STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G486	A. BUILDING 00 B. WING	07/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
COMMUNITY ALTERNATIVES-ADEPT	7919 SAN RICARDO DR INDIANAPOLIS, IN 46256

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for a pre-determined full recertification and state licensure survey. Dates of Survey: July 15, 16, 17, 18, 19 and 22, 2019. Facility Number: 001000 Provider Number: 15G486 AIMS Number: 100245010 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 7/25/19.	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, the facility neglected to meet the Condition of Participation: Governing Body for 2 of 3 sampled clients (#1 and #3). The governing body failed to exercise general policy, budget and operating direction over the facility to ensure staff thoroughly investigated and implemented effective corrective measures to prevent the repeated falls of client #3, neglected to prevent the extended elopement of client #3 and neglected to prevent client #1, a G (Gastroenteral)-tube feed only, from ingesting and choking on an apple. Findings include: 1. The governing body failed to ensure staff thoroughly investigated and implemented	W 0102	**CORRECTION:** *The facility must ensure that specific governing body and management requirements are met.* Specifically: The facility has installed wheelchair and bed alarms for client #3 to alert staff when client #3 attempts to stand or transfer without assistance. Additionally, the facility has implemented a system of alarm function tests to be completed on all shifts for wheelchair, bed and door alarms. Nursing staff have arranged for	08/21/2019

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

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	effective corrective measures to prevent the repeated falls of client #3, neglected to prevent the extended elopement of client #3 and neglected to prevent client #1, a G (Gastroenteral)-tube feed only, from ingesting and choking on an apple. Please see W104. 2. The governing body failed to meet the Condition of Participation: Client Protections to ensure staff thoroughly investigated and implemented effective corrective measures to prevent the repeated falls of client #3, neglected to prevent the extended elopement of client #3 and neglected to prevent client #1, a G (Gastroenteral)-tube feed only, from ingesting and choking on an apple. Please see W122. 9-3-1(a)		reassessment of client #3 by licensed physical and occupational therapists, to assure client 3 has appropriate supports to prevent falls and optimize mobility. The governing body has increased staffing on all shifts to provide additional supervision and increase safety for all clients, across environments. All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. The investigator assigned responsibility for completing investigations at the facility will receive additional training regarding investigation timelines and components of a thorough investigation. This training will include side by side collaborative completion of an investigation with the Quality Assurance Manager. In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigator will receive ongoing	

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			mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence, development of appropriate scope and conclusions. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. Additionally, the governing body has developed an investigation follow-up checklist to assist will supervisory review and oversight of all investigations. When deficiencies are noted, The Quality Assurance Manager and/or QIDP Manager will make corrections to investigations to assure they are thorough and meet regulatory requirements. **PREVENTION:** The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Quality Assurance Manager, Quality Assurance Coordinators, QIDP Manager Executive Director, Program Director, Program Managers, Nurse Manager and Assistant Nurse Manager. The QA Manager will meet with his/her QA Department investigators as needed but no less than weekly to	

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			review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. The Quality Assurance Manager will maintain final responsibility for critical review of all investigations and evaluation of the effectiveness of ongoing training.	

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			When incidents occur, The QIDP Manager will coordinate with the trained investigator and QIDP, through the investigation and corrective measure implementation process, providing follow-up as needed but no less than daily. Additionally, the Quality Assurance Manager and QIDP Manager will follow-up with administrative level program staff (Program Manager and Operations Manager). An Area Supervisor or Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training to assure behavior supports and protective measures are implemented as written. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger Assistant Nurse Manager) and the QIDP will conduct administrative monitoring during varied shifts/times, daily, to assure interaction with multiple staff, involved in a full range of active treatment scenarios. After 30 days, administrative observations will occur no less than three times weekly until all staff demonstrate	

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			competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed Administrative oversight will include: assuring behavior supports and protective measures are in place and implemented as written. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team,	

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			Direct Support Staff, Operations Team, Regional Director	
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 3 sampled clients (#1 and #3), the governing body failed to exercise general policy, budget and operating direction over the facility to ensure staff thoroughly investigated and implemented effective corrective measures to prevent the repeated falls of client #3, neglected to prevent the extended elopement of client #3 and neglected to prevent client #1, a G (Gastroenteral)-tube feed only, from ingesting and choking on an apple. Findings include: 1. The governing body neglected to implement their policy and procedures to thoroughly investigate and implement effective corrective measures to prevent the repeated falls of client #3, neglected to prevent the extended elopement of client #3 and neglected to prevent client #1, a G (Gastroenteral)-tube feed only, from ingesting and choking on an apple. Please see W149. 2. The governing body failed to ensure the facility conducted thorough investigations regarding the repeated falls of client #3 and client #3's extended elopement. Please see W154. 3. The governing body failed to ensure the facility implemented effective corrective measures to prevent the repeated falls with injury to client #3. Please see W157.	W 0104	**CORRECTION:** *The governing body must exercise general policy, budget, and operating direction over the facility.* Specifically, The facility has installed wheelchair and bed alarms for client #3 to alert staff when client #3 attempts to stand or transfer without assistance. Additionally, the facility has implemented a system of alarm function tests to be completed on all shifts for wheelchair, bed and door alarms. Nursing staff have arranged for reassessment of client #3 by licensed physical and occupational therapists, to assure client 3 has appropriate supports to prevent falls and optimize mobility. The governing body has increased staffing on all shifts to provide additional supervision and increase safety for all clients, across environments. All facility investigations will be completed by trained	08/21/2019

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	9-3-1(a)		investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. The investigator assigned responsibility for completing investigations at the facility will receive additional training regarding investigation timelines and components of a thorough investigation. This training will include side by side collaborative completion of an investigation with the Quality Assurance Manager. In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigator will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence, development of appropriate scope and conclusions. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. Additionally, the governing body has developed an investigation follow-up checklist to assist will supervisory review and oversight of	

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			all investigations. When deficiencies are noted, The Quality Assurance Manager and/or QIDP Manager will make corrections to investigations to assure they are thorough and meet regulatory requirements. **PREVENTION:** The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Quality Assurance Manager, Quality Assurance Coordinators, QIDP Manager Executive Director, Program Director, Program Managers, Nurse Manager and Assistant Nurse Manager. The QA Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the	

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			results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. The Quality Assurance Manager will maintain final responsibility for critical review of all investigations and evaluation of the effectiveness of ongoing training. When incidents occur, The QIDP Manager will coordinate with the trained investigator and QIDP, through the investigation and corrective measure implementation process, providing follow-up as needed but no less than daily. Additionally, the Quality Assurance Manager and QIDP Manager will follow-up with administrative level program staff (Program Manager and Operations Manager). An Area Supervisor or Residential	

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			Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training to assure behavior supports and protective measures are implemented as written. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger Assistant Nurse Manager) and the QIDP will conduct administrative monitoring during varied shifts/times, daily, to assure interaction with multiple staff, involved in a full range of active treatment scenarios. After 30 days, administrative observations will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor	

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			must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed Administrative oversight will include: assuring behavior supports and protective measures are in place and implemented as written. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	
W 0122 Bldg. 00	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on observation, record review and interview, the facility failed to meet the Condition of Participation: Client Protections for 2 of 3 sampled clients (#1 and #3). The facility neglected to implement its policy and procedures to ensure staff thoroughly investigated and implemented effective corrective measures to prevent the repeated falls of client #3, neglected to prevent	W 0122	**CORRECTION:** *The facility must ensure that specific client protections requirements are met.* Specifically, the governing body facilitated the following: The facility has installed	08/21/2019

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	the extended elopement of client #3 and neglected to prevent client #1, a G (Gastroenteral)-tube feed only, from ingesting and choking on an apple. Findings include: 1. The facility neglected to implement its policy and procedures to ensure staff thoroughly investigated and implemented effective corrective measures to prevent the repeated falls of client #3, neglected to prevent the extended elopement of client #3 and neglected to prevent client #1, a G (Gastroenteral)-tube feed only, from ingesting and choking on an apple. Please see W149. 2. The facility failed to conduct thorough investigations regarding the repeated falls of client #3 and client #3's extended elopement. Please see W154. 3. The facility failed to implement effective corrective measures to prevent the repeated falls with injury to client #3. Please see W157. 9-3-2(a)		wheelchair and bed alarms for client #3 to alert staff when client #3 attempts to stand or transfer without assistance. Additionally, the facility has implemented a system of alarm function tests to be completed on all shifts for wheelchair, bed and door alarms. Nursing staff have arranged for reassessment of client #3 by licensed physical and occupational therapists, to assure client 3 has appropriate supports to prevent falls and optimize mobility. The governing body has increased staffing on all shifts to provide additional supervision and increase safety for all clients, across environments. All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. The investigator assigned responsibility for completing investigations at the facility will receive additional training	

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			regarding investigation timelines and components of a thorough investigation. This training will include side by side collaborative completion of an investigation with the Quality Assurance Manager. In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigator will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence, development of appropriate scope and conclusions. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. Additionally, the governing body has developed an investigation follow-up checklist to assist will supervisory review and oversight of all investigations. When deficiencies are noted, The Quality Assurance Manager and/or QIDP Manager will make corrections to investigations to assure they are thorough and meet regulatory requirements. **PREVENTION:** The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the	

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			Operations Team, comprised of the Quality Assurance Manager, Quality Assurance Coordinators, QIDP Manager Executive Director, Program Director, Program Managers, Nurse Manager and Assistant Nurse Manager. The QA Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may	

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			result in progressive corrective action to all applicable team members. The Quality Assurance Manager will maintain final responsibility for critical review of all investigations and evaluation of the effectiveness of ongoing training. When incidents occur, The QIDP Manager will coordinate with the trained investigator and QIDP, through the investigation and corrective measure implementation process, providing follow-up as needed but no less than daily. Additionally, the Quality Assurance Manager and QIDP Manager will follow-up with administrative level program staff (Program Manager and Operations Manager). An Area Supervisor or Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training to assure behavior supports and protective measures are implemented as written. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger	

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			Assistant Nurse Manager) and the QIDP will conduct administrative monitoring during varied shifts/times, daily, to assure interaction with multiple staff, involved in a full range of active treatment scenarios. After 30 days, administrative observations will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed	

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			Administrative oversight will include: assuring behavior supports and protective measures are in place and implemented as written. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Health Services Team, Direct Support Staff, Operations Team, Regional Director	
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 3 sampled clients (#1 and #3), the facility neglected to implement its policy and procedures to thoroughly investigate and implement effective corrective measures to prevent the repeated falls of client #3, neglected to prevent the extended elopement of client #3 and neglected to prevent client #1, a G (Gastroenteral)-tube feed only, from ingesting and choking on an apple. Findings include: Observations were conducted at the group home on 7/15/19 from 3:38 PM through 6:15 PM and on 7/16/19 from 6:10 AM through 8:00 AM. Clients #1 and #3 were observed throughout the observation period. On 7/15/19 at 3:58 PM client #3 was seated in his wheelchair. Client #3's seat belt was not fastened. Client #3's wheelchair did not have an alarm attached to the wheelchair. Client #3 had a 1 inch scar/scab on the right, upper side of his	W 0149	**CORRECTION:** *The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.* Specifically: The facility has installed wheelchair and bed alarms for client #3 to alert staff when client #3 attempts to stand or transfer without assistance. Additionally, the facility has implemented a system of alarm function tests to be completed on all shifts for wheelchair, bed and door alarms. Nursing staff have arranged for reassessment of client #3 by licensed physical and occupational therapists, to assure client 3 has appropriate supports	08/21/2019

