STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G745	A. BUILDING 00 B. WING	06/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
RES CARE SOUTHEAST INDIANA	16611 SIMA GRAY RD HENRYVILLE, IN 47126

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W 0000 Bldg. 00	This visit was for the investigation of complaints #IN00382381 and #IN00379435. This visit resulted in an Immediate Jeopardy. Complaint #IN00382381: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149, W157 and W159. Complaint #IN00379435: Substantiated, Federal and state deficiencies related to the allegation(s) are cited at W102, W104, W122, W149 and W159. Dates of Survey: 6/8/22, 6/9/22, 6/10/22, 6/13/22, 6/14/22, 6/15/22, 6/16/22, 6/17/22, 6/20/22 and 6/21/22. Facility Number: 011663 Provider Number: 15G745 AIMS Number: 200902020 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 6/29/22.	W 0000		
W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview for 2 of 2 sampled clients (A and B) and 1 additional client (C), the facility failed to meet the Condition of Participation: Governing Body. The facility's governing body failed to exercise operating direction over the facility to prohibit	W 0102	To correct the deficient practice all current site staff as well as subs have been re-trained on the ResCare ANEM policy. Including the reporting process. All supervisory staff have been	07/21/2022

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

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	abuse, neglect, and/or mistreatment to prevent neglect from a lack of staff supervision and the implementation of clients A and B's behavioral support plans to prevent their elopement on 6/7/22, which resulted in a motor vehicle collision and 2) the alleged mistreatment of clients B and C. Findings include: 1. Please refer to W104. For 2 of 2 sampled clients (A and B) and 1 additional client (C), the facility's governing body failed to exercise operating direction over the facility to prohibit abuse, neglect, and/or mistreatment to prevent neglect from a lack of staff supervision and the implementation of clients A and B's behavioral support plans to prevent their elopement on 6/7/22, which resulted in a motor vehicle collision and 2) the alleged mistreatment of clients B and C. 2. Please refer to W122. For 2 of 2 sampled clients (A and B) and 1 additional client (C), the facility's governing body failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (A and B) and 1 additional client (C). The governing body neglected to implement its policy and procedures to ensure their system to prohibit and prevent abuse, neglect, and/or mistreatment was implemented concerning the elopement risks of clients A and B, and 2) the alleged mistreatment of clients B and C. The governing body neglected to ensure clients A and B's Behavior Support Plans had adequate behavioral strategies to address elopement risk and implementation of the behavioral support plan. The governing body neglected to take sufficient corrective action to prevent elopement after a previous elopement incident. This federal tag relates to complaint #IN00382381.		re-trained on ensuring appropriate levels of supervision are in place to ensure staff are following plans, and the ANEM policy. Client A will be discharged from services. Client B's BSP and ISP have been revised for appropriate safety measures. The team will review the rights restrictions and behavioral data quarterly and as needed to discuss appropriateness of client B's plans. All site staff have been trained on the updated plans. Additional monitoring will be achieved by twice daily administrative observations for a period of 2 months. As well as the administrative team will meet daily for a period of one month to discuss ongoing issues at the site. Ongoing monitoring will be achieved through the BC/QIDP/AS/PM doing routine observations and staff trainings. The BC will be at the home at least ten hours a week. QIDP will coordinates, monitor, and integrate each week at the ESN home with monitoring by the QIDP lead. Additional ongoing monitoring will be achieved through monthly administrative meetings regarding the site to discuss any ongoing issues and address at that time.	

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	This federal tag relates to complaint #IN00379435. 9-3-1(a)			
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 observation, record review and interview for 2 of 2 sampled clients (A and B), and 1 additional client (C), the facility's governing body failed to exercise operating direction over the facility to prohibit abuse, neglect, and/or mistreatment, to prevent neglect from a lack of staff supervision and the implementation of clients A and B's behavioral support plans to prevent their elopement on 6/7/22, which resulted in a motor vehicle collision and 2) the alleged mistreatment of clients B and C. Findings include: 1. Please refer to W149. For 2 of 2 sampled clients (A and B) and 1 additional client (C), the governing body neglected to implement its policy and procedures to ensure their system to prohibit and prevent abuse, neglect, and/or mistreatment was implemented concerning 1) the elopement risks of clients A and B. The governing body neglected to ensure clients A and B's plans had adequate behavioral strategies to address elopement risk and implementation of the behavioral support plans, and 2) the alleged mistreatment of clients B and C. 2. Please refer to W157. For 2 of 2 sampled clients (A and B), the facility failed to take sufficient corrective action to prevent the 6/7/22 elopement	W 0104	To correct the deficient practice all current site staff as well as subs have been re-trained on the ResCare ANEM policy. Including the reporting process. All supervisory staff have been re-trained on ensuring appropriate levels of supervision are in place to ensure staff are following plans, and the ANEM policy. Client A will be discharged from services. Client B's BSP and ISP have been revised for appropriate safety measures. The team will review the rights restrictions and behavioral data quarterly and as needed to discuss appropriateness of client B's plans. All site staff have been trained on the updated plans. Additional monitoring will be achieved by twice daily administrative observations for a period of 2 months. As well as the administrative team will meet daily for a period of one month to discuss ongoing issues at the site. Ongoing monitoring will be achieved through the BC/QIDP/AS/PM doing routine	07/21/2022

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	after a previous elopement incident which occurred on 4/16/22 involving clients A and B. 3. Please refer to W159. For 2 of 2 sampled clients (A and B) and 1 additional client (C), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans. The QIDP failed to ensure clients A and B had adequate behavioral strategies to address elopement risk and implementation of their behavioral support plans and 2) the alleged mistreatment of clients B and C. This federal tag relates to complaint #IN00382381. This federal tag relates to complaint #IN00379435. 9-3-1(a)		observations and staff trainings. The BC will be at the home at least ten hours a week. QIDP will coordinates, monitor, and integrate each week at the ESN home with monitoring by the QIDP lead. Additional ongoing monitoring will be achieved through monthly administrative meetings regarding the site to discuss any ongoing issues and address at that time.	
W 0122 Bldg. 00	483.420(a) CLIENT PROTECTIONS The facility must ensure the rights of all clients. Therefore the facility must Based on observation, record review, and interview for 2 of 2 sampled clients (A and B) and 1 additional client (C), the facility failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (A and B) and 1 additional client (C). The facility neglected to implement its policy and procedures to ensure their system to prohibit and prevent abuse, neglect, and/or mistreatment was implemented concerning the elopement risks of clients A and B and 2) the alleged mistreatment of clients B and C. The facility neglected to ensure clients A and B's Behavior Support Plans had adequate behavioral strategies to address elopement risk and implementation of the behavioral support plan. The facility neglected to take sufficient corrective action to prevent elopement after a previous	W 0122	To correct the deficient practice all current site staff as well as subs have been re-trained on the ResCare ANEM policy. Including the reporting process. All supervisory staff have been re-trained on ensuring appropriate levels of supervision are in place to ensure staff are following plans, and the ANEM policy. Client A will be discharged from services. Client B's BSP and ISP have been revised for appropriate safety measures. The team will review the rights restrictions and behavioral data quarterly and as needed to discuss	07/21/2022

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	elopement incident. This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 6/10/22 at 10:45 AM. The Associate Executive Director and Quality Assurance Manager were notified of the Immediate Jeopardy on 6/10/22 at 1:37 PM. The Immediate Jeopardy began on 4/16/22 when clients A and B first eloped from the Extensive Support Needs (ESN) home. The facility neglected to develop adequate behavioral strategies to prevent the reoccurrence of clients A and B's risk for elopement. The facility neglected to implement the abuse, neglect, exploitation, mistreatment or a violation of individual's rights policy. The facility neglected to develop effective behavioral strategies and staff monitoring to prevent clients A and B's continued plans to elope, which resulted in a second incident on 6/7/22. The 6/7/22 elopement incident involved clients A and B in a company vehicle obtained while staff allegedly slept on duty, police involvement to locate them, and a car collision to end the elopement incident. On 6/13/22 at 9:37 AM, the facility's undated plan to remove the Immediate Jeopardy was reviewed and indicated the following: "1. Client A will not return to [address]. 2. Client B's Behavior Support plan was reviewed and revised by the IDT (interdisciplinary team) on 6/10/2022. Facility staff will be retrained on updated BSP (Behavior Support Plan) by Behavior Clinician to and (sic) the line-of-sight definition added to Client B's plans and facility staff trained before next scheduled shift. 3. Client B's ISP (Individual Support Plan) was		appropriateness of client B's plans. All site staff have been trained on the updated plans. To ensure no others are affected the regional operations support specialist (ROSS) will be reviewing all ESN 2 plans with the BC/QIDP to thoroughly review the plans for appropriate behavioral objectives. Additional monitoring will be achieved by twice daily administrative observations for a period of 2 months. As well as the administrative team will meet daily for a period of one month to discuss ongoing issues at the site. Ongoing monitoring will be achieved through the BC/QIDP/AS/PM doing routine observations and staff trainings. Ongoing monitoring will be achieved through the BC being at the home at least ten hours a week, documented on the weekly contact notes. QIDP will coordinates, monitor, and integrate each week at the ESN home with monitoring by the QIDP lead. As well as monthly administrative meetings regarding the site to discuss any ongoing issues and address at that time. Additionally the items implemented during the IJ remain in place are as followed: Alarm systems checks completed by the security system, Keyless entry installed on the office door, Self-closing hinges installed on the office door, Gate latches	

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	reviewed and revised by the IDT on 6/10/2022. QIDP (Qualified Intellectual Disabilities Professional) to address challenging behaviors Theft, Risk Taking Behavior, and Exploitation. Facility staff will be retrained on updated ISP by the QIDP before next scheduled shift. 4. Line of Site (sic) staff will be assigned to Client B, designated by schedule maintained in the home verified by Area Supervisor, Program Manager and AED (Associate Executive Director). 5. The Facility will hold (sic) daily administrative meeting to discuss progress, advise improvements, and track progress beginning 6/10/2022. 6. Administrative Observations were implemented in the home consisting of two night shift observations and 1 day shift observation. 7. The Behavior Clinician will continue to be in the home at least 10 hours per week to ensure that plans, as well as policy/procedures, are being followed. 8. The QIDP will continue to be in the home at least 10 hours per week to ensure that plans, as well as policy/procedures, are being followed. 9. Immediate retraining for any areas of concern will take place if administrative staff deem necessary and completed retraining documentation will be submitted to the QIDP Manager. 10. Security Services contractor is scheduled to perform a complete system check to all exterior doors/windows and recommend any additional monitoring devices applicable to maintaining		purchased and installed, Window sash locks purchased and installed, van key and gas card to be locked and kept together along with a sign off, Tracking devices purchased for the van, Box installed over the alarm panel to prevent tampering, Twice daily administration observations, Tracking BS and QIDP weekly hours, 15 minute client checks, Daily administrative team calls, Client B is on eye sight protocol, Staff smoking rules set in place.	

