STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G723	A. BUILDING 00 B. WING	12/05/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00210610 which resulted in an Immediate Jeopardy. Complaint #IN00210610: Substantiated, federal and state deficiencies related to the allegations are cited at W102, W104, W122, W149, W154, W157, W186, W240 and W249. This visit was in conjunction with the post certification revisit to the recertification and state licensure survey. Dates of Survey: 11/21/16, 11/22/16, 11/23/16, 11/28/16, 11/29/16, 11/30/16, 12/1/16, 12/2/16 and 12/5/16. Facility Number: 004615 Provider Number: 15G723 AIMS Number: 200528230 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 12/6/16.	W 0000		

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

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W 0102 Bldg. 00	483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met. Based on observation, record review and interview for 2 of 2 sampled clients (A and B), the governing body failed to meet the Condition of Participation: Governing Body. The governing body neglected to implement its written policy and procedures to prevent abuse in regard to the targeted aggression of client A from client B. The governing body neglected to prevent multiple injuries requiring outside medical treatment to client A from client B. The governing body neglected to ensure client A's safety. The governing body neglected to ensure staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The governing body neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A from a pattern of client to client abuse.	W 0102	**W102:** The facility must ensure that specific governing body and management requirements are met. **Corrective Action: (Specific):** The one to one for clients A and B remain in place. Staffing ratios are monitored every shift to ensure that staffing ratios are consistent with scheduled hours for the home. Client A will be moving on or before 12/25/2016. Administrative Observations have been implemented in the home for at least 16 hours per day until Client A moves to an alternate location agreed on by the team and guardian. **How others will be identified: (Systemic):** The Behavior Clinician and the QIDP will complete observations in the home at least 10 hours per week	01/04/2017

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	The governing body failed to meet the Condition of Participation: Client Protections for 2 of 2 sampled clients (A and B). Findings include: 1. The governing body failed to meet the Condition of Participation: Client Protections for clients A and B. The governing body neglected to implement its written policy and procedures to prevent abuse in regard to the targeted aggression of client A from client B. The governing body neglected to prevent multiple injuries requiring outside medical treatment to client A from client B. The governing body neglected to ensure client A's safety. The governing body neglected to ensure staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The governing body neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A from a pattern of client to client abuse. Please see W122. 2. The governing body neglected to exercise operating direction over the facility to implement its written policy and procedures to prevent abuse in regard to the targeted aggression of client A		to provide monitoring, oversight and coordination of all client program plans. Administrative Observations will continue in the home for at least 16 hours a day until Client A moves to an alternate location agreed on by the team and guardian. After Client A moves to an alternate location administrative observations will continue in the home at least 8 hours per day at least 5 days per week for the next 30 days to ensure staff are implementing client program plans as written. **Measures to be put in place:** The one to one for clients A and B remain in place. Staffing ratios are monitored every shift to ensure that staffing ratios are consistent with scheduled hours for the home. Client A will be moving on or before 12/25/2016. Administrative Observations have been implemented in the home for at least 16 hours per day until Client A moves to an alternate location agreed on by the team and guardian. **Monitoring of Corrective Action:** The Behavior Clinician and the QIDP will complete observations in the home at least 10 hours per week to provide monitoring, oversight and	

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	from client B. The governing body neglected to prevent multiple injuries requiring outside medical treatment to client A from client B. The governing body neglected to ensure client A's safety. The governing body neglected to ensure staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The governing body neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A from a pattern of client to client abuse. Please see W104. This federal tag relates to complaint #IN00210610. 9-3-1(a)		coordination of all client program plans. Administrative Observations will continue in the home for at least 16 hours a day until Client A moves to an alternate location agreed on by the team and guardian. After Client A moves to an alternate location administrative observations will continue in the home at least 8 hours per day at least 5 days per week for the next 30 days to ensure staff are implementing client program plans as written. **Completion date: 1/4/17**	
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	W 0104	**W104:** The governing body must exercise general policy, budget	01/04/2017

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	interview for 2 of 2 sampled clients (A and B), the governing body neglected to exercise operating direction over the facility to implement its written policy and procedures to prevent abuse in regard to the targeted aggression of client A from client B. The governing body neglected to prevent multiple injuries requiring outside treatment to client A from client B. The governing body neglected to ensure client A's safety from client B. The governing body neglected to ensure facility staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The governing body neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A from a pattern of client to client abuse. The governing body failed to ensure allegations of client to client abuse/mistreatment regarding clients A and B were thoroughly investigated and had corrective actions or recommendations. The governing body failed to develop and implement corrective measures to prevent recurrence of abuse/aggression to client A from client B. Findings include: 1. The governing body neglected to		and operating direction over the facility. **Corrective Action: (Specific):** The one to one for clients A and B remain in place. Staffing ratios are monitored every shift to ensure that staffing ratios are consistent with scheduled hours for the home. Client A will be moving on or before 12/25/2016. Administrative Observations have been implemented in the home for at least 16 hours per day until Client A moves to an alternate location agreed on by the team and guardian. **How others will be identified: (Systemic):** The Behavior Clinician and the QIDP will complete observations in the home at least 10 hours per week to provide monitoring, oversight and coordination of all client program plans. Administrative Observations will continue in the home for at least 16 hours a day until Client A moves to an alternate location agreed on by the team and guardian. After Client A moves to an alternate location administrative observations will continue in the home at least 8 hours per day for at least 5 days per week for the next 30 days to ensure staff are implementing client program	

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	implement its written policy and procedures to prevent abuse in regard to the targeted aggression of client A from client B. The governing body neglected to prevent multiple injuries requiring outside treatment to client A from client B. The governing body neglected to ensure client A's safety from client B. The governing body neglected to ensure staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The governing body neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A from a pattern of client to client abuse. Please see W149. 2. The governing body failed to exercise operating direction over the facility to ensure allegations of client to client abuse/mistreatment regarding clients A and B were thoroughly investigated and had corrective actions or recommendations. Please see W154. 3. The governing body failed to exercise operating direction over the facility to develop and implement corrective measures to prevent recurrence of abuse/aggression to client A from client B. Please see W157. 4. The governing body failed to exercise		plans as written. **Measures to be put in place:** The one to one for clients A and B remain in place. Staffing ratios are monitored every shift to ensure that staffing ratios are consistent with scheduled hours for the home. Client A will be moving on or before 12/25/2016. Administrative Observations have been implemented in the home for at least 16 hours per day until Client A moves to an alternate location agreed on by the team and guardian. **Monitoring of Corrective Action:** The Behavior Clinician and the QIDP will complete observations in the home at least 10 hours per week to provide monitoring, oversight and coordination of all client program plans. Administrative Observations will continue in the home for at least 16 hours a day until Client A moves to an alternate location agreed on by the team and guardian. After Client A moves to an alternate location administrative observations will continue in the home at least 8 hours per day at least days per week for the next 30 days to ensure staff are implementing client program plans as written.	

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	operating direction over the facility to provide sufficient staffing and/or deploy staff in a way to implement plans for clients A and B during the day and evening shifts. Please see W186. This federal tag relates to complaint #IN00210610. 9-3-1(a)		**Completion date: 1/4/2017**	
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 2 sampled clients (A and B). The facility neglected to implement its written policy and procedures to prevent abuse in regard to the targeted aggression	W 0122	**W122:** The facility must ensure that specific client protections requirements are met. **Corrective Action: (Specific):** The one to one for clients A and B remain in place. Staffing ratios	01/04/2017

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	of client A from client B. The facility neglected to prevent multiple injuries requiring outside medical treatment to client A from client B. The facility neglected to ensure client A's safety. The facility neglected to ensure staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The facility neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A from a pattern of client to client abuse. This noncompliance resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 11/23/16 at 4:42 PM. The Executive Director and Program Manager were notified of the Immediate Jeopardy on 11/28/16 at 1:06 PM. The Immediate Jeopardy began on 11/13/16 when the facility failed to prevent targeted aggression of client A from client B. The facility also failed to implement written policy and procedures to prevent the neglect of client A in regard to not addressing the pattern of aggression and the facility's failure to provide sufficient staffing. The facility failed to follow/implement Behavior Support Plans (BSP) to protect client A. The Immediate Jeopardy was not removed.		are monitored every shift to ensure that staffing ratios are consistent with scheduled hours for the home. Client A will be moving on or before 12/25/2016. Administrative Observations have been implemented in the home for at least 16 hours per day until Client A moves to an alternate location agreed on by the team and guardian. All staff working at the home has been trained on Client B's BSP. **How others will be identified: (Systemic):** The Behavior Clinician and the QIDP will complete observations in the home at least 10 hours per week to provide monitoring, oversight and coordination of all client program plans. Administrative Observations will continue in the home for at least 16 hours a day until Client A moves to an alternate location agreed on by the team and guardian. After Client A moves to an alternate location administrative observations will continue in the home at least 8 hours per day at least 5 days per week for the next 30 days to ensure staff are implementing client program plans as written. **Measures to be put in place:** The one to one for clients A and	