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	forehead, and a 1 inch scab/scar above his right eyelid which was darkened red in color. On 7/15/19 at 5:55 PM staff #1 administered client #1's medications and G-Tube feeding. Staff #1 attached a plastic syringe to a 1 1/2 foot plastic tube attached to client #1's abdomen. Staff #1 poured 8 ounces of Glucerna (feeding formula) 1.5 Cal (calculator) and 2 medications: Azithromycin (antibiotic) 5 ml (milliliters) and Midrodine 10 MG (milligrams) (blood pressure) into the plastic syringe. The contents then flowed through client #1's G-tube via gravity feed into client #1's stomach. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 7/15/19 at 1:00 PM. 1. A BDDS report dated 1/30/19 indicated on, "... On 1/29/19, while [client #3] was dressing himself after his evening shower, staff heard him (client #3) slip to the ground in the bathroom and went to check. Staff helped him (client #3) up and checked his body for injuries and noted a bruise, less than three inches in diameter on his right shoulder... [Client #3] had a history of falls prior to moving into his current home and a high risk plan is in place...". -A review of the BDDS report dated 1/30/19 indicated client #3 fell while dressing himself alone in the bathroom. The review indicated client #3 had a history of falls prior to moving into the group home. -An IS (Investigative Summary) dated 1/29/19 to 2/3/19 indicated the following, -"... Summary of Interviews:.."		to prevent falls and optimize mobility. The governing body has increased staffing on all shifts to provide additional supervision and increase safety for all clients, across environments. All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. The investigator assigned responsibility for completing investigations at the facility will receive additional training regarding investigation timelines and components of a thorough investigation. This training will include side by side collaborative completion of an investigation with the Quality Assurance Manager. In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigator will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary	

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	-"[Staff #2]" -"On the 29th (January), I worked 7:00 AM to 7:00 PM." -"[Client #3] fell right before I left for the day." -"[Client #3] was in the bathroom drying himself and dressing after his shower." -"He (client #3) would not let us help him." -"He (client #3) wanted his privacy and wanted to dress himself." -"I (staff #2) asked him (client #3) if he wanted help up, he said he wanted to do it himself." -"(Staff #2) let him try and then helped him (client #3) up." -"He (client #3) has a risk plan for falls but when he moved in, we were told he gets around on his own...". -"[Staff #3]:" -"... I (staff #3) was working on laundry when [client #3] fell." -"I (staff #3) think [staff #2] helped him (client #3)." -"He (client #3) won't let us help him in the bathroom." -"He (client #3) thinks he can do everything himself." -"He (client #3) needs help but he doesn't		evidence, development of appropriate scope and conclusions. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. Additionally, the governing body has developed an investigation follow-up checklist to assist will supervisory review and oversight of all investigations. When deficiencies are noted, The Quality Assurance Manager and/or QIDP Manager will make corrections to investigations to assure they are thorough and meet regulatory requirements. **PREVENTION:** The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Quality Assurance Manager, Quality Assurance Coordinators, QIDP Manager Executive Director, Program Director, Program Managers, Nurse Manager and Assistant Nurse Manager. The QA Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring	

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	understand." -"When he (client #3) moved in last week, we didn't know he couldn't do things without help." -"The nursing home told us he walked but he (client #3) came with a wheelchair...". -"Conclusion:" -"1. It is substantiated that [client #3] fell in the bathroom." -"2. It is substantiated that staff followed [client #3's] Behavior Support Plan (BSP)." -"3. It is substantiated that staff followed Rescare policy and procedures." -"Recommendations" -"1. Continue to follow Behavior Support Plan." -A review of the IS dated 1/29/19 to 2/3/19 indicated client #3 had moved into the group home one week prior (1/23/19) to his fall on 1/29/19. The review indicated staff were told client #3 was independent with his mobility needs. The review did not indicate documentation client #3 was interviewed for the IS dated 1/29/19 to 2/3/19. 2. A BDDS report dated 2/14/19 indicated, "... On 2/13/19, while [client #3] and his housemates were being transported to ResCare Day Service, staff noted that [client #3] was not sitting properly in his wheelchair and staff pulled over to check [client #3], staff discovered that [client #3] had fallen out of his wheelchair, staff picked him up and assessed him for injury... [client #3] sustained a 2 cm (centimeter) bruise on the bridge of his		investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. The Quality Assurance Manager will maintain final responsibility for critical review of all investigations and evaluation of the effectiveness of ongoing training. When incidents occur, The QIDP Manager will coordinate with the trained investigator and QIDP, through the investigation and	

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	nose... It should be noted that all tie-downs and the van shoulder/lap belt were functioning properly at the time of the incident... Additionally, the team will purchase a wheelchair seat belt for him to use in addition to the required tie-downs and shoulder lap/belt provided in the van...". -A review of the BDDS report dated 2/14/19 indicated client #3 fell out of his wheelchair while the group home's van was moving. The review did not indicate client #3 had a seatbelt on his wheelchair. The review did not indicate documentation of an investigation regarding client #3 falling out of his wheelchair while on a moving van. The review did not indicate the number of staff on the group home's van at the time of the incident. 3. A BDDS report dated 2/18/19 indicated, "... On 2/17/19, as [client #3] woke for the day, staff observed [client #3] to have a red scratch on the right eyelid measuring less than an inch in length... No bleeding occurred and the skin was not broken... An investigation into the origin of the injury is underway...". -An IS dated 2/17/19 to 2/22/19 indicated the following, -"... Summary of Interviews:.." -"[Staff #2]" -"I (staff #2) saw the scratch." -"I (staff #2) am not sure how he got it." -"He (client #3) is always getting up on his own." -"[Staff #4]"		corrective measure implementation process, providing follow-up as needed but no less than daily. Additionally, the Quality Assurance Manager and QIDP Manager will follow-up with administrative level program staff (Program Manager and Operations Manager). An Area Supervisor or Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training to assure behavior supports and protective measures are implemented as written. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger Assistant Nurse Manager) and the QIDP will conduct administrative monitoring during varied shifts/times, daily, to assure interaction with multiple staff, involved in a full range of active treatment scenarios. After 30 days, administrative observations will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional	

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	-"Yes, I was working when we discovered the scratch." -"I (staff #4) provided first (sic) and called the nurse." -"[Staff #5]" -"I (staff #5) worked that day." -"I (staff #5) discovered the scratch." " I (staff #5) called the nurse and provided first aid." -"[Client #3]" -"Yes, I (client #3) fell and got the scratch." -"I (client #3) think I fell getting out of bed to use the bathroom the other day." -" I (client #3) didn't ask staff for help." -"I am strong, look at my arms...". -"Conclusion:" -"1. The original origin of the scratch was [client #3] getting out of bed to use the bathroom without staff help." -"2. It is substantiated that staff followed [client #3] Behavior Support Plan (BSP)." -"3. It is substantiated that staff followed Rescare policy and procedures." -"Recommendations"		Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed Administrative oversight will include: assuring behavior supports and protective measures are in place and implemented as written. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, BDDS Generalist, Regional Director	

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-"1. Continue to follow Behavior Support Plan."

-A review of the IS dated 2/17/19 to 2/22/19 indicated the facility substantiated client #3 had an unwitnessed fall while attempting to get out of his (client #3's) bed. The review did not indicate any corrective measures or were initiated due to client #3's fall.

4. A BDDS report dated 2/27/19 indicated, "... On 2/26/19, [Client #3] was feeling tired and staff took him to his room, assisted him onto his bed and continued to assist his housemates with getting dinner ready. When staff went to check on [client #3] after 15 minutes, [client #3] was found on the floor where he had slid while attempting to get up from the bed. [Client #3] sustained a 2 cm scratch above his left eyelid... [Client #3] has a history of falls and a high-risk plan is in place...".

-An IS dated 2/26/19 to 2/31/19 (sic) indicated the following,

-"... Summary of Interviews:.."

-"[Staff #5]"

-"I (staff #5) worked that day."

-"I (staff #5) went back after about 15 minutes and he (client #3) had tried to get up. And fell (sic)".

-"I (staff #5) called the nurse and provided first aid."

-"[Client #3]"

-"I (client #3) knew it was close to dinner time, I was getting up to eat."

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-"I (client #3) wasn't feeling good earlier and went to lay down."

-"I (client #3) thought eating something would make me feel better."

-"I (client #3) did get a scratch when I fell...".

-"Conclusion:"

-"1. [Client #3] admitted that it (fall) more than likely happened when getting out of bed without staff assistance."

-"2. It is substantiated that staff followed [client #3] Behavior Support Plan (BSP)."

-"3. It is substantiated that staff followed Rescare policy and procedures."

-"Recommendations"

-"1. Continue to follow Behavior Support Plan."

A review of the IS dated 2/26/19 to 2/31/19 (sic) indicated the facility substantiated client #3 sustained an unwitnessed fall while attempting to get out of his bed. The review did not indicate the facility initiated any corrective measures or enhanced supervision due to client #3's fall on 2/26/19.

5. A BDDS report dated 3/19/19 indicated, "... On 3/18/19, [Client #3] was sitting in his wheelchair and rolled himself out the front door, with staff following. Once outside, he (client #3) unbuckled his seatbelt and stood up and attempted to walk away. Staff approached him to assist and he (client #3) began hitting staff and fell to the

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	ground, hitting the right side of his head. Staff observed swelling beside [client #3's] right eyebrow and called 911 (Emergency Services) and notified the supervisor and the nurse. EMS (Emergency Medical Services) transported [client #3] via ambulance to [name] Emergency Department for evaluation. ER personnel performed a head CT (Computerized Tomography) scan which produced negative results. The attending physician, noted no neurological symptoms, diagnosed [client #3] with Contusion of the Right Periorbital (swelling around eye area) Region and released him (client #3) to ResCare staff with no new orders and a recommendation to monitor [client #3] for concussion symptoms... The interdisciplinary team (IDT) will meet to develop strategies to address [client #3's] non-cooperation with his comprehensive high-risk plan for falls...". A review of the BDDS report dated 3/9/19 indicated client #3 fell and sustained an injury to his right eyebrow area. The review did not indicate documentation of an investigation regarding the fall with injury to client #3 on 3/8/19. 6. A BDDS report dated 3/19/19 indicated, "... On 3/18/19, [Client #3] became agitated because he said he wanted to be taken home and he (client #3) attempted to walk off by getting up from his wheelchair and he (client #3) fell to the ground sustaining a laceration on his face. [Client #3] was taken to [Name] Emergency Room (ER) where the physician on duty diagnosed facial abrasion and recommended washing his face with warm water and applying bacitracin (antiseptic) cream...". -An IS dated 3/18/19 to 3/23/19 indicated the following,			

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	-"... Summary of Interviews:.." "[Staff #6]" -"I (staff #6) was trying to keep him calm, he wanted to go home." -"We weren't moving fast enough for [client #3], so he took his belt off and tried to walk away." -"He (client #3) is forever walking away from his wheelchair." -"I (staff #6) always try to stay right by him (client #3)." -"I (staff #6) did not see him hit his head on the floor...". -"[Client #3]" -"I (client #3) just wanted to get home." -"I (client #3) can do things fine on my own." -"Staff does not need to help me, I can show you." -"I (client #3) did not hit my head." -"[Staff #7]" -"I (staff #7) was there when he (client #3) fell." -"I (staff #7) did not see him hit his head." -"He (client #3) was wanting to go home." -"[Client #3] got up fast then fell to the ground on his own...".			

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-"Conclusion:"

-"1. [Client #3] got out of his wheelchair by taking off his seat belt."

-"2. [Client #3] did not hit his head when he fell."

-"3. It is substantiated that staff followed [client #3] Behavior Support Plan (BSP)."

-"4. It is substantiated that staff followed Rescare policy and procedures."

-"Recommendations"

-"1. Continue to follow Behavior Support Plan."

-A review of the IS dated 3/18/19 to 3/23/19 indicated the facility substantiated client #3 took off his seat belt and fell out of his wheelchair. The review did not indicate the facility initiated any corrective measures due to client #3's fall on 2/26/19.