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	client safety no later than 6/15/2022. 11. Staff will implement 15-minute checks on all client documentation maintained at the facility checked daily by random administrative observation. 12. The van keys and gas card will be kept together and remain behind double lock in the staff office. Off going day shift staff will verify keys are in place, signing off to document checked daily by random administrative observation. 13. PIN (personal identification number) number for the gas card will not be kept in the van. PIN number will be kept in a place only accessible by staff checked daily by random administrative observation. 14. Tracking Devices were ordered on 6/7/2022 to add to key fob and will be added as soon as received. 15. Keyless entry pad has been installed on the office door. The keypad code will be changed once monthly documented by ResCare Maintenance Manager. 16. Self-closing hinges will be installed on office door by ResCare Maintenance no later than 6/15/2022. 17. Staff will be in serviced on the office door always being secure, door status checked daily by random administrative observation. Persons Responsible: Executive Director, Associate Executive Director, Program Director, Area Supervisor, QIDP, BC, Quality Assurance			

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	Manager, ResCare Maintenance Manager." The Immediate Jeopardy was removed on 6/20/22 at 3:57 PM when through monitoring observations, interviews and record reviews on 6/10/22, 6/13/22, 6/14/22, 6/15/22, 6/16/22, 6/17/22 and 6/20/22, it was determined the facility had implemented the plan of action to remove the Immediate Jeopardy and that the steps taken removed the immediacy of the problem. An observation was conducted on 6/10/22 from 2:46 PM through 4:26 PM. The observation indicated client A was not present at the home. On 6/10/22 at 2:50 PM, staff #1 indicated client A had not been released from law enforcement and wasn't able to return to the home. Client B was making a bucket of mop water and proceeded to mop the day room floor. An observation was conducted on 6/13/22 from 1:09 PM through 2:52 PM. The observation indicated client A was not present at the home. Client B was in the office with the behavior clinician and staff #7. Clients C and D were in their bedrooms. At 1:20 PM, client B and staff #7 returned to client B's side of the home. Client B went to his room. The behavior clinician indicated it was leisure time for all three of the clients. Staff #7 indicated clients B and C had their annual physical earlier in the morning, that everyone had just finished lunch and were now relaxing for about an hour. Staff #7 indicated client B was now line of sight supervision due to the recent elopement incident on 6/7/22. Staff #7 was asked if he had received training and/or in-servicing. Staff #7 stated, "Yes, I signed papers with [behavior clinician] today". Staff #7 was asked if the training included how to securely maintain the vehicle keys and gas card. Staff #7 stated, "Yes sir. Like			

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	keeping them in a drawer". Staff #7 was asked if that location was double locked. Staff #7 stated, "I believe so, yes". Staff #7 was asked if he had received training on client B's Individual Support Plan (ISP). Staff #7 stated, "I know we did the line of sight and the keys". Staff #7 indicated he was not aware of client B's challenging behavior indicated in his ISP such as theft, risk taking behavior, and/or exploitation. At 1:36 PM, the Program Manager entered the home and went into the garage. At 1:48 PM, the Qualified Intellectual Disabilities Professional (QIDP) entered the home. Client B remained in his room with staff #7 seated in the day room adjacent to client B's bedroom entrance. At 1:52 PM, the Surveyor Supervisor entered the home. Upon entering the home, the Surveyor Supervisor had a discussion with a group of facility staff members near the dining area while being screened for Covid-19 safety precautions. During this conversation, it was indicated the QIDP made weekly visits to the home prior to the 6/7/22 elopement incident. At 2:03 PM, staff #7 was asked how often the QIDP visited the home and what duration the QIDP would monitor supports and services provided to clients. Staff #7 stated, "An hour. Maybe once a week". At 2:45 PM, client B showed the surveyor and the surveyor supervisor his bedroom. Client B showed how he opened his window to exit the home on 6/7/22 to elope. Client B was asked how he and client A took the keys to the van. Client B stated, "The day before. When [staff #6] and [staff #4] were in the garage smoking". An observation was conducted on 6/14/22 from 4:35 PM through 5:52 PM. Upon entering the home, a gray company van was parked in the driveway of the home. Client A was not present at the home due to the law enforcement actions that continued. Client B was on his side of the home			

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	with staff #5. Client C had just finished his shower and returned to his bedroom. Client C indicated he wanted to speak with the surveyor. Client D was in his bedroom watching a movie. At 4:52 PM, the QIDP was asked where the keys for the gray company van were located. The QIDP indicated she would need to follow up with the Area Supervisor (AS #1) and walked toward the medication administration room. Once in the medication administration room, the QIDP asked the AS #1 where the keys to the gray van were located. The AS #1 stated, "[neighboring home]". The QIDP and AS #1 were asked if the keys were in the locked medication cabinet inside the medication administration room. Both the QIDP and AS #1 stated, "No". On 6/14/22 at 5:29 PM, staff #5 was interviewed. Staff #5 was asked about training and/or in-serving on client B's plans. Staff #5 stated, "He is one-to-one or can't leave line of sight. If you are a smoker you'll have a designated smoking area". Staff #5 was asked if the in-service included information about vehicle keys. Staff #5 stated, "Just that they're to be double locked". At 5:33 PM, the QIDP stated, "[AS #1] found the keys. There in the office now double locked". An observation was conducted on 6/15/22 from 1:42 PM to 3:05 PM. Upon entering the home, no van was present in the driveway. The garage door entering from the driveway was open. Client A was not at the home. Client B was in the bathroom and exited to return to his bedroom. Client C was in the day room having a conversation with staff #13. At 1:51 PM, staff #5 was asked if members of the interdisciplinary team and administrative staff had visited the home during his shift. Staff #5 indicated the behavior clinician had been at the home earlier, during the morning hours. Staff #5			

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	was asked how often the behavior clinician visited the home. Staff #5 stated, "Twice, three times a week". Staff #5 was asked how often the nurse visited the home. Staff #5 stated, "About the same as [behaviorist]. Maybe a little more". Staff #5 was asked how often the QIDP visited the home. Staff #5 stated, "Not as often". Staff #5 was asked how often if he estimated. Staff #5 stated, "Before you came, I would say I saw her about 2 weeks before. I definitely see [behavior clinician] and [nurse] more". Staff #5 was asked if he would say weekly visitation. Staff #5 stated, "I would say every 8 or 9 days". Staff #5 was asked if the van was ever parked in the garage. Staff #5 stated, "Since I've been here it's always been stuffed (garage)". Staff #5 was asked about a smoking protocol. Staff #5 stated, "You would have to tell the other staff members if they would be [client B's] one-to-one. You could only have one person smoking at a time". Staff #5 was asked if this smoking protocol was prior to the 6/7/22 elopement incident by clients A and B. Staff #5 stated, "I assume it was prior, but they told me after they had eloped". Staff #5 was asked about checking the doors at night and the alarm system to ensure functionality. Staff #5 indicated he checked the garage door when he worked nights on client B's side of the home and the gate in the courtyard. On 6/15/22 at 2:10 PM, staff #14 was interviewed. Staff #14 was asked what time he began his shift. Staff #14 indicated at 7:00 AM and it was the first day he had worked at the home. Staff #14 was asked if he had received training and/or an in-service at the beginning of his shift. Staff #14 indicated he had received training from the behaviorist. Staff #14 was asked what training information was reviewed. Staff #14 stated, "Basically went over their target behaviors and mealtime plans. The consumer specific, I think			

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	they call it". Staff #14 was asked about client B's training information learned. Staff #14 stated, "She said right now [client B] was line of sight. Kind of a one-to-one deal right now". Staff #14 was asked if the behavior clinician indicated why client B was on an increased supervision level. Staff #14 stated, "No. I know there was stuff that went down at this home, but I didn't get into the specifics of that really". Staff #14 was asked if the in-service included information about vehicles, keys and the gas card. Staff #14 stated, "Not here. I know over at my home they went over the card. Nothing like that though this morning". Staff #14 was asked where would keys to the van be kept. Staff #14 stated, "Here! I would not know that. Over at my house we keep them in the med (medication) cabinet. I would assume it would be the same here". Staff #14 was asked where the gas card would be kept. Staff #14 stated, "Well, if it's the same as over there (neighboring home), I would assume on the key chain. We got a new key chain with a pocket that we keep it with". Staff #14 was asked what the smoking protocol was. Staff #14 stated, "I believe I signed the same thing over there as I did here, which is at designated spots and only one staff at a time. They call it buddy smoking. No buddy smoking". At 2:27 PM, two sets of vehicle keys hung from hooks mounted onto the backside of the medication administration office door. One set had a label with the name "ResCare" written on the label. At 2:30 PM, the door from client B's day room leading into the courtyard was opened. The alarm system did not make an audible sound when opened. The door was tested four times. On two occasions the alarm sounded and on two other occasions the alarm did not make an audible			

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	15G745	A. BUILDING 00 B. WING	06/21/2022

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	sound to indicate the door had been opened. At 2:32 PM, staff #5 stated, "I did not know that door would not alarm". Staff #5 indicated he would follow up with administrative staff to communicate the alarm system for the door leading into the courtyard on client B's day room was not functioning properly. At 2:36 PM, staff #5 was asked about the keys that hung on the hooks on the backside of the medication administration room door. Staff #5 indicated he did not know what vehicles those keys went to. Staff #5 asked staff #13 if the keys hanging on the backside of the medication administration room door were his. Staff #13 stated, "No, mine are in my pocket". Staff #5 stated, "Are these van keys? I don't know what these keys go to. Especially since we don't have a van". At 2:42 PM, staff #14 left client B's day room to go outside as staff #5 was entering the garage area. The surveyor indicated to staff #5 that no staff had line of sight of client B. Staff #5 stated, "Ok. He could have told me was going out". Staff #5 then stayed in the day room to maintain line of sight of client B. At 2:42 PM, staff #14 reentered the home. At 2:47 PM, the Area Supervisor (AS #2) and the QIDP entered the home. On 6/15/22 at 2:53 PM, staff #13 was interviewed. Staff #13 was asked when he came onto shift. Staff #13 indicated he began his shift at 7:00 AM. Staff #13 was asked if he had received an in-service prior to the start of his shift working at the home. Staff #13 indicated he had received training from the AS #1 and behavior clinician. Staff #13 indicated AS #1 went over the smoking protocol with him and the behavior clinician went over behavior plans. Staff #13 was asked about			

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	working with client B to support him according to the in-service he had received. Staff #13 stated, "I've worked with [client B]. It was keep an eye one him, he is a one-to-one now. That was the biggest part of it". Staff #13 was asked if client B's supervision level as a one-to-one was at an arm reach distance or line of sight. Staff #13 stated, "I'm pretty sure his is just line of sight". Staff #13 was asked if any training over the ISPs for challenging behavior such as theft, risk taking behavior and being easily exploited had been covered though his in-service prior to beginning his shift at 7:00 AM. Staff #13 stated, "Yeah, I took that upon myself for [client C's]". Staff #13 was asked about client B's challenging behaviors like risk for theft and being easily exploited. Staff #13 stated, "Yeah, that he could be convinced by other clients". Staff #13 was asked if a protocol was in place for the vehicle at the home and keys to that vehicle. Staff #13 stated, "Keys are pretty much the only protocol. The gas card needs to be kept with the keys at all times". Staff #13 was asked where the lanyard with the keys and gas card be kept. Staff #13 stated, "Like I said, I don't know here but at house [neighboring home], the medication cabinet". Staff #13 was asked if the training did not go over maintaining the keys at the home he was currently assigned. Staff #13 stated, "No. I would assume in the medications cabinet. I'm not going to lie. I didn't ask where the keys were when I got here". At 3:03 PM, staff #5 was asked if anyone of the three coming onto first shift at 7:00 AM (#5, #13 and #14), checked to see where or if there were keys locked in the medication cabinet for the home. Staff #5 stated, "No. I don't believe so". On 6/15/22 at 3:47 PM, the Associate Executive Director (AED) and Quality Assurance Manager			

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	(QAM) were interviewed. The AED and QAM were asked about security of the group home's exterior doors and courtyard gate during the evening hours, and were informed that the exterior door on client B's day room leading to the courtyard failed to make an audible alarm. The AED indicated the exterior doors were secured so no one could enter the home from the outside, but due to life safety regulations, the doors were required to have doorknobs that could be turned and opened from the inside in the event of an emergency. The AED indicated the audible alarm should function properly and further follow up would be completed to ensure the alarming system would function properly. The AED and QAM were asked about vehicle keys found in the medication administration room on 6/15/22 and shown pictures, the observation on 6/14/22 of a gray van parked in the driveway and when asked about the keys to the van those were being maintained at a neighboring home rather than doubled locked in the medication cabinet within the medication administration room, and if the daily administrative observations by the facility for the Immediate Jeopardy's plan of removal should identify and correct these issues. The AED and QAM indicated the management team met daily to review concerns and issues from the daily administrative observations and a decision to purchase lock boxes to maintain the vehicle keys was being pursued. The AED and QAM were asked if it should be the surveyor bringing attention to these types of issues and the effectiveness of the facility's administrative observations. The QAM stated, "Clearly, our observations are not catching things". On 6/15/22 at 10:15 PM, follow up information in the form of a video was received to indicate the audible alarm for the exterior door in client B's day			

