Support Needs) ... Does this consumer have a history of elopement and is it addressed appropriately in the ISP (Individual Support Plan)/ BSP and Health Care Plan? Client had arrived to home with a history of elopement. However, client had not had documentation of any elopements in past 6 months. BSP does address elopement as a target behavior. Were there any environmental factors that contributed to the elopement? If yes, please explain what. Staff did not hear an alarm go off to alert them to client's elopement. Do any changes need to be made to prevent future occurrences? Staff have been instructed to be more aware of client's movements due to this being his first experience with so much freedom ...Was there sufficient staff at the time of the incident? Yes, at the time this is the usual staffing. However,			

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RES CARE COMMUNITY ALTERNATIVES SE IN	13009 HORIZON DR MEMPHIS, IN 47143

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staffing needs to be reviewed. Recommendations: Team will develop plans to address any issues that will deter client from eloping (sic) the home".

-BDDS incident report dated 8/3/21 indicated, "[Client B] was in his bedroom watching tv (television) when he left the group home through the window (alarm malfunctioned). [Client B] went to neighbor's barn and drove their tractor to the end of the street. On the way back to the barn, [client B] fell off the tractor. He then returned to the group home. Police were called by a neighbor witnessing the incident, as the tractor continued on its path until landing up ending against a grain silo. [Client B] was transported to [hospital name] for evaluation and was released with discharge paperwork stating no injuries noted. Plan to Resolve: [Client B] was admitted to the group home on 7/30/21 and it was not reported in his history that he is elopement risk. The IDT (Interdisciplinary Team) is meeting on 8/3/21 to discuss the incident and what measures need to be added to plans to address the behavior. Staff will continue to monitor [client B]. Window alarm was tested and repaired on 8/2/21".

Investigation Summary dated 8/3/21 indicated, "Briefly describe the incident and any sustained injury if any. Client eloped from home and went to neighbor farmer's barn. Client started tractor and drove that tractor into side of silo. Client returned to home as the police arrived to notify staff that client had been involved in incident. Where did the elopement occur or happen? It is unclear as to how the elopement occurred. It is suspected that client went out the bedroom window. However, upon investigation, it is possible he may have gone out back door ... Recommendations: IDT met to discuss changes that need to take place. BSP will reflect line of sight during waking hours and

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	15 minutes physical checks (to be documented) during sleep time. A request will be made to hardwire the alarm system. A request to place a cover on current system's control panel has been made. Staffing will now be three staff until 10 PM every day. Team will request that stairs to back deck be placed into backyard area to prevent client's (sic) being able to just walk off the deck to outside of assigned area". -BDDS incident report dated 8/13/21 indicated, "Staff completed checks, per BSP, and found [client B] was not in his bedroom. Staff discovered [client B] left the home and walked across the street. Staff redirected [client B] back inside, he went to his bedroom and no further incidents were reported. Plan to Resolve: [Client B] has a BSP in place to address the behavior. There were no injuries as a result of this incident. [Client B] was out of staff's sight for approximately 5 minutes". Investigation Summary dated 8/16/21 indicated, "Briefly describe the incident and any sustained injury if any. Client was in his bedroom watching a movie on his bed upon check by staff.(sic) Five minutes later, staff saw client across the street. Staff responded and redirected client back to the house and reviewed with client the need to remain on the property. Where did the elopement occur? The back door of the home. What was going on prior to the elopement? Client was checked on and was noted to have been in his room watching a movie ... Were there any environmental factors that contributed to the elopement? If yes, please explain what. The back door had been reported to [name of repair company] several times for alarm not functioning appropriately ...Was there sufficient staff at the time? Yes, there were four staff at the time. Recommendations: Staff will continue to do frequent checks on client,			

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especially while in his room alone. Staff will follow current BSP that addresses elopements".

On 9/21/21 at 10:50 AM, client B's record was reviewed. The record indicated the following:

-Individual Support Plan (ISP) dated 7/30/21 indicated, "Challenging Behaviors: ... Elopement ...".

-Behavior Support Plan dated 9/10/21 indicated, "Target Behaviors and Goals: ...Elopement: any occurrence of leaving the area with the intent to escape staff supervision at home or in the community ... Leaving Assigned Area: any occurrence of him going to another area of the home that is not his assigned area of the home .... Door and Window Alarms: Due to housemate behaviors in the home, alarms will be placed on the bedroom windows and exterior doors of the home ... Precursor Behaviors: ...It is hypothesized he displays elopement/leaving assigned areas when he is bored and not fully supervised. Due to this hypothesis and safety concerns, [client B] is line of sight during waking hours with 15-minute checks while sleeping at night".

On 9/20/21 at 5:29 PM, the Area Supervisor (AS) was interviewed. The AS was asked about client B's elopement incidents and the home alarm system's functionality. The AS indicated the elopement incidents had occurred. The AS was asked about the repair of the alarm system. The AS stated, "They (contract company) have one guy that is good. I have to follow up. They sometimes say the order is complete, but it's not. I have to stay on them". The AS was asked about client B's window and testing to ensure the alarms system is functioning. The AS then attempted to open client B's window and was unable after

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several attempts. The AS was asked if the metal bar in the window seal was preventing the window from being lifted up. The AS stated, "I would say so". The AS was asked if the metal bar prevents him from being able to open and test the window alarms functionality. The AS stated, "I would agree with that. When we first come in (main entrance of home), it (alarm system) shows that window is alarmed". The AS indicated client B was line of sight during waking hours and 15 minutes checks when in his room asleep. The AS indicated the alarm system, which included client B's bedroom window, was checked 4 times a day. The AS stated, "It's on our checks 4 times. Morning, Dinner, Supper and Nights".

On 9/21/21 at 10:30 AM, the Qualified Intellectual Disabilities Professional (QIDP) was interviewed. The QIDP was asked about client B's incidents of elopement. The QIDP stated, "He has had like 4 in the first 4 days". The QIDP was asked when the tractor incident occurred. The QIDP stated, "It was on 8/2/21". The QIDP was asked if client B had any additional elopement incidents or history since 8/2/21. The QIDP stated, "He had 1 attempt. [AS] spent a lot of time on outlining his yard and where he could go". The QIDP was asked about client B's current level of behavioral supports after the recent incidents of elopement. The QIDP stated, "Line of sight and 15 minute checks". The QIDP was asked if this was still in place to monitor client B and to prevent further elopements. The QIDP stated, "Yes". The QIDP was asked if client B should be prevented from going to the neighbors and driving the neighbors tractor. The QIDP stated, "Absolutely". The QIDP indicated the abuse, neglect, exploitation, mistreatment and or violation of individuals rights policy should be implemented at all times.

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On 9/21/21 at 10:42 PM, the Nurse was interviewed. The Nurse was asked about client B's incidents of elopement and driving the neighbor's tractor. The Nurse indicated client B's incident of elopement had occurred. The Nurse stated, "The incident on 8/2/21 (driving neighbor's tractor) he was sent out medically for evaluation. His ER visit did not produce anything. Along with alarms, we also had a psych (psychiatry) appointment and some med changes. It seems like a much more manageable [client B]". The Nurse indicated the abuse, neglect, exploitation, mistreatment and or violation of individuals rights policy should be implemented at all times.

On 9/20/21 at 4:33 PM, the Quality Assurance Coordinator (QAC #1) was interviewed. The QAC #1 was asked about client B's incident history. The QAC #1 indicated client B's elopements had occurred. The QAC #1 was asked about the implementation of the abuse, neglect, exploitation, mistreatment and violation of individual's rights (ANE) policy. The QAC #1 indicated the ANE policy should be implemented at all times.

On 9/21/21 at 1:15 PM, a review of the Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual Rights (ANE) policy was conducted. The ANE policy 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".

This federal tag relates to complaint #IN00361161.

9-3-2(a)