7. A BDDS report dated 3/25/19 indicated, "... On 3/24/19, [Client #3] became agitated because he was verbally redirected out of his housemate's bedroom. [Client #3] became upset and flipped himself out of his wheelchair and hit his head. Staff notified the supervisor and nurse and transported [client #3] (sic) [name] Emergency Department for evaluation. Where the physician on duty diagnosed [client #3] with Fall, initial encounter and released him (client #3) to ResCare staff with no new orders and a recommendation to apply ice to the affected areas and monitor [client #3] for concussion symptoms... The interdisciplinary team (IDT) will meet to develop strategies to address [client #3's] non-cooperation

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	with his comprehensive high-risk plan for falls...". -An IS (Investigative Summary) dated 1/29/19 to 2/3/19 indicated the following, -"... Summary of Interviews:.." -"[Staff #2]" -"[Client #3] was in [client #8's] bedroom, I (staff #2) told him to come out of [client #8's] room. When he (client #3) came out of the room he tried (sic) stand up and get out of the wheelchair. I (staff #2) re-directed him, and he (client #3) sat back down. As soon as I (staff #2) turned he (client #3) stood back up out of the wheelchair and tripped over his foot and fell face forward." -"I (staff #2) called the nurse and took him (client #3) to the Emergency Room (ER)...". -"[Client #3]" -"I (client #3) don't remember why I was in his (client #8's) room." -"I (client #3) wasn't trying to take anything, so I don't know why I had to get out of the room." -"I (client #3) just remember trying to stand up and my foot got caught and I fell." -"Yes, I (client #3) remember going to the ER." -"[Staff #7]" -"I (staff #7) was working with [staff #2] when [client #3] fell, he got upset because he (client #3) was in another housemate's bedroom and [staff #2] had him to come out, that is when he (client			

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	#3) threw himself out of his wheelchair." -"The nurse was called." -"[Staff #2] took him (client #3) to Emergency room." -"Conclusion:" -"1. [Client #3] did not remember the reason he was in his housemate's room." -"2. DSP (Direct Support Professional) [staff #2] asked [client #3] to come out of his housemate's room." -"3. [Client #3] reports, while trying to stand up my (client #3's) foot got caught on something an (sic) I (client #3) fell, Staff reports than [client #3] tried standing on his on (sic) and fell face forward." -"4. Staff did follow [client #3] Behavior Support Plan (BSP)." -"5. Staff did follow Rescare policy and procedures." -"Recommendations" -"1. Continue to follow Behavior Support Plan." -A review of the IS dated 3/24/19 to 3/29/19 did not indicate the facility made recommendations for corrective measures due to client #3's repeated falls with injury. The review did not indicate the facility initiated corrective measures due to client #3's repeated falls with injury. 8. A BDDS report dated 4/6/19 indicated, "... On			

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	4/6/19, [Client #3] was in his room changing his clothes with staff assistance. While staff went to the living room to retrieve his shoes, [client #3] attempted to stand and fell to the floor. Staff assisted him (client #3) back into his wheelchair, assessed him for injuries and notified the supervisor and the nurse. [Client #3] sustained a 1.5 circular red bruise on his left shoulder blade and a half-inch circular bruise on his (client #3's) mid-lower back. Staff provided him (client #3) with emotional support and reminded him (client #3) to wait for assistance with standing and transferring. [Client #3] has a history of falls with a high-risk plan in place...". -A review of the BDDS report dated 4/6/19 indicated client #3 sustained an injury due to an unwitnessed fall on 4/6/19. The review did not indicate documentation of an investigation regarding the fall with injury to client #3 on 4/6/19. The review did not indicate the facility made recommendations for corrective measures due to client #3's repeated falls with injury. The review did not indicate the facility initiated corrective measures due to repeated falls with injury. 9. A BDDS report dated 5/10/19, "... On 5/9/19, while sitting in his wheelchair, [client #3] removed his seat belt and then leaned forward and he (client #3) fell face forward sustaining a 1.5 inch laceration. [Client #3] was taken to the [Name] Emergency department per nurse directive. The physician on duty ordered a CT head without IV (intravenous) contrast which produced unremarkable results and diagnosed [client #3] with Facial Laceration, initial Encounter and fall, Initial Encounter (sic). The physician closed the laceration with one suture and administered the following medication to [client #3]: Lidocaine-Epinephrine (to numb part of body)...			

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	and Tetanus-diphtheria-pertussis (Vaccination)... The interdisciplinary team will meet to develop strategies to address [client #3's] non-cooperation with his comprehensive high-risk plan for falls. [Client #3] will return to the ER in 5 days to have the suture removed...". -A review of the BDDS report dated 5/10/19 indicated client #3 sustained an injury due to a fall on 5/9/19. The review indicated client #3 fell after he unfastened the seatbelt on his wheelchair. The review did not indicate documentation of an investigation regarding the fall with injury to client #3 on 5/9/19. The review did not indicate client #3's level of supervision at the time of his fall on 5/9/19. The review did not indicate the facility made recommendations for corrective measures due to client #3's repeated falls with injury. 10. A BDDS report dated 5/20/19, "... On 5/19/19, staff observed [client #3] had a swollen left ear after he woke up in the morning. Staff informed the supervisor and ResCare nurse and [client #3] was transported to the [Name] Emergency Department, per nurse instruction... [Client #3] was released to ResCare staff with no new orders and a recommendation to schedule a follow up appointment with an otolaryngolosist (Ear, Nose. Throat Specialist) as soon as possible... Staff will monitor the healing process of the affected area and an investigation is underway to determine the cause of the hematoma (bruise)." -A review of the BDDS report dated 5/20/19 indicated client #3 sustained an injury of unknown origin on 5/19/19. The review did not indicate documentation of an investigation regarding the injury of unknown injury to client #3 on 5/19/19.			

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11. A BDDS report dated 6/2/19, "... On the morning of 6/1/19, staff heard a noise and entered [client #3's] bedroom and observed him lying on the ground. Staff performed a physical assessment and assisted him into his wheelchair. Staff noted that he sustained a one-centimeter laceration on the upper right side of his scalp. Staff notified the supervisor and nurse and took him (client #3) to [Name] MedCheck [location] for evaluation per nurse instructions. The clinical physician evaluated [client #3] and diagnosed him with Laceration of Scalp and Head Injury... The quality assurance team has initiated an investigation into the circumstances of the incident and the administrative team was informed."

-A review of the BDDS report dated 6/2/19 indicated staff found client #3 laying on the floor in his bedroom. The review indicated client #3 had sustained a 1 inch laceration to the right side of his scalp/head. The review did not indicate documentation of an investigation regarding the laceration to client #3's scalp/head on 6/1/19. The review did not indicate client #3's level of supervision at the time of his unwitnessed fall on 6/1/19. The review did not indicate the facility made recommendations for corrective measures due to client #3's repeated falls with injury.

12. A BDDS report dated 7/7/19, "... On 7/6/19, staff reported that [client #3] was attempted (sic) to stand up from his wheelchair he lost balance and fell towards the floor before staff was able to assist him (client #3) back into his wheelchair. Once staff was able to sit [client #3] on his wheelchair, staff completed a full body scan to check for any injuries. Staff located a bruise that appeared on top of a previous scratch; staff

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	applied Bacitracin to the wounded area... [Client #3] has experienced an emerging pattern of falls and a high-risk plan is in place...". -A review of the BDDS report dated 7/7/19 indicated client #3 fell as he attempted to stand up from his wheelchair. The review did not indicate documentation of an investigation regarding client #3's fall with injury on 7/6/19. The review did not indicate what corrective measures the facility took due to client #3's repeated falls with injury. 2 A. A BDDS report dated 4/9/19, "... On the evening of 4/8/19, one staff was assisting individuals with preparing dinner and the other staff was assisting individuals with showers. At 7:15 PM, when it was [client #3's] turn to use the shower, staff noted that he (client #3) was not in his room. He was not located after search of the house and perimeter and the police were notified. Staff and police searched the area and the police found [client #3] at the intersection of [names of streets] which is about 1.2 miles from the house. He [client #3] returned to the house and he had no visible injuries... Elopement is addressed in [client #3's] Behavior Support Plan and the incident is under investigation." -A review of the BDDS report dated 4/9/19 indicated client #3 eloped from the group home on 4/8/19. The review indicated the Police located client #3 approximately 1.2 miles from the group home. The review did not indicate the facility indicated client #3 utilized a wheelchair for all of his mobility needs. -An IS dated 4/8/19 to 4/13/19 indicated the following:			

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	-"Introduction:" -"On the evening of 4/8/19, one staff was assisting individuals with preparing dinner and the other staff was assisting individuals with showers. At 7:15 PM, when it was [client #3's] turn to use the shower, staff noted that he (client #3) was not in his room. He was not located after search of the house and perimeter and the police were notified. Staff and police searched the area and the police found [client #3] at the intersection of [names of streets] which is about 1.2 miles from the house. He [client #3] returned to the house without incident. [Client #3] was without ResCare staff supervising for approximately two hours. A body check was conducted after [client #3] was brought to the house and he had no visible injuries." -"... Scope of Investigation:" -"1. How did [client #3] get out of the home?" -"2. Why did the door alarms not ring?" -"3. How long was [client #3's] elopement?" -"4. Did staff follow [client #3's] Behavior Support Plan?" -"5. Did staff follow ResCare policy and procedure...". -"... Summary of Interviews:.." -"[Staff #4]" -"I (staff #4) was helping finishing (sic) cleaning from dinner in the kitchen and other staff was helping other clients with showers."			

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	-"When it was [client #3's] turn to shower we could not find him." -"We looked around the house, then called the supervisor." -"The supervisor told us to call the police for help in looking for him (client #3)." -"The police found him up by the hospital and return home." -"[Staff #5]" -"I (staff #5) was giving showers and when it was [client #3's] turn I did not know where he (client #3) was." -"We looked around the house and outside the house and he (client #3) was nowhere." -"We called the supervisor, who told us to call the police and she was on her way to help look for him." -"[Client #3] was returned to the home by the police." -"[RM (Residential Manager #1)]" -"Staff called me about what was happening, and I told them to call the police." -"The police found him on [name of a heavily trafficked street] and brought him (client #3) home." -"The door alarms did not have batteries in them, I have put in a work order."			

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-"[Client #3]"

-"I (client #3) wanted to leave the house."

-"I (client #3) don't want to be here, I'm not supposed to be here."

-"I (client #3) can do things on my own, I don't need help like the others."

-"I (client #3) just kept going as far away as I could."

-"No, I (client #3) was not trying to go to the hospital."

-"The police took me back to the house...".

-"Factual Findings:"

-"1. [Client #3] did leave the home without staff supervision."

-"2. Staff could not find [client #3] and did not know where he had gone."

-"3. Police were called."

-"4. Door Alarm's (sic) not working."

-A review of the IS dated 4/8/19 to 4/13/19 indicated client #3 eloped from the group home on 4/8/19 and was out of line of sight/supervision of staff for approximately 2 hours. The review indicated staff called the Police for assistance locating client #3. The review indicated the police located client #3 near a Hospital, approximately 1.2 miles from the group home. The review indicated client #3 used a wheelchair for all of his mobility

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	needs and client #3 was in his wheelchair when he eloped from the facility. The review indicated the group home's door alarms were not turned on or functional when client #3 eloped on 4/8/19. The review did not indicate the facility's investigation made conclusions or recommendations in the IS dated 4/8/19 to 4/13/19 regarding client #3's elopement on 4/8/19. 3 A. A BDDS report dated 7/14/19 indicated on 7/13/19, "... They (clients #1 and #3) live in a supervised group living home with six other males. On 7/13/19, while staff was putting away [client #1's] g-tube feeding supplies, [client #3] gave [client #1], who (client #1) receives nothing by mouth due to risk of aspiration, a piece of apple which resulted in [client #1] choking. Staff observed that [client #1] was choking and applied abdominal thrust-dislodging the food successfully. Staff called 911 per protocol. EMS personnel observed [client #1], took his vital signs and noted that his (client #1's) lungs sounded clear. The paramedics determined that he (client #1) did not require additional evaluation at the ER (Emergency Room) and left without taking further action... The team counseled [client #3] about the dangers of providing food or beverages to his housemate...". -A review of the BDDS report dated 7/14/19 indicated Client #1 was NPO (nothing by mouth). The review indicated client #3 gave client #1 a piece of apple which caused client #1 to choke. The review did not indicate client #1 or client #3's level of supervision at the time of the incident. Client #3's record was reviewed on 7/16/19 at 12:49 PM. Client #3's BSP (Behavior Support Plan) dated 2/6/19 and revised on 5/10/19 indicated the following:			

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-"... Behavioral History"

-"... [Client #3] is dependent on others to make reasonable decisions and maintain personal safety... [Client #3's] gait (walking motion) is very unsteady (sic) is able to walk for only short distances without falling or stopping to rest due to fatigue...".

-"05/10/2019:"

-"[Client #3] has consistently been observed to be non-cooperative with staffs (sic) with the use of his wheelchair safety belt. [Client #3] will once agitated, try to get off his wheelchair and will remove seat belt by himself and most times falls to the ground as he (client #3] is very shaky on his legs hence the reason why he (client #3) is on (sic) a wheelchair. Staff will continue to monitor and emphasize to [client #3] why he needs to stay in his wheelchair and use the safety belt for his own safety."

-"Target Behaviors and Goals:...".

-"Leaving Assigned Area: any time [client #3] leaves an assigned area including areas in the home or areas where group (defined as the staff that is with him on a community outing) is at without staff acknowledgement. This includes walking out of the house to the front yard, the back yard, the (sic) or leaving the property without staff acknowledgement as well as entering housemates' bedrooms without permission...".

-A review of Client #3's BSP (Behavior Support Plan) dated 2/6/19 and revised on 5/10/19 indicated client #3 required assistance to make reasonable/informed decisions. The review

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	indicated client #3 had an unsteady gait. The review indicated client #3 was non-compliant with the use of his wheelchair and wheelchair's seatbelt. The review indicated client #3 had a targeted behavior for elopement. The review did not indicate client #3 had enhanced supervision due to his non-compliance with the use of his wheelchair and wheelchair's seatbelt/repeated falls. -A DPN (Daily Progress Note) for client #3 dated 7/12/19 and completed by staff #1 indicated, "[Client #3] had dinner, currently sitting in living room, no issues. [Client #3] has been told several times how important sitting in his wheelchair which he (sic) constantly out of, causing unnecessary falls." -A DPN for client #3 dated 7/12/19 and completed by staff #2 indicated, "[Client #3] ate his dinner, showered. Sat in the living room, later stood up on his wheelchair several times, and doesn't listen to instructions...". -A ROV (Record Of Visit) for client #3 dated 5/9/19 and completed by PA (Physician's Assistant #1) indicated, "... 1. Reason for Visit: Facial injury 2. Results/Findings of examination: facial laceration... Return to [name] ED in 5-7 days for suture removal...". -A ROV (Record Of Visit) for client #3 dated 5/19/19 and completed by PA #2 indicated, "1. Reason for Visit: L (left) ear hematoma/L ear swelling 2. Results/Findings of examination: L ear hematoma...". -A ROV (Record Of Visit) for client #3 dated 6/1/19 and completed by MD (Medical Doctor #1) indicated, "1. Reason for Visit: Fall, head injury 2.			

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	Results/Findings of examination: Laceration and head injury. No repair needed. Injury on the right top of his (client #3's) head, approx. (approximately) 4 cm (centimeters) in diameter and circular in size. Laceration 1 cm, not gaping, not bleeding...". An INN (Individual Nursing Note) dated 6/21/19 and completed by Nurse #1 indicated, "... Patient (client #3) is pleasant and cooperative with med's, staff, house duties. Staff continue to need assist (sic) because patient (client #3) has little to no safety awareness and often will unbuckle seat belt, attempt to stand and fall cause (sic) himself injury. Can make basic needs known, but needs assist because he (client #3) will continue to stand/walk regardless of staff intervention and often has to (sic) checked at least q (every) 15 min. (minutes)...". Client #1's record was reviewed on 7/16/19 at 11:26 AM. Client #1's PO's (Physician's Orders) dated 7/1/19 to 7/31/19 indicated, "... NPO (nothing by mouth)... Diagnosis... silent aspiration, g-tube 2 (secondary to) oropharyngeal dysphagia (a condition in which food, liquids, saliva or vomit is breathed into the airways)...". Client #1's CHRHP (Comprehensive High Risk Health Plan) dated 7/9/19 and completed by Nurse #1 indicated, ".. Patient (client #1) is NPO has a recently placed g-tube after he (client #1) was found to be aspirating silently. Secondary to oropharyngeal dysphagia... Expected Outcome: [Client #1's] safety will be maintained during eating & drinking through 12/2020." Client #3 was interviewed on 7/15/19 at 4:06 PM.			

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	Client #3 was asked if he had fallen recently. Client #3 stated, "Yeah, when I walk." Client #3 was asked how he was able to leave the group home on 4/8/19 without staff noticing. Client #3 stated, "I was making sure they weren't watching." Client #8 was interviewed on 7/15/19 at 4:14 PM. Client #8 was asked if he had seen client #3 fall at the group home. Client #8 stated, "Yeah in his room, everywhere." Client #8 was asked if staff monitored client #3. Client #8 stated "They try to." Client #2 was interviewed on 7/15/19 at 4:21 PM. Client #2 was asked if he had seen client #3 fall at the group home. Client #2 stated, "Yes, sometimes he will get out of his wheelchair and try to walk by himself. Sometimes he will make it to the door." Client #2 was asked if client #3 had left/eloped from the group home. Client #2 stated, "He'll (client #3) turn the knob and try to get out through the front door. Sometimes the woman in the pink dress tries to stop him, but [client #3] is really persistent." Client #2 was asked if he had observed client #1 choke on 7/13/19. Client #2 stated, "[Client #1] ate an apple and he was choking. He can't eat or drink."Client #1 was interviewed on 7/15/19 at 5:36 PM. Client #1 was asked if he was able to eat solid food and drink liquids. Client #1 stated, "Can't drink water, can't drink pop." Client #1 was asked if he had choked on an			

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	apple. Client #1 stated, "2 pieces."RM (Residential Manager #1) was interviewed on 7/15/19 at 3:44 PM. RM #1 was asked what was client #3's level of supervision. RM #1 stated, "[Client #3] is 15 minute checks. We document that in the progress notes." RM #1 was asked if the facility had discussed one on one/1:1 supervision for client #3. RM #1 stated, "We've discussed it but he's not able to be a 1:1 at this time. I've requested it." RM #1 was asked if she believed client #3 should be on 1:1 supervision. RM #1 stated, "I do, if he doesn't he (client #3) will hurt himself or try to hurt himself."Staff #1 was interviewed on 7/15/19 at 4:28 PM. Staff #1 was asked if client #3 was a fall risk. Staff #1 stated, "Yes, most definitely. He gets up, he'll take it off, the seat belt." Staff #1 was asked if she had seen client #3 elope on 4/8/19. Staff #1 stated, "I wasn't here when he eloped." Staff #1 was asked if client #3 tries to elope/vacate the group home. Staff #1 stated, "Most definitely." Staff #1 was asked if client #3's required more staff supervision. Staff #1 stated, "He (client #3) should be 1:1 for real. He needs a 1:1 to me." Staff #1 was asked if she was present when client #1 choked on 7/13/19. Staff #1 stated, "I work the weekend. Three individuals had gone to the movies. I (staff #1) was here by myself with [client #3], [client #1] and [client #6]			

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	and [client #8]." Staff #1 was asked what had happened. Staff #1 stated, "I just got through feeding [client #1]. I had to be out here in the kitchen to watch [client #3]. No sooner I turned my back for a second and [client #1] was purple. [Client #2] said [client #3] gave him (client #1) an apple." Staff #2 was interviewed on 7/15/19 at 4:39 PM. Staff #2 was asked why client #3 had repeated falls since his admission on 1/23/19. Staff #2 stated, "His disability, his body is like in a weakened state." He (client #3) still wants to do the things he used to be able to do. He'll fall forward, timber, like a tree." Staff #2 was asked what was client #3's level of supervision. Staff #2 stated, "He's line of sight, fifteen minute checks. He needs to I'll be honest with you a 1:1. Because of the endangerment to hisself." Staff #2 was asked if he was on the group home's van when client #3 fell on 2/13/19. Staff #2 stated, "Yes, he (client #3) just flipped over the seat. I just pulled over immediately to the side and put him back in his seat." Staff #2 was asked if he was the only staff on the van. "Staff #2 stated, "Yes." Staff #2 was asked if there were other clients on the van at that time. Staff #2 stated, "Yes, maybe 4, including him (client #3) maybe 5."Staff #4 was interviewed on 7/15/19 at 5:38 PM. Staff #4 was asked if she had observed client #3 fall. Staff #4			

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	stated, "Yes, he tries to walk by himself and he always refuses to use his wheelchair." Staff #4 was asked if she was working when client #3 eloped an 4/8/19. Staff #4 stated, "I think we were only 2 staff here. I was fixing dinner, other staff was giving showers. I think the alarm battery was down." Staff #4 was asked to clarify if the door alarm was working. Staff #4 stated, "No." Staff #4 was asked what was client #3's level of supervision. Staff #4 stated, "He's 15 minute checks but we watch him all the time." Staff #4 was asked if client #3 should be on 1:1 supervision. Staff #4 stated, "Yes, best thing to do."Staff #5 was interviewed on 7/16/19 at 7:29 AM. Staff #5 indicated he worked the overnight shift. Staff #5 was asked how often he checked on client #3. Staff #5 stated, "I check on him every 15 minutes." Staff #5 was asked if client #3 tried to get out of the bed without staff assistance. Staff #5 stated, "Yes, he tries to get out of the bed all the time." Staff #5 was asked if client #3 had a bed alarm on his bed. Staff #5 stated, "No, that would be helpful. And he's not supposed to be standing up, he's going to fall so he (client #3) needs to be a 1:1." RM #1 was interviewed a second time on 7/19/19 at 10:27 AM. RM #1 was asked how many staff were on duty when client #1 choked on 7/13/19. RM #1 stated, "2 staff, one staff took a couple of consumers to the			

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	movies." RM #1 was asked if client #1 should have been able to eat a piece of apple. RM #1 stated, "Of course not, because [client #1 is nothing by mouth." RM #1 was asked if she had requested 1:1 supervision for client #3. RM #1 stated, "Yes I have. We have a team meeting scheduled. We're going to discuss different plans for [client #3]. I'm sure we will discuss the 1:1."QIDP (Qualified Intellectual Disabilities Professional #1) was interviewed on 7/16/19 at 2:45 PM. QIDP #1 was asked if the client #3 was assessed to have safe pedestrian skills. QIDP #1 stated, "No, he (client #3) is to have supervision 24 hours a day."QIDPM (Qualified Intellectual Disabilities Professional Manager #1) was interviewed on 7/16/19 at 2:45 PM. QIDPM #1 was asked why client #3 had repeated falls at the group home. QIDPM #1 stated, "Typically due to non-cooperation with his wheelchair." QIDPM #1 was asked if client #3 had sustained injuries as a result of his repeated falls. QIDPM #1 stated, "Yes." QIDPM #1 was asked if client #1 was NPO/nothing by mouth. QIDPM #1 stated, Yes." QIDPM #1 was asked how client #1 choked on 7/13/19. QIDPM #1 stated, "A housemate gave him a piece of apple." QIDPM #1 was asked if staff had to use emergency intervention to assist client #1. QIDPM #1 stated, "Abdominal thrusts,			

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	yes." QIDPM #1 was asked if client #3 eloped from the group home on 4/8/19 while in his wheelchair. QIDPM #1 stated, "Yes." QIDPM #1 was asked if the group home's door alarms were working at that time. QIDPM #1 stated, "No." QIDPM #1 indicated the facility's policy on the prevention of abuse, neglect and mistreatment should be implemented as written. QIDPM #1 indicated all allegations of abuse, neglect and mistreatment should be thoroughly investigated all witnesses or potential witnessed should be interviewed. QIDPM #1 indicated the facility's investigations/recommendations should develop effective corrective measures to prevent the repeated falls of client #3.The Facility's policy and procedures were reviewed on 7/17/19 at 9:30 AM. The facility's Abuse, Neglect, Exploitation policy revised on 2/26/18 indicated, "Policy: Adept staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect and exploitation shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ADEPT, Rescare and local, state and federal guidelines..."Emotional/physical neglect: failure to provide goods and/or services necessary for the individual to avoid			

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	physical harm. Failure to provide the support necessary to an individual's psychological and social well being. Failure to meet the basic need requirements such as food, shelter, clothing and to provide a safe environment." "Program intervention neglect: ...Failure to implement a support plan, inappropriate application of intervention with out (sic) a qualified person notification/review..."."6. A full investigation will be conducted by ADEPT personnel...".9-3-2(a)			
W 0154 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. Based on record review and interview for 9 of 36 allegations of abuse, neglect and mistreatment reviewed, the facility failed to conduct thorough investigations regarding the repeated falls of client #3 and client #3's extended elopement. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 7/15/19 at 1:00 PM. 1. A BDDS report dated 1/30/19 indicated, "... On 1/29/19, while [client #3] was dressing himself after his evening shower, staff heard him (client #3) slip to the ground in the bathroom and went to check. Staff helped him (client #3) up and checked his body for injuries and noted a bruise, less than three inches in diameter on his right shoulder... [Client #3] had a history of falls prior to moving into his current home and a high risk plan is in	W 0154	**CORRECTION:** *The facility must have evidence that all alleged violations are thoroughly investigated.* Specifically: All facility investigations will be completed by trained investigators. Investigation focus will include but not be limited to interviewing all potential witnesses and comparing documentary and testimonial evidence to identify and clarify discrepancies. Copies of all investigations will be maintained by the Quality Assurance Department to be available for review, as required. The investigator assigned responsibility for completing	08/21/2019

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	place...". -A review of the BDDS report dated 1/30/19 indicated client #3 fell while dressing himself alone in the bathroom. The review indicated client #3 had a history of falls prior to moving into the group home. -An IS (Investigative Summary) dated 1/29/19 to 2/3/19 indicated the following, -"... Summary of Interviews:.." -"[Staff #2]" -"On the 29th (January), I worked 7:00 AM to 7:00 PM." -"[Client #3] fell right before I left for the day." -"[Client #3] was in the bathroom drying himself and dressing after his shower." -"He (client #3) would not let us help him." -"He (client #3) wanted his privacy and wanted to dress himself." -"I (staff #2) asked him (client #3) if he wanted help up, he said he wanted to do it himself." -"(Staff #2) let him try and then helped him (client #3) up." -"He (client #3) has a risk plan for falls but when he moved in, we were told he gets around on his own...". -"[Staff #3]:"		investigations at the facility will receive additional training regarding investigation timelines and components of a thorough investigation. This training will include side by side collaborative completion of an investigation with the Quality Assurance Manager. In addition to weekly face to face training and follow-up with the Quality Assurance Manager, the investigator will receive ongoing mentorship from the QIDP Manager, including but not limited to interview techniques, gathering and analysis of documentary evidence, development of appropriate scope and conclusions. The QIDP Manager will provide weekly follow-up to the QA Manager regarding progress and additional training needs. Additionally, the governing body has developed an investigation follow-up checklist to assist will supervisory review and oversight of all investigations. When deficiencies are noted, The Quality Assurance Manager and/or QIDP Manager will make corrections to investigations to assure they are thorough and meet regulatory requirements. **PREVENTION:** The QIDP Manager will maintain a tracking spreadsheet for incidents requiring investigation, follow-up and corrective/protective measures	

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	-"... I (staff #3) was working on laundry when [client #3] fell." -"I (staff #3) think [staff #2) helped him (client #3)." -"He (client #3) won't let us help him in the bathroom." -"He (client #3) thinks he can do everything himself." -"He (client #3) needs help but he doesn't understand." -"When he (client #3) moved in last week, we didn't know he couldn't do things without help." -"The nursing home told us he walked but he (client #3) came with a wheelchair...". -"Conclusion:" -"1. It is substantiated that [client #3] fell in the bathroom." -"2. It is substantiated that staff followed [client #3] Behavior Support Plan (BSP)." -"3. It is substantiated that staff followed Rescare policy and procedures." -"Recommendations" -"1. Continue to follow Behavior Support Plan." -A review of the IS dated 1/29/19 to 2/3/19 indicated client #3 had moved into the group home one week prior (1/23/19) to his fall on 1/29/19. The review indicated staff were told client		will be maintained and distributed daily to facility supervisors and the Operations Team, comprised of the Quality Assurance Manager, Quality Assurance Coordinators, QIDP Manager Executive Director, Program Director, Program Managers, Nurse Manager and Assistant Nurse Manager. The QA Manager will meet with his/her QA Department investigators as needed but no less than weekly to review the progress made on all investigations, review incidents and assign responsibility for new incidents/issues requiring investigation. QA team members will be required to attend and sign an in-service documentation at these meetings stating that they are aware of which investigations with which they are required to conduct, as well as the specific components of the investigation for which they are responsible, within the five-business day timeframe. The QA Manager will review the results of these weekly meetings with the Executive Director to assure appropriate follow through occurs. The Quality Assurance Team will review each investigation to ensure that they are thorough –meeting regulatory and operational standards, and will not designate an investigation, as completed, if it does not meet these criteria. Failure to complete thorough	

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	#3 was independent with his mobility needs. The review did not indicate documentation client #3 was interviewed for the IS dated 1/29/19 to 2/3/19. 2. A BDDS report dated 2/14/19 indicated, "... On 2/13/19, while [client #3] and his housemates were being transported to ResCare Day Service, staff noted that [client #3] was not sitting properly in his wheelchair and staff pulled over to check [client #3], staff discovered that [client #3] had fallen out of his wheelchair, staff picked him up and assessed him for injury... [client #3] sustained a 2 cm (centimeter) bruise on the bridge of his nose... It should be noted that all tie-downs and the van shoulder/lap belt were functioning properly at the time of the incident... Additionally, the team will purchase a wheelchair seat belt for him to use in addition to the required tie-downs and shoulder lap/belt provide in the van...". -A review of the BDDS report dated 2/14/19 indicated client #3 fell out of his wheelchair while the group home's van was moving. The review did not indicate client #3 had a seatbelt on his wheelchair. The review did not indicate documentation of an investigation regarding client #3 falling out of his wheelchair while on a moving van. 3. A BDDS report dated 3/19/19 indicated, "... On 3/18/19, [Client #3] was sitting in his wheelchair and rolled himself out the front door, with staff following. Once outside, he (client #3) unbuckled his seatbelt and stood up and attempted to walk away. Staff approached him to assist and he (client #3) began hitting staff and fell to the ground, hitting the right side of his head. Staff observed swelling beside [client #3's] right eyebrow and called 911 (Emergency Services) and notified the supervisor and the nurse. EMS		investigations within the allowable five business day timeframe may result in progressive corrective action to all applicable team members. The Quality Assurance Manager will maintain final responsibility for critical review of all investigations and evaluation of the effectiveness of ongoing training. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	(Emergency Medical services) transported [client #3] via ambulance to [name] Emergency Department for evaluation. ER personnel performed a head CT (Computerized Tomography) scan which produced negative results. The attending physician, noted no neurological symptoms, diagnosed [client #3] with Contusion of the Right Periorbital (swelling around eye area) Region and released him (client #3) to ResCare staff with no new orders and a recommendation to monitor [client #3] for concussion symptoms... The interdisciplinary team (IDT) will meet to develop strategies to address [client #3's] non-cooperation with his comprehensive high-risk plan for falls...". A review of the BDDS report dated 3/9/19 indicated client #3 fell and sustained an injury to his right eyebrow area. The review did not indicate documentation of an investigation regarding the fall with injury to client #3 on 3/8/19. 4. A BDDS report dated 4/6/19 indicated, "... [Client #3] was in his room changing his clothes with staff assistance. While staff went to the living room to retrieve his shoes, [client #3] attempted to stand and fell to the floor. Staff assisted him (client #3) back into his wheelchair, assessed him for injuries and notified the supervisor and the nurse. [Client #3] sustained a 1.5 circular red bruise on his left shoulder blade and a half-inch circular bruise on his (client #3's) mid-lower back. Staff provided him (client #3) with emotional support and reminded him (client #3) to wait for assistance with standing and transferring. [Client #3] has a history of falls with a high-risk plan in place...". -A review of the BDDS report dated 4/6/19 indicated client #3 sustained an injury due to an			

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	unwitnessed fall on 4/6/19. The review did not indicate documentation of an investigation regarding the fall with injury to client #3 on 4/6/19. 5. A BDDS report dated 5/10/19 indicated, "... On 5/9/19, while sitting in his wheelchair, [client #3] removed his seat belt and then leaned forward and he (client #3) fell face forward sustaining a 1.5 inch laceration. [Client #3] was taken to the [Name] Emergency department per nurse directive. The physician on duty ordered a CT head without IV (intravenous) contrast which produced unremarkable results and diagnosed [client #3] with Facial Laceration, initial Encounter and fall, Initial Encounter (sic). The physician closed the laceration with one suture and administered the following medication to [client #3]: Lidocaine-Epinephrine (to numb part of body)... and Tetanus-diphtheria-pertussis (Vaccination)... The interdisciplinary team will meet to develop strategies to address [client #3's] non-cooperation with his comprehensive high-risk plan for falls. [Client #3] will return to the ER in 5 days to have the suture removed...". -A review of the BDDS report dated 5/10/19 indicated client #3 sustained an injury due to a fall on 5/9/19. The review indicated client #3 fell after he unfastened the seatbelt on his wheelchair. The review did not indicate documentation of an investigation regarding the fall with injury to client #3 on 5/9/19. 6. A BDDS report dated 5/20/19 indicated, "... On 5/19/19, staff observed [client #3] had a swollen left ear after he woke up in the morning. Staff informed the supervisor and ResCare nurse and [client #3] was transported to the [Name] Emergency Department, per nurse instruction... [Client #3] was released to ResCare staff with no			

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new orders and a recommendation to schedule a follow up appointment with an otolaryngolosist (Ear, Nose. Throat Specialist) as soon as possible... Staff will monitor the healing process of the affected area and an investigation is underway to determine the cause of the hematoma (bruise)."

-A review of the BDDS report dated 5/20/19 indicated client #3 sustained an injury of unknown origin on 5/19/19. The review did not indicate documentation of an investigation regarding the injury of unknown injury to client #3 on 5/19/19.

7. A BDDS report dated 6/2/19 indicated, "... On the morning of 6/1/19, staff heard a noise and entered [client #3's] bedroom and observed him lying on the ground. Staff performed a physical assessment and assisted him into his wheelchair. Staff noted that he sustained a one-centimeter laceration on the upper right side of his scalp. Staff notified the supervisor and nurse and took him (client #3) to [Name] MedCheck [location] for evaluation per nurse instructions. The clinical physician evaluated [client #3] and diagnosed him with Laceration of Scalp and Head Injury... The quality assurance team has initiated an investigation into the circumstances of the incident and the administrative team was informed."

-A review of the BDDS report dated 6/2/19 indicated staff found client #3 laying on the floor in his bedroom. The review indicated client #3 had sustained a 1 inch laceration to the right side of his scalp/head. The review did not indicate documentation of an investigation regarding the laceration to client #3's scalp/head on 6/1/19.

8. A BDDS report dated 7/7/19 indicated, "... On

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	7/6/19, staff reported that [client #3] was attempted (sic) to stand up from his wheelchair he lost balance and fell towards the floor before staff was able to assist him (client #3) back into his wheelchair. Once staff was able to sit [client #3] on his wheelchair, staff completed a full body scan to check for any injuries. Staff located a bruise that appeared on top of a previous scratch; staff applied Bacitracin to the wounded area... [Client #3] has experienced an emerging pattern of falls and a high-risk plan is in place...". -A review of the BDDS report dated 7/7/19 indicated client #3 fell as he attempted to stand up from his wheelchair. The review did not indicate documentation of an investigation regarding client #3's fall with injury on 7/6/19. 9. A BDDS report dated 4/9/19 indicated on 4/8/19, "... On the evening of 4/8/19, one staff was assisting individuals with preparing dinner and the other staff was assisting individuals with showers. At 7:15 PM, when it was [client #3's] turn to use the shower, staff noted that he (client #3) was not in his room. He was not located after search of the house and perimeter and the police were notified. Staff and police searched the area and the police found [client #3] at the intersection of [names of streets] which is about 1.2 miles from the house. He [client #3] returned to the house and he had no visible injuries... Elopement is addressed in [client #3's] Behavior Support Plan and the incident is under investigation." -A review of the BDDS report dated 4/9/19 indicated client #3 eloped from the group home on 4/8/19. The review indicated the Police located client #3 approximately 1.2 miles from the group home. The review did not indicate the facility indicated client #3 utilized a wheelchair for all of			

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	his mobility needs. -An IS dated 4/8/19 to 4/13/19 indicated the following: -"Introduction:" -"On the evening of 4/8/19, one staff was assisting individuals with preparing dinner and the other staff was assisting individuals with showers. At 7:15 PM, when it was [client #3's] turn to use the shower, staff noted that he (client #3) was not in his room. He was not located after search of the house and perimeter and the police were notified. Staff and police searched the area and the police found [client #3] at the intersection of [names of streets] which is about 1.2 miles from the house. He [client #3] returned to the house without incident. [Client #3] was without ResCare staff supervising for approximately two hours. A body check was conducted after [client #3] was brought to the house and he had no visible injuries." -"... Scope of Investigation:" -"1. How did [client #3] get out of the home?" -"2. Why did the door alarms not ring?" -"3. How long was [client #3's] elopement?" -"4. Did staff follow [client #3's] Behavior Support Plan?" -"5. Did staff follow ResCare policy and procedure...". -"... Summary of Interviews:.."			

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	-"[Staff #4]" -"I (staff #4) was helping finishing (sic) cleaning from dinner in the kitchen and other staff was helping other clients with showers." -"When it was [client #3's] turn to shower we could not find him." -"We looked around the house, then called the supervisor." -"The supervisor told us to call the police for help in looking for him (client #3)." -"The police found him up by the hospital and return home." -"[Staff #5]" -"I (staff #5) was giving showers and when it was [client #3's] turn I did not know where he (client #3) was." -"We looked around the house and outside the house and he (client #3) was nowhere." -"We called the supervisor, who told us to call the police and she was on her way to help look for him." -"[Client #3] was returned to the home by the police." -"[RM (Residential Manager #1)]" -"Staff called me about what was happening, and I told them to call the police." -"The police found him on [name of a heavily			

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	trafficked street] and brought him (client #3) home." -"The door alarms did not have batteries in them, I have put in a work order." -"[Client #3]" -"I (client #3) wanted to leave the house." -"I (client #3) don't want to be here, I'm not supposed to be here." -"I (client #3) can do things on my own, I don't need help like the others." -"I (client #3) just kept going as far away as I could." -"No, I (client #3) was not trying to go to the hospital." -"The police took me back to the house...". -"Factual Findings:" -"1. [Client #3] did leave the home without staff supervision." -"2. Staff could not find [client #3] and did not know where he had gone." -"3. Police were called." -"4. Door Alarm's (sic) not working." -A review of the IS dated 4/8/19 to 4/13/19 indicated client #3 eloped from the group home on 4/8/19 and was out of line of sight/supervision of staff for approximately 2 hours. The review			

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	indicated staff called the Police for assistance locating client #3. The review indicated the police located client #3 near a Hospital, approximately 1.2 miles from the group home. The review indicated client #3 used a wheelchair for all of his mobility needs and client #3 was in his wheelchair when he eloped from the facility. The review indicated the group home's door alarms were not turned on or functional when client #3 eloped on 4/8/19. The review did not indicate the facility's investigation made conclusions or recommendations in the IS dated 4/8/19 to 4/13/19 regarding client #3's elopement on 4/8/19. Client #3 was interviewed on 7/15/19 at 4:06 PM. Client #3 was asked if he had fallen recently. Client #3 stated, "Yeah, when I walk." Client #3 was asked how he was able to leave the group home on 4/8/19 without staff noticing. Client #3 stated, "I was making sure they weren't watching." Client #8 was interviewed on 7/15/19 at 4:14 PM. Client #8 was asked if he had seen client #3 fall at the group home. Client #8 stated, "Yeah in his room, everywhere." Client #8 was asked if staff monitored client #3. Client #8 stated "They try to." Client #2 was interviewed on 7/15/19 at 4:21 PM. Client #2 was asked if he had seen client #3 fall at the group home. Client #2 stated, "Yes, sometimes he will get out of his wheelchair and try to walk by himself. Sometimes he will make it to the door." Client #2 was asked if client #3 had left/eloped from the group home. Client #2 stated, "He'll (client #3) turn the knob and try to get out through the front door. Sometimes the woman in the pink dress tries to stop him, but [client #3] is really persistent."			

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RM (Residential Manager #1) was interviewed on 7/15/19 at 3:44 PM. RM #1 was asked what was client #3's level of supervision. RM #1 stated, "[Client #3] is 15 minute checks. We document that in the progress notes." RM #1 was asked if the facility had discussed one on one/1:1 supervision for client #3. RM #1 stated, "We've discussed it but he's not able to be a 1:1 at this time. I've requested it." RM #1 was asked if she believed client #3 should be on 1:1 supervision. RM #1 stated, "I do, if he doesn't he (client #3) will hurt himself or try to hurt himself."

Staff #1 was interviewed on 7/15/19 at 4:28 PM. Staff #1 was asked in client #3 was a fall risk. Staff #1 stated, "Yes, most definitely. He gets up, he'll take it off, the seat belt." Staff #1 was asked if she had seen client #3 elope on 4/8/19. Staff #1 stated, "I wasn't here when he eloped." Staff #1 was asked if client #3 tries to elope/vacate the group home. Staff #1 stated, "Most definitely." Staff #1 was asked what if client #3's required more staff supervision. Staff #1 stated, "He (client #3) should be 1:1 for real. He needs a 1:1 to me."

Staff #2 was interviewed on 7/15/19 at 4:39 PM. Staff #2 was asked why client #3 had repeated falls since his admission on 1/23/19. Staff #2 stated, "His disability, his body is like in a weakened state." He (client #3) still wants to do the things he used to be able to do. He'll fall forward, timber, like a tree." Staff #2 was asked what was client #3's level of supervision. Staff #2 stated, "He's line of sight, fifteen minute checks. He needs to I'll be honest with you a 1:1. Because of the endangerment to hisself." Staff #2 was asked if he was on the group home's van when client #3 fell on 2/13/19. Staff #2 stated, "Yes, he (client #3) just flipped over the seat. I just pulled

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over immediately to the side and put him back in his seat." Staff #1 was asked if he was the only staff on the van. "Staff #2 stated, "Yes." Staff #2 was asked if there were other clients on the van at that time. Staff #2 stated, "Yes, maybe 4, including him (client #3) maybe 5."

Staff #4 was interviewed on 7/15/19 at 5:38 PM. Staff #4 was asked if she had observed client #3 fall. Staff #4 stated, "Yes, he tries to walk by himself and he always refuses to use his wheelchair." Staff #4 was asked if she was working when client #3 eloped an 4/8/19. Staff #4 stated, "I think we were only 2 staff here. I was fixing dinner other staff was giving showers. I think the alarm battery was down," Staff #4 was asked to clarify the door alarm if the door alarm was working. Staff #4 stated, "No." Staff #4 was asked what was client #3's level of supervision. Staff #4 stated, "He's 15 minute checks but we watch him all the time." Staff #4 was asked if client #3 should be on 1:1 supervision. Staff #4 stated, "Yes, best thing to do."

Staff #5 was interviewed on 7/16/19 at 7:29 AM. Staff #5 indicated he worked the overnight shift. Staff #5 was asked how often he checked on client #3. Staff #5 stated, "I check on him every 15 minutes." Staff #5 was asked dif client #3 tried to get out of the bed without staff assistance. Staff #5 stated, "Yes, he tries to get out of the bed all the time." Staff #5 was asked if client #3 had a bed alarm on his bed. Staff #5 stated, "No, that would be helpful. And he's not supposed to be standing up, he's going to fall so he (client #3) needs to be a 1:1."

RM #1 was interviewed a second time on 7/19/19 at 10:27 AM. RM #1 was asked if she had requested 1:1 supervision for client #3. RM #1

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	stated, "Yes I have. We have a team meeting scheduled. We're going to discuss different plans for [client #3]. I'm sure we will discuss the 1:1." QIDP (Qualified Intellectual Disabilities Professional #1) was interviewed on 7/16/19 at 2:45 PM. QIDP #1 was asked if the client #3 was assessed to have safe pedestrian skills. QIDP #1 stated, "No, he (client #3) is to have supervision 24 hours a day." QIDPM (Qualified Intellectual Disabilities Professional Manager #1) was interviewed on 7/16/19 at 2:45 PM. QIDPM #1 was asked why client #3 had repeated falls at the group home. QIDPM #1 stated, "Typically due to non-cooperation with his wheelchair." QIDPM #1 was asked if client #3 had sustained injuries as a result of his repeated falls. QIDPM #1 stated, "Yes." QIDPM #1 was asked if client #3 eloped from the group home on 4/8/19 while in his wheelchair. QIDPM #1 stated, "Yes." QIDPM #1 was asked if the group home's door alarms were working at that time. QIDPM #1 stated, "No." QIDPM #1 indicated all allegations of abuse, neglect and mistreatment should be thoroughly investigated all witnesses or potential witnessed should be interviewed. 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 record review and interview for 11 of 36 allegations of abuse, neglect and mistreatment reviewed, the facility failed to implement effective corrective measures to prevent the repeated falls with injury to client #3.	W 0157	**CORRECTION:** *If the alleged violation is verified, appropriate corrective action must be taken.* Specifically, the following protective measures are	08/21/2019

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	Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed on 7/15/19 at 1:00 PM. 1. A BDDS report dated 1/30/19 indicated, "... On 1/29/19, while [client #3] was dressing himself after his evening shower, staff heard him (client #3) slip to the ground in the bathroom and went to check. Staff helped him (client #3) up and checked his body for injuries and noted a bruise, less than three inches in diameter on his right shoulder... [Client #3] had a history of falls prior to moving into his current home and a high risk plan is in place...". -A review of the BDDS report dated 1/30/19 indicated client #3 fell while dressing himself alone in the bathroom. The review indicated client #3 had a history of falls prior to moving into the group home. -An IS (Investigative Summary) dated 1/29/19 to 2/3/19 indicated the following, -"... Summary of Interviews:.." -"[Staff #2]" -"On the 29th (January), I worked 7:00 AM to 7:00 PM." -"[Client #3] fell right before I left for the day." -"[Client #3] was in the bathroom drying himself and dressing after his shower." -"He (client #3) would not let us help him."		in place: The facility has installed wheelchair and bed alarms for client #3 to alert staff when client #3 attempts to stand or transfer without assistance. Additionally, the facility has implemented a system of alarm function tests to be completed on all shifts for wheelchair, bed and door alarms. Nursing staff have arranged for reassessment of client #3 by licensed physical and occupational therapists, to assure client 3 has appropriate supports to prevent falls and optimize mobility. The governing body has increased staffing on all shifts to provide additional supervision and increase safety for all clients, across environments. **PREVENTION:** When incidents occur, The QIDP Manager will coordinate with the trained investigator and QIDP, through the investigation and corrective measure implementation process, providing follow-up as needed but no less than daily. Additionally, the Quality Assurance Manager and QIDP Manager will follow-up with administrative level program staff (Program Manager and Operations Manager).	

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	-"He (client #3) wanted his privacy and wanted to dress himself." -"I (staff #2) asked him (client #3) if he wanted help up, he said he wanted to do it himself." -"(Staff #2) let him try and then helped him (client #3) up." -"He (client #3) has a risk plan for falls but when he moved in, we were told he gets around on his own...". -"[Staff #3]:" -"... I (staff #3) was working on laundry when [client #3] fell." -"I (staff #3) think [staff #2] helped him (client #3)." -"He (client #3) won't let us help him in the bathroom." -"He (client #3) thinks he can do everything himself." -"He (client #3) needs help but he doesn't understand." -"When he (client #3) moved in last week, we didn't know he couldn't do things without help." -"The nursing home told us he walked but he (client #3) came with a wheelchair...". -"Conclusion:" -"1. It is substantiated that [client #3] fell in the		An Area Supervisor or Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training to assure behavior supports and protective measures are implemented as written. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger Assistant Nurse Manager) and the QIDP will conduct administrative monitoring during varied shifts/times, daily, to assure interaction with multiple staff, involved in a full range of active treatment scenarios. After 30 days, administrative observations will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Administrative Monitoring is defined as follows: · The role of the administrative monitor is not simply to observe & Report.	

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	bathroom." -"2. It is substantiated that staff followed [client #3's] Behavior Support Plan (BSP)." -"3. It is substantiated that staff followed Rescare policy and procedures." -"Recommendations" -"1. Continue to follow Behavior Support Plan." -A review of the IS dated 1/29/19 to 2/3/19 indicated client #3 had moved into the group home one week prior (1/23/19) to his fall on 1/29/19. The review indicated staff were told client #3 was independent with his mobility needs. 2. A BDDS report dated 2/14/19 indicated, "... On 2/13/19, while [client #3] and his housemates were being transported to ResCare Day Service, staff noted that [client #3] was not sitting properly in his wheelchair and staff pulled over to check [client #3], staff discovered that [client #3] had fallen out of his wheelchair, staff picked him up and assessed him for injury... [client #3] sustained a 2 cm (centimeter) bruise on the bridge of his nose... It should be noted that all tie-downs and the van shoulder/lap belt were functioning properly at the time of the incident... Additionally, the team will purchase a wheelchair seat belt for him to use in addition to the required tie-downs and shoulder lap/belt provided in the van...". -A review of the BDDS report dated 2/14/19 indicated client #3 fell out of his wheelchair while the group home's van was moving. The review did not indicate client #3 had a seatbelt on his wheelchair. The review did not indicate the number of staff on the group home's van at the		· When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in, and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed Administrative oversight will include: assuring behavior supports and protective measures are in place and implemented as written. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Direct Support Staff, Operations Team, Regional Director	

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	time of the incident. 3. A BDDS report dated 2/18/19 indicated, "... On 2/17/19, as [client #3] woke for the day, staff observed [client #3] to have a red scratch on the right eyelid measuring less than an inch in length... No bleeding occurred and the skin was not broken... An investigation into the origin of the injury is underway...". -An IS dated 2/17/19 to 2/22/19 indicated the following, -"... Summary of Interviews:.." -"[Staff #2]" -"I (staff #2) saw the scratch." -"I (staff #2) am not sure how he got it." -"He (client #3) is always getting up on his own." -"[Staff #4]" -"Yes, I was working when we discovered the scratch." -"I (staff #4) provided first (sic) and called the nurse." -"[Staff #5]" -"I (staff #5) worked that day." -"I (staff #5) discovered the scratch." " I (staff #5) called the nurse and provided first aid."			

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	-"[Client #3]" -"Yes, I (client #3) fell and got the scratch." -"I (client #3) think I fell getting out of bed to use the bathroom the other day." -" I (client #3) didn't ask staff for help." -"I am strong, look at my arms...". -"Conclusion:" -"1. The original origin of the scratch was [client #3] getting out of bed to use the bathroom without staff help." -"2. It is substantiated that staff followed [client #3] Behavior Support Plan (BSP)." -"3. It is substantiated that staff followed Rescare policy and procedures." -"Recommendations" -"1. Continue to follow Behavior Support Plan." -A review of the IS dated 2/17/19 to 2/22/19 indicated the facility substantiated client #3 had an unwitnessed fall while attempting to get out of his (client #3's) bed. The review did not indicate any corrective measures were initiated due to client #3's fall. 4. A BDDS report dated 2/27/19 indicated, "... On 2/26/19, [Client #3] was feeling tired and staff took him to his room, assisted him onto his bed and continued to assist his housemates with getting dinner ready. When staff went to check on [client #3] after 15 minutes, [client #3] was found on the			

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	floor where he had slid while attempting to get up from the bed. [Client #3] sustained a 2 cm scratch above his left eyelid... [Client #3] has a history of falls and a high-risk plan is in place...". -An IS dated 2/26/19 to 2/31/19 (sic) indicated the following, -"... Summary of Interviews:.." -"[Staff #5]" -"I (staff #5) worked that day." -"I (staff #5) went back after about 15 minutes and he (client #3) had tried to get up. And fell (sic)". -"I (staff #5) called the nurse and provided first aid." -"[Client #3]" -"I (client #3) knew it was close to dinner time, I was getting up to eat." -"I (client #3) wasn't feeling good earlier and went to lay down." -"I (client #3) thought eating something would make me feel better." -"I (client #3) did get a scratch when I fell...". -"Conclusion:" -"1. [Client #3] admitted that it (fall) more than likely happened when getting out of bed without staff assistance." -"2. It is substantiated that staff followed [client			

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	#3] Behavior Support Plan (BSP)." -"3. It is substantiated that staff followed Rescare policy and procedures." -"Recommendations" -"1. Continue to follow Behavior Support Plan." A review of the IS dated 2/26/19 to 2/31/19 (sic) indicated the facility substantiated client #3 sustained an unwitnessed fall while attempting to get out of his bed. The review did not indicate the facility initiated any corrective measures due to client #3's fall on 2/26/19. 5. A BDDS report dated 3/19/19 indicated, "... On 3/18/19, [Client #3] was sitting in his wheelchair and rolled himself out the front door, with staff following. Once outside, he (client #3) unbuckled his seatbelt and stood up and attempted to walk away. Staff approached him to assist and he (client #3) began hitting staff and fell to the ground, hitting the right side of his head. Staff observed swelling beside [client #3's] right eyebrow and called 911 (Emergency Services) and notified the supervisor and the nurse. EMS (Emergency Medical Services) transported [client #3] via ambulance to [name] Emergency Department for evaluation. ER personnel performed a head CT (Computerized Tomography) scan which produced negative results. The attending physician, noted no neurological symptoms, diagnosed [client #3] with Contusion of the Right Periorbital (swelling around eye area) Region and released him (client #3) to ResCare staff with no new orders and a recommendation to monitor [client #3] for concussion symptoms... The interdisciplinary team (IDT) will meet to develop strategies to address [client #3's]			

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	non-cooperation with his comprehensive high-risk plan for falls...". A review of the BDDS report dated 3/9/19 indicated client #3 fell and sustained an injury to his right eyebrow area. 6. A BDDS report dated 3/19/19 indicated, "... On 3/18/19, [Client #3] became agitated because he said he wanted to be taken home and he (client #3) attempted to walk off by getting up from his wheelchair and he (client #3) fell to the ground sustaining a laceration on his face. [Client #3] was taken to [Name] Emergency Room (ER) where the physician on duty diagnosed facial abrasion and recommended washing his face with warm water and applying bacitracin (antiseptic) cream...". -An IS dated 3/18/19 to 3/23/19 indicated the following, -"... Summary of Interviews:.." "[Staff #6]" -"I (staff #6) was trying to keep him calm, he wanted to go home." -"We weren't moving fast enough for [client #3], so he took his belt off and tried to walk away." -"He (client #3) is forever walking away from his wheelchair." -"I (staff #6) always try to stay right by him (client #3)." -"I (staff #6) did not see him hit his head on the floor...".			

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	-"[Client #3]" -"I (client #3) just wanted to get home." -"I (client #3) can do things fine on my own." -"Staff does not need to help me, I can show you." -"I (client #3) did not hit my head." -"[Staff #7]" -"I (staff #7) was there when he (client #3) fell." -"I (staff #7) did not see him hit his head." -"He (client #3) was wanting to go home." -"[Client #3] got up fast then fell to the ground on his own...". -"Conclusion:" -"1. [Client #3] got out of his wheelchair by taking off his seat belt." -"2. [Client #3] did not hit his head when he fell." -"3. It is substantiated that staff followed [client #3] Behavior Support Plan (BSP)." -"4. It is substantiated that staff followed Rescare policy and procedures." -"Recommendations" -"1. Continue to follow Behavior Support Plan." -A review of the IS dated 3/18/19 to 3/23/19			

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indicated the facility substantiated client #3 took off his seat belt and fell out of his wheelchair. The review did not indicate the facility initiated any corrective measures due to client #3's fall on 2/26/19.

7. A BDDS report dated 3/25/19 indicated, "... On 3/24/19, [Client #3] became agitated because he was verbally redirected out of his housemate's bedroom. [Client #3] became upset and flipped himself out of his wheelchair and hit his head. Staff notified the supervisor and nurse and transported [client #3] (sic) [name] Emergency Department for evaluation. Where the physician on duty diagnosed [client #3] with Fall, initial encounter and released him (client #3) to ResCare staff with no new orders and a recommendation to apply ice to the affected areas and monitor [client #3] for concussion symptoms... The interdisciplinary team (IDT) will meet to develop strategies to address [client #3's] non-cooperation with his comprehensive high-risk plan for falls...".

-An IS (Investigative Summary) dated 1/29/19 to 2/3/19 indicated the following,

-"... Summary of Interviews:.."

-"[Staff #2]"

-"[Client #3] was in [client #8's] bedroom, I (staff #2) told him to come out of [client #8's] room. When he (client #3) came out of the room he tried (sic) stand up and get out of the wheelchair. I (staff #2) re-directed him, and he (client #3) sat back down. As soon as I (staff #2) turned he (client #3) stood back up out of the wheelchair and tripped over his foot and fell face forward."

-"I (staff #2) called the nurse and took him (client

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	#3) to the Emergency Room (ER)...". -"[Client #3]" -"I (client #3) don't remember why I was in his (client #8's) room." -"I (client #3) wasn't trying to take anything, so I don't know why I had to get out of the room." -"I (client #3) just remember trying to stand up and my foot got caught and I fell." -"Yes, I (client #3) remember going to the ER." -"[Staff #7]" -"I (staff #7) was working with [staff #2] when [client #3] fell, he got upset because he (client #3) was in another housemate's bedroom and [staff #2] had him to come out, that is when he (client #3) threw himself out of his wheelchair." -"The nurse was called." -"[Staff #2] took him (client #3) to Emergency room." -"Conclusion:" -"1. [Client #3] did not remember the reason he was in his housemate's room." -"2. DSP (Direct Support Professional) [staff #2] asked [client #3] to come out of his housemate's room." -"3. [Client #3] reports, while trying to stand up my (client #3's) foot got caught on something an (sic) I (client #3) fell, Staff reports than [client #3]			

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	tried standing on his on (sic) and fell face forward." -"4. Staff did follow [client #3] Behavior Support Plan (BSP)." -"5. Staff did follow Rescare policy and procedures." -"Recommendations" -"1. Continue to follow Behavior Support Plan." -A review of the IS dated 3/24/19 to 3/29/19 did not indicate the facility made recommendations for corrective measures due to client #3's repeated falls with injury. 8. A BDDS report dated 4/6/19 indicated, "... On 4/6/19, [Client #3] was in his room changing his clothes with staff assistance. While staff went to the living room to retrieve his shoes, [client #3] attempted to stand and fell to the floor. Staff assisted him (client #3) back into his wheelchair, assessed him for injuries and notified the supervisor and the nurse. [Client #3] sustained a 1.5 circular red bruise on his left shoulder blade and a half-inch circular bruise on his (client #3's) mid-lower back. Staff provided him (client #3) with emotional support and reminded him (client #3) to wait for assistance with standing and transferring. [Client #3] has a history of falls with a high-risk plan in place...". -A review of the BDDS report dated 4/6/19 indicated client #3 sustained an injury due to an unwitnessed fall on 4/6/19. The review did not indicate the facility made recommendations for corrective measures due to client #3's repeated falls with injury. The review did not indicate the			

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	facility initiated corrective measures due to repeated falls with injury. 9. A BDDS report dated 5/10/19 indicated, "... On 5/9/19, while sitting in his wheelchair, [client #3] removed his seat belt and then leaned forward and he (client #3) fell face forward sustaining a 1.5 inch laceration. [Client #3] was taken to the [Name] Emergency department per nurse directive. The physician on duty ordered a CT head without IV (intravenous) contrast which produced unremarkable results and diagnosed [client #3] with Facial Laceration, initial Encounter and fall, Initial Encounter (sic). The physician closed the laceration with one suture and administered the following medication to [client #3]: Lidocaine-Epinephrine (to numb part of body)... and Tetanus-diphtheria-pertussis (Vaccination)... The interdisciplinary team will meet to develop strategies to address [client #3's] non-cooperation with his comprehensive high-risk plan for falls. [Client #3] will return to the ER in 5 days to have the suture removed...". -A review of the BDDS report dated 5/10/19 indicated client #3 sustained an injury due to a fall on 5/9/19. The review indicated client #3 fell after he unfastened the seatbelt on his wheelchair. The review did not indicate client #3's level of supervision at the time of his fall on 5/9/19. The review did not indicate the facility made recommendations for corrective measures due to client #3's repeated falls with injury. 10. A BDDS report dated 6/2/19 indicated, "... On the morning of 6/1/19, staff heard a noise and entered [client #3's] bedroom and observed him lying on the ground. Staff performed a physical assessment and assisted him into his wheelchair. Staff noted that he sustained a one-centimeter			

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	laceration on the upper right side of his scalp. Staff notified the supervisor and nurse and took him (client #3) to [Name] MedCheck [location] for evaluation per nurse instructions. The clinical physician evaluated [client #3] and diagnosed him with Laceration of Scalp and Head Injury... The quality assurance team has initiated an investigation into the circumstances of the incident and the administrative team was informed." -A review of the BDDS report dated 6/2/19 indicated staff found client #3 laying on the floor in his bedroom. The review indicated client #3 had sustained a 1 inch laceration to the right side of his scalp/head. The review did not indicate the facility made recommendations for corrective measures due to client #3's repeated falls with injury. 11. A BDDS report dated 7/7/19 indicated, "... On 7/6/19, staff reported that [client #3] was attempted (sic) to stand up from his wheelchair he lost balance and fell towards the floor before staff was able to assist him (client #3) back into his wheelchair. Once staff was able to sit [client #3] on his wheelchair, staff completed a full body scan to check for any injuries. Staff located a bruise that appeared on top of a previous scratch; staff applied Bacitracin to the wounded area... [Client #3] has experienced an emerging pattern of falls and a high-risk plan is in place...". -A review of the BDDS report dated 7/7/19 indicated client #3 fell as he attempted to stand up from his wheelchair. The review did not indicate what corrective measures the facility took due to client #3's repeated falls with injury. Client #3 was interviewed on 7/15/19 at 4:06 PM.			

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	Client #3 was asked if he had fallen recently. Client #3 stated, "Yeah, when I walk." Client #8 was interviewed on 7/15/19 at 4:14 PM. Client #8 was asked if he had seen client #3 fall at the group home. Client #8 stated, "Yeah in his room, everywhere." Client #8 was asked if staff monitored client #3. Client #8 stated "They try to." Client #2 was interviewed on 7/15/19 at 4:21 PM. Client #2 was asked if he had seen client #3 fall at the group home. Client #2 stated, "Yes, sometimes he will get out of his wheelchair and try to walk by himself. Sometimes he will make it to the door." RM (Residential Manager #1) was interviewed on 7/15/19 at 3:44 PM. RM #1 was asked what was client #3's level of supervision. RM #1 stated, "[Client #3] is 15 minute checks. We document that in the progress notes." RM #1 was asked if the facility had discussed one on one/1:1 supervision for client #3. RM #1 stated, "We've discussed it but he's not able to be a 1:1 at this time. I've requested it." RM #1 was asked if she believed client #3 should be on 1:1 supervision. RM #1 stated, "I do, if he doesn't he (client #3) will hurt himself or try to hurt himself." Staff #1 was interviewed on 7/15/19 at 4:28 PM. Staff #1 was asked in client #3 was a fall risk. Staff #1 stated, "Yes, most definitely. He gets up, he'll take it off, the seat belt." Staff #1 was asked what if client #3's required more staff supervision. Staff #1 stated, "He (client #3) should be 1:1 for real. He needs a 1:1 to me." Staff #2 was interviewed on 7/15/19 at 4:39 PM. Staff #2 was asked why client #3 had repeated falls since his admission on 1/23/19. Staff #2			

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	stated, "His disability, his body is like in a weakened state." He (client #3) still wants to do the things he used to be able tod do. He'll fall forward, timber, like a tree." Staff #2 was asked what was client #3's level of supervision. Staff #2 stated, "He's line of sight, fifteen minute checks. He needs to I'll be honest with you a 1:1. Because of the endangerment to hisself." Staff #2 was asked if he was on the group home's van when client #3 fell on 2/13/19. Staff #2 stated, "Yes, he (client #3) just flipped over the seat. I just pulled over immediately to the side and put him back in his seat." Staff #1 was asked if he was the only staff on the van. "Staff #2 stated, "Yes." Staff #2 was asked if there were other clients on the van at that time. Staff #2 stated, "Yes, maybe 4, including him (client #3) maybe 5." Staff #4 was interviewed on 7/15/19 at 5:38 PM. Staff #4 was asked if she had observed client #3 fall. Staff #4 stated, "Yes, he tries to walk by himself and he always refuses to use his wheelchair." Staff #5 was interviewed on 7/16/19 at 7:29 AM. Staff #5 indicated he worked the overnight shift. Staff #5 was asked how often he checked on client #3. Staff #5 stated, "I check on him every 15 minutes." Staff #5 was asked if client #3 tried to get out of the bed without staff assistance. Staff #5 stated, "Yes, he tries to get out of the bed all the time." Staff #5 was asked if client #3 had a bed alarm on his bed. Staff #5 stated, "No, that would be helpful. And he's not supposed to be standing up, he's going to fall so he (client #3) needs to be a 1:1." RM #1 was interviewed a second time on 7/19/19 at 10:27 AM. RM #1 was asked if she had requested 1:1 supervision for client #3. RM #1			

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	15G486	A. BUILDING 00 B. WING	07/22/2019

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	stated, "Yes I have. We have a team meeting scheduled. We're going to discuss different plans for [client #3]. I'm sure we will discuss the 1:1." QIDPM (Qualified Intellectual Disabilities Professional Manager #1) was interviewed on 7/16/19 at 2:45 PM. QIDPM #1 was asked why client #3 had repeated falls at the group home. QIDPM #1 stated, "Typically due to non-cooperation with his wheelchair." QIDPM #1 was asked if client #3 had sustained injuries as a result of his repeated falls. QIDPM #1 stated, "Yes." QIDPM #1 indicated the facility's investigations/recommendations should develop effective corrective measures to prevent the repeated falls of client #3. 9-3-2(a)			
W 0336 Bldg. 00	483.460(c)(3)(iii) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. Based on record review and interview for 2 of 3 sampled clients (#1 and #3), the facility's nursing services failed to ensure clients #1 and #3's health status was reviewed by the nurse on a quarterly basis. Findings include: Client #1's record was reviewed on 7/16/19 at 11:26 AM. Client #1's record did not indicate client #1's health status had been reviewed for the first quarter (January, February, March) of 2019. Client #3's record was reviewed on 7/16/19 at 12:49	W 0336	**CORRECTION:** *Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need.* Specifically, new nurse has been hired for the facility and she will be trained on expectations for quarterly nursing physicals. Nursing physicals will be completed for all clients for the current quarter.	08/21/2019

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	PM. Client #3's record did not indicate client #3's health status had been reviewed for the first quarter (January, February, March) of 2019. Nurse #1 was interviewed on 7/16/19 at 2:45 PM. Nurse #1 indicated the facility did not have documentation the facility's nursing services reviewed client #1 and #3's health status for the first quarter of 2019. 9-3-6(a)		**PREVENTION:** · The Facility nurse will complete monthly audits of all charts and turn in the audits to the Nurse Manager for review. · The Nurse Manager will review issues revealed in audits with the Executive Director and Department heads weekly for follow-up. · The Executive Director and will follow-up with the Nurse Manager as needed to address issues raised through audits, incident reports or other concerns brought to management attention. Members of the Operations Team (comprised of the Executive Director, Operations Directors, Program Managers, Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manager and Assistant Nurse Manager) and nursing staff will incorporate medical chart reviews into their formal audit process, which will occur no less than monthly to assure that medical follow-along including but not limited to quarterly nursing physical examinations take place as required. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Site Supervisor, Direct Support Staff, Health	

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W 0369 Bldg. 00	483.460(k)(2) DRUG ADMINISTRATION The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error. Based on observation, record review and interview for 1 of 3 sampled clients (#2), the facility failed to ensure client #2 received his prescription medications as ordered by a physician. Findings include: Observations were conducted at the group home on 7/15/19 from 3:38 PM through 6:15 PM and on 7/16/19 from 6:10 AM through 8:00 AM. Client #2 was observed throughout the observation period. On 7/15/19 at 5:01 PM staff #1 administered client #2's evening medications. At 5:02 PM staff #1 administered one 15 mg (Milligram) Buspirone (Anxiety) to client #2. Client #2 took his medication and left the medication room. At 5:04 PM the surveyor reviewed client #2's medication card/bubble pack which indicated, "Buspirone Tab 15 MG Give (2) Tablets (30) MG by Mouth Twice Daily...". The surveyor read client #2's physician order out loud and staff #1 stated, "My fault, he (client #2) needs to get another pill." Staff #2 proceeded to pop one additional 15 MG tablet of Buspirone and called client #2 to come back to the medication room. At 5:06 PM client #2 was yelling and slapping the arm rest of the couch and refused to come back to the medication room. Staff #1 and RM (Residential Manager #1) redirected client #2 and at 5:10 PM, staff #1 administered the 2nd 15 MG tablet of Buspirone to client #2.	W 0369	Services Team, Operations Team **CORRECTION:** *The system for drug administration must assure that all drugs, including those that are self-administered, are administered without error.* Specifically, all facility staff will be retrained toward implementation of the agency's medication administration procedures. Although this deficient practice did not affect additional clients, supervisors and/or nursing staff will review agency medication and treatment administration protocols with all staff. **PREVENTION:** The Residential Manager will be present, supervising active treatment during no less than five active treatment sessions per week, on varied shifts to assist with and monitor skills training including but not limited to including but not limited to assuring medications are administered without error. For the next 30 days, members of the Operations Team (comprised of the Executive Director, Operations Managers, Program Managers,	08/21/2019

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	Client #2's record was reviewed on 7/16/19 at 2:10 PM. Client #2's (PO's) Physician's Orders dated 7/1/19 to 7/31/19 indicated, "Buspirone Tab 15 MG Give (2) Tablets (30) MG by Mouth Twice Daily 6 AM, 5 PM...". Nurse #1 was interviewed on 7/16/19 at 2:45 PM. Nurse #1 was asked if staff should have administered client #2 30 MG of Buspirone on 7/15/19 at 5 PM. Nurse #1 stated, "Yes." Nurse #1 indicated staff #1 did not follow the facility's medication administration procedure correctly. 9-3-6(a)		Quality Assurance Manager, QIDP Manager, Quality Assurance Coordinators, Nurse Manger Assistant Nurse Manager) and the QIDP will conduct administrative monitoring during varied shifts/times, daily, to assure interaction with multiple staff, involved in a full range of active treatment scenarios. After 30 days, administrative observations will occur no less than three times weekly until all staff demonstrate competence. After this period of enhanced administrative monitoring and support, the Executive Director and Regional Director will determine the level of ongoing support needed at the facility. Operations Team members have been trained on monitoring expectations. Specifically, Administrative Monitoring is defined as follows: · The role of the administrative monitor is not simply to observe & Report. · When opportunities for training are observed, the monitor must step in and provide the training and document it. · If gaps in active treatment are observed the monitor is expected to step in and model the appropriate provision of supports. · Assuring the health and safety of individuals receiving supports at the time of the	

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			observation is the top priority. · Review all relevant documentation, providing documented coaching and training as needed. Administrative support at the home will include assuring staff provide continuous active treatment during formal and informal opportunities, including but not limited to assuring medications are administered without error. **RESPONSIBLE PARTIES:** QIDP, Area Supervisor, Residential Manager, Heath Services Team, Direct Support Staff, Operations Team, Regional Director	