STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	15G194	A. BUILDING 00 B. WING	07/14/2022

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RES CARE COMMUNITY ALTERNATIVES SE IN	115 STONEGATE BEDFORD, IN 47421

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00383486. Complaint #IN00383486: Substantiated, Federal/state deficiencies related to the allegation(s) are cited at W149, W155, W156 and W331. Unrelated deficiency cited. Survey Dates: July 11, 12, 13 and 14, 2022 Facility Number: 000724 Provider Number: 15G194 AIM Number: 100243320 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 7/27/22.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 3 of 3 clients in the sample (A, B and C) and 5 additional clients (D, E, F, G and H), the facility failed to implement its policies and procedures to prevent abuse and neglect of the clients, prevent further neglect while an investigation was in progress, ensure the results of investigations were reported to the administrator within 5 working days, identify patterns related to injuries of unknown origin and take appropriate corrective actions to address injuries of unknown origin in a timely	W 0149	To correct the deficient practice all site staff have been re-trained on the ResCare ANE policy and procedure, CPR, and on-call communication procedures. All QA and administrative staff responsible for site have been re-trained on ensuring Investigations are completed within 5 business days, appropriate safety measures are	08/14/2022

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

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	manner. Findings include: On 7/11/22 at 11:31 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) A 6/18/22 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "It was reported [client A] had been sleeping when he got up to use the restroom. While in the restroom [client A] fell out of his wheelchair. Staff contacted nurse and reported the incident, and that [client A] was alert. The nurse advised staff to complete 15-minute checks and [client A] became less alert. Nurse was contacted and advised staff to contact EMS (Emergency Medical Services). EMS arrived and pronounced [client A] deceased. Cause of death unknown currently. [Client A] had been ill and was scheduled to be evaluated for hospice services at the request of his guardian after having seen his physician the day prior to his death." On 7/11/22 at 5:56 PM, a review of a Draft Investigative Summary, dated 6/17/22 to 7/11/22, indicated in the Conclusion section, "Substantiated [client A] saw his PCP (primary care physician) on 6/16 who noted [client A] was basically DNR (do not resuscitate) and suggested nursing facility admission. Substantiated [client A's] guardian wanted [client A] to remain at the group home. Substantiated staff did not initiate CPR (Cardiopulmonary Resuscitation). Substantiated cause of death was cardiopulmonary arrest and Down Syndrome." On 7/13/22 at 8:17 AM, a review of the 7/12/22 Investigative Summary was conducted. The		put in place timely, completing recommendations timely, and identifying/preventing patterns. Additionally, the safety measures put in place for IUO patterns will remain in place. Additional monitoring will be achieved through twice weekly administrative observation to ensure staff are following the ANE policy as well as identifying any patterns or issues at the site. Ongoing monitoring will be achieved through monthly site reviews by ResCare administrative staff.	

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	investigation indicated, "On 6/17 [client A] was assisted to restroom by [staff #6] and was seated in his wheelchair when [staff #6] heard one of [client A's] housemates get out of bed. [Staff #6] left [client A] sitting in the wheelchair to go attend (sic) housemate. [Staff #6] then heard a noise and went back to [client A], finding him lying on the floor. [Staff #6] assisted [client A] back into the wheelchair and took [client A] back to his bedroom and assisted [client A] back to bed. [Client A] was responding to [staff #6] at that time. [Staff #6] attempted to contact nurse with no answer. [Staff #6] then contacted Program Manager (PM) and reported the fall. PM told [staff #6] to complete 15-minute checks. [Staff #6] completed checks and at approximately 6:53 AM [staff #6] contacted PM and reported [client A] was limp, PM told [staff #6] to help [client A] sit up and he saw that [client A's] back was purple. PM told [staff #6] to call 911. EMS (Emergency Medical Services) arrived at approximately 7:08 (AM) and said [client A] was deceased. Official cause of death is Cardiopulmonary Arrest and Down's Syndrome." The Conclusion section indicated, "Substantiated [client A] saw his PCP on 6/16 who advised [client A] should be DNR and suggested nursing facility admission. Substantiated [client A's] guardian wanted [client A] to remain at the group home. Substantiated staff did not initiate CPR. Substantiated [client A] died from Cardiopulmonary Arrest and Down Syndrome." The 7/12/22 Investigation Peer Review indicated the following: "-Term [staff #6]. -Reinstate [staff #1]. -Retrain management on directing staff to contact 911 in the event staff are unable to reach nursing			

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	and there is a medical concern. -CPR refresher with all staff. -Retrain staff on nursing chain of command. -Retrain staff on Change of condition procedure. -Retrain staff on when to call 911/911 protocol. -DON (Director of Nursing) to review protocols/procedures with state Nurse Manager regarding plan of action for individuals who are awaiting assessment/intervention for Hospice. -Retrain QA (Quality Assurance) on investigation completion within 5 business days. -Hourly bed checks on clients. -Client specific training completed with staff." The results of the investigation were not submitted to the administrator for review within 5 working days. The facility failed to prevent further potential neglect while the investigation was in progress by failing to immediately suspend staff #1 and #6. On 7/12/22 at 12:31 PM, the Residential Manager (RM) indicated staff #6 was suspended on 6/22/22 after client A passed away on 6/17/22. The RM indicated staff #6 should have been suspended immediately. She was not sure why there was a delay. The RM indicated staff #1 was suspended on 7/11/22 after working several shifts over the past month. On 7/11/22 at 11:23 AM, the Associate Executive Director (AED) indicated he wanted to know the timelines of what happened. The AED indicated there was conflicting information regarding the timelines. On 7/12/22 at 2:01 PM, the Associate Executive Director (AED) indicated client A died on 6/17/22. The AED stated staff #6 was suspended due to "possible neglect" on 6/20/22. The AED indicated staff #6 worked on 6/18/22 and			

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	6/19/22 prior to being suspended. The AED indicated staff #1 was suspended due to possible neglect on 7/11/22. The AED stated staff #1 worked "several shifts" since client A died on 6/17/22. The AED indicated neither staff performed CPR. The AED indicated neither staff took client A's vitals. The AED indicated the investigation of client A's death and the staffs' actions should have been completed within 5 working days. The AED indicated the mortality review of the death had a timeframe of 30 days however the events surrounding client A's death should be been investigated and the results reported to the administrator within 5 working days. The AED stated "still have a five day requirement for the investigation." On 7/12/22 at 2:28 PM, the QIDP (Qualified Intellectual Disabilities Professional) Lead stated "safety measures should have been implemented immediately." He indicated staff #1 was suspended on 7/11/22 but he was not sure why. He indicated the timeframe for reporting the results of an investigation to the administrator was 5 working days. On 7/11/22 at 3:53 PM, the nurse indicated he spoke to staff #6 on 6/17/22 after client A fell however staff #6 did not communicate any indications of a change in client A's status. The nurse indicated staff #6 did not report any information which indicated the need for 911 to be called. The nurse indicated the Area Supervisor called him about an hour later and told him she told staff #6 to call 911. The nurse indicated client A was at the doctor the day before he passed away. On 7/12/22 at 8:24 AM, staff #1 indicated she just got suspended on 7/11/22 due to not initiating			