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	The facility submitted a Plan of Correction (POC) for the removal of the Immediate Jeopardy (IJ) on 11/29/16 at 5:55 PM. The facility's POC for removal indicated the following: "1. All staff at the home have been re-trained on Client A's behavior support plan and the one to one (staffing). 2. Client B's behavior support plan has been updated to include a one to one defined as within arms length during waking hours, staff positioned between client B and client A when in common areas of the home, staff positioned between client B and client A while on the van and 15 minute checks during sleeping hours. 3. All staff at the home has been retrained on client B's updated behavior support plan. 4. Experienced staff have been assigned to the home to assist with additional staff training and implementation of plans to ensure client B's safety. 5. Staffing ratios will be monitored on every shift by the Area Supervisor and the Program Manager to ensure the ratios are consistent with scheduled hours for the home. 6. All staff at the home will be re-trained on the Operation Standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment and		B remain in place. Staffing ratios are monitored every shift to ensure that staffing ratios are consistent with scheduled hours for the home. Client A will be moving on or before 12/25/2016. Administrative Observations have been implemented in the home for at least 16 hours per day until Client A moves to an alternate location agreed on by the team and guardian. All staff working at the home has been trained on Client B's BSP. **Monitoring of Corrective Action:** The Behavior Clinician and the QIDP will complete observations in the home at least 10 hours per week to provide monitoring, oversight and coordination of all client program plans. Administrative Observations will continue in the home for at least 16 hours a day until Client A moves to an alternate location agreed on by the team and guardian. After Client A moves to an alternate location administrative observations will continue in the home at least 8 hours per day at least 5 days per week for the next 30 days to ensure staff are implementing client program plans as written.	

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	violation of individual rights. 7. Administrative observations will be implemented in the home twice daily for the next 7 days to ensure staff are implementing the one to one staffing as written for client A and client B and that staffing ratios in the home are consistent with scheduled hours, then at least daily for the next 14 days, then at least three times weekly for the next 30 days. Administrative observations will be documented on the observation form and turned in to the Program Manager. 8. The Behavior Clinician will be in the home at least 10 hours per week to ensure the one to one staffing is being implemented as written for clients A and B. 9. The QIDP (Qualified Intellectual Disabilities Professional) will be in the home at least 10 hours per week to ensure the one to one staffing is being implemented as written for clients A and B. 10. All administrative staff completing observations will be trained on all clients' plans and will have a copy of them during observation periods. 11. Immediate re-training will take place if administrative staff deem necessary and will turn in completed re-training documentation to the Program Manager. Based on observation, interview and		**Completion date: 1/4/2017**	

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	record review, it was determined the plan of action had not removed the Immediate Jeopardy and the Immediate Jeopardy continued because the facility failed to ensure staff working with client B provided one to one staffing as defined within arms length during waking hours. The facility failed to ensure all staff working with client B were trained on client B's BSP. Observations were conducted at the group home on 12/5/16 from 7:30 AM through 8:30 AM. Client A was sleeping throughout the observation period. At 7:45 AM House Manager (HM) #1 indicated client A had 15 minute checks while he was sleeping. HM #1 indicated staff #6 was client A's 1:1. HM #1 indicated client B had gone to bed and staff #6 was positioned in the hallway between client A and B's rooms watching both clients. HM #1 was in the home's office. At 8:00 AM client B was observed walking through the living room eating a pop tart with no staff around him and entered the kitchen. Staff #6 did not get up and follow client B; staff #6 remained seated in the hallway. At 8:01 AM HM #1 indicated client B should be within arms length of staff during waking hours. At 8:02 AM the site supervisor indicated client B's plan was not being implemented. Program Manager (PM) #1			

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	arrived in the home at 8:12 AM for administrative staff observations at 8:12 AM. Inservice records were reviewed for staff on 11/30/16 at 10:55 AM. All of the home's current staff were retrained on client B's BSP. Staff #6 was not trained on client B's BSP. HM #1 was interviewed on 12/5/16 at 8:01 AM. HM #1 indicated staff #6 was new and had been with the facility about 2 weeks. Behavioral Consultant (BC) #1 was interviewed on 11/28/16 at 10:20 AM. BC #1 indicated staff had been retrained on more than one occasion. BC #1 had provided all staff training on BSPs on 11/28/16 and 11/30/16. Program Manager (PM) #1 was interviewed on 11/30/16 at 12:34 PM. PM #1 indicated all staff in the home have been trained on client A and B's BSPs. The Immediate Jeopardy was not removed. Findings include: 1. The facility neglected to implement its			

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	written policy and procedures to prevent abuse in regard to the targeted aggression of client A from client B. The facility neglected to prevent multiple injuries requiring outside treatment to client A from client B. The facility neglected to ensure client A's safety from client B. The facility neglected to ensure facility staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The facility neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A from a pattern of client to client abuse. 2. The facility failed to ensure allegations of client to client abuse/mistreatment regarding clients A and B were thoroughly investigated and had corrective actions or recommendations. Please see W154. 3. The facility failed to develop and implement corrective measures to prevent recurrence of abuse/aggression to client A from client B. Please see W157. This federal tag relates to complaint #IN00210610. 9-3-2(a)			

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W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on observation, record review and interview for 2 of 2 sampled clients (A and B), the facility neglected to implement its written policy and procedures to prevent abuse in regard to the targeted aggression of client A from client B. The facility neglected to prevent multiple injuries requiring outside treatment to client A from client B. The facility neglected to ensure client A's safety from client B. The facility neglected to ensure facility staff followed/implemented Behavior Support Plans (BSP) to prevent the abuse and/or potential abuse of client A. The facility neglected to ensure sufficient staffing was available and/or deployed in a way to implement BSPs to protect client A from	W 0149	**W149:** That facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. **Corrective Action: (Specific):** The one to one for clients A and B remain in place. Staffing ratios are monitored every shift to ensure that staffing ratios are consistent with scheduled hours for the home. Client A will be moving on or before 12/25/2016. Administrative Observations have been implemented in the home for at least 16 hours per day until Client A moves to an alternate location agreed on by the team and guardian. All staff working at	01/04/2017

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	15G723	A. BUILDING 00 B. WING	12/05/2016

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	a pattern of client to client abuse. Findings include: Observations were conducted at the group home on 11/21/16 from 4:00 PM through 5:45 PM. Clients A and B were observed in the home throughout the observation period. Client A was mostly non-verbal and small in stature. Client B was verbal and had a large frame/build. At 4:27 PM client A was observed in his bedroom on his bed. Client A was sitting up with a cover over him shaking and crying. Client A had mucus running from his nose to his mouth. Client A's right eye was swollen, black and purple. At 4:30 PM Qualified Intellectual Disabilities Professional (QIDP) #1 indicated client A had a black eye from client B hitting him in the kitchen last week. QIDP #1 stated, "[Client A] will sometimes cry as a behavior." QIDP #1 indicated client A had gotten in trouble earlier for taking pudding out of the office. At 5:07 PM client D was interviewed. Client D indicated he had seen client B and client A fighting. Client D stated,"[Client B] has sat on me, last night he gave [client C] like 5 wedgies. Staff watch but they don't do anything." Client D indicated he was worried about client B being mean. At 5:35 PM client D stated, "One time there was only 2 staff here, and one of		the home has been trained on Client B's BSP and will be re-trained on the Operation Standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual's rights. **How others will be identified: (Systemic):** The Behavior Clinician and the QIDP will complete observations in the home at least 10 hours per week to provide monitoring, oversight and coordination of all client program plans. Administrative Observations will continue in the home for at least 16 hours a day until Client A moves to an alternate location agreed on by the team and guardian. After Client A moves to an alternate location administrative observations will continue in the home at least 8 hours per day at least 5 days per week for the next 30 days to ensure staff are implementing client program plans as written. **Measures to be put in place:** The one to one for clients A and B remain in place. Staffing ratios are monitored every shift to ensure that staffing ratios are consistent with scheduled hours for the home. Client A will be moving on or before 12/25/2016.	

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	them left to go to the store. [Client B] attacked [client A] and I had to help staff so they didn't get hurt." Observations were conducted on 11/22/16 from 7:00 AM through 8:15 AM. Clients A and B were observed in the home throughout the observation period. At 7:00 AM clients A and B were sitting beside each other at the kitchen table eating breakfast. Client A did not look at client B while eating his breakfast. There were no staff between clients A and B; one staff was in the kitchen at the counter. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations were reviewed on 11/21/16 at 2:15 PM. The review indicated the following: 1. On 9/6/16, the BDDS report indicated, "[Client A] was in his room getting up when staff saw [client B] in [client A's] room, and then observed [client B] hit [client A] in the lip. Staff asked [client B] why he hit [client A] and he first stated there was no reason why he hit him. [Client B] later stated it was because [client A] had bit (sic) him, no bite marks were noted. [Client B] was redirected to his room where he displayed property destruction. Staff called police and EMS		Administrative Observations have been implemented in the home for at least 16 hours per day until Client A moves to an alternate location agreed on by the team and guardian. All staff working at the home has been trained on Client B's BSP and will be re-trained on the Operation Standard for reporting and investigating allegations of abuse neglect exploitation mistreatment or violation of individual's rights. **Monitoring of Corrective Action:** The Behavior Clinician and the QIDP will complete observations in the home at least 10 hours per week to provide monitoring, oversight and coordination of all client program plans. Administrative Observations will continue in the home for at least 16 hours a day until Client A moves to an alternate location agreed on by the team and guardian. After Client A moves to an alternate location administrative observations will continue in the home at least 8 hours per day at least 5 days per week for the next 30 days to ensure staff are implementing client program plans as written.	

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	(Emergency Medical Services) for assistance and for further evaluation of [client A]." The 9/6/16 Investigation indicated, "There was insufficient staff in the home. BSP (Behavior Support Plan) was not followed. The other 2 staff were not in the home at the time of the incident. When they arrived they helped to take [client A] to Urgent Care. Recommendations: Staff to follow BSP." 2. On 9/18/16, the BDDS report indicated, "[Client B] picked [client A] up, because [client A] took his pop tart, [client A] dropped his body weight and fell (sic), hitting his head on [client B's] bed causing a 2 inch abrasion to the back of his head. Staff called EMS and applied pressure to the area, EMS arrived and transported [client A] to the hospital for evaluation." The facility's 9/20/16 Investigation indicated, "By review of documents and interview of staff it was determined there was one staff working in the home while the home called for 3 (staff). Staff was unable to be in [client B's] room to witness the incident as he was passing medications." The investigation indicated Client A received 7 staples to the back of his head. The facility neglected to ensure		**Completion date: 1/4/17**	

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	recommendations or corrective actions were taken. 3. On 10/2/16 the BDDS report indicated, "[Client B] hit [client A] in the head after [client A] bit [client B]. No injuries have been noted and the nurse was notified." The facility's 10/5/16 Investigation indicated, "It was revealed staff were not following plans, did not have [client B] on 1 to 1 (1 staff to 1 client), and the home was not sufficiently staffed." The facility neglected to ensure recommendations or corrective actions were taken. 4. On 11/13/16, "[Client A] ran into the kitchen and went to grab a piece of pizza. [Client B] was sitting at the dining room table and when staff entered the kitchen, [client B] was holding [client A] up against the cabinet and stated [client A] hit his eye on the corner of the cabinet. When staff examined [client A] his left (physician report indicated right eye) eye was black and he had a contusion of the eye. The nurse was contacted and [client A] was taken to Urgent Care for evaluation." Observations of client A on 11/21/16 at the group home indicated his right eye was black. The 11/14/16 Investigation indicated, "Client's 1 on 1 staff were (sic) not in			

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	close proximity resulting in the incident occurring. Staff were not following protocol appropriately. All staff will be in-serviced on appropriate 1 on 1 training to prevent incidents of this nature from happening again. There is a pattern of occurrences between [client A] and [client B]." The facility neglected to clarify if client A's left or right eye was injured during the incident. 5. On 9/16/16 the BDDS report indicated, "A routine visit from the BDDS service coordinator was conducted on 9/16/16 and the following was reported during the visit. The home was out of ratio, 1 staff was present when the home called for 3 staff to be present, the staff member who was working was being picked up from work and his ride was standing in the yard of the group home upon service coordinator's arrival and [client B] reported staff are having non ResCare employees to the home, the front door to the home was left open and the alarm was off, medications were given late and narcotics were not double locked." The Plan to resolve was indicated as staff would be inserviced on the facility's no call no show policy, and the QIDP (Qualified Intellectual Disabilities Professional) would work with the Supervisor to ensure all shifts are covered.			

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The time sheets were reviewed on 11/23/16 at 2:14 PM for 11/1/16 through 11/20/16. The time sheets indicated the home was under ratio for the following days on first shift: November 2, 3, 7, and 18th. The home was under ratio for second shift: November 3, 4, 5, 9, 14, 17 and 18.
The facility neglected to ensure sufficient staff worked and/or were deployed in a manner to monitor the clients to prevent client B from targeting/injuring client A. The facility neglected to take sufficient corrective action to address the recurring staff shortage in the home.

Client A's record was reviewed on 11/22/16 at 11:23 AM. Client A's 9/6/16 Medical Discharge Sheet (MDS) from [name of hospital] indicated a diagnosis of Lip Laceration. Client A's 9/18/16 MDS from [Emergency Room] indicated a diagnosis of head laceration with staples. Client A's 11/13/16 MDS from [hospital] indicated a diagnosis of Right eye/Orbital trauma to face.

Client A's 9/27/16 BSP indicated, "[Client A] should be line of sight supervision, (close enough to physically intervene), and one to one in the shower." Client A's 9/27/16 BSP indicated the facility neglected to ensure facility staff

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	implemented client A's BSP to ensure client A was monitored by staff to prevent client B from targeting client A. Client B's record was reviewed on 11/22/16 at 1:56 PM. Client B's 6/1/16 IDT (Interdisciplinary Team) indicated client B should be on 1:1 staffing due to issues with elopement. Client B's 9/27/16 BSP indicated client B had demonstrated physical aggression before moving to this home. The facility neglected to indicate how client B was to be monitored to prevent him from targeting/abusing client A. Client B's BSP and/or record indicated the client's IDT (interdisciplinary team) neglected to meet to review/address client B's aggression toward client A. Staff #1 was interviewed on 11/22/16 at 7:40 AM. Staff #1 indicated he felt like client A was scared of client B. Staff #1 indicated client A will avoid client B. Staff #2 was interviewed on 11/22/16 at 7:42 AM. Staff #2 stated he felt like client A was "afraid" of client B. Staff #2 indicated client A will usually stay in a different room than client B. LPN #1 was interviewed on 11/23/16 at 8:52 AM. LPN #1 stated she felt client A was "nervous" when client B had behaviors. LPN #1 stated, "It's not normal			

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	for [client A] to sit on his bed and cry, however, he has been more agitated lately." LPN #1 stated, "[Client A] is [Client B's] target, he always goes after him." QIDP #1 was interviewed on 11/22/16 at 2:36 PM. QIDP #1 indicated they were retraining staff on one on one staffing procedures to keep clients in the home safe. QIDP #1 indicated staff had been retrained several times already. When asked if he thought this time would be more effective then the other retraining attempts, QIDP #1 indicated he was unsure, and he had only been with the facility for 3 weeks. QIDP #1 indicated client A should be within line of sight at all times. QIDP #1 indicated client B should be one on one within arm's distance at all times. QIDP #1 indicated the facility would be putting some senior staff in the home to ensure staffing wasn't an issue. Program Manager (PM) #1 was interviewed on 11/22/16 at 2:36 PM. PM #1 indicated the home should have 3 staff on first and second shifts and 2 staff on the third shift. PM #1 indicated all of the facility's policy and procedures should be followed as well as BSPs. PM #1 indicated the home was having difficulty getting staff to follow plans. PM #1			

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	indicated the facility would be moving staff around in an effort to correct the problem. PM #1 indicated the home currently had no house manager. Behavioral Consultant (BC) #1 was interviewed on 11/28/16 at 10:20 AM. BC #1 indicated she believed one staff could block client B, but she wasn't sure if one staff would be able to put client B in a YSIS (You're Safe I'm Safe Hold). BC #1 indicated staff have been retrained on more than one occasion, and they have not changed the staffing or added more staffing to the home. BC #1 indicated she doesn't believe the staff are following the plans. BC #1 indicated she was to work 10 hours a week at the group home. BC #1 indicated the 10 hours a week included her time in the group home and the paperwork. BC #1 provided retraining documents on 11/28/16 at 10:51 AM. ResCare 1/2016 Abuse, Neglect, Exploitation, Mistreatment or Violation of Individual Rights policy was reviewed on 11/21/16 at 12:36 PM. ResCare Policy indicated, "All allegations of occurrences of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels."			

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	This federal tag relates to complaint #IN00210610. 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 observation, record review and interview for 3 of 4 allegations of abuse,	W 0154	**W154:** The facility must have evidence that all alleged	01/04/2017

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	neglect or mistreatment reviewed, the facility failed to ensure allegations of client to client abuse/mistreatment regarding clients A and B were thoroughly investigated and had corrective actions or recommendations. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations were reviewed on 11/21/16 at 2:15 PM. The review indicated the following: 1. On 9/18/16, the BDDS report indicated, "[Client B] picked [client A] up, because [client A] took his pop tart, [client A] dropped his body weight and fell (sic), hitting his head on [client B's] bed causing a 2 inch abrasion to the back of his head. Staff called EMS and applied pressure to the area, EMS arrived and transported [client A] to the hospital for evaluation." The facility's 9/20/16 Investigation indicated, "By review of documents and interview of staff it was determined there was one staff working in the home while the home called for 3 (staff). Staff was unable to be in [client B's] room to witness the incident as he was passing medications." The investigation indicated		violations are thoroughly investigated. **Corrective Action: (specific):** The Quality Assurance Manager will be re-trained on the investigation process to ensure that all alleged violations are investigated thoroughly. A thorough investigation includes all staff and individuals in the home/location or staff and individual that could be involved in the incident or may have been in the same area when the incident occurred will be interviewed regarding the incident at hand, the investigation will be completed within 5 business days. After an investigation is completed a peer review will be completed to review the findings of the investigation. Follow up on corrective action and/or recommendations will be completed by QA and the PM and a copy of the recommendations will be placed in the investigation file. **How others will be identified: (Systemic)**: Quality Assurance will ensure that full scale investigations are completed when warranted and especially after a pattern of occurrences has been established. A peer review	

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	Client A received 7 staples to the back of his head. The facility neglected to ensure recommendations or corrective actions were part of the investigation. 2. On 10/2/16 the BDDS report indicated, "[Client B] hit [client A] in the head after [client A] bit [client B]. No injuries have been noted and the nurse was notified." The facility's 10/5/16 Investigation indicated, "It was revealed staff were not following plans, did not have [client B] on 1 to 1 (1 staff to 1 client), and the home was not sufficiently staffed." The facility neglected to ensure recommendations or corrective actions were part of the investigation. 3. On 11/13/16, "[Client A] ran into the kitchen and went to grab a piece of pizza. [Client B] was sitting at the dining room table and when staff entered the kitchen, [client B] was holding [client A] up against the cabinet and stated [client A] hit his eye on the corner of the cabinet. When staff examined [client A] his left (physician report indicated right eye) eye was black and he had a contusion of the eye. The nurse was contacted and [client A] was taken to Urgent Care for evaluation." Observations of client A on 11/21/16 from 4:00 PM to 5:45 PM at the group		will be completed with each investigation to review findings and ensure that the investigation is thorough. **Measures to be put in place:** The Quality Assurance Manager will be re-trained on the investigation process to ensure that all alleged violations are investigated thoroughly. A thorough investigation includes all staff and individuals in the home/location or staff and individual that could be involved in the incident or may have been in the same area when the incident occurred will be interviewed regarding the incident at hand, the investigation will be completed within 5 business days. After an investigation is completed a peer review will be completed to review the findings of the investigation. Follow up on corrective action and/or recommendations will be completed by QA and the PM and a copy of the recommendations will be placed in the investigation file. **Monitoring of Corrective Action:** Quality Assurance will ensure that full scale investigations are completed when warranted and especially	

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	home indicated his right eye was black. The 11/14/16 Investigation indicated, "Client's 1 on 1 staff were (sic) not in close proximity resulting in the incident occurring. Staff were not following protocol appropriately. All staff will be in-serviced on appropriate 1 on 1 training to prevent incidents of this nature from happening again. There is a pattern of occurrences between [client A] and [client B]." The facility failed to clarify in the investigation if client A's left or right eye was injured during the incident. Client A's record was reviewed on 11/22/16 at 11:23 AM. Client A's 9/6/16 Medical Discharge Sheet (MDS) from [name of hospital] indicated a diagnosis of Lip Laceration. Client A's 9/18/16 MDS from [Emergency Room] indicated a diagnosis of head laceration with staples. Client A's 11/13/16 MDS from [hospital] indicated a diagnosis of Right eye/Orbital trauma to face. Program Manager (PM) #1 was interviewed on 11/22/16 at 2:36 PM. PM #1 indicated all investigations should be thorough. Behavioral Consultant (BC) #1 was interviewed on 11/28/16 at 10:20 AM. BC #1 indicated client A's right eye was		after a pattern of occurrences has been established. A peer review will be completed with each investigation to review findings and ensure that the investigation is thorough. **Completion date: 1/4/17**	

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	black. BC #1 indicated the investigation should have clarified if there was an error in documentation. This federal tag relates to complaint #IN00210610. 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 4 of 4 allegations of abuse and client to client aggression and for 1 of 1 allegation of neglect reviewed, the facility failed to develop and implement corrective measures to prevent recurrence of abuse/aggression to client A from client B and to address the recurrent staffing shortage. Findings include: The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations were reviewed on 11/21/16 at 2:15 PM. The review	W 0157	**W157: If the alleged violation is verified, appropriate corrective action must be taken.** **Corrective Action: (Specific):** All staff at the home and the Quality Assurance Manager will be retrained on the operation standard for reporting and investigating abuse, neglect, exploitation, mistreatment or violation of an individual's rights, including client to client aggression. The Quality Assurance Manager will be re-trained on thorough investigations including	01/04/2017

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	indicated the following: 1. On 9/6/16, the BDDS report indicated, "[Client A] was in his room getting up when staff saw [client B] in [client A's] room, and then observed [client B] hit [client A] in the lip. Staff asked [client B] why he hit [client A] and he first stated there was no reason why he hit him. [Client B] later stated it was because [client A] had bit (sic) him, no bite marks were noted. [Client B] was redirected to his room where he displayed property destruction. Staff called police and EMS (Emergency Medical Services) for assistance and for further evaluation of [client A]." The 9/6/16 Investigation indicated, "There was insufficient staff in the home. BSP (Behavior Support Plan) was not followed. The other 2 staff were not in the home at the time of the incident. When they arrived they helped to take [client A] to Urgent Care. Recommendations: Staff to follow BSP." 2. On 9/18/16, the BDDS report indicated, "[Client B] picked [client A] up, because [client A] took his pop tart, [client A] dropped his body weight and fell (sic), hitting his head on [client B's] bed causing a 2 inch abrasion to the back of his head. Staff called EMS and applied		recommendations to prevent future occurrence for all substantiated allegations and reporting the investigation findings and recommendations to the administrator within 5 business days. A peer review of investigations will be completed to ensure that recommendations and/or plans are implemented to prevent future occurrences and QA and the PM will follow up to ensure that the recommendations and/or plans to prevent future occurrences are implemented as written. The Site Supervisor will be re-trained on ensuring that staffing ratios are consistent with the scheduled hours for the home. **How others will be identified: (Systemic):** Quality Assurance will ensure that full scale investigations are completed when warranted and especially after a pattern of occurrences has been established. A peer review will be completed with each investigation to review findings and ensure that the investigation is thorough and all recommendations are implemented. The Area Supervisor will be at the home at least three times weekly to ensure that staffing ratios are consistent with the scheduled	

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	pressure to the area, EMS arrived and transported [client A] to the hospital for evaluation." The facility's 9/20/16 Investigation indicated, "By review of documents and interview of staff it was determined there was one staff working in the home while the home called for 3 (staff). Staff was unable to be in [client B's] room to witness the incident as he was passing medications." The investigation indicated Client A received 7 staples to the back of his head. The facility neglected to ensure recommendations or corrective actions were taken. 3. On 10/2/16 the BDDS report indicated, "[Client B] hit [client A] in the head after [client A] bit [client B]. No injuries have been noted and the nurse was notified." The facility's 10/5/16 Investigation indicated, "It was revealed staff were not following plans, did not have [client B] on 1 to 1 (1 staff to 1 client), and the home was not sufficiently staffed." The facility neglected to ensure recommendations or corrective actions were taken. 4. On 11/13/16, "[Client A] ran into the kitchen and went to grab a piece of pizza. [Client B] was sitting at the dining room table and when staff entered the kitchen,		hours for the home and/or based on client census in the home. **Measures to be put in place:** All staff at the home and the Quality Assurance Manager will be retrained on the operation standard for reporting and investigating abuse, neglect, exploitation, mistreatment or violation of an individual's rights, including client to client aggression. The Quality Assurance Manager will be re-trained on thorough investigations including recommendations to prevent future occurrence for all substantiated allegations and reporting the investigation findings and recommendations to the administrator within 5 business days. A peer review of investigations will be completed to ensure that recommendations and/or plans are implemented to prevent future occurrences and QA and the PM will follow up to ensure that the recommendations and/or plans to prevent future occurrences are implemented as written. The Site Supervisor will be re-trained on ensuring that staffing ratios are consistent with the scheduled hours for the home. **Monitoring of Corrective**	

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	[client B] was holding [client A] up against the cabinet and stated [client A] hit his eye on the corner of the cabinet. When staff examined [client A] his left (physician report indicated right eye) eye was black and he had a contusion of the eye. The nurse was contacted and [client A] was taken to Urgent Care for evaluation." The 11/14/16 Investigation indicated, "Client's 1 on 1 staff were (sic) not in close proximity resulting in the incident occurring. Staff were not following protocol appropriately. All staff will be in-serviced on appropriate 1 on 1 training to prevent incidents of this nature from happening again. There is a pattern of occurrences between [client A] and [client B]." The facility neglected to clarify if client A's left or right eye was injured during the incident. Client A's record was reviewed on 11/22/16 at 11:23 AM. Client A's 9/6/16 Medical Discharge Sheet (MDS) from [name of hospital] indicated a diagnosis of Lip Laceration. Client A's 9/18/16 MDS from [Emergency Room] indicated a diagnosis of head laceration with staples. Client A's 11/13/16 MDS from [hospital] indicated a diagnosis of Right eye/Orbital trauma to face.		**Action:** Quality Assurance will ensure that full scale investigations are completed when warranted and especially after a pattern of occurrences has been established. A peer review will be completed with each investigation to review findings and ensure that the investigation is thorough and all recommendations are implemented. The Area Supervisor will be at the home at least three times weekly to ensure that staffing ratios are consistent with the scheduled hours for the home and/or based on client census in the home. **Completion date: 1/4/17**	

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	5. On 9/16/16 the BDDS report indicated, "A routine visit from the BDDS service coordinator was conducted on 9/16/16 and the following was reported during the visit. The home was out of ratio, 1 staff was present when the home called for 3 staff to be present, the staff member who was working was being picked up from work and his ride was standing in the yard of the group home upon service coordinator's arrival and [client B] reported staff are having non ResCare employees to the home, the front door to the home was left open and the alarm was off, medications were given late and narcotics were not double locked." The Plan to resolve was indicated as staff would be inserviced on the facility's no call no show policy, and the QIDP (Qualified Intellectual Disabilities Professional) would work with the Supervisor to ensure all shifts are covered. The time sheets were reviewed on 11/23/16 at 2:14 PM for 11/1/16 through 11/20/16. The time sheets indicated the home was under ratio for the following days on first shift: November 2, 3, 7, and 18th. The home was under ratio for second shift: November 3, 4, 5, 9, 14, 17 and 18. The facility neglected to take sufficient			

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	corrective action to address the recurring staff shortage in the home. Client A's record was reviewed on 11/22/16 at 11:23 AM. Client A's 9/6/16 Medical Discharge Sheet (MDS) from [name of hospital] indicated a diagnosis of Lip Laceration. Client A's 9/18/16 MDS from [Emergency Room] indicated a diagnosis of head laceration with staples. Client A's 11/13/16 MDS from [hospital] indicated a diagnosis of Right eye/Orbital trauma to face. Client A's 9/27/16 BSP indicated, "[Client A] should be line of sight supervision, (close enough to physically intervene), and one to one in the shower." Client A's 9/27/16 BSP indicated the facility neglected to ensure facility staff implemented client A's BSP to ensure client A was monitored by staff to prevent client B from targeting client A. Client B's record was reviewed on 11/22/16 at 1:56 PM. Client B's 6/1/16 IDT (Interdisciplinary Team) indicated client B should be on 1:1 staffing due to issues with elopement. Client B's 9/27/16 BSP indicated client B had demonstrated physical aggression before moving to this home. The facility neglected to indicate how client B was to be monitored to prevent him from targeting/abusing client			

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	A. Client B's BSP and/or record indicated the client's IDT (interdisciplinary team) neglected to meet to review/address client B's aggression toward client A. Staff #1 was interviewed on 11/22/16 at 7:40 AM. Staff #1 indicated he felt like client A was scared of client B. Staff #1 indicated client A will avoid client B. Staff #2 was interviewed on 11/22/16 at 7:42 AM. Staff #2 stated he felt like client A was "afraid" of client B. Staff #2 indicated client A will usually stay in a different room than client B. LPN #1 was interviewed on 11/23/16 at 8:52 AM. LPN #1 stated she felt client A was "nervous" when client B had behaviors. LPN #1 stated, "It's not normal for [client A] to sit on his bed and cry, however, he has been more agitated lately." LPN #1 stated, "[Client A] is [Client B's] target, he always goes after him." QIDP #1 was interviewed on 11/22/16 at 2:36 PM. QIDP #1 indicated they were retraining staff on one on one staffing procedures to keep clients in the home safe. QIDP #1 indicated staff had been retrained several times already. When asked if he thought this time would be more effective then the other retraining			

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	attempts, QIDP #1 indicated he was unsure, and he had only been with the facility for 3 weeks. QIDP #1 indicated client A should be within line of sight at all times. QIDP #1 indicated client B should be one on one within arm's distance at all times. QIDP #1 indicated the facility would be putting some senior staff in the home to ensure staffing wasn't an issue. Program Manager (PM) #1 was interviewed on 11/22/16 at 2:36 PM. PM #1 indicated the home should have 3 staff on first and second shifts and 2 staff on the third shift. PM #1 indicated the home was having difficulty getting staff to follow plans. PM #1 indicated the facility would be moving staff around in an effort to correct the problem. PM #1 indicated the home currently had no house manager. Behavioral Consultant (BC) #1 was interviewed on 11/28/16 at 10:20 AM. BC #1 indicated she believed one staff could block client B, but she wasn't sure if one staff would be able to put client B in a YSIS (You're Safe I'm Safe Hold). BC #1 indicated staff have been retrained on more than one occasion, and they have not changed the staffing or added more staffing to the home. BC #1 indicated she doesn't believe the staff are following the			

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	plans. BC #1 indicated she was to work 10 hours a week at the group home. BC #1 indicated the 10 hours a week included her time in the group home and the paperwork. BC #1 provided retraining documents on 11/28/16 at 10:51 AM. This federal tag relates to complaint #IN00210610. 9-3-2(a)			
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, record review and interview for 2 of 2 sampled clients (A and B), the facility failed to provide and/or deploy sufficient staffing during the day and evening shifts to ensure clients' plans were implemented to protect client A from client to client abuse.	W 0186	**W186:** The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. **Corrective Action: (Specific):** A new site supervisor has been hired for the home and has been	01/04/2017

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	Findings include: Observations were conducted at the group home on 11/21/16 from 4:00 PM through 5:45 PM. Clients A and B were observed in the home throughout the observation period. Client A was mostly non-verbal and small in stature. Client B was verbal and had a large frame/build. At 4:27 PM client A was observed in his bedroom on his bed. Client A was sitting up with a cover over him shaking and crying. Client A had mucus running from his nose to his mouth. Client A's right eye was swollen, black and purple. At 4:30 PM Qualified Intellectual Disabilities Professional (QIDP) #1 indicated client A had a black eye from client B hitting him in the kitchen last week. QIDP #1 stated, "[Client A] will sometimes cry as a behavior." QIDP #1 indicated client A had gotten in trouble earlier for taking pudding out of the office. At 5:07 PM client D was interviewed. Client D indicated he had seen client B and client A fighting. Client D stated,"[Client B] has sat on me, last night he gave [client C] like 5 wedgies. Staff watch but they don't do anything." Client D indicated he was worried about client B being mean. At 5:35 PM client D stated, "One time there was only 2 staff here, and one of them left to go to the store. [Client B]		thoroughly trained on expectations regarding ensuring that staffing ratios are consistent with the scheduled hours for the home. **How others will be identified: (Systemic):** The Area Supervisor will be in the home at least three times weekly to ensure that staffing ratios in the home are consistent with scheduled hours. The Program Manager will be in the home at least twice weekly to ensure that staffing ratios are consistent with scheduled hours. **Measures to be put in place:** A new site supervisor has been hired for the home and has been thoroughly trained on expectations regarding ensuring that staffing ratios are consistent with the scheduled hours for the home. **Monitoring of Corrective Action:** The Area Supervisor will be in the home at least three times weekly to ensure that staffing ratios in the home are consistent with scheduled hours. The Program Manager will be in the home at least twice weekly to ensure that staffing ratios are consistent with scheduled hours.	

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	attacked [client A] and I had to help staff so they didn't get hurt." Observations were conducted on 11/22/16 from 7:00 AM through 8:15 AM. Clients A and B were observed in the home throughout the observation period. At 7:00 AM clients A and B were sitting beside each other at the kitchen table eating breakfast. Client A did not look at client B while eating his breakfast. There were no staff between clients A and B; one staff was in the kitchen at the counter. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations were reviewed on 11/21/16 at 2:15 PM. The review indicated the following: 1. On 9/6/16, the BDDS report indicated, "[Client A] was in his room getting up when staff saw [client B] in [client A's] room, and then observed [client B] hit [client A] in the lip. Staff asked [client B] why he hit [client A] and he first stated there was no reason why he hit him. [Client B] later stated it was because [client A] had bit (sic) him, no bite marks were noted. [Client B] was redirected to his room where he displayed property destruction. Staff called police and EMS (Emergency Medical Services) for		**Completion date: 1/4/17**	

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	assistance and for further evaluation of [client A]." The 9/6/16 Investigation indicated, "There was insufficient staff in the home. BSP (Behavior Support Plan) was not followed. The other 2 staff were not in the home at the time of the incident. When they arrived they helped to take [client A] to Urgent Care. Recommendations: Staff to follow BSP." 2. On 9/18/16, the BDDS report indicated, "[Client B] picked [client A] up, because [client A] took his pop tart, [client A] dropped his body weight and fell (sic), hitting his head on [client B's] bed causing a 2 inch abrasion to the back of his head. Staff called EMS and applied pressure to the area, EMS arrived and transported [client A] to the hospital for evaluation." The facility's 9/20/16 Investigation indicated, "By review of documents and interview of staff it was determined there was one staff working in the home while the home called for 3 (staff). Staff was unable to be in [client B's] room to witness the incident as he was passing medications." The investigation indicated Client A received 7 staples to the back of his head.			

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	3. On 10/2/16 the BDDS report indicated, "[Client B] hit [client A] in the head after [client A] bit [client B]. No injuries have been noted and the nurse was notified." The facility's 10/5/16 Investigation indicated, "It was revealed staff were not following plans, did not have [client B] on 1 to 1 (1 staff to 1 client), and the home was not sufficiently staffed." 4. On 11/13/16, "[Client A] ran into the kitchen and went to grab a piece of pizza. [Client B] was sitting at the dining room table and when staff entered the kitchen, [client B] was holding [client A] up against the cabinet and stated [client A] hit his eye on the corner of the cabinet. When staff examined [client A] his left (physician report indicated right eye) eye was black and he had a contusion of the eye. The nurse was contacted and [client A] was taken to Urgent Care for evaluation." The 11/14/16 Investigation indicated, "Client's 1 on 1 staff were (sic) not in close proximity resulting in the incident occurring. Staff were not following protocol appropriately. All staff will be in-serviced on appropriate 1 on 1 training to prevent incidents of this nature from happening again. There is a pattern of occurrences between [client A] and [client B]."			

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	5. On 9/16/16 the BDDS report indicated, "A routine visit from the BDDS service coordinator was conducted on 9/16/16 and the following was reported during the visit. The home was out of ratio, 1 staff was present when the home called for 3 staff to be present, the staff member who was working was being picked up from work and his ride was standing in the yard of the group home upon service coordinator's arrival and [client B] reported staff are having non ResCare employees to the home, the front door to the home was left open and the alarm was off, medications were given late and narcotics were not double locked." The Plan to resolve was indicated as staff would be inserviced on the facility's no call no show policy, and the QIDP (Qualified Intellectual Disabilities Professional) would work with the Supervisor to ensure all shifts are covered. The time sheets were reviewed on 11/23/16 at 2:14 PM for 11/1/16 through 11/20/16. The time sheets indicated the home was under ratio for the following days on first shift: November 2, 3, 7, and 18th. The home was under ratio for second shift: November 3, 4, 5, 9, 14, 17 and 18. The facility neglected to ensure sufficient			

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	15G723	A. BUILDING 00 B. WING	12/05/2016

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	staff worked and/or were deployed in a manner to monitor the clients to prevent client B from targeting/injuring client A. Client A's record was reviewed on 11/22/16 at 11:23 AM. Client A's 9/6/16 Medical Discharge Sheet (MDS) from [name of hospital] indicated a diagnosis of Lip Laceration. Client A's 9/18/16 MDS from [Emergency Room] indicated a diagnosis of head laceration with staples. Client A's 11/13/16 MDS from [hospital] indicated a diagnosis of Right eye/Orbital trauma to face. Client A's 9/27/16 BSP indicated, "[Client A] should be line of sight supervision, (close enough to physically intervene), and one to one in the shower." Client A's 9/27/16 BSP indicated the facility neglected to ensure facility staff implemented client A's BSP to ensure client A was monitored by staff to prevent client B from targeting client A. Client B's record was reviewed on 11/22/16 at 1:56 PM. Client B's 6/1/16 IDT (Interdisciplinary Team) indicated client B should be on 1:1 staffing due to issues with elopement. Client B's 9/27/16 BSP indicated client B had demonstrated physical aggression before moving to this home. The facility neglected to indicate how client B was to be monitored to			

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	prevent him from targeting/abusing client A. Program Manager (PM) #1 was interviewed on 11/22/16 at 2:36 PM. PM #1 indicated the home should have 3 staff on first and second shifts and 2 staff on the third shift. Behavioral Consultant (BC) #1 was interviewed on 11/28/16 at 10:20 AM. BC #1 indicated she believed one staff could block client B, but she wasn't sure if one staff would be able to put client B in a YSIS (You're Safe I'm Safe Hold). BC #1 indicated staff have been retrained on more than one occasion, and they have not changed the staffing or added more staffing to the home. This federal tag relates to complaint #IN00210610. 9-3-3(a)			

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W 0240 Bldg. 00	483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence. Based on observation, interview and record review for 1 of 2 sampled clients (B), the client's Behavior Support Plan (BSP) failed to indicate how client B was to be monitored to prevent him from targeting/abusing client A and to specifically address physical aggression. Findings include: Observations were conducted at the group home on 11/21/16 from 4:00 PM through 5:45 PM. Clients A and B were observed in the home throughout the observation period. Client A was mostly non-verbal and small in stature. Client B was verbal and had a large frame/build. At 4:27 PM client A was observed in his bedroom on his bed. Client A was sitting up with a cover over him shaking and crying. Client A had mucus running from his nose to his mouth. Client A's right eye was swollen, black and purple. At 4:30 PM Qualified Intellectual Disabilities Professional (QIDP) #1 indicated client A had a black eye from client B hitting him in the kitchen last week. QIDP #1 stated, "[Client A] will sometimes cry as a behavior." QIDP #1 indicated client A	W 0240	**W240:** The individual program plan must describe relevant interventions to support the individual toward independence. **Corrective Action: (Specific):** All staff will be re-trained on working the entirety of their scheduled shift and not leaving the home without staff in place to relieve them. All clients active treatment schedules will be reviewed by the team and revised as indicated. All staff at the home will be re-trained on active treatment and all client active treatment schedules. Client A's BSP has been revised to include a one to one staff defined s within 5 feet at all times while awake with staff positioned between Client A and Client B when in the common areas of the home and in the van and 15 minute checks while asleep. All staff at the home have been re-trained on all client BSP's. The IDT met to discuss Client B's current placement, the team determined that an alternate placement needed to be secured. A transition call has been completed and Client B is scheduled to move out of the home on 12/23/2016. Administrative Observations have been implemented in the home	01/04/2017

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	had gotten in trouble earlier for taking pudding out of the office. At 5:07 PM client D was interviewed. Client D indicated he had seen client B and client A fighting. Client D stated,"[Client B] has sat on me, last night he gave [client C] like 5 wedgies. Staff watch but they don't do anything." Client D indicated he was worried about client B being mean. At 5:35 PM client D stated, "One time there was only 2 staff here, and one of them left to go to the store. [Client B] attacked [client A] and I had to help staff so they didn't get hurt." Observations were conducted on 11/22/16 from 7:00 AM through 8:15 AM. Clients A and B were observed in the home throughout the observation period. At 7:00 AM clients A and B were sitting beside each other at the kitchen table eating breakfast. Client A did not look at client B while eating his breakfast. There were no staff between clients A and B; one staff was in the kitchen at the counter. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations were reviewed on 11/21/16 at 2:15 PM. The review indicated the following: 1. On 9/6/16, the BDDS report indicated,		for at least 16 hours per day to ensure that all staff is implementing plans as written. The Administrative Observations for at least 16 hours per day in the home will continue until after Client B moves from the home. Once Client A moves from the home Client B's BSP will be evaluated by the team to determine if the one to one is still needed. **How others will be identified: (Systemic):** The QIDP will be at the home at least 10 hours per week to monitor, coordinate and integrate all client program plans and ensure that staff is implementing all client plans as written. The Administrative staff completing the observations in the home will be ensuring that staff is implementing Client A and Client B's program plans to ensure the safety of Client A as well as all other clients in the home. Administrative observations in the home will continue after Client A moves at least 8 hours per day for at least 5 days per week for the next 30 days. **Measures to be put in place:** All staff will be re-trained on working the entirety of their scheduled shift and not leaving the home	

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	"[Client A] was in his room getting up when staff saw [client B] in [client A's] room, and then observed [client B] hit [client A] in the lip. Staff asked [client B] why he hit [client A] and he first stated there was no reason why he hit him. [Client B] later stated it was because [client A] had bit (sic) him, no bite marks were noted. [Client B] was redirected to his room where he displayed property destruction. Staff called police and EMS (Emergency Medical Services) for assistance and for further evaluation of [client A]." The 9/6/16 Investigation indicated, "There was insufficient staff in the home. BSP (Behavior Support Plan) was not followed. The other 2 staff were not in the home at the time of the incident. When they arrived they helped to take [client A] to Urgent Care. Recommendations: Staff to follow BSP." 2. On 9/18/16, the BDDS report indicated, "[Client B] picked [client A] up, because [client A] took his pop tart, [client A] dropped his body weight and fell (sic), hitting his head on [client B's] bed causing a 2 inch abrasion to the back of his head. Staff called EMS and applied pressure to the area, EMS arrived and transported [client A] to the hospital for evaluation."		without staff in place to relieve them. All clients active treatment schedules will be reviewed by the team and revised as indicated. All staff at the home will be re-trained on active treatment and all client active treatment schedules. Client A's BSP has been revised to include a one to one staff defined s within 5 feet at all times while awake with staff positioned between Client A and Client B when in the common areas of the home and in the van and 15 minute checks while asleep. All staff at the home have been re-trained on all client BSP's. The IDT met to discuss Client B's current placement, the team determined that an alternate placement needed to be secured. A transition call has been completed and Client B is scheduled to move out of the home on 12/23/2016. Administrative Observations have been implemented in the home for at least 16 hours per day to ensure that all staff is implementing plans as written. The Administrative Observations for at least 16 hours per day in the home will continue until after Client B moves from the home. Once Client A moves from the home Client B's BSP will be evaluated by the team to determine if the one to one is still needed.	

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	The facility's 9/20/16 Investigation indicated, "By review of documents and interview of staff it was determined there was one staff working in the home while the home called for 3 (staff). Staff was unable to be in [client B's] room to witness the incident as he was passing medications." The investigation indicated Client A received 7 staples to the back of his head. 3. On 10/2/16 the BDDS report indicated, "[Client B] hit [client A] in the head after [client A] bit [client B]. No injuries have been noted and the nurse was notified." The facility's 10/5/16 Investigation indicated, "It was revealed staff were not following plans, did not have [client B] on 1 to 1 (1 staff to 1 client), and the home was not sufficiently staffed." 4. On 11/13/16, "[Client A] ran into the kitchen and went to grab a piece of pizza. [Client B] was sitting at the dining room table and when staff entered the kitchen, [client B] was holding [client A] up against the cabinet and stated [client A] hit his eye on the corner of the cabinet. When staff examined [client A] his left (physician report indicated right eye) eye was black and he had a contusion of the eye. The nurse was contacted and [client A] was taken to Urgent Care for		**Monitoring of Corrective Action:** The QIDP will be at the home at least 10 hours per week to monitor, coordinate and integrate all client program plans and ensure that staff is implementing all client plans as written. The Administrative staff completing the observations in the home will be ensuring that staff is implementing Client A and Client B's program plans to ensure the safety of Client A as well as all other clients in the home. Administrative observations in the home will continue after Client A moves at least 8 hours per day for at least 5 days per week for the next 30 days. **Completion date: 1/4/17**	

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	evaluation." The 11/14/16 Investigation indicated, "Client's 1 on 1 staff were (sic) not in close proximity resulting in the incident occurring. Staff were not following protocol appropriately. All staff will be in-serviced on appropriate 1 on 1 training to prevent incidents of this nature from happening again. There is a pattern of occurrences between [client A] and [client B]." Client B's record was reviewed on 11/22/16 at 1:56 PM. Client B's 6/1/16 IDT (Interdisciplinary Team) indicated client B should be on 1:1 staffing due to issues with elopement. Client B's 9/27/16 BSP indicated client B had demonstrated physical aggression before moving to this home. The facility neglected to indicate how client B was to be monitored to prevent him from targeting/abusing client A. There were no guidelines to address physical aggression of client B. Staff #1 was interviewed on 11/22/16 at 7:40 AM. Staff #1 indicated he felt like client A was scared of client B. Staff #1 indicated client A will avoid client B. Staff #2 was interviewed on 11/22/16 at 7:42 AM. Staff #2 stated he felt like client A was "afraid" of client B. Staff #2			

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	indicated client A will usually stay in a different room than client B. LPN #1 was interviewed on 11/23/16 at 8:52 AM. LPN #1 stated she felt client A was "nervous" when client B had behaviors. LPN #1 stated, "It's not normal for [client A] to sit on his bed and cry, however, he has been more agitated lately." LPN #1 stated, "[Client A] is [Client B's] target, he always goes after him." Program Manager (PM) #1 was interviewed on 11/22/16 at 2:36 PM. PM #1 indicated client B's current BSP was for elopement only but the team would be meeting to revise it to include physical aggression. Behavioral Consultant (BC) #1 was interviewed on 11/28/16 at 10:20 AM. BC #1 indicated she had revised client B's BSP to include physical aggression as of 11/28/16. This federal tag relates to complaint #IN00210610. 9-3-4(a)			
W 0249	483.440(d)(1) PROGRAM IMPLEMENTATION			

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Bldg. 00	As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 2 of 2 sampled clients (A and B), the facility failed to implement the clients' plans as written to provide proper supervision to clients A and B. Findings include: Observations were conducted at the group home on 11/21/16 from 4:00 PM through 5:45 PM. Clients A and B were observed in the home throughout the observation period. Client A was mostly non-verbal and small in stature. Client B was verbal and had a large frame/build. At 4:27 PM client A was observed in his bedroom on his bed. Client A was sitting up with a cover over him shaking and crying. Client A had mucus running from his nose to his mouth. Client A's right eye was swollen, black and purple. At 4:30 PM Qualified Intellectual Disabilities Professional (QIDP) #1 indicated client A had a black eye from client B hitting him in the kitchen last week. QIDP #1 stated, "[Client A] will sometimes cry as	W 0249	**W249:** As soon as the interdisciplinary team has formulated a clients' individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. **Corrective Action: (Specific):** All staff will be re-trained on working the entirety of their scheduled shift and not leaving the home without staff in place to relieve them. All clients active treatment schedules will be reviewed by the team and revised as indicated. All staff at the home will be re-trained on active treatment and all client active treatment schedules. Client A's BSP has been revised to include a one to one staff defined s within 5 feet at all times while awake with staff positioned between Client A and Client B when in the common areas of the home and in the van and 15 minute checks while asleep. All staff at the home have been re-trained on all	01/04/2017

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	a behavior." QIDP #1 indicated client A had gotten in trouble earlier for taking pudding out of the office. At 5:07 PM client D was interviewed. Client D indicated he had seen client B and client A fighting. Client D stated,"[Client B] has sat on me, last night he gave [client C] like 5 wedgies. Staff watch but they don't do anything." Client D indicated he was worried about client B being mean. At 5:35 PM client D stated, "One time there was only 2 staff here, and one of them left to go to the store. [Client B] attacked [client A] and I had to help staff so they didn't get hurt." Observations were conducted on 11/22/16 from 7:00 AM through 8:15 AM. Clients A and B were observed in the home throughout the observation period. At 7:00 AM clients A and B were sitting beside each other at the kitchen table eating breakfast. Client A did not look at client B while eating his breakfast. There were no staff between clients A and B; one staff was in the kitchen at the counter. The facility's BDDS (Bureau of Developmental Disabilities Services) reports and Investigations were reviewed on 11/21/16 at 2:15 PM. The review indicated the following:		client BSP's. The IDT met to discuss Client B's current placement, the team determined that an alternate placement needed to be secured. A transition call has been completed and Client B is scheduled to move out of the home on 12/23/2016. Administrative Observations have been implemented in the home for at least 16 hours per day to ensure that all staff is implementing plans as written. The Administrative Observations for at least 16 hours per day in the home will continue until after Client B moves from the home. Once Client A moves from the home Client B's BSP will be evaluated by the team to determine if the one to one is still needed. **How others will be identified: (Systemic):** The QIDP will be at the home at least 10 hours per week to monitor, coordinate and integrate all client program plans and ensure that staff is implementing all client plans as written. The Administrative staff completing the observations in the home will be ensuring that staff is implementing Client A and Client B's program plans to ensure the safety of Client A as well as all other clients in the home. Administrative observations in the home will	

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	1. On 9/6/16, the BDDS report indicated, "[Client A] was in his room getting up when staff saw [client B] in [client A's] room, and then observed [client B] hit [client A] in the lip. Staff asked [client B] why he hit [client A] and he first stated there was no reason why he hit him. [Client B] later stated it was because [client A] had bit (sic) him, no bite marks were noted. [Client B] was redirected to his room where he displayed property destruction. Staff called police and EMS (Emergency Medical Services) for assistance and for further evaluation of [client A]." The 9/6/16 Investigation indicated, "There was insufficient staff in the home. BSP (Behavior Support Plan) was not followed. The other 2 staff were not in the home at the time of the incident. When they arrived they helped to take [client A] to Urgent Care. Recommendations: Staff to follow BSP." 2. On 9/18/16, the BDDS report indicated, "[Client B] picked [client A] up, because [client A] took his pop tart, [client A] dropped his body weight and fell (sic), hitting his head on [client B's] bed causing a 2 inch abrasion to the back of his head. Staff called EMS and applied pressure to the area, EMS arrived and transported [client A] to the hospital for		continue after Client A moves at least 8 hours per day for at least 5 days per week for the next 30 days. **Measures to be put in place:** All staff will be re-trained on working the entirety of their scheduled shift and not leaving the home without staff in place to relieve them. All clients active treatment schedules will be reviewed by the team and revised as indicated. All staff at the home will be re-trained on active treatment and all client active treatment schedules. Client A's BSP has been revised to include a one to one staff defined s within 5 feet at all times while awake with staff positioned between Client A and Client B when in the common areas of the home and in the van and 15 minute checks while asleep. All staff at the home have been re-trained on all client BSP's. The IDT met to discuss Client B's current placement, the team determined that an alternate placement needed to be secured. A transition call has been completed and Client B is scheduled to move out of the home on 12/23/2016. Administrative Observations have been implemented in the home for at least 16 hours per day to ensure that all staff is implementing plans as written. The Administrative Observations	

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	evaluation." The facility's 9/20/16 Investigation indicated, "By review of documents and interview of staff it was determined there was one staff working in the home while the home called for 3 (staff). Staff was unable to be in [client B's] room to witness the incident as he was passing medications." The investigation indicated Client A received 7 staples to the back of his head. 3. On 10/2/16 the BDDS report indicated, "[Client B] hit [client A] in the head after [client A] bit [client B]. No injuries have been noted and the nurse was notified." The facility's 10/5/16 Investigation indicated, "It was revealed staff were not following plans, did not have [client B] on 1 to 1 (1 staff to 1 client), and the home was not sufficiently staffed." 4. On 11/13/16, "[Client A] ran into the kitchen and went to grab a piece of pizza. [Client B] was sitting at the dining room table and when staff entered the kitchen, [client B] was holding [client A] up against the cabinet and stated [client A] hit his eye on the corner of the cabinet. When staff examined [client A] his left (physician report indicated right eye) eye was black and he had a contusion of the eye. The nurse was contacted and [client		for at least 16 hours per day in the home will continue until after Client B moves from the home. Once Client A moves from the home Client B's BSP will be evaluated by the team to determine if the one to one is still needed. **Monitoring of Corrective Action:** The QIDP will be at the home at least 10 hours per week to monitor, coordinate and integrate all client program plans and ensure that staff is implementing all client plans as written. The Administrative staff completing the observations in the home will be ensuring that staff is implementing Client A and Client B's program plans to ensure the safety of Client A as well as all other clients in the home. Administrative observations in the home will continue after Client A moves at least 8 hours per day for at least 5 days per week for the next 30 days. **Completion date: 1/4/17**	

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	15G723	A. BUILDING 00 B. WING	12/05/2016

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	A] was taken to Urgent Care for evaluation." The 11/14/16 Investigation indicated, "Client's 1 on 1 staff were (sic) not in close proximity resulting in the incident occurring. Staff were not following protocol appropriately. All staff will be in-serviced on appropriate 1 on 1 training to prevent incidents of this nature from happening again. There is a pattern of occurrences between [client A] and [client B]." 5. On 9/16/16 the BDDS report indicated, "A routine visit from the BDDS service coordinator was conducted on 9/16/16 and the following was reported during the visit. The home was out of ratio, 1 staff was present when the home called for 3 staff to be present, the staff member who was working was being picked up from work and his ride was standing in the yard of the group home upon service coordinator's arrival and [client B] reported staff are having non ResCare employees to the home, the front door to the home was left open and the alarm was off, medications were given late and narcotics were not double locked." The Plan to resolve was indicated as staff would be inserviced on the facility's no call no show policy, and the QIDP (Qualified Intellectual Disabilities			

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	Professional) would work with the Supervisor to ensure all shifts are covered. Client A's record was reviewed on 11/22/16 at 11:23 AM. Client A's 9/6/16 Medical Discharge Sheet (MDS) from [name of hospital] indicated a diagnosis of Lip Laceration. Client A's 9/18/16 MDS from [Emergency Room] indicated a diagnosis of head laceration with staples. Client A's 11/13/16 MDS from [hospital] indicated a diagnosis of Right eye/Orbital trauma to face. Client A's 9/27/16 BSP indicated, "[Client A] should be line of sight supervision, (close enough to physically intervene), and one to one in the shower." Client A's 9/27/16 BSP indicated the facility neglected to ensure facility staff implemented client A's BSP to ensure client A was monitored by staff to prevent client B from targeting client A. Client B's record was reviewed on 11/22/16 at 1:56 PM. Client B's 6/1/16 IDT (Interdisciplinary Team) indicated client B should be on 1:1 staffing due to issues with elopement. Client B's 9/27/16 BSP indicated client B had demonstrated physical aggression before moving to this home. The facility neglected to indicate how client B was to be monitored to			

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	prevent him from targeting/abusing client A. QIDP #1 was interviewed on 11/22/16 at 2:36 PM. QIDP #1 indicated client A should be within line of sight at all times. QIDP #1 indicated client B should be one on one within arm's distance at all times. Behavioral Consultant (BC) #1 was interviewed on 11/28/16 at 10:20 AM. BC #1 indicated she believed one staff could block client B, but she wasn't sure if one staff would be able to put client B in a YSIS (You're Safe I'm Safe Hold). BC #1 indicated she doesn't believe the staff are following the plans. This federal tag relates to complaint #IN00210610. 9-3-4(a)			