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	room had been adjusted by the facility contractor to correct the alarming issue. The video also indicated the courtyard gate was repaired and a latching system installed. An observation was conducted on 6/16/22 from 12:07 PM to 1:46 PM. Client A was not at the home. Client B was on his side the home in his bedroom talking with AS #2. Client C was with staff #5 going from his room to the garage. The garage was in the process of being cleaned and organized. At 12:23 PM, staff #13 was preparing medications for administration. The vehicle keys that hung on hooks on the backside of the medication administration room door had been removed. At 12:31 PM, client B was in the kitchen with staff #5. Client B used utensils to stir and assist staff #5 was preparing the meal. At 12:36 PM, client B continued to assist with the meal preparation in the kitchen with staff #5. At 12:52 PM, an administrative monitor for the immediate jeopardy removal plan entered the home and was followed by the Surveyor Supervisor entering the home. At 12:53 PM, the Surveyor Supervisor asked the administrative monitor what the protocol for keys to a vehicle at the home was. The administrative monitor stated, "I don't know, it's not my home". At 1:25 PM, the AS #2 was asked to open the windows in client A's bedroom to test the functionality of the alarm system. The window above the bed in client A's bedroom was not able to be opened to test. The AS #2 was asked how the functionality of the alarm system could be completed if the window could not be opened. The AS #2 stated, "Yeah, you're right". At 1:38 PM, the exterior door in client B's day room was tested. The AS #2 opened the exterior door three times and it alerted all three times. At 1:40 PM, client B opened his two windows in his bedroom and an audible alarm was sounded for			

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	each window opened. An observation was conducted on 6/17/22 from 10:41 AM through 12:29 PM. Client A was not at the home. No company vehicle was onsite at the home. Client B was in the dining room with staff #7 and staff #12. Client B was working on scenarios to address challenging behaviors that could be in the form of exploitation. This was a part of the Immediate Jeopardy removal plan to update and address challenging behaviors within client B's Individual Support Plan. Client C was playing a card game in the day room on his side of the home. At 10:49 AM, a maintenance person was replacing the broken medication administration room door with a new door. At 10:53 AM, client A's two windows in his bedroom were opened to test the audible alarm system. An audible sound was made for each window when opened. At 10:54 AM, client C's two windows in his bedroom were opened. An audible sound was made for each window when opened. At 10:56 AM, the hallway sensor was tested and an audible alarm indicated motion was detected. The door to the kitchen was opened and the AS #2 was notified the kitchen door had not been secured when the last person left. At 10:58 AM, client B's two windows in his bedroom were opened. An audible sound was made for each window when opened. At 10:59 AM, the exterior door in client B's day room going to the courtyard was opened. An audible alarm was made. At 11:01 AM, the garage door in the laundry room and the exterior garage door to the parking area were tested. An audible sound was made for both garage doors when opened. At 11:03 AM, the dining room windows were opened. An audible sound was made with the exception of the window closest to the medication administration room. This dining room window could not be opened by			

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	the AS #2 to test the audible alarm system. The AS #2 indicated the latch to release the window was broken and therefore the window could not be opened. At 11:05 AM, the AS #2 indicated to both staff #7 and staff #12 to ensure the kitchen door was closed when leaving to secure the area. At 11:06 AM, the Associate Executive Director (AED) provided follow up to the police report filed when clients A and B had eloped on 6/7/22. The AED indicated law enforcement had been notified of the investigative findings and the conclusion that staff #2 and staff #3 had falsified information within their police report of clients A and B assaulting them. The AED indicated this would aid in the removal of assault and battery charges against clients A and B. At 11:51 AM, the AS #2 indicated the maintenance person had replaced the broken latch on the dining. The AS #2 opened the window and an audible sound was made to alert the window had been opened. At 11:52 AM, the AS #2 was asked to produce vehicle keys, gas card, and PIN number for the home's company vehicle. The AS #2 indicated the home's van did not have any of these items presently and the company van clients A and B used in the 6/7/22 elopement was still impounded where the accident occurred. At 12:27 PM, a maintenance person began do work on the exterior door to the courtyard in client B's dayroom. An observation was conducted on 6/20/22 from 12:20 PM to 1:32 PM. Client A was not at the home. No company vehicle was onsite at the home. Clients B, C and D were preparing for their noon meal and seated at the dining room table. The noon meal consisted of chicken pasta salad, mashed potatoes, bread, peaches and water to drink. At 12:32 PM, two windows within client C's bedroom were opened to test the security system. When both windows were opened an audible			

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	sound was made to indicate each of the two windows had been opened. At 12:33 PM, two windows within client A's bedroom were opened. When both windows were opened an audible sound was made to indicate each window had been opened. At 12:34 PM, the 2 windows on clients A and C's day room were opened. An audible sound was made for both windows to indicate they had been opened. At 12:36 PM, a newly installed medication administration room door was opened. The newly installed door self-closing latches functioned to close the door automatically and the lockable keypad enter functioned to secure the door. When opened the AS #2 indicated new security lock boxes had been installed for inside the medication administration room. The AS #2 pointed to the new security box and stated, "Not using it at this time". The AS #2 indicated the home did not have a van, van keys or a gas card, but the security box was in place was the company vehicle is released from impoundment. The AS #2 indicated she had developed a quiz to review with staff for securing the vehicle, vehicle keys, gas card and the personal identification number to the gas once the vehicle was returned from the impoundment. At 12:40 PM, the 3 dining room windows were opened. An audible sound was made for all 3 dining room windows to indicate they had been opened. Going from the dining room into the hallway in front of the kitchen, an audible sound was made indicating motion was detected. The AS #2 shut the kitchen door as we navigated from the dining room toward the garage way entrance. At 12:42 PM, the garage door adjacent to the laundry room and exterior door adjacent to the parking area, were both opened. An audible alarm was made for each of the garage doors to indicate they had been opened. At 12:43 PM, the 2 windows and an exterior door to the courtyard on clients B			

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	and D's day room were opened. An audible sound was made for and windows and the exterior door to indicate they had been opened. At 12:44 PM, the 2 windows in client D's bedroom were opened. An audible sound was made to indicate both windows had been opened. At 12:46 PM, the 2 windows in client B's bedroom were opened. An audible sound was made to indicate both windows had been opened. At 12:48 PM, the AS #2 was asked if any incidents occurred over the weekend. The AS #2 indicated she had worked over the weekend at the home and had no reports of any incidents. The AS #2 stated, "No. We've not had one for a while, since the IJ was called". At 12:51 PM, the AS #1 entered the home. The AS #1 discussed with client C what they were going to do during the afternoon once client C finished doing dishes. Client B returned to his bedroom after lunch to rest during his leisure time. Client D returned to his bedroom after lunch to watch television during his leisure time. Staff #5 was seated in the day room across from client B's bedroom. Staff #5 position allowed him to maintain a line of sight of client B. At 1:04 PM, the AS #2 indicated to staff #5 she would maintain the line of sight for client B, if staff #5 would assist client D with changing his television show. At 1:05 PM, the AS #2 and QIDP both had a discussion with client B in the day room about challenging behaviors and the potential for being exploited and taken advantage of according the scenarios from his revised Individual Support Plan. Client B indicated the difference between wants and needs and not running from staff. The AS asked why he should not drive a vehicle. Client B stated, "Because I don't have a license". At 1:16 PM, client B indicated he needed assistance with his remote control for his television. Client B went to his room, obtained his remote control, and handed it to the AS #2. The			

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	AS #2 asked the QIDP to remain with client B and maintain the line of sight according to his revised behavioral strategies while she searched for batteries to install in client B's remote control. The QIDP remained with client B until the AS #2 returned and indicated new batteries the correct size would have to be purchased. Even though the facility's corrective actions removed the Immediate Jeopardy on 6/20/22 at 3:57 PM, the facility remained out of compliance at the Condition level (Governing Body) and (Client Protections). The facility needed to ensure staff supervised client B, the group home was monitored by the agency, and ensure the policies and procedures for abuse, neglect, and/or mistreatment were followed. The facility needed to develop and implement effective corrective measures to prevent recurrence of elopement and ensure the effectiveness of its plan of removal to ensure client B's protection. Findings include: 1. Please refer to W149. For 2 of 2 sampled clients (A and B) and 1 additional client (C), the facility neglected to implement its policy and procedures to ensure their system to prohibit and prevent abuse, neglect, and/or mistreatment was implemented concerning 1) the elopement risks of clients A and B. The facility neglected to ensure clients A and B's had adequate behavioral strategies to address elopement risk and implementation of the behavioral support plans, and 2) the alleged mistreatment of clients B and C. 2. Please refer to W157. For 2 of 2 sampled clients (A and B), the facility failed to take sufficient corrective action to prevent the 6/7/22 elopement after a previous elopement incident which			

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	occurred on 4/16/22 involving clients A and B. This federal tag relates to complaint #IN00382381. This federal tag relates to complaint #IN00379435. 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 observation, record review, and interview for 2 of 2 sampled clients (A and B) and 1 additional client (C), the facility neglected to implement its policy and procedures to ensure their system to prohibit and prevent abuse, neglect, and/or mistreatment was implemented concerning 1) the elopement risks of clients A and B. The facility neglected to ensure clients A and B's had adequate behavioral strategies to address elopement risk and implementation of the behavioral support plans, and 2) the alleged mistreatment of clients B and C. Findings include: 1) An observation was conducted on 6/8/22 from 2:47 PM through 4:47 PM. During the observation, clients A and B were not at the Extensive Support Needs (ESN) home. At 2:53 PM, staff #6 stated, "[Client B] is at the office. I'm about to pick him up. [Client A] is in jail. He had a hearing today and has a second hearing [date] is what we were told." Staff #6 indicated clients A and B were involved in an elopement incident on 6/7/22 which involved the use of the company vehicle and a minor car collision. At 3:02 PM, staff #6, staff #7 and client C left the home to go pick up client B from the	W 0149	To correct the deficient practice all current site staff as well as subs have been re-trained on the ResCare ANEM policy. Including the reporting process. All supervisory staff have been re-trained on ensuring appropriate levels of supervision are in place to ensure staff are following plans, and the ANEM policy. To ensure no others were affected the QA department will review a year's worth of investigations and incident reports to ensure appropriate measures were taken. To promote communication between clients and staff QIDP/BC will meet individually with each client weekly to discuss any concerns at that time. As well as one on one coaching with staff as needed. Documented on the weekly contact log. Additional monitoring will be achieved by twice daily administrative observations for a period of 2 months. As well as the	07/21/2022

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	office. The group did not return to the home prior to the end of the observation. At 3:03 PM, staff #4 was asked about elopement incidents of clients A and B. Staff #4 stated, "I guess the clients busted through the door and beat up [staff #2]." Staff #4 was asked where the second staff was at during the incident. Staff #4 stated, "I heard in the restroom. I think it was yesterday or the day before". At 3:22 PM, the Qualified Intellectual Disabilities Professional (QIDP) entered the home. At 3:51 PM, the QIDP was asked about clients A and B's elopement incident. The QIDP stated, "I was notified at 7:22 AM yesterday morning (6/7/22). [Behavior Clinician] called me and notified of an incident that [client B] and [client A] were missing and the van was gone". The QIDP indicated local law enforcement had been notified in the effort to locate clients A and B. The QIDP was asked about history of elopement between client A and client B. The QIDP indicated client B was being released, however client A was being held due to a previous history of Grand Theft Auto. The QIDP stated, "Yes, he (client A) was already on probation for Grand Theft Auto and they (court) want to talk with his probation officer". The QIDP indicated clients A and B attempted a prior elopement in April 2022. The QIDP was asked about revision to clients A and B's behavior support plans for elopement. The QIDP stated, "I think in April I updated [client A's] discharge criteria on added behavior aspects". The QIDP was asked how clients A and B's behavioral strategies for elopement changed after the April 2022 elopement attempt. The QIDP stated, "Following that day they were separated. [Client B] was on one side and [client A] on the other (bedrooms opposite side of the home). There was to be a staff between them at all times. On the van,		administrative team will meet daily for a period of one month to discuss ongoing issues at the site. Ongoing monitoring will be achieved through the BC/QIDP/AS/PM doing routine observations and staff trainings. Ongoing monitoring will be achieved through the BC being at the home at least ten hours a week. QIDP will coordinates, monitor, and integrate each week at the ESN home with monitoring by the QIDP lead. Documented on the weekly contact notes. Additional ongoing monitoring will be achieved through monthly administrative meetings regarding the site to discuss any ongoing issues and address at that time.	

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RES CARE SOUTHEAST INDIANA	16611 SIMA GRAY RD HENRYVILLE, IN 47126

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	one in front, one in back, and a staff between them". The QIDP was asked about the conclusion from her investigation into the April elopement incident. The QIDP indicated the investigation found neither of the two clients would admit to who planned the April elopement initially, but client A clarified and took ownership of being responsible in a subsequent interview with his probation officer. The QIDP was asked to clarify what client A admitted to. The QIDP stated, "[Client A] met with his probation officer and during the meeting, said that he was the plotter. He confessed that he was trying to get him (client B) to go to [gas station], to rob it. To get money to go on the road. [Behavior Clinician] was in on that meeting. We took precautions to keep them separated, so there was no planning". An observation was conducted on 6/9/22 from 2:48 PM to 5:16 PM. Upon entering the facility, the Area Supervisor (AS #1) assisted the surveyor with completion of COVID-19 screening. The AS #1 was asked about clients and staff at the home and indicated no clients and/or direct care staff were at the home and stated, "Nope". The Behavior Clinician (BC) was in the medication administration room upon entering the home. At 2:57 PM, the Behavior Clinician (BC) was asked when the clients would return home from their outing. The BC stated, "I don't know. I did text them to say you were here". The BC indicated the group would return, however, no clients and/or staff returned prior to the end of the observation. The BC was asked about the incident of clients A and B taking the company vehicle to elope on 6/7/22, prior incident history and how clients A and B's behavior strategies to address elopement had changed. The BC indicated the same alleged incident of clients A and B using force to hit and kick staff #2 in the office and to take the keys to			

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	the vehicle while staff #3 was in the restroom. The BC indicated client A had a history of elopement and stealing vehicles prior to admission to services with a probation and probation officer in place at time of admission. The BC was asked about the plan to maintain separation of clients A and B to prevent planning of further incidents after the attempt in April 2022. The BC indicated separation with a staff between clients A and B was an in-service with staff. The BC was asked what aspect of clients A and B's behavioral intervention failed to prevent the 6/7/22 elopement incident with the vehicle. The BC stated, "Staff supervision! Paying attention. Balancing between being too reactive with being proactive". The BC was asked about interventions to prevent elopement. The BC stated, "I did not see the need for one-to-one staffing. We had discussion about it (after the April 2022 elopement incident). The results of the investigation, it was the separation and an emphasis on separating them more ... formally we put the separation in place on the basketball court". An observation was conducted on 6/10/22 from 2:46 PM to 4:26 PM. Client A was not present at the home. Staff #1 indicated client A remained in jail. Client B was present at the home and making mop water to mop the day room floor on his side of the home. Client B was present at the home with client C. Client D was on an outing in the community. On 6/9/22 at 12:16 PM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following incidents which affected clients A and B:			

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	-BDDS incident report dated 6/7/22 indicated, "Staff reported [client A] and [client B] ran into the office, while staff was preparing to complete documentation, and hit staff, causing them to fall to the floor. Once on the floor, both individuals began kicking the staff member. Staff yelled for assistance, from the other staff on shift, who was in the restroom at the time. When the other staff came to assist, [client A] and [client B] had left the property in company vehicle. Plan to Resolve: Police were contacted along with members of ResCare management. An all-points bulletin was issued for the vehicle. It was reported [client B] and [client A] were located in Indianapolis (approximately 90 miles from the home) at approximately [time] after involvement in a minor rear end collision. Individuals were uninjured and taken into custody. Individuals are being held at [name] county jail awaiting court appearance. Staff members on shift at the time of incident have been placed on administrative leave pending investigation. The IDT (interdisciplinary team) met to discuss the incident. Van key and gas card will be placed together in a locked cabinet in the office, maintenance has been contacted to install a keypad on the office door, random drop in visits will be conducted by administrative staff, and additional protective measures will be implemented if warranted at conclusion of investigation". Investigation summary dated 6/7/22 through 6/9/22 indicated, "Introduction: ... staff reported on 6/7/22 clients [client A] and [client B] ran into the office while staff, [staff #2], was preparing to complete documentation. Staff alleged clients hit [staff #2], causing him to fall to the floor the clients began kicking him. [Staff #2] yelled for assistance from other staff on shift, [staff #3], who			

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	was in the restroom at the time. When [staff #3] responded to assist, [client B] and [client A] had left the property in the company vehicle. During the course of the investigation allegations of staff sleeping were also reported. Staff members, [staff #2] and [staff #3] were placed on administrative leave pending investigation ... Scope of Investigation: 1) Did [staff #2] and [staff #3] provide appropriate supervision levels? 2) How were [client B] and [client A] able to obtain the possession of the van keys? 3) Were [staff #2] and [staff #3] asleep on their shift?... Summary of Interviews: [Staff #2], DSP (Direct Support Professional): ... [staff #2] states he stepped outside, near the basketball goal area/patio, probably twice an hour to smoke. [Staff #3] would do the same, in the same area, but they would not go at the same time. [Staff #2] states he was outside a minute or two each time ... [Staff #2] states during the time he was stationed on [client B's] side of the home, he did fall asleep for 15 to 20 minutes. After he woke up, he didn't hear any sounds coming from the side [staff #3] was on so he walked over to where [staff #3] was and saw him asleep on the couch. [Staff #2] woke [staff #3] up and said let's switch sides ... [Staff #3], DSP: ... [Staff #3] states he did step outside to smoke a few times, by the basketball goal on the patio ... [Staff #3] did not complete bed checks on [client B] before or after audits ...Around 11:50 PM or midnight, [client A] exited his room. [Staff #3] asked [client A] what he was doing, but [client A] didn't answer and went to the bathroom ... [Staff #3] he sat on the couch until 3:00 AM when [staff #2] came to his side to			

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	switch stations. [Staff #3] states he was not asleep. [Staff #3] did not complete bed checks at the switch ... [Staff #3] states after switching back to [client B's] side of the house, he took an hour-long nap. [Staff #3] woke up around 4:00 AM ... [Client B]: [Client B] states on 6/6 (2022), staff, (unsure of names) were outside smoking, [client B] states it was after dinner (unsure of time) and medications ... [Client B] walked to [client A's] side of the house, and they attempted to get into the office, but it was locked. [Client B] went to the kitchen, grabbed a spoon from the dishwasher and went back to the office and pried to door open. Once in the office, [client A] grabbed the keys from either the drawer or the desk. They left the office and went back to their bedrooms. Staff were still outside. [Client B] states he woke up (unsure of the time), climbed through his window, then tapped on [client A's] window to wake him up. [Client A] woke up, and walked through the house, to [client B's] room and climbed through the window. They walked out of the gate and to the van. [Client B] states once in the van, [client A] was driving, and they decided to go to Walmart. They also went to a gas station but were unable to get gas because the store wasn't open, and they didn't know how to use the gas card in the van in the book. They drove back and forth, then went to Walmart, but it was closed. [Client B] states they went to another gas station, spoke with a clerk at the gas station and asked how to get gas. She told them they needed the PIN (personal identification number) and odometer reading. [Client B] then remembered the PIN was in the book in the van. [Client A] put the information in at the pump and they got gas. They went back to Walmart and were there for approximately 15 minutes. After Walmart, [client			

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	B] states they got on the highway and drove for a while. Once in Indianapolis, they were getting off the exit and rear-ended another vehicle and police were contacted. They give (sic) the police the registration to the vehicle and were arrested. [Client B] states at no time did they beat staff up or have physical aggression towards staff. [Client A]: [Client A] states on 6/6/ (2022) [staff #2] and [staff #3] were working and went out to the garage. Prior to going to the garage, they told clients to go their bedrooms, which they did. This was around 6:00 PM or 7:00 PM, but after medications. [Client A] stayed in his room for a while then came out after staff went to the garage. [Client A] attempted to get the office door open but couldn't. [Client B] went to the dishwasher and got a spoon and pried the office door open. Once in the office, [client A] grabbed the van keys from the drawer. [Client A] states this was not preplanned, it just happened. When they left the office, the office locked on its own after shutting the door. [Client A] put the keys in his pocket and went to bed. [Client B] went to his room as well. [Client A] states he believes it was around midnight when [client B] knocked on his window, from outside which woke him up. [Client A] walked out his bedroom door, but once in the living room, he ran into the table, which woke [staff #3] up. [Staff #3] asked [client A] what he was doing, and he told him he was going to get a drink of water. [Client A] got a drink then went back to his bedroom to wait for [staff #3] to go back to sleep. After a few moments of waiting, [client A] walked out of his room. [Staff #3] was asleep on the loveseat by the office. [Client A] walked in front of [staff #3] and to [client B's] side of the home. As [client A] walked down the hall, the motion detector did go off, alerting motion in the hall. [Staff #2] was on [client B's] side of the			

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	home, and he was also asleep on the couch. The alert did not wake staff up. [Client A] entered [client B's] bedroom and climbed out the window. [Client A] and [client B] walked out of the courtyard to the van. [Client A] started the van; they reversed out of the driveway and decided they were going to Walmart. They went to a gas station first in Scottsburg but couldn't get gas, and then went to Walmart. Walmart was closed, so they sat in the parking lot in the van listening to music. Once Walmart open, they went inside and were inside Walmart for approximately 30 minutes. [Client A] states it was around 7:00 AM when they got back to the van. They decided to go get gas, they were unable to at first but figured out how to use the PIN, which was in the book, and entered the odometer. [Client A] states he read the screen at the pump, and it told him what was needed. [Client A] states they did make one more stop at Circle K and got a drink. They got in the van and headed to Indianapolis, where he planned to go to a mall. When they were exiting the highway they got in a wreck. Police came and asked for license and registration. [Client A] told him he didn't have a license and gave the registration to the police. Police ran the registration and came back to [client A] asking for the keys, which he gave it to them and they were arrested. Factual Findings: 6/7/22 3:00 AM [staff #2] he woke up, went to [client A's] side of the home ... and saw [staff #3] asleep. 3:00 - 4:00 AM, [staff #3] states he was asleep on [client B's] side of the home. 5:29 AM - attempted gas purchase ... Scottsburg, IN, unsuccessful. 5:31 AM - attempted gas purchase ... Scottsburg,			

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	IN, unsuccessful. 5:32 AM - video footage from [gas station] was obtained which shows [client B] and [client A] walking into the store ... 8:14 AM - attempted gas purchase ... Memphis, IN, unsuccessful. 8:22 AM - attempted gas purchase ... Memphis, IN, successful. Conclusion: 1) It is substantiated [staff #2] and [staff #3] did not provide appropriate supervision levels. 2) [Client B] and [client A] were able to obtain possession of the van keys on 6/6 (2022) while [staff #2] and [staff #3] were on shift. [Client B] and [client A] broke into the office and took the van keys from the drawer. The door was locked, but [client B] used a spoon to open it. 3) It is substantiated [staff #3] and [staff #2] slept during their shift on 6/7 (2022) ... Investigation Peer Review: ... Recommendations: 1) Term (termination of employment) [staff #2] and [staff #3] 2) Contact police regarding results of investigation 3) Retrain all staff on BSPs (behavior support plans) and ISPs (Individual Support Plans) 4) Bill of rights and grievance reviewed with [client B] and [client A] 5) Retrain all staff on Op. (operational) standard for ANE (Abuse, Neglect and Exploitation) with focus on sleeping 6) Random drop in visits on all shifts by management 7) Daily administrative observations 8) Retrain staff on buddy smoking".			

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	-BDDS incident report dated 4/17/22 indicated, "Staff reported [client B] and [client A] were outside playing basketball when they ran outside the gate, across the street and towards the creek. Staff followed both individuals, verbally redirecting them back to the group home. [Client B] stopped running and returned home with one of the staff. [Client A] continued running through the woods, with other staff following. [Client A] slipped in mud, while running, and hit his face. Staff went to [client A] and attempted 1:1 verbal redirection. [Client A] then bit staff. After releasing, staff continued 1:1 redirection but was unsuccessful and [client A] attempted to run away from staff, again. Staff initiated two person You're Safe I'm Safe (YSIS/physical intervention), after [client A] attempted physical aggression. YSIS used to redirect [client A] to the van, once in the van staff and [client A] returned to the group home. Plan to Resolve: [Client A] sustained 3 scratch marks to the left side of his face approximately 1/8 inch, swelling under his left eye and 2 1/8 inch abrasions on left side of his forehead. Staff applied first aid and initiated head tracking. Nursing will completed follow up assessment and elopement investigation will be completed". Investigation summary dated 4/20/22 indicated, "Description of incident: On 4/16/22 around 6:50 PM, [client B] and [client A] were outside playing basketball on the patio of the home. They both ran out of the gate and across the street to a creek. Staff immediately followed clients on foot and in a van. Staff provided verbal redirection and [client B] complied and came back to home. [Client A] continued to run. He kept running until he slipped in the mud and hit his face on a tree. Staff attempted one-to-one YSIS but client (client A) bit			

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	and hit staff. Another staff came to assist, and client (client A) was placed in two person YSIS and escorted to the awaiting van. While in the van, client (client A) became verbally aggressive and made allegations against staff. Upon return to the home, client (client A) stated he would kill himself. Safety protocol was initiated. Client (client A) recanted the allegation and apologized. Staff notified nurse of head injury and head tracking was begun. [Client B] had returned to his room. [Client A] calmed and took his evening meds (medication) and went to his room. Witness statements: QIDP (Qualified Intellectual Disabilities Professional) interviewed [client B] on 4/20/22 at [home]. 'I didn't do it. [Client A] had the idea. He told me while we were playing basketball that we should run. I didn't want to, but I did. I ran but stopped when staff told me to come back. He kept running but I listened and came back. I didn't fight them like he did'. [Client A], QIDP interviewed client (client A) on 4/20/22 at [home]. 'It wasn't my idea. He came up with a plan and asked me if I wanted to do it. So, I said yes. I didn't plan it, he planned it. I just went along because he is my friend. I didn't stop because I knew I was caught. I didn't want to go back' ... Where did the elopement occur or happen? Elopement occurred from the patio of the home out the front gate ... Does this consumer have a history of elopement and is it addressed appropriately in the ISP/BSP (Individual Support Plan / Behavior Support Plan) and Health Care Plan? [Client A] has a history of elopement, and it is addressed in the BSP. [Client B] has a history of elopement and it is addressed			

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	in the BSP... Do any changes need to be made to prevent future occurrences? The two clients will need to be supervised closely when they are in the same area ... Conclusion: Neither client took responsibility for the plan to elope. Both clients insist that the other was the person who planned the elopement ... Recommendations: BC (Behavior Clinician) has reviewed with all staff the need to be in the same area as these two clients (A and B) when they are together ... all staff are aware of the potential for these two clients to plan things together and need to be alert when they have any contact". Review of the investigation summary dated 4/20/22 indicated the investigation did not address the discrepancy between client A's and client B's statements to the QIDP. The investigation failed to include the updated information obtained from client A's probation officer regarding a potential robbery being planned. On 6/9/22 at 4:45 PM, a focused review of client A's record was conducted. The record indicated the following: -Behavior Support Plan (BSP) dated 4/20/22 indicated, "Target Behaviors and Goals: ... any occurrence of leaving the area with the intent to escape staff supervision at home or in community. Goal: [Client A] will have 5 or fewer occurrences of elopement per month for three consecutive months by 4/20/2023 ...". On 6/9/22 at 4:52 PM, a focused review of client			

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	B's record was conducted. The record indicated the following: -Behavior Support Plan (BSP) dated 4/20/22 indicated, "Target Behaviors and Goals: ... any occurrence of leaving the area with the intent to escape staff supervision at home or in community. Goal: [Client B] will have 0 occurrences of elopement per month for three consecutive months by 4/20/2023 ...". The undated Reimbursement Guidelines for the 24-hour Extensive Support Need Residences were reviewed on 6/9/22 at 5:00 PM. The ESN guidelines 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." On 6/10/22 at 2:58 PM, client C was interviewed. Client C was asked about the elopement incident between clients A and B on 6/7/22 and his knowledge of it. Client C stated, "Yes, I know all about it. The guys (clients A and B) were planning it". Client C was asked who planned the elopement. Client C stated, "[Client A], and [client B] was in on it". Client C was asked how he knew the two had planned to elope. Client C stated, "They told me about a week ago. I tried to tell staff, but they did not believe me because they think I am a liar. I told [client A] I was not going to be a part of it. He had the keys, but he did take off. He waited until it was really dark, so no one could see him. He told me if I did not go with him, he said he would not be my friend ...". On 6/10/22 at 3:59 PM, client B was interviewed. Client B was asked about the incident on 6/7/22			

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	when he and client A took a vehicle to elope. Client B indicated he and client A did take a vehicle and had a car collision. Client B was asked where the staff were when he and client A took a vehicle to elope. Client B stated, "Over here asleep (pointing toward the living room)". Client B was asked who was asleep. Client B stated, "[Staff #2] and [staff #3]. It was early morning. It was still dark out". Client B was asked why he took the van. Client B stated, "I didn't take the van. He (client A) had the keys prior, from this drawer (pointed to a drawer in the office). He said he was driving". Client B was asked who he was. Client B stated, "[Client A]. He's still in jail". Client B was asked if he and client A hit the staff. Client B stated, "I did not hit the staff. Someone said we jumped the staff". Client B was asked if client A hit the staff. Client B stated, "Nope". Client B was asked how he and client A got out of the house. Client B stated, "I jumped out of my window and knocked on his. Then he came around". Client B was asked how client A got out of the house. Client B stated, "He snuck past the staff. I told [client A] I would be the better driver in daylight. He got us to Indianapolis where we went to a gas station. He stole a lighter. Then we smoked cardboard. Then we went to a gas station and asked for [name] cigarettes. Filled up at [gas station]". Client B was asked how they filled the vehicle up with gas. Client B stated, "The PIN (personal identification number) was in the driver book". Client B was asked if they had the debit card for gas. Client B stated, "Yeah. It was in the slot right by the radio. We basically totaled the car. When we pulled up to the gas station he (client A) hit the curb. He told me to pull up". Client B was asked if the van had been wrecked. Client B stated, "He (client A) did". Client B was asked what client A had hit. Client B stated, "The curb, that's what made the tire rim come off and			

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	then in Indianapolis when we got off the ramp, it was crazy! When we pulled off on the right, we hit someone". On 6/13/22 at 3:19 PM, the Associate Executive Director (AED) and Quality Assurance Manager (QAM) were interviewed. The AED and QAM were asked about preliminary findings and conclusion for the investigation in process for the 6/7/22 elopement incident between clients A and B. The QAM indicated a substantiated neglect finding was determined. The AED and QAM were asked about a discrepancy between staff's statement of being hit and additional interviews alleging they were asleep while on duty. The QAM stated, "The biggest difference is staff saying it happened at 6:30 AM and there is video of the clients at a gas station (in Scottsburg)". The AED and QAM were asked what time clients A and B were at the gas station. AED stated "5:32 AM". The AED and QAM were asked if the investigation in process had determined the time to travel from clients A and B's home to the first gas station had been reviewed. Both the AED and QAM indicated the average time to travel from clients A and B's home would be around 20 to 30 minutes to the first gas station in Scottsburg. The QAM was asked if neglect would be an investigative conclusion from the 6/7/22 elopement incident be clients A and B. The QAM stated, "Yes. The recommendation will be substantiating neglect". 2) Confidential Interview (CI #1): stated, "they (staff #6 and staff #4) brought 6 (clients) of them to my [family member] party. They kept the clients on the van". The CI was asked when this occurred. The CI stated, "About 3 months ago ... He (staff #4) showed my [family member] pictures of how the guys fight. [Staff #4] brags about it. I			

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	worry about the young men there. I think they are being physically abused". The CI was asked how many clients were brought to the party. The CI stated, "6". The CI was asked for the names of those 6 clients taken to the party. The CI stated, "I don't". The CI was asked how long the 6 clients remained on the van. The CI stated, "Hours. It was an all-day party". The CI indicated the clients were not allowed to have food or drink while attending the party. The CI was asked if there were additional concerns. The CI stated, "Just the physical abuse. It scares me". The CI was asked if physical abuse had been witnessed during the family members party. The CI stated, "No, just the food and drinks". An observation was conducted on 6/9/22 from 2:48 PM to 5:16 PM. Upon entering the facility, the Area Supervisor (AS #1) assisted the surveyor with completion of COVID-19 screening. The AS #1 was asked about clients and staff at the home and the AS #1 indicated no clients and/or direct care staff were at the home and stated, "Nope". The Behavior Clinician (BC) was in the medication administration room upon entering the home. At 2:57 PM, the BC was asked when the clients would return home from their outing. The BC stated, "I don't know. I did text them to say you were here". The BC indicated the group would return, however, no clients and/or staff returned prior to the end of the observation to continue with interviews. On 6/10/22 at 2:58 PM, client C was interviewed. During the interview process, client C alleged mistreatment had occurred to him by both staff #6 and staff #4. Client C was asked if anyone hit him. Client C stated, "[staff #6] and [staff #4] slap me in the face". Client C was asked if he had reported this to anyone. Client C stated, "I've tried to, but			

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	they won't let me. They won't let me go to the phone to call 911 or house manager". On 6/10/22 at 3:23 PM, client C was reinterviewed with the facility Nurse present as a facility witness to client C's interview process. Client C was asked to explain the allegation of staff slapping him in the face. Client C stated, "It was a couple days before the movie". Client C was asked who slapped him. Client C stated, "Both of them. [Staff #6] and [staff #4]. They told me not to tell anyone". The Nurse asked client C if he had reported this. Client C stated, "No. I'm telling the truth. They told me not to tell". The Nurse explained to client C the surveyor could not relocate and/or move him from the home and the importance of not making false allegations. Client C indicated he was telling the truth. At 3:40 PM, the Nurse contacted the Quality Assurance Manager to inform an allegation of mistreatment had been made by client C to ensure the investigative process would be implemented. On 6/10/22 at 3:59 PM, client B was interviewed. Due to the allegation made by client C during his interview, the nurse was asked to remain through the interview as a facility witness. Client B was asked if he had ever seen a staff hit another client or himself. Client B stated, "Sometimes". Client B was asked when this occurred. Client B stated, "Usually, like when [client C], when he says I'm sorry, I'm sorry". Client B was asked which staff hit client C. Client B stated, "[staff #6]". Client B was asked if any other staff hit client C or himself. Client B then indicated he was on a van earlier in the day with staff (staff #8 and staff #11), but he did not know the name of the staff who had hit him on the van. Client B was asked to clarify if he knew the name of the staff who had hit him. Client B stated, "I don't know". Client B was asked when			

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this occurred. Client B stated, "Today. I was hit today. He's a real best friend of [staff #2]". Client B was asked if he had ever seen staff #4 hit client C. Client B stated, "maybe once or twice".

On 6/13/22 at 10:27 AM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports was conducted. The review indicated the following incidents which affected clients B and C:

-BDDS incident report dated 6/10/22 indicated, "During an interview with state surveyor, [client C] reported staff, [staff #6] and [staff #4], smack him in the face daily. Plan to Resolve: The staff members in question have been placed on administrative leave pending investigation. ResCare LPN (Nurse) was on site at time of allegation and completed a physical skin assessment, no injuries or markings were present".

-Investigation was initiated.

-BDDS incident report dated 6/10/22 indicated, "During an interview with state surveyor, [client B] reported he was in the van, on 6/10 (2022), with two of his peers and a staff, whose name he didn't know. While in the van, [client B] alleged he was hit multiple times, in the face and head. Plan to Resolve: The staff member was identified and placed on administrative leave pending investigation. ResCare LPN (Nurse) was on site at time of allegat
ion and completed a physical skin assessment, no injuries or markings were present".-Investigation was initiated.An observation was conducted on 6/14/22 from 4:35 PM to 5:52 PM. Upon entering the

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	home, client C indicated he wanted to talk again. At 4:46 PM, client B approached the surveyor while interviewing staff #12. The Qualified Intellectual Disabilities Professional (QIDP) verbally redirected client C and stated, "In a minute [client C]". At 4:52 PM, client C was seated in the day room with his head down looking at the floor. The QIDP was asked to join the interview process as a facility witness to a subsequent interview with client C. At 5:03 PM, client C was interviewed. Client C stated, "I have a couple of things to clear up. I told a couple lies to you. I did that for attention". Client C was asked what aspects of his interview statement he was referring too. Client C stated, "Lying to you about people not taking us out on outings. They do take us places". Client C was asked "When you told me you were hit, was that a lie or the truth"? Client C stated, "It was a lie. Yeah, playing around. These guys (staff #6 and staff #4) should not be getting suspended because of me. I lied to them and [nurse]". Client C was asked "Who is them"? Client C stated, "[staff #6] and [staff #4]. I was just trying to make fun of it and I got myself in trouble". Client C was asked "What does that mean"? Client C stated, "Not listening got me into trouble and not able to do things. They take us to shows. I don't feel they should be suspended because of me". At 5:15 PM, the			

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	QIDP clarified with client C that he could express himself with the Investigator when interviewed about his allegation of mistreatment. Client C was then asked by the surveyor, "Did [staff #6] and [staff #4] use their hands to touch your face like you described"? Client C stated, "Yeah. Playful (placed his hand in front of his face and moved it from side to side)". On 6/14/22 at 5:55 PM, the QIDP was interviewed. The QIDP was asked about client C's interview, the use of his hands in front of his face to indicate physical interactions had occurred between him, staff #6, and staff #4 and his statement of it being playful. The QIDP stated, "Yeah. He really did not recant his story". The QIDP was asked to share the observed interview of client C with the Investigator and the surveyors conclusion of client C's body language to indicate some level of physical interactions to client C's face allegedly by staff #6 and staff #4 depicted, a new statement from client C describing this physical interaction as being playful with his focus on staff suspension "due to him". On 6/16/22 at 2:21 PM, the Investigator was asked about the alleged incidents of mistreatment made by both clients B and C and the status of those investigations. The investigator stated, "I'm getting as much information as I can. I've spoke with him (client C) twice. He recanted			

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	to staff that he was mad at them and going to get them fired. An hour later he said it didn't happen and he wanted them fired. I called him today and re-asked him questions. He (client C) is still telling me that they (staff #6 and staff #4) hit him". The investigator was asked how client C described the mistreatment. The Investigator stated, "He (client C) said they do it every day". The Investigator if staff talked with him about not reporting his concerns for how he was being treated. The Investigator stated, "[Client C] said they (staff #6 and staff #4) would keep him from his activities for 4 years and for 4 months". The Investigator was asked if client C meant the work "for" rather then the number. The Investigator indicated she clarified with client C through interview to mean the number for both years and months. The Investigator was asked was asked if any additional witnesses had been identified. The Investigator stated, "No. I still need to interview [client B]. He was getting his allegation (mistreatment on the van) and the elopement (6/7/22 with a van) confused. I normally try and talk about one thing at a time. I'm going to interview with [client B[further on that". The Investigator indicated no determination had been made to client C's allegation of mistreatment. The Investigator was asked about client B's allegation of mistreatment during a			

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	community outing with a neighboring home. The Investigator indicated the date of the outing had been determined to be 6/10/22, the day client B reported the allegation of mistreatment to the surveyor. The Investigator was asked if a determination for who the staff was had been made, as client B did not know the name of the person when he initially reported his allegation of mistreatment. The Investigator stated, "[Staff #11] and [staff #8]". The Investigator stated client B was able to provide a statement which described the staff who had mistreated him on the van as, "The guy wearing the bright colored hoodie all the time". The Investigator indicated at that point a staff had been determined and both staff #8 and staff #11 were suspended pending outcome from further investigation. The Investigator was asked if any other fact finding in the form of evidence had been determined. The Investigator stated, "I've interviewed [client B]. Just from him, I believe the ESN #2 staff (staff #8) was not present. [Client B] said they stopped in a convenience store and his staff (staff #8) went in to get drinks". The Investigator was asked who allegedly hit client B. The Investigator stated, "[Staff #11]". The Investigator was asked to describe how the activity planning on 6/10/22 led to client B participating with a staff from a different			

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	home and if client B described the mistreatment. The Investigator indicated clients B and C ended up on a community outing with a neighboring home's staff and one client because it was [client B's] outing day and his home had no van. The Investigator stated, "He (client B) said he was laughing if he did not pay a fine like $750.00 he would have to go back to jail. He (staff #11) then came between the seats and said you think that's funny and went like that (moved open hand side to side in a motion of hitting someone)". On 6/17/22 at 11:59 AM, the QIDP was interviewed. The QIDP was asked about the observation on 6/9/22 from 2:48 PM to 5:16 PM and how no one returned after the indication a message was sent with an expectation the group would return. The QIDP indicated she stayed an additional hour after the surveyor left to identify where the group had been, and no client and staff returned even after she stayed another hour. The QIDP indicated she reviewed the daily notes and staff #6 and staff #4 had documented the group went to a park. The QIDP was asked if the group was supposed to return to the home or if it was miscommunication. The QIDP stated, "Everyone (QIDP, BC and AED) thought they were (go to return)". On 6/20/22 at 3:11 PM, the Investigator was interviewed. The Investigator was asked			

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	about the conclusions of clients B and C's alleged mistreatment. The Investigator indicated the investigations into clients B and C's allegations were going to be reviewed by a peer review on this date, 6/20/22. The Investigator stated, "I reinterviewed [client C] probably twice since last Friday". The Investigator was asked if any changes were identified and/or determined. The Investigator stated, "He (client C) was still sticking to the story. I had to pin him down on answers". The Investigator was asked what aspect of client C's allegation had not changed. The Investigator stated, "Basically, everyday [staff #6] and [staff #4] come to work they hit him in the face, and nobody is around". The Investigator was asked about client B's interview concerning client C's alleged allegation of mistreatment. The Investigator stated, "When he's at the dining room table or when [client C] is not listening saying I'm sorry, I'm sorry they would tap him in the back of the head, but not hitting him. [Client C] told me it does not happen anywhere, but his bedroom". The Investigator was asked if any other witnesses had been determined. The Investigator stated, "Nope". The Investigator indicated the alleged mistreatment was unsubstantiated. The Investigator stated. "My preliminary findings are to reinstate (staff #6 and staff #4) and move them two to			

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	a different location". The Investigator was asked about oversight and monitoring of staff #6 and staff #4's interaction with clients. The Investigator stated, "Yes. Check and balances. Someone being in contact and give the clients the opportunity to talk if they have allegations". The Investigator was asked about monitoring and oversight of staff #6 and staff #4. The Investigator stated, "Place where they're not going to work alone and go to a place where clients have the ability to communicate". The Investigator was asked about client B's investigation conclusion for allegedly being hit by staff #11 on the van. The Investigator stated, "I could not substantiate. No other staff was there and [client C] said he was not there. The note (staff documentation) said he was there, but [client C] could not remember. [Client B] said he (staff #11) hit him hard enough he felt it. He (client B) said he (staff #11) apologized for it". The Investigator was asked to clarify the recommendations being reviewed by the peer review process. The Investigator indicated the reinstatement of staff #4, staff #6, staff #8 and staff #11, review of the Bill of Rights with clients B and C, oversight, and gentle teaching (appropriate conduct) in-service with staff members". The Investigator was asked if staff #11 would continue to have contact with client B. The Investigator stated, "He			

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	shouldn't. He (staff #11) might see him at cookouts or group activities". The Investigator was asked about monitoring of for the implementation of the Abuse, Neglect, Exploitation, Mistreatment and/or Violation of Individuals Rights policy after the staff instatement occurred. The Investigator stated, "Yeah. Administrative random visits. That will be wherever the other two (staff #6 and staff #4) go to as well. If the committee agrees".On 6/21/22 at 10:30 AM, the investigation summaries into clients B and C's alleged mistreatment allegations were provided for review. The investigation summaries indicated the following:-A draft investigation summary dated 6/10/22 through 6/17/22 indicated, "Introduction: An investigation was initiated when [client C] reported that staff [staff #6] and [staff #4] smack him in the face daily ... Conclusion: Unsubstantiated [staff #4] hits [client C]. Unsubstantiated [staff #6] hits [client C]".-A draft investigation summary dated 6/13/22 through 6/17/22 indicated, "Introduction: An investigation was initiated when [client B] reported to ISDH (Indiana State Department of Health) Surveyor that staff [staff #11] and [staff #8] hit [client B] ...Conclusion: Unsubstantiated [staff #8] hit [client B]. Unsubstantiated [staff #11] hit [client B]". On 6/13/22 at 3:45 PM, a review of the Abuse, Neglect, Exploitation,			

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	Mistreatment and/or Violation of Individuals Rights (ANE) policy dated 5/5/21 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 #IN00382381. This federal tag relates to complaint #IN00379435.9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on observation, record review and interview for 2 of 2 sampled clients (A and B), the facility failed to take sufficient corrective action to prevent clients A and B's elopement on 6/7/22 after a previous elopement occurred on 4/16/22 involving clients A and B. Findings include: An observation was conducted on 6/8/22 from 2:47 PM through 4:47 PM. During the observation, clients A and B were not at the Extensive Support Needs (ESN) home. At 2:53 PM, staff #6 stated, "[Client B] is at the office. I'm about to pick him up. [Client A] is in jail. He had a hearing today and has a second hearing [date] is what we were told." Staff #6 indicated clients A and B were involved in an elopement incident on 6/7/22 which involved the use of the company vehicle and a minor car collision. At 3:02 PM, staff #6, staff #7 and client C left the home to go pick up client B from the office. The group did not return to the home prior to the end of the observation. At 3:03 PM, staff #4 was asked about elopement incidents of clients A	W 0157	To correct the deficient practice client A will be discharged from services. Client B's BSP and ISP have been revised for appropriate safety measures. The team will review the rights restrictions and behavioral data quarterly and as needed to discuss appropriateness of client B's plans. All site staff have been trained on the updated plans. To promote communication between clients and staff QIDP/BC will meet individually with each client weekly to discuss any concerns at that time. As well as one on one coaching with staff as needed. Documented on the weekly contact log. To ensure no others are affected the regional operations support specialist (ROSS) will be reviewing all ESN 2 plans with the BC/QIDP to thoroughly review the plans for	07/21/2022

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	and B. Staff #4 stated, "I guess the clients busted through the door and beat up [staff #2]." Staff #4 was asked where the second staff was at during the incident. Staff #4 stated, "I heard in the restroom. I think it was yesterday or the day before". At 3:22 PM, the Qualified Intellectual Disabilities Professional (QIDP) entered the home. At 3:51 PM, the QIDP was asked about clients A and B's elopement incident. The QIDP stated, "I was notified at 7:22 AM yesterday morning (6/7/22). [Behavior Clinician] called me and notified of an incident that [client B] and [client A] were missing and the van was gone". The QIDP indicated local law enforcement had been notified in the effort to locate clients A and B. The QIDP was asked about history of elopement between client A and client B. The QIDP indicated client B was being released, however client A was being held due to a previous history of Grand Theft Auto. The QIDP stated, "Yes, he (client A) was already on probation for Grand Theft Auto and they (court) want to talk with his probation officer". The QIDP indicated clients A and B attempted a prior elopement in April 2022. The QIDP was asked about revision to clients A and B's behavior support plans for elopement. The QIDP stated, "I think in April I updated [client A's] discharge criteria on added behavior aspects". The QIDP was asked how clients A and B's behavioral strategies for elopement changed after the April 2022 elopement attempt. The QIDP stated, "Following that day they were separated. [Client B] was on one side and [client A] on the other (bedrooms opposite side of the home). There was to be a staff between them at all times. On the van, one in front, one in back, and a staff between them". The QIDP was asked about the conclusion from her investigation into the April elopement		appropriate behavioral objectives. Additional monitoring will be achieved by the administrative team who will meet daily for a period of one month to discuss and correct ongoing issues at the site. Ongoing monitoring will be achieved through monthly review of all plans with ROSS/QIDP/BC/QIDP Lead.	

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	incident. The QIDP indicated the investigation found neither of the two clients would admit to who planned the April elopement initially, but client A clarified and took ownership of being responsible in a subsequent interview with his probation officer. The QIDP was asked to clarify what client A admitted to. The QIDP stated, "[Client A] met with his probation officer and during the meeting, said that he was the plotter. He confessed that he was trying to get him (client B) to go to [gas station], to rob it. To get money to go on the road. [Behavior Clinician] was in on that meeting. We took precautions to keep them separated, so there was no planning". An observation was conducted on 6/9/22 from 2:48 PM to 5:16 PM. Upon entering the facility, the Area Supervisor (AS #1) assisted the surveyor with completion of COVID-19 screening. The AS #1 was asked about clients and staff at the home and indicated no clients and/or direct care staff were at the home and stated, "Nope". The Behavior Clinician (BC) was in the medication administration room upon entering the home. At 2:57 PM, the Behavior Clinician (BC) was asked when the clients would return home from their outing. The BC stated, "I don't know. I did text them to say you were here". The BC indicated the group would return, however, no clients and/or staff returned prior to the end of the observation. The BC was asked about the incident of clients A and B taking the company vehicle to elope on 6/7/22, prior incident history and how clients A and B's behavior strategies to address elopement had changed. The BC indicated the same alleged incident of clients A and B using force to hit and kick staff #2 in the office and to take the keys to the vehicle while staff #3 was in the restroom. The BC indicated client A had a history of elopement and stealing vehicles prior to admission to			

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	services with a probation and probation officer in place at time of admission. The BC was asked about the plan to maintain separation of clients A and B to prevent planning of further incidents after the attempt in April 2022. The BC indicated separation with a staff between clients A and B was an in-service with staff. The BC was asked what aspect of clients A and B's behavioral intervention failed to prevent the 6/7/22 elopement incident with the vehicle. The BC stated, "Staff supervision! Paying attention. Balancing between being too reactive with being proactive". The BC was asked about interventions to prevent elopement. The BC stated, "I did not see the need for one-to-one staffing. We had discussion about it (after the April 2022 elopement incident). The results of the investigation, it was the separation and an emphasis on separating them more ... formally we put the separation in place on the basketball court". An observation was conducted on 6/10/22 from 2:46 PM to 4:26 PM. Client A was not present at the home. Staff #1 indicated client A remained in jail. Client B was present at the home and making mop water to mop the day room floor on his side of the home. Client B was present at the home with client C. Client D was on an outing in the community. On 6/9/22 at 12:16 PM, a review of the facility's Bureau of Developmental Disabilities Services (BDDS) reports and accompanying investigation summaries was conducted. The review indicated the following incidents which affected clients A and B: -BDDS incident report dated 6/7/22 indicated, "Staff reported [client A] and [client B] ran into the office, while staff was preparing to complete			

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	documentation, and hit staff, causing them to fall to the floor. Once on the floor, both individuals began kicking the staff member. Staff yelled for assistance, from the other staff on shift, who was in the restroom at the time. When the other staff came to assist, [client A] and [client B] had left the property in company vehicle. Plan to Resolve: Police were contacted along with members of ResCare management. An all-points bulletin was issued for the vehicle. It was reported [client B] and [client A] were located in Indianapolis (approximately 90 miles from the home) at approximately [time] after involvement in a minor rear end collision. Individuals were uninjured and taken into custody. Individuals are being held at [name] county jail awaiting court appearance. Staff members on shift at the time of incident have been placed on administrative leave pending investigation. The IDT (interdisciplinary team) met to discuss the incident. Van key and gas card will be placed together in a locked cabinet in the office, maintenance has been contacted to install a keypad on the office door, random drop in visits will be conducted by administrative staff, and additional protective measures will be implemented if warranted at conclusion of investigation". Investigation summary dated 6/7/22 through 6/9/22 indicated, "Introduction: ... staff reported on 6/7/22 clients [client A] and [client B] ran into the office while staff, [staff #2], was preparing to complete documentation. Staff alleged clients hit [staff #2], causing him to fall to the floor the clients began kicking him. [Staff #2] yelled for assistance from other staff on shift, [staff #3], who was in the restroom at the time. When [staff #3] responded to assist, [client B] and [client A] had left the property in the company vehicle. During			

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	the course of the investigation allegations of staff sleeping were also reported. Staff members, [staff #2] and [staff #3] were placed on administrative leave pending investigation ... Scope of Investigation: 1) Did [staff #2] and [staff #3] provide appropriate supervision levels? 2) How were [client B] and [client A] able to obtain the possession of the van keys? 3) Were [staff #2] and [staff #3] asleep on their shift?... Summary of Interviews: [Staff #2], DSP (Direct Support Professional): ... [staff #2] states he stepped outside, near the basketball goal area/patio, probably twice an hour to smoke. [Staff #3] would do the same, in the same area, but they would not go at the same time. [Staff #2] states he was outside a minute or two each time ... [Staff #2] states during the time he was stationed on [client B's] side of the home, he did fall asleep for 15 to 20 minutes. After he woke up, he didn't hear any sounds coming from the side [staff #3] was on so he walked over to where [staff #3] was and saw him asleep on the couch. [Staff #2] woke [staff #3] up and said let's switch sides ... [Staff #3], DSP: ... [Staff #3] states he did step outside to smoke a few times, by the basketball goal on the patio ... [Staff #3] did not complete bed checks on [client B] before or after audits ...Around 11:50 PM or midnight, [client A] exited his room. [Staff #3] asked [client A] what he was doing, but [client A] didn't answer and went to the bathroom ... [Staff #3] he sat on the couch until 3:00 AM when [staff #2] came to his side to switch stations. [Staff #3] states he was not asleep. [Staff #3] did not complete bed checks at the switch ... [Staff #3] states after switching back			

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	to [client B's] side of the house, he took an hour-long nap. [Staff #3] woke up around 4:00 AM ... [Client B]: [Client B] states on 6/6 (2022), staff, (unsure of names) were outside smoking, [client B] states it was after dinner (unsure of time) and medications ... [Client B] walked to [client A's] side of the house, and they attempted to get into the office, but it was locked. [Client B] went to the kitchen, grabbed a spoon from the dishwasher and went back to the office and pried to door open. Once in the office, [client A] grabbed the keys from either the drawer or the desk. They left the office and went back to their bedrooms. Staff were still outside. [Client B] states he woke up (unsure of the time), climbed through his window, then tapped on [client A's] window to wake him up. [Client A] woke up, and walked through the house, to [client B's] room and climbed through the window. They walked out of the gate and to the van. [Client B] states once in the van, [client A] was driving, and they decided to go to Walmart. They also went to a gas station but were unable to get gas because the store wasn't open, and they didn't know how to use the gas card in the van in the book. They drove back and forth, then went to Walmart, but it was closed. [Client B] states they went to another gas station, spoke with a clerk at the gas station and asked how to get gas. She told them they needed the PIN (personal identification number) and odometer reading. [Client B] then remembered the PIN was in the book in the van. [Client A] put the information in at the pump and they got gas. They went back to Walmart and were there for approximately 15 minutes. After Walmart, [client B] states they got on the highway and drove for a while. Once in Indianapolis, they were getting off the exit and rear-ended another vehicle and police			

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	were contacted. They give (sic) the police the registration to the vehicle and were arrested. [Client B] states at no time did they beat staff up or have physical aggression towards staff. [Client A]: [Client A] states on 6/6/ (2022) [staff #2] and [staff #3] were working and went out to the garage. Prior to going to the garage, they told clients to go their bedrooms, which they did. This was around 6:00 PM or 7:00 PM, but after medications. [Client A] stayed in his room for a while then came out after staff went to the garage. [Client A] attempted to get the office door open but couldn't. [Client B] went to the dishwasher and got a spoon and pried the office door open. Once in the office, [client A] grabbed the van keys from the drawer. [Client A] states this was not preplanned, it just happened. When they left the office, the office locked on its own after shutting the door. [Client A] put the keys in his pocket and went to bed. [Client B] went to his room as well. [Client A] states he believes it was around midnight when [client B] knocked on his window, from outside which woke him up. [Client A] walked out his bedroom door, but once in the living room, he ran into the table, which woke [staff #3] up. [Staff #3] asked [client A] what he was doing, and he told him he was going to get a drink of water. [Client A] got a drink then went back to his bedroom to wait for [staff #3] to go back to sleep. After a few moments of waiting, [client A] walked out of his room. [Staff #3] was asleep on the loveseat by the office. [Client A] walked in front of [staff #3] and to [client B's] side of the home. As [client A] walked down the hall, the motion detector did go off, alerting motion in the hall. [Staff #2] was on [client B's] side of the home, and he was also asleep on the couch. The alert did not wake staff up. [Client A] entered [client B's] bedroom and climbed out the window.			

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	[Client A] and [client B] walked out of the courtyard to the van. [Client A] started the van; they reversed out of the driveway and decided they were going to Walmart. They went to a gas station first in Scottsburg but couldn't get gas, and then went to Walmart. Walmart was closed, so they sat in the parking lot in the van listening to music. Once Walmart open, they went inside and were inside Walmart for approximately 30 minutes. [Client A] states it was around 7:00 AM when they got back to the van. They decided to go get gas, they were unable to at first but figured out how to use the PIN, which was in the book, and entered the odometer. [Client A] states he read the screen at the pump, and it told him what was needed. [Client A] states they did make one more stop at Circle K and got a drink. They got in the van and headed to Indianapolis, where he planned to go to a mall. When they were exiting the highway they got in a wreck. Police came and asked for license and registration. [Client A] told him he didn't have a license and gave the registration to the police. Police ran the registration and came back to [client A] asking for the keys, which he gave it to them and they were arrested. Factual Findings: 6/7/22 3:00 AM [staff #2] he woke up, went to [client A's] side of the home ... and saw [staff #3] asleep. 3:00 - 4:00 AM, [staff #3] states he was asleep on [client B's] side of the home. 5:29 AM - attempted gas purchase ... Scottsburg, IN, unsuccessful. 5:31 AM - attempted gas purchase ... Scottsburg, IN, unsuccessful. 5:32 AM - video footage from [gas station] was obtained which shows [client B] and [client A]			

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	walking into the store ... 8:14 AM - attempted gas purchase ... Memphis, IN, unsuccessful. 8:22 AM - attempted gas purchase ... Memphis, IN, successful. Conclusion: 1) It is substantiated [staff #2] and [staff #3] did not provide appropriate supervision levels. 2) [Client B] and [client A] were able to obtain possession of the van keys on 6/6 (2022) while [staff #2] and [staff #3] were on shift. [Client B] and [client A] broke into the office and took the van keys from the drawer. The door was locked, but [client B] used a spoon to open it. 3) It is substantiated [staff #3] and [staff #2] slept during their shift on 6/7 (2022) ... Investigation Peer Review: ... Recommendations: 1) Term (termination of employment) [staff #2] and [staff #3] 2) Contact police regarding results of investigation 3) Retrain all staff on BSPs (behavior support plans) and ISPs (Individual Support Plans) 4) Bill of rights and grievance reviewed with [client B] and [client A] 5) Retrain all staff on Op. (operational) standard for ANE (Abuse, Neglect and Exploitation) with focus on sleeping 6) Random drop in visits on all shifts by management 7) Daily administrative observations 8) Retrain staff on buddy smoking". -BDDS incident report dated 4/17/22 indicated, "Staff reported [client B] and [client A] were outside playing basketball when they ran outside			

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	the gate, across the street and towards the creek. Staff followed both individuals, verbally redirecting them back to the group home. [Client B] stopped running and returned home with one of the staff. [Client A] continued running through the woods, with other staff following. [Client A] slipped in mud, while running, and hit his face. Staff went to [client A] and attempted 1:1 verbal redirection. [Client A] then bit staff. After releasing, staff continued 1:1 redirection but was unsuccessful and [client A] attempted to run away from staff, again. Staff initiated two person You're Safe I'm Safe (YSIS/physical intervention), after [client A] attempted physical aggression. YSIS used to redirect [client A] to the van, once in the van staff and [client A] returned to the group home. Plan to Resolve: [Client A] sustained 3 scratch marks to the left side of his face approximately 1/8 inch, swelling under his left eye and 2 1/8 inch abrasions on left side of his forehead. Staff applied first aid and initiated head tracking. Nursing will completed follow up assessment and elopement investigation will be completed". Investigation summary dated 4/20/22 indicated, "Description of incident: On 4/16/22 around 6:50 PM, [client B] and [client A] were outside playing basketball on the patio of the home. They both ran out of the gate and across the street to a creek. Staff immediately followed clients on foot and in a van. Staff provided verbal redirection and [client B] complied and came back to home. [Client A] continued to run. He kept running until he slipped in the mud and hit his face on a tree. Staff attempted one-to-one YSIS but client (client A) bit and hit staff. Another staff came to assist, and client (client A) was placed in two person YSIS and escorted to the awaiting van. While in the			

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	van, client (client A) became verbally aggressive and made allegations against staff. Upon return to the home, client (client A) stated he would kill himself. Safety protocol was initiated. Client (client A) recanted the allegation and apologized. Staff notified nurse of head injury and head tracking was begun. [Client B] had returned to his room. [Client A] calmed and took his evening meds (medication) and went to his room. Witness statements: QIDP (Qualified Intellectual Disabilities Professional) interviewed [client B] on 4/20/22 at [home]. 'I didn't do it. [Client A] had the idea. He told me while we were playing basketball that we should run. I didn't want to, but I did. I ran but stopped when staff told me to come back. He kept running but I listened and came back. I didn't fight them like he did'. [Client A], QIDP interviewed client (client A) on 4/20/22 at [home]. 'It wasn't my idea. He came up with a plan and asked me if I wanted to do it. So, I said yes. I didn't plan it, he planned it. I just went along because he is my friend. I didn't stop because I knew I was caught. I didn't want to go back' ... Where did the elopement occur or happen? Elopement occurred from the patio of the home out the front gate ... Does this consumer have a history of elopement and is it addressed appropriately in the ISP/BSP (Individual Support Plan / Behavior Support Plan) and Health Care Plan? [Client A] has a history of elopement, and it is addressed in the BSP. [Client B] has a history of elopement and it is addressed in the BSP... Do any changes need to be made to prevent			

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	future occurrences? The two clients will need to be supervised closely when they are in the same area ... Conclusion: Neither client took responsibility for the plan to elope. Both clients insist that the other was the person who planned the elopement ... Recommendations: BC (Behavior Clinician) has reviewed with all staff the need to be in the same area as these two clients (A and B) when they are together ... all staff are aware of the potential for these two clients to plan things together and need to be alert when they have any contact". Review of the investigation summary dated 4/20/22 indicated the investigation did not address the discrepancy between client A's and client B's statements to the QIDP. The investigation failed to include the updated information obtained from client A's probation officer regarding a potential robbery being planned. On 6/9/22 at 4:45 PM, a focused review of client A's record was conducted. The record indicated the following: -Behavior Support Plan (BSP) dated 4/20/22 indicated, "Target Behaviors and Goals: ... any occurrence of leaving the area with the intent to escape staff supervision at home or in community. Goal: [Client A] will have 5 or fewer occurrences of elopement per month for three consecutive months by 4/20/2023 ...". On 6/9/22 at 4:52 PM, a focused review of client B's record was conducted. The record indicated the following:			

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	-Behavior Support Plan (BSP) dated 4/20/22 indicated, "Target Behaviors and Goals: ... any occurrence of leaving the area with the intent to escape staff supervision at home or in community. Goal: [Client B] will have 0 occurrences of elopement per month for three consecutive months by 4/20/2023 ...". The undated Reimbursement Guidelines for the 24-hour Extensive Support Need Residences were reviewed on 6/9/22 at 5:00 PM. The ESN guidelines 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." On 6/10/22 at 2:58 PM, client C was interviewed. Client C was asked about the elopement incident between clients A and B on 6/7/22 and his knowledge of it. Client C stated, "Yes, I know all about it. The guys (clients A and B) were planning it". Client C was asked who planned the elopement. Client C stated, "[Client A], and [client B] was in on it". Client C was asked how he knew the two had planned to elope. Client C stated, "They told me about a week ago. I tried to tell staff, but they did not believe me because they think I am a liar. I told [client A] I was not going to be a part of it. He had the keys, but he did take off. He waited until it was really dark, so no one could see him. He told me if I did not go with him, he said he would not be my friend ...". On 6/10/22 at 3:59 PM, client B was interviewed. Client B was asked about the incident on 6/7/22 when he and client A took a vehicle to elope. Client B indicated he and client A did take a vehicle and had a car collision. Client B was asked			

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	where the staff were when he and client A took a vehicle to elope. Client B stated, "Over here asleep (pointing toward the living room)". Client B was asked who was asleep. Client B stated, "[Staff #2] and [staff #3]. It was early morning. It was still dark out". Client B was asked why he took the van. Client B stated, "I didn't take the van. He (client A) had the keys prior, from this drawer (pointed to a drawer in the office). He said he was driving". Client B was asked who he was. Client B stated, "[Client A]. He's still in jail". Client B was asked if he and client A hit the staff. Client B stated, "I did not hit the staff. Someone said we jumped the staff". Client B was asked if client A hit the staff. Client B stated, "Nope". Client B was asked how he and client A got out of the house. Client B stated, "I jumped out of my window and knocked on his. Then he came around". Client B was asked how client A got out of the house. Client B stated, "He snuck past the staff. I told [client A] I would be the better driver in daylight. He got us to Indianapolis where we went to a gas station. He stole a lighter. Then we smoked cardboard. Then we went to a gas station and asked for [name] cigarettes. Filled up at [gas station]". Client B was asked how they filled the vehicle up with gas. Client B stated, "The PIN (personal identification number) was in the driver book". Client B was asked if they had the debit card for gas. Client B stated, "Yeah. It was in the slot right by the radio. We basically totaled the car. When we pulled up to the gas station he (client A) hit the curb. He told me to pull up". Client B was asked if the van had been wrecked. Client B stated, "He (client A) did". Client B was asked what client A had hit. Client B stated, "The curb, that's what made the tire rim come off and then in Indianapolis when we got off the ramp, it was crazy! When we pulled off on the right, we hit someone".			

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	On 6/17/22 at 1:11 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about a lack of corrective measures to identify behavioral strategies after the 4/16/22 elopement of clients A and B and the failure to prevent reoccurrence on 6/7/22. The QAM stated, "Yeah. I had a conversation with [BC] and [QIDP] to have strategies to educate on goals with [client B]. I don't disagree, the separation (to prevent clients A and B planning to elope) was not effective". This federal tag relates to complaint #IN00382381. 9-3-2(a)			
W 0159 Bldg. 00	483.430(a) QIDP Each client's active treatment program must be integrated, coordinated and monitored by a qualified intellectual disability professional who- Based on observation, record review and interview for 2 of 2 sampled clients (A and B) and 1 additional client (C), the Qualified Intellectual Disabilities Professional (QIDP) failed to integrate, coordinate and monitor the clients' program plans. The QIDP failed to ensure clients A and B's had adequate behavioral strategies to address elopement risk and implementation of their behavioral support plans and 2) the alleged mistreatment of clients B and C. Findings include: An observation was conducted on 6/13/22 from 1:09 PM through 2:52 PM. At 1:52 PM, the Surveyor Supervisor entered the home. Upon entering the home, the Surveyor Supervisor had a	W 0159	To correct the deficient practice the QIDP will coordinates, monitor, and integrate each week at the ESN home with monitoring by the QIDP lead. In addition, a weekly report will be sent to the ED of the QIDP activities in the home. To ensure no others are affected the regional operations support specialist (ROSS) will be reviewing all ESN 2 with the BC/QIDP to thoroughly review the plans for appropriate behavioral objectives. Additionally, monitoring will be achieved by the administrative team who will meet daily for a period of one month to	07/21/2022

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	discussion with a group of facility staff members following the Covid-19 safety precaution screening. During the conversation, it was indicated the QIDP made weekly visits to the home prior to the 6/7/22 elopement incident. At 2:03 PM, staff #7 was asked how often the QIDP visited the home and the duration for monitoring supports and services. Staff #7 indicated, "An hour. Maybe once a week". An observation was conducted on 6/15/22 from 1:42 PM to 3:05 PM. Upon entering the home, no van was present in the driveway. The garage door entering from the driveway was open. Client A was not at the home. Client B was in the bathroom and exited to return to his bedroom. Client C was in the day room having a conversation with staff #13. At 1:51 PM, staff #5 was asked if members of the interdisciplinary team and administrative staff had visited the home during his shift. Staff #5 indicated the behavior clinician had been at the home earlier during the morning hours. Staff #5 was asked how often the behavior clinician visited the home. Staff #5 stated, "Twice, three times a week". Staff #5 was asked how often the nurse visited the home. Staff #5 stated, "About the same as [behaviorist]. Maybe a little more". Staff #5 was asked how often the QIDP visited the home. Staff #5 stated, "Not as often". Staff #5 was asked how often if he estimated. Staff #5 stated, "Before you came, I would say I saw her about 2 weeks before. I definitely see [behavior clinician] and [nurse] more". Staff #5 was asked if he would say weekly visitation. Staff #5 stated, "I would say every 8 or 9 days". An observation was conducted on 6/16/22 from 12:07 PM to 1:46 PM. At 1:14 PM, the Surveyor Supervisor asked the QIDP how often she was in the home. The QIDP indicated prior to the		discuss and correct ongoing issues at the site. Ongoing monitoring will be achieved through monthly review of all plans with ROSS/QIDP/BC/QIDP Lead. Additionally, the QIDP and QIDP Lead will meet weekly to discuss ongoing issues at the assigned sites.	

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	elopement incident on 6/7/22, she was completing weekly visits. On 6/17/22 at 11:06 AM, the Associate Executive Director (AED) was interviewed. The AED was asked about a lack of monitoring clients A and B's integration of their program plans with only weekly visits by the QIDP an hour or two at a time. The AED stated, "Yeah. We have made efforts to hire another QIDP to separate their caseloads down. We are working on that. We are taking steps to change the oversight of the QIDPs. That was a plan prior to this event, but we're working to change that". On 6/17/22 at 1:11 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about a lack of monitoring clients A and B's integration of their program plans with only weekly visits by the QIDP an hour or two at a time. The QAM indicated before the Immediate Jeopardy (IJ) the Regional Director only wanted the QIDP role to have 4 homes (case load). For us, that is not just [QIDP] responsibility. We have split the Area Supervisor so each will have 2 ESN (Essential Support Needs) homes. We do have a plan for more monitoring, even after the IJ and conditions through nights and ongoing". On 6/17/22 at 11:59 AM, the QIDP was interviewed. The QIDP was asked about monitoring for the integration of client program plans. The QIDP stated, "I document with staff on all the changes to the plan and goals. So, they (staff) understand what the expectation is and I demonstrate that myself". Reviewed with the QIDP was the aspect of a weekly visit for an hour or two to complete training and modeling with the staff, was insufficient to identify a culture in the home such as staff sleeping during their shift, a			

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	lack of implementing behavioral strategies and to be present and available enough for clients to express their wants, needs, and concerns such as mistreatment. The QIDP stated, "I can see that. It's been an open discussion and because of that they're trying to find someone". Please refer to W149. For 2 of 2 sampled clients (A and B) and 1 additional client (C), the facility neglected to implement its policy and procedures to ensure their system to prohibit and prevent abuse, neglect, and/or mistreatment was implemented concerning 1) the elopement risks of clients A and B. The facility neglected to ensure clients A and B's had adequate behavioral strategies to address elopement risk and implementation of the behavioral support plans, and 2) the alleged mistreatment of clients B and C. This federal tag relates to complaint #IN00382381. This federal tag relates to complaint #IN00379435. 9-3-3(a)			