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	CPR when she arrived to the group home. Staff #1 indicated when she first saw client A in his bed, he was pale and she immediately knew he was dead. Staff #1 stated she did not initiate CPR "because it was obvious he was dead." She stated the paramedics indicated to her client A "had been gone for quite some time." Staff #1 stated "don't think [staff #6] is telling the truth. Blood settled in his (client A's) back... Think he was dead for a while." Staff #1 indicated she was first interviewed about client A's death on 7/8/22. She indicated she was not sure why it took so long to interview her. Staff #1 indicated staff #6 was suspended 3-4 days after client A died and he continued to work at the home for a couple of days before being suspended. On 7/12/22 at 9:40 PM, staff #6 indicated client A was not assisting with transfers due to his physical limitations. Staff #6 stated on 6/16/22 to 6/17/22 during the overnight shift, he "let him (client A) stay in bed and not try to get him up due to him not being able to assist." He woke client A up at 5:30 AM and transferred him to his wheelchair to take him to the bathroom. Although client A put his hands on the rail, he would not bear any weight so he allowed him to rest while he when to check on client H. He indicated he heard a thump and went to check on client A. Client A was on the bathroom floor with a red mark on his forehead. He was responsive. Staff #6 indicated he put client A back into his wheelchair and took him to his room. He transferred him back to his bed, got his oxygen back on and covered him up. He called the Area Supervisor (AS) to inform her of the situation. He called the nurse but was unable to get a hold of him. He indicated he was trying to cook breakfast, assist other clients and check on client A. Client A was getting paler so he called the AS again. She told him to sit client			

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	A up. He did however client A's back was purple and he was unresponsive. He was instructed to 911. Staff #6 indicated staff #1 arrived right after he called 911. He said staff #1 saw him and said he looked bad. Paramedics arrived about 10 minutes later. He indicated he did not attempt CPR. He said he did not know client A needed it. He indicated staff #1 did not attempt CPR. The paramedics did not attempt CPR. He stated "they (paramedics) said he had been gone awhile." Staff #1 indicated client A was responding to him shortly before he called 911. He stated, "I checked on him and he seemed to be alive." Staff #1 indicated following client A's death, he worked Saturday and Sunday, attended a staff meeting on Monday, and then he was suspended on Wednesday. On 7/12/22 at 9:25 AM, the Quality Assurance Coordinator (QAC) stated, "The investigation may need an addendum. Currently in draft form." The QAC stated "thought we had longer than the 5 working days. Did first interviews, got initial information, reinterviewed as needed and then wrote the draft report." The QAC indicated the timeframe for reporting the results to the administrator was 5 working days. The QAC indicated staff #6 did not conduct CPR. The QAC indicated staff #6 did not know client A was not breathing. The QAC indicated staff #1 did not conduct CPR. The QAC stated staff #1 "said it was obvious to her he was gone." The QAC indicated although client A had a physical therapy (PT) assessment the recommended home health PT was not completed due to PT being short staffed. When staff called to schedule appointments, they were told the PT was short staffed and did not have anyone to send. The QAC indicated she was not sure if there was documentation of staff calling to schedule an			

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	appointment. The QAC stated, "They should have documented it. If it's not documented, it didn't happen." The QAC indicated the corrective actions were not determined yet. The peer review needed to be conducted prior to the corrective actions being recommended. On 7/13/22 at 2:48 PM, the Qualified Intellectual Disabilities Professional (QIDP) Lead stated staff #6's termination notice "will say he failed to provide CPR for 20 minutes before EMS arrived." He stated staff #6 failing to provide CPR was "negligence." The QIDP Lead indicated the investigation was not conducted timely. The investigation should have indicated whether or not neglect was substantiated. On 7/13/22 at 2:26 PM, the Quality Assurance Manager (QAM) indicated staff #6 was terminated for not taking action to perform CPR. She stated "there was a delay in action. His actions or lack thereof performing lifesaving measures was the reason... He noticed a change in his condition. There was a delay in action." The QAM indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. The QAM indicated the investigation needed to include a clear conclusion. The QAM indicated the staff were suspended once it was figured out they did not perform CPR. She stated at the beginning, there was "no suspected neglect." 2) On 3/25/22, an allegation was made indicating former staff #7 left clients A, B, C, D, E, F, G and H at the group home unsupervised. The 3/29/22 Investigative Summary indicated, "[Program Manager/PM] received a call from [Residential Manager/RM] at 8:44 PM stating [staff #7] texted her stating he was not at the group home and he			

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	was on his way back. [PM] went to the home to find [staff #7] pulling into the driveway and running to the house. The 9PM staff was already inside. [PM] spoke with [staff #7] and he admitted his wrongdoing and was placed on leave... [Staff #6] arrived for his shift at [group home] at 3/25/22 around 8:40 PM. The front door was locked and there was no answer at the door. [Staff #6] walked around back to find the back door unlocked and saw [staff #7's] items at the house but could not locate him. [Staff #6] called [RM] to inform her and stated [staff #7] and [PM] arrived at the home around 8:50 PM...." Staff #7's statement in the investigation indicated, "He worked at [name of group home] on 3/25/22 approximately 8:30 AM to 8:30 PM and stated he left for an emergency around 8:30 PM, leaving the clients unattended. He stated he arrived back around 8:50 PM." The Factual Findings section indicated, "[Staff #7] texted his supervisor [RM] at 8:42 PM on 3/25/22 stating he left the group home. [Staff #6] arrived at the group home at approximately 8:40 PM to find no staff on duty at the home. [Staff #7] was seen arriving back at the home around 8:50 PM by [RM] and [staff #6]. [Staff #7] admitted he left the clients unattended for approximately 20 minutes. Client plans state the clients are always to be supervised." The Conclusion section indicated, "It is substantiated [staff #7] left the [name of group home] clients unsupervised on 3/25/22." A 3/30/22 Corrective Action Form indicated, in part, "...ResCare Standards of Conduct 7.1, Sections A.1 States Any acts of disrespect, exploitation, abuse, and/or neglect toward the individuals we serve. During a QA (Quality Assurance) investigation you admitted to leaving the clients home alone while you left the premises. Rescare has a zero-tolerance policy for neglect, due to your actions we are terminating your			

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	employment...." 3) On 2/13/22 (no time indicated), bruises of an unknown origin were found on client E. The undated Unknown Injury Investigation indicated, "...During routine body scans on 2-13-22 several small bruises were found on [client E]. Right upper chest ½" (inches). Right Calf ½". Left arm ½". Lower Right Arm ½". Upper Right arm >½". Left Shin ½".... Does the staff have any recollection of how the injury may have occurred? No, all home staff were questioned, and no one could give an exact reason as to why the marks occurred. Some speculations from staff were that he often bumps into things, has a history of SIB (self injurious behavior), and furniture has been moved in his bedroom that he could have ran (sic) into... Not that any of the staff are aware of. [Client E's] BSP (behavior support plan) reflects SIB and physical aggression as well as his roommates (sic) BSP. However, there is an HRC (Human Rights Committee) baby monitor in their room and staff would have heard an altercation even with the door closed...." The Recommendations section indicated, "1. Staff will continue hourly room checks. 2. The AS (Area Supervisor) and QIDP (Qualified Intellectual Disabilities Professional) will complete routine observations to ensure plans are being followed. 3. Re-train staff on completing daily body scans." Staff #6 worked with client E prior to the injuries being found. There was no documentation when the results of the investigation were submitted to the administrator for review. There was no documentation the recommended observations were conducted.			

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	4) On 2/13/22 (no time indicated), client H was found to have scratch marks on his back. The undated Unknown Injury Investigation indicated, "Scratch marks on upper back greater than 3 inches." The report indicated, "...No, all home staff were questioned, and no one could give an exact reason as to why the mark occurred. Staff did speculate that it was very possible [client H] scratched himself while itching...." The Recommendations section indicated, "1. All staff are to ensure [client H's] nails are routinely maintained. 2. Staff will continue hourly room checks. 3. The AS and QIDP will complete routine observations to ensure plans are being followed. 4. Re-train staff on completing daily body scans." Staff #6 worked with client H prior to the injuries being found. There was no documentation when the results of the investigation were submitted to the administrator for review. There was no documentation the recommended observations were conducted. 5) On 3/5/22 at 9:00 AM, staff #1 found scratches and a bruise on client H's back. The undated Unknown Injury Investigation indicated, "[Staff #1] notice (sic) scratches across [client H's] back roughly 10 inches, like fingernails and a bruise on the upper right arm about a quarter size." The investigation indicated, "...All staff that worked with in days of the incident: [staff #6, #3, #5 and RM] had no idea how the marks could have occurred. No one reported behaviors or seeing any falls. The reporter [staff #1] noted that when she found the scratches, she noticed [client H's] fingernails were 'extremely' long. [Staff #1]			

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	speculated that [client H] could have scratched himself. [Staff #1] also noted she appears to be the only staff to trim his nails. The bruising on the arm was undetermined as to how it could have occurred." The Recommendations section indicated, "Recommendations: 1. Due to the pattern of IUO (injuries of unknown origin) with [client H], it should be recommended that the AS/RM/AED (Area Supervisor/Residential Manager/Assistant Executive Director) do drop ins during the weekend between 7p and 6a. 2. All staff to be re-trained on completing nail trimmings routinely. 3. All staff to be trained to complete full body assessments at every shift change for a minimum of 30 days, and longer if the team determines it is needed." Staff #6 worked with client H prior to the injuries being found. There was no documentation when the results of the investigation were submitted to the administrator for review. There was no documentation the recommended observations were conducted. 6) On 3/23/22 (no time indicated), client E was found to have a bruise on his penis. The 3/30/22 Unknown Injury Investigation indicated, "During hygiene routines staff found [client E's] penis to have a bruise on it. The bruise was purple and about a half inch. ...." Staff #1's statement in the investigation indicated, "...I worked 10a-5p. When I arrived, [staff #7] showed me the bruise he found. We were unaware of how or when it happened. I do know the toilet seat in 'his' (client E's) bathroom is broken, and he masturbates frequently... I brought [client E] to the restroom to shower on Wednesday about 915a and notice			

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	(sic) a bruise on the tip of his penis. Have you seen anything that could have caused this? There is a toilet seat in the far bathroom that he uses that is loose and could have pinched. He does masturbate a lot and could have also caused...." The Conclusion section indicated, "After further review the following can be concluded. [Client E] had a small bruise on his penis. There has been no event reported that could have caused this. Staff did note a broken toilet seat that could have caused the injury. No staff indicated any suspicion of physical abuse." 7) On 3/25/22 at 6:00 AM, staff #6 found client E with scratches on his face. The 3/30/22 Unknown Injury Investigation indicated, "Staff heard a distressed noise coming from [client H's and client E's] room. Upon inspection staff found both clients up. [Client H] had a toy in his hand and [client E] was found to have fresh scratches on his face. Two scratches were found - one under his chin and one on his lip. Both (sic) about two inches in length... Staff did not witness how the scratches occurred. Staff speculates from the noise he heard and the situation he found upon inspection. (Sic) That [client E] had one of [client H's] toys and [client H] got upset and struck [client E]. Staff also noted that [client E] could have scratched himself, but due to the location of the marks. (Sic) It seems more possible it was a strike from [client H]. After further review the following can be concluded. [Client E] in (sic) [client H] were in their shared bedroom with the door shot (sic) and the HRC (Human Rights Committee) approved audio monitor on. Staff heard a noise over the baby monitor and responded. Staff found [client H] standing with a toy and [client E] sitting on his bed. Staff found marks on [client E's] face that			

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	15G194	A. BUILDING 00 B. WING	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	appeared to have just occurred. [Client E's] scratches were treated, and no further incidents occurred. Staff speculate that [client H] aggressed towards [client E] over a toy... The IDT (interdisciplinary team) should convene to discuss potential roommate changes or other options of supervision due to the pattern of injuries of unknown origins (sic) between [clients E and H]." Staff #6 worked with client H prior to the injuries being found. 8) On 4/23/22 (time not indicated), bruising was found on client H's legs and back. The 4/29/22 Unknown Injury Investigation indicated, "On 4-23-22 bruising was found on [client H's] legs and back. Left thigh 4 inch (sic), and back about 2 inches... All staff that worked within a few days of finding the marks had no recollection of what could have been causing the bruising. Most staff have noted that [client H] jumps into his bed and often bumps into things. Staff are also following up with his PCP (primary care physician) to ensure he is not anemic and causing extreme bruising... After further review it can be concluded that [client H] had sustained bruising to his leg and back sometime Friday afternoon to Saturday AM (morning). Staff were unable to recall how that could have occurred. Speculations of a medical condition or bumping into things. Recommendations: 1. Follow up with PCP to determine to medical issues are causing increased bruising. 2. Administrative staff should do once weekly drop ins specifically on the weekends for 2 months...." Staff #6 worked 4/21/22 and 4/22/22 from 9:00 PM to 8:00 AM.			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	There was no documentation the recommended observations were conducted. 9) The 5/13/22 Unknown Origin Investigation indicated, "During the (date and time not indicated) AM routine staff found multiple scratches on [client C's] upper left arm. Ranging for (sic) a half inch up to 4 inches in length." The investigation indicated, "...[RM] stated that she believed the scratches to be self-inflicted due to [client C's] nails being long and staff witnessing him scratching. [RM] also stated he was laying (sic) on the zipper of his wedge pillow which also could have caused the scratches... [Staff #1] found the scratches on Sunday 5-8-22. She assumed they were caused by [client C] scratching himself...." 10) On 6/5/22 at 9:00 AM, a bruise was found on client G's left hip. The 6/10/22 Unknown Injury Investigation indicated, "...On 6-5-22 during shower routines staff found a 5 inch bruise on [client G's] left hip. The bruise appeared to be fresh in color...." The investigation indicated, "[Staff #1] stated [staff #5] found a bruise on [client G] on 6-5-22 during showers, between 9 am and 9:30 am. The bruise was on his left hip and was 5 inches long. [Staff #1] states the bruise looked as if [client G] had fell (sic) across something. It was blue and seemed 'fresh'. On 6-4-22 (sic) 7pm [client G] had an incident of smearing feces and she (staff #1) changed him. During that time, there were no injuries...." The Conclusion indicated, "After further review [client G] sustained an injury to his hip causing a five-inch-long bruise across his hip. The cause of the bruise is undetermined. However, staff noted it looked as if he ran into something. [Client G] is unsteady in his gait and has a fall risk...."			

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	15G194	A. BUILDING 00 B. WING	07/14/2022

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Staff #6 worked with client H prior to the injuries being found.

On 7/12/22 at 3:08 PM, a review of an interdisciplinary team (IDT) meeting was conducted. The IDT indicated, "From today's meeting to address unknown injuries, we are doing the following:
-Random drop ins to be implemented by AS (Area Supervisor) and PM (Program Manager), with focus on overnight shifts, at least 2 per month. [AS] will implemented (sic) schedule.
-Body observations to be completed in morning and before bed, as well as a during toileting.
-Rooms will be switched, [AS] contacting guardians to inform and confirm they are in agreement. Looking at [clients H and B], [clients E and D], (and) [clients C and A].
-Door alarm will be placed with HRC (Human Rights Committee) for approval for [clients H's and E's] room.
-Monitor in [client H's and E's] room, one in place but will need another since they are being separated. Will need HRC for new roommates.
-Nail trim/check completed weekly, [nurse] will put on TAR (Treatment Administration Record).
-Nail file and clippers purchased for each client.
-[Nurse] is getting copy of blood work for [client H] to place in medical chart to show there is no findings related to increased risk for bruising."

On 7/12/22 at 12:31 PM, the Residential Manager (RM) indicated most of the injuries of unknown origin were between Thursday and Sunday and always between 7:00 PM and 7:00 AM. The RM indicated there were two staff involved: staff #5 and #6. The RM indicated there have been no injuries of unknown origin since staff #6 was suspended related to client A's death. The RM

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	15G194	A. BUILDING 00 B. WING	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	indicated the corrective actions for injuries of unknown origin were implemented about 2 weeks ago after client A's death. The RM indicated the actions included clients E and H being separated from sharing a room, daily skin assessments, audio monitors in both client E's and H's bedrooms, and daily observations by administrative staff. On 7/12/22 at 12:50 PM, staff #2 indicated she worked at the group home Mondays, Tuesdays and Wednesdays. Staff #2 indicated there were no injuries of unknown injury when she left on Wednesdays and when she returned to work on Mondays, she'd hear about injuries. She indicated most of the unknown injuries occurred on the weekends involving staff #5, #6 and former staff #7. Staff #2 stated the injuries of unknown origin were "definitely not client to client." Staff #2 indicated clients E and H changed bedrooms about 3 weeks ago after client A's funeral, both clients E and H have an audio monitor, and daily observations were being conducted by administrative staff just started. On 7/12/22 at 12:59 PM, staff #3 stated she felt client G's injury of unknown origin was "strange." Staff #3 stated, when asked if there was a pattern to the injuries of unknown origin, "Absolutely." She indicated she suspected staff #5 or staff #6 of causing the injuries. She indicated since staff #6 had been suspended, no injuries of unknown origin have been found. She indicated daily body assessments were implemented recently, clients E and H moved out of their shared bedroom to split them up, both clients E and H have audio monitors in their rooms, and increased monitoring of the home by administrative staff. She indicated the corrective actions to address injuries of unknown origin were implemented less than one			

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	month. On 7/12/22 at 2:01 PM, the Associate Executive Director (AED) indicated, initially, all the injuries of unknown origin occurred in clients E and H's bedroom. He indicated none of the staff saw anything. He initially indicated there was no pattern noted of a staff who worked prior to the injuries being discovered. Later in the interview, the AED indicated a pattern was noted involving staff #6. The AED indicated none of the clients have had injuries of unknown origin since staff #6 was suspended after client A died on 6/17/22. The AED indicated staff #6 was suspended on 6/20/22 after he got off work at 11:00 AM. The AED indicated the facility implemented several corrective actions to address the injuries of unknown origin including daily observations, daily skin assessments, clients E and H changing bedrooms, and client E having an audio monitor. The AED indicated he was not sure when the corrective actions were implemented. On 7/12/22 at 2:28 PM, the QIDP Lead indicated he found a pattern related to the injuries of unknown origin being discovered on the weekends. He indicated the staff involved seemed to be staff #1, who typically found the injuries, staff #5 and staff #6. He stated some of the injuries "were a little weird." He indicated he asked during the investigations if staff was doing the injuries and no one said anything. He indicated it was clear to him clients E and H were hitting each other. The QIDP Lead indicated there was no documentation the recommended pop ins on weekends were completed. He stated, regarding the injuries of unknown origin, "Some were indicative of abuse." He indicated the recommended observations were conducted although there was no documentation of them being done. He indicated the facility			

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	implemented a room change with clients E and H to split them up, audio monitors for both clients E and H, door alarm on client E's bedroom, daily body scans. The QIDP Lead indicated the corrective actions were implemented within the past month. When asked if the corrective actions were timely, he stated "seems like April and May (2022) were OK then implemented the safety measures." On 7/13/22 at 2:48 PM, the QIDP Lead although the recommended observations were conducted by administrative staff, there was no documentation to verify it. On 7/12/22 at 10:27 AM, the nurse indicated he noticed most of the injuries of unknown origin were found on the weekends. The nurse stated "sometimes seemed like it was when certain people worked. Usually around when [staff #5 and #6] worked. Could have been a coincidence." The nurse indicated he conducted assessment of injuries of unknown origin but did not document all of his assessments. On 7/12/22 at 10:08 AM, staff #1 indicated since staff #6 had been suspended, there have been no issues with injuries of unknown origin. Staff #1 stated she was "not sure if there was a connection." She stated she "felt most were occurring during the weekends when [staff #6] worked (Thursday to Saturday). Seems suspicious. All the staff put it together that the bruises stopped since he's been suspended. No bruising found since he's been off." On 7/12/22 at 5:00 PM, a review of the October 2018 Change of Condition policy indicated, "General: Any change in an individual's physical, mental, or psychological status must be reported to a nurse and reviewed/assessed timely. The following are guidelines intended for the review			

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RES CARE COMMUNITY ALTERNATIVES SE IN	115 STONEGATE BEDFORD, IN 47421

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	process... On 7/12/22 at 5:00 PM, a review of the 10/16/20 Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or a Violation of Individual's Rights policy indicated, in part, "ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights. These include but are not limited to any of the following: corporal punishment i.e. forced physical activity, prone restraints, contingent exercise, hitting, pinching, the application of pain or noxious stimuli, the use of electric shock, the infliction of physical pain, seclusion in an area which exit is prohibited, an example of seclusion is locking an individual in their bedroom and not allowing them to leave, negative practice or overcorrection, visual or facial screening, verbal abuse including screaming, swearing, name-calling, belittling, damaging an individual's self-respect or dignity, failure to follow physician's orders, denial of sleep, shelter, food, drink, physical movement for prolonged periods of time, Medical treatment or care or use of bathroom facilities... This federal tag relates to complaint #IN00383486.9-3-2(a)			
W 0155 Bldg. 00	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must prevent further potential abuse while the investigation is in progress. Based on record review and interview for 1 of 25 incident/investigative reports reviewed affecting client A, the facility failed to prevent further potential abuse while an investigation was in progress by delaying the suspension of 2 staff present when client A died. Findings include:	W 0155	To correct the deficient practice all QA and administrative staff responsible for site have been re-trained on ensuring appropriate safety measures are put in place timely. Additional monitoring will be achieved by the QAM reviewing all incident reports and assigning	08/14/2022

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	On 7/11/22 at 11:31 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: A 6/18/22 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "It was reported [client A] had been sleeping when he got up to use the restroom. While in the restroom [client A] fell out of his wheelchair. Staff contacted nurse and reported the incident, and that [client A] was alert. The nurse advised staff to complete 15-minute checks and [client A] became less alert. Nurse was contacted and advised staff to contact EMS (Emergency Medical Services). EMS arrived and pronounced [client A] deceased. Cause of death unknown currently. [Client A] had been ill and was scheduled to be evaluated for hospice services at the request of his guardian after having seen his physician the day prior to his death." On 7/13/22 at 8:17 AM, a review of the 7/12/22 Investigative Summary was conducted. The investigation indicated, "On 6/17 [client A] was assisted to restroom by [staff #6] and was seated in his wheelchair when [staff #6] heard one of [client A's] housemates get out of bed. [Staff #6] left [client A] sitting in the wheelchair to go attend (sic) housemate. [Staff #6] then heard a noise and went back to [client A], finding him lying on the floor. [Staff #6] assisted [client A] back into the wheelchair and took [client A] back to his bedroom and assisted [client A] back to bed. [Client A] was responding to [staff #6] at that time. [Staff #6] attempted to contact nurse with no answer. [Staff #6] then contacted Program Manager (PM) and reported the fall. PM told [staff #6] to complete 15-minute checks. [Staff #6] completed checks and at approximately 6:53 AM		safety measures as needed. Ongoing monitoring will be achieved quarterly through the quality and safety committee reviewing all incidents for patterns and appropriate safety measures.	

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	[staff #6] contacted PM and reported [client A] was limp, PM told [staff #6] to help [client A] sit up and he saw that [client A's] back was purple. PM told [staff #6] to call 911. EMS (Emergency Medical Services) arrived at approximately 7:08 (AM) and said [client A] was deceased. Official cause of death is Cardiopulmonary Arrest and Down's Syndrome." The Conclusion section indicated, "Substantiated [client A] saw his PCP on 6/16 who advised [client A] should be DNR and suggested nursing facility admission. Substantiated [client A's] guardian wanted [client A] to remain at the group home. Substantiated staff did not initiate CPR. Substantiated [client A] died from Cardiopulmonary Arrest and Down Syndrome." The facility failed to prevent further potential neglect while the investigation was in progress by failing to immediately suspend staff #1 and #6. On 7/12/22 at 12:31 PM, the Residential Manager (RM) indicated staff #6 was suspended on 6/22/22 after client A passed away on 6/17/22. The RM indicated staff #6 should have been suspended immediately. She was not sure why there was a delay. The RM indicated staff #1 was suspended on 7/11/22 after working several shifts over the past month. On 7/12/22 at 2:01 PM, the Associate Executive Director (AED) indicated client A died on 6/17/22. The AED stated staff #6 was suspended due to "possible neglect" on 6/20/22. The AED indicated staff #6 worked on 6/18/22 and 6/19/22 prior to being suspended. The AED indicated staff #1 was suspended due to possible neglect on 7/11/22. The AED stated staff #1 worked "several shifts" since client A died on 6/17/22. The AED			

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	15G194	A. BUILDING 00 B. WING	07/14/2022

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	indicated neither staff performed CPR. The AED indicated neither staff took client A's vitals. On 7/12/22 at 2:28 PM, the QIDP Lead stated "safety measures should have been implemented immediately." He indicated staff #1 was suspended on 7/11/22 but he was not sure why. On 7/11/22 at 3:53 PM, the nurse indicated he spoke to staff #6 on 6/17/22 after client A fell however staff #6 did not communicate any indications of a change in client A's status. The nurse indicated staff #6 did not report any information which indicated the need for 911 to be called. The nurse indicated the Area Supervisor called him about an hour later and told him she told staff #6 to call 911. The nurse indicated client A was at the doctor the day before he passed away. On 7/12/22 at 8:24 AM, staff #1 indicated she just got suspended on 7/11/22 due to not initiating CPR when she arrived to the group home. Staff #1 indicated when she first saw client A in his bed, he was pale and he immediately knew he was dead. Staff #1 stated she did not initiate CPR "because it was obvious he was dead." She stated the paramedics indicated to her client A "had been gone for quite some time." Staff #1 indicated staff #6 was suspended 3-4 days after client A died and he continued to work at the home for a couple of days before being suspended. This federal tag relates to complaint #IN00383486. 9-3-2(a)			
W 0156	483.420(d)(4) STAFF TREATMENT OF CLIENTS			

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Bldg. 00	The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. Based on record review and interview for 4 of 25 incident/investigative reports reviewed affecting clients A, E and H, the facility failed to ensure the results of investigations were reported to the administrator within 5 working days of the incident. Findings include: On 7/11/22 at 11:31 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) A 6/18/22 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "It was reported [client A] had been sleeping when he got up to use the restroom. While in the restroom [client A] fell out of his wheelchair. Staff contacted nurse and reported the incident, and that [client A] was alert. The nurse advised staff to complete 15-minute checks and [client A] became less alert. Nurse was contacted and advised staff to contact EMS (Emergency Medical Services). EMS arrived and pronounced [client A] deceased. Cause of death unknown currently. [Client A] had been ill and was scheduled to be evaluated for hospice services at the request of his guardian after having seen his physician the day prior to his death." On 7/11/22 at 5:56 PM, a review of a Draft Investigative Summary, dated 6/17/22 to 7/11/22, indicated in the Conclusion section, "Substantiated [client A] saw his PCP (primary care physician) on 6/16 who noted [client A] was	W 0156	To correct the deficient practice all QA and administrative staff responsible for site have been re-trained on Investigations are completed within 5 business days. Additional monitoring will be achieved by the QAM reviewing all incident reports and assigning investigations. The QAM will assign a deadline for all investigations to be completed and submitted for peer review. Ongoing monitoring will be achieved quarterly through the quality and safety committee reviewing all incidents for patterns and appropriate safety measures.	08/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	basically DNR (do not resuscitate) and suggested nursing facility admission. Substantiated [client A's] guardian wanted [client A] to remain at the group home. Substantiated staff did not initiate CPR (Cardiopulmonary Resuscitation). Substantiated cause of death was cardiopulmonary arrest and Down Syndrome." On 7/13/22 at 8:17 AM, a review of the 7/12/22 Investigative Summary was conducted. The investigation indicated, "On 6/17 [client A] was assisted to restroom by [staff #6] and was seated in his wheelchair when [staff #6] heard one of [client A's] housemates get out of bed. [Staff #6] left [client A] sitting in the wheelchair to go attend (sic) housemate. [Staff #6] then heard a noise and went back to [client A], finding him lying on the floor. [Staff #6] assisted [client A] back into the wheelchair and took [client A] back to his bedroom and assisted [client A] back to bed. [Client A] was responding to [staff #6] at that time. [Staff #6] attempted to contact nurse with no answer. [Staff #6] then contacted Program Manager (PM) and reported the fall. PM told [staff #6] to complete 15-minute checks. [Staff #6] completed checks and at approximately 6:53 AM [staff #6] contacted PM and reported [client A] was limp, PM told [staff #6] to help [client A] sit up and he saw that [client A's] back was purple. PM told [staff #6] to call 911. EMS (Emergency Medical Services) arrived at approximately 7:08 (AM) and said [client A] was deceased. Official cause of death is Cardiopulmonary Arrest and Down's Syndrome." The Conclusion section indicated, "Substantiated [client A] saw his PCP on 6/16 who advised [client A] should be DNR and suggested nursing facility admission. Substantiated [client A's] guardian wanted [client A] to remain at the group home.			

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	15G194	A. BUILDING 00 B. WING	07/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	Substantiated staff did not initiate CPR. Substantiated [client A] died from Cardiopulmonary Arrest and Down Syndrome." The 7/12/22 Investigation Peer Review indicated the following: "-Term [staff #6]. -Reinstate [staff #1]. -Retrain management on directing staff to contact 911 in the event staff are unable to reach nursing and there is a medical concern. -CPR refresher with all staff. -Retrain staff on nursing chain of command. -Retrain staff on Change of condition procedure. -Retrain staff on when to call 911/911 protocol. -DON (Director of Nursing) to review protocols/procedures with state Nurse Manager regarding plan of action for individuals who are awaiting assessment/intervention for Hospice. -Retrain QA (Quality Assurance) on investigation completion within 5 business days. -Hourly bed checks on clients. -Client specific training completed with staff." The results of the investigation were not submitted to the administrator for review within 5 working days. 2) On 2/13/22 (no time indicated), bruises of an unknown origin were found on client E. The undated Unknown Injury Investigation indicated, "...During routine body scans on 2-13-22 several small bruises were found on [client E]. Right upper chest ½" (inches). Right Calf ½". Left arm ½". Lower Right Arm ½". Upper Right arm >½". Left Shin ½".... Does the staff have any recollection of how the injury may have occurred? No, all home staff were questioned, and no one could give an exact reason as to why the marks occurred. Some speculations from staff were that			

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	he often bumps into things, has a history of SIB (self injurious behavior), and furniture has been moved in his bedroom that he could have ran (sic) into... Not that any of the staff are aware of. [Client E's] BSP (behavior support plan) reflects SIB and physical aggression as well as his roommates (sic) BSP. However, there is an HRC (Human Rights Committee) baby monitor in their room and staff would have heard an altercation even with the door closed...." The Recommendations section indicated, "1. Staff will continue hourly room checks. 2. The AS (Area Supervisor) and QIDP (Qualified Intellectual Disabilities Professional) will complete routine observations to ensure plans are being followed. 3. Re-train staff on completing daily body scans." There was no documentation when the results of the investigation were submitted to the administrator for review. 3) On 2/13/22 (no time indicated), client H was found to have scratch marks on his back. The undated Unknown Injury Investigation indicated, "Scratch marks on upper back greater than 3 inches." The report indicated, "...No, all home staff were questioned, and no one could give an exact reason as to why the mark occurred. Staff did speculate that it was very possible [client H] scratched himself while itching...." The Recommendations section indicated, "1. All staff are to ensure [client H's] nails are routinely maintained. 2. Staff will continue hourly room checks. 3. The AS and QIDP will complete routine observations to ensure plans are being followed. 4. Re-train staff on completing daily body scans." There was no documentation when the results of the investigation were submitted to the administrator for review.			

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	4) On 3/5/22 at 9:00 AM, staff #1 found scratches and a bruise on client H's back. The undated Unknown Injury Investigation indicated, "[Staff #1] notice (sic) scratches across [client H's] back roughly 10 inches, like fingernails and a bruise on the upper right arm about a quarter size." The investigation indicated, "...All staff that worked with in days of the incident: [staff #6, #3, #5 and HM] had no idea how the marks could have occurred. No one reported behaviors or seeing any falls. The reporter [staff #1] noted that when she found the scratches, she noticed [client H's] fingernails were 'extremely' long. [Staff #1] speculated that [client H] could have scratched himself. [Staff #1] also noted she appears to be the only staff to trim his nails. The bruising on the arm was undetermined as to how it could have occurred." The Recommendations section indicated, "Recommendations: 1. Due to the pattern of IUO (injuries of unknown origin) with [client H], it should be recommended that the AS/RM/AED (Area Supervisor/Residential Manager/Assistant Executive Director) do drop ins during the weekend between 7p and 6a. 2. All staff to be re-trained on completing nail trimmings routinely. 3. All staff to be trained to complete full body assessments at every shift change for a minimum of 30 days, and longer if the team determines it is needed." There was no documentation when the results of the investigation were submitted to the administrator for review. On 7/12/22 at 2:01 PM, the Associate Executive Director (AED) indicated the investigation of client A's death and the staffs' actions should have been completed within 5 working days. The AED indicated the mortality review of the death			

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	had a timeframe of 30 days however the events surrounding client A's death should be been investigated and the results reported to the administrator within 5 working days. The AED stated "still have a five day requirement for the investigation." On 7/12/22 at 2:28 PM, the QIDP Lead indicated the timeframe for reporting the results of an investigation to the administrator was 5 working days. On 7/12/22 at 9:25 AM, the Quality Assurance Coordinator (QAC) stated, "The investigation may need an addendum. Currently in draft form." The QAC stated "thought we had longer than the 5 working days. Did first interviews, got initial information, reinterviewed as needed and then wrote the draft report." The QAC indicated the timeframe for reporting the results to the administrator was 5 working days. On 7/13/22 at 2:26 PM, the Quality Assurance Manager (QAM) indicated the timeframe for reporting the results of investigations to the administrator was 5 working days. This federal tag relates to complaint #IN00383486. 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 for 8 of 25 incident/investigative reports reviewed affecting clients C, E, G and H, the facility failed to implement corrective actions in a timely manner to address recurrent issues with injuries of unknown	W 0157	To correct the deficient practice all QA and administrative staff responsible for site have been re-trained on ensuring all incident patterns are addressed timely as	08/14/2022

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	origin and failed to recognize and take appropriate actions to address patterns related to injuries of unknown origin. Findings include: On 7/11/22 at 11:31 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) On 2/13/22 (no time indicated), bruises of an unknown origin were found on client E. The undated Unknown Injury Investigation indicated, "...During routine body scans on 2-13-22 several small bruises were found on [client E]. Right upper chest ½" (inches). Right Calf ½". Left arm ½". Lower Right Arm ½". Upper Right arm >½". Left Shin ½".... Does the staff have any recollection of how the injury may have occurred? No, all home staff were questioned, and no one could give an exact reason as to why the marks occurred. Some speculations from staff were that he often bumps into things, has a history of SIB (self injurious behavior), and furniture has been moved in his bedroom that he could have ran (sic) into... Not that any of the staff are aware of. [Client E's] BSP (behavior support plan) reflects SIB and physical aggression as well as his roommates (sic) BSP. However, there is an HRC (Human Rights Committee) baby monitor in their room and staff would have heard an altercation even with the door closed...." The Recommendations section indicated, "1. Staff will continue hourly room checks. 2. The AS (Area Supervisor) and QIDP (Qualified Intellectual Disabilities Professional) will complete routine observations to ensure plans are being followed. 3. Re-train staff on completing daily body scans." Staff #6 worked with client E prior to the injuries		well as investigation recommendations being completed. Additional monitoring will be achieved by the QIDP Lead tracking all Group home incidents and reviewing for patterns. If patterns of incidents are found the IDT will meet to put appropriate measures in place. Ongoing monitoring will be achieved quarterly through the quality and safety committee reviewing all incidents for patterns and appropriate safety measures.	

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	being found. There was no documentation the recommended observations were conducted. 2) On 2/13/22 (no time indicated), client H was found to have scratch marks on his back. The undated Unknown Injury Investigation indicated, "Scratch marks on upper back greater than 3 inches." The report indicated, "...No, all home staff were questioned, and no one could give an exact reason as to why the mark occurred. Staff did speculate that it was very possible [client H] scratched himself while itching...." The Recommendations section indicated, "1. All staff are to ensure [client H's] nails are routinely maintained. 2. Staff will continue hourly room checks. 3. The AS and QIDP will complete routine observations to ensure plans are being followed. 4. Re-train staff on completing daily body scans." Staff #6 worked with client H prior to the injuries being found. There was no documentation the recommended observations were conducted. 3) On 3/5/22 at 9:00 AM, staff #1 found scratches and a bruise on client H's back. The undated Unknown Injury Investigation indicated, "[Staff #1] notice (sic) scratches across [client H's] back roughly 10 inches, like fingernails and a bruise on the upper right arm about a quarter size." The investigation indicated, "...All staff that worked with in days of the incident: [staff #6, #3, #5 and RM] had no idea how the marks could have occurred. No one reported behaviors or seeing any falls. The reporter [staff #1] noted that when she found the scratches, she noticed [client H's] fingernails were 'extremely' long. [Staff #1]			

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	speculated that [client H] could have scratched himself. [Staff #1] also noted she appears to be the only staff to trim his nails. The bruising on the arm was undetermined as to how it could have occurred." The Recommendations section indicated, "Recommendations: 1. Due to the pattern of IUO (injuries of unknown origin) with [client H], it should be recommended that the AS/RM/AED (Area Supervisor/Residential Manager/Assistant Executive Director) do drop ins during the weekend between 7p and 6a. 2. All staff to be re-trained on completing nail trimmings routinely. 3. All staff to be trained to complete full body assessments at every shift change for a minimum of 30 days, and longer if the team determines it is needed." Staff #6 worked with client H prior to the injuries being found. There was no documentation the recommended observations were conducted. 4) On 3/23/22 (no time indicated), client E was found to have a bruise on his penis. The 3/30/22 Unknown Injury Investigation indicated, "During hygiene routines staff found [client E's] penis to have a bruise on it. The bruise was purple and about a half inch. ...." Staff #1's statement in the investigation indicated, "...I worked 10a-5p. When I arrived, [staff #7] showed me the bruise he found. We were unaware of how or when it happened. I do know the toilet seat in 'his' (client E's) bathroom is broken, and he masturbates frequently... I brought [client E] to the restroom to shower on Wednesday about 915a and notice (sic) a bruise on the tip of his penis. Have you seen anything that could have caused this? There is a toilet seat in the far bathroom that he uses that is loose and could have pinched. He			

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	does masturbate a lot and could have also caused...." The Conclusion section indicated, "After further review the following can be concluded. [Client E] had a small bruise on his penis. There has been no event reported that could have caused this. Staff did note a broken toilet seat that could have caused the injury. No staff indicated any suspicion of physical abuse." 5) On 3/25/22 at 6:00 AM, staff #6 found client E with scratches on his face. The 3/30/22 Unknown Injury Investigation indicated, "Staff heard a distressed noise coming from [client H's and client E's] room. Upon inspection staff found both clients up. [Client H] had a toy in his hand and [client E] was found to have fresh scratches on his face. Two scratches were found - one under his chin and one on his lip. Both (sic) about two inches in length... Staff did not witness how the scratches occurred. Staff speculates from the noise he heard and the situation he found upon inspection. (Sic) That [client E] had one of [client H's] toys and [client H] got upset and struck [client E]. Staff also noted that [client E] could have scratched himself, but due to the location of the marks. (Sic) It seems more possible it was a strike from [client H]. After further review the following can be concluded. [Client E] in (sic) [client H] were in their shared bedroom with the door shot (sic) and the HRC (Human Rights Committee) approved audio monitor on. Staff heard a noise over the baby monitor and responded. Staff found [client H] standing with a toy and [client E] sitting on his bed. Staff found marks on [client E's] face that appeared to have just occurred. [Client E's] scratches were treated, and no further incidents occurred. Staff speculate that [client H] aggressed towards [client E] over a toy... The IDT			

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	(interdisciplinary team) should convene to discuss potential roommate changes or other options of supervision due to the pattern of injuries of unknown origins (sic) between [clients E and H]." Staff #6 worked with client E prior to the injuries being found. 6) On 4/23/22 (time not indicated), bruising was found on client H's legs and back. The 4/29/22 Unknown Injury Investigation indicated, "On 4-23-22 bruising was found on [client H's] legs and back. Left thigh 4 inch (sic), and back about 2 inches... All staff that worked within a few days of finding the marks had no recollection of what could have been causing the bruising. Most staff have noted that [client H] jumps into his bed and often bumps into things. Staff are also following up with his PCP (primary care physician) to ensure he is not anemic and causing extreme bruising... After further review it can be concluded that [client H] had sustained bruising to his leg and back sometime Friday afternoon to Saturday AM (morning). Staff were unable to recall how that could have occurred. Speculations of a medical condition or bumping into things. Recommendations: 1. Follow up with PCP to determine to medical issues are causing increased bruising. 2. Administrative staff should do once weekly drop ins specifically on the weekends for 2 months...." Staff #6 worked 4/21/22 and 4/22/22 from 9:00 PM to 8:00 AM. There was no documentation the recommended observations were conducted. 7) The 5/13/22 Unknown Origin Investigation			

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	indicated, "During the (date and time not indicated) AM routine staff found multiple scratches on [client C's] upper left arm. Ranging for (sic) a half inch up to 4 inches in length." The investigation indicated, "...[RM] stated that she believed the scratches to be self-inflicted due to [client C's] nails being long and staff witnessing him scratching. [RM] also stated he was laying (sic) on the zipper of his wedge pillow which also could have caused the scratches... [Staff #1] found the scratches on Sunday 5-8-22. She assumed they were caused by [client C] scratching himself...." 8) On 6/5/22 at 9:00 AM, a bruise was found on client G's left hip. The 6/10/22 Unknown Injury Investigation indicated, "...On 6-5-22 during shower routines staff found a 5 inch bruise on [client G's] left hip. The bruise appeared to be fresh in color...." The investigation indicated, "[Staff #1] stated [staff #5] found a bruise on [client G] on 6-5-22 during showers, between 9 am and 9:30 am. The bruise was on his left hip and was 5 inches long. [Staff #1] states the bruise looked as if [client G] had fell (sic) across something. It was blue and seemed 'fresh'. On 6-4-22 (sic) 7pm [client G] had an incident of smearing feces and she (staff #1) changed him. During that time, there were no injuries...." The Conclusion indicated, "After further review [client G] sustained an injury to his hip causing a five-inch-long bruise across his hip. The cause of the bruise is undetermined. However, staff noted it looked as if he ran into something. [Client G] is unsteady in his gait and has a fall risk...." Staff #6 worked with client G prior to the injuries being found.			

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	On 7/12/22 at 3:08 PM, a review of an interdisciplinary team (IDT) meeting was conducted. The IDT indicated, "From today's meeting to address unknown injuries, we are doing the following: -Random drop ins to be implemented by AS (Area Supervisor) and PM (Program Manager), with focus on overnight shifts, at least 2 per month. [AS] will implemented (sic) schedule. -Body observations to be completed in morning and before bed, as well as a during toileting. -Rooms will be switched, [AS] contacting guardians to inform and confirm they are in agreement. Looking at [clients H and B], [clients E and D], (and) [clients C and A]. -Door alarm will be placed with HRC (Human Rights Committee) for approval for [clients H's and E's] room. -Monitor in [client H's and E's] room, one in place but will need another since they are being separated. Will need HRC for new roommates. -Nail trim/check completed weekly, [nurse] will put on TAR (Treatment Administration Record). -Nail file and clippers purchased for each client. -[Nurse] is getting copy of blood work for [client H] to place in medical chart to show there is no findings related to increased risk for bruising." On 7/12/22 at 12:31 PM, the Residential Manager (RM) indicated most of the injuries of unknown origin were between Thursday and Sunday and always between 7:00 PM and 7:00 AM. The RM indicated there were two staff involved: staff #5 and #6. The RM indicated there have been no injuries of unknown origin since staff #6 was suspended related to client A's death. The RM indicated the corrective actions for injuries of unknown origin were implemented about 2 weeks ago after client A's death. The RM indicated the actions included clients E and H being separated			

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	from sharing a room, daily skin assessments, audio monitors in both client E's and H's bedrooms, and daily observations by administrative staff. On 7/12/22 at 12:50 PM, staff #2 indicated she worked at the group home Mondays, Tuesdays and Wednesdays. Staff #2 indicated there were no injuries of unknown injury when she left on Wednesdays and when she returned to work on Mondays, she'd hear about injuries. She indicated most of the unknown injuries occurred on the weekends involving staff #5, #6 and former staff #7. Staff #2 stated the injuries of unknown origin were "definitely not client to client." Staff #2 indicated clients E and H changed bedrooms about 3 weeks ago after client A's funeral, both clients E and H have an audio monitor, and daily observations were being conducted by administrative staff just started. On 7/12/22 at 12:59 PM, staff #3 stated she felt client G's injury of unknown origin was "strange." Staff #3 stated, when asked if there was a pattern to the injuries of unknown origin, "Absolutely." She indicated she suspected staff #5 or staff #6 of causing the injuries. She indicated since staff #6 had been suspended, no injuries of unknown origin have been found. She indicated daily body assessments were implemented recently, clients E and H moved out of their shared bedroom to split them up, both clients E and H have audio monitors in their rooms, and increased monitoring of the home by administrative staff. She indicated the corrective actions to address injuries of unknown origin were implemented less than one month. On 7/12/22 at 2:01 PM, the Associate Executive Director (AED) indicated, initially, all the injuries			

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	15G194	A. BUILDING 00 B. WING	07/14/2022

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	of unknown origin occurred in clients E and H's bedroom. He indicated none of the staff saw anything. He initially indicated there was no pattern noted of a staff who worked prior to the injuries being discovered. Later in the interview, the AED indicated a pattern was noted involving staff #6. The AED indicated none of the clients have had injuries of unknown origin since staff #6 was suspended after client A died on 6/17/22. The AED indicated staff #6 was suspended on 6/20/22 after he got off work at 11:00 AM. The AED indicated the facility implemented several corrective actions to address the injuries of unknown origin including daily observations, daily skin assessments, clients E and H changing bedrooms, and client E having an audio monitor. The AED indicated he was not sure when the corrective actions were implemented. On 7/12/22 at 2:28 PM, the QIDP Lead indicated he found a pattern related to the injuries of unknown origin being discovered on the weekends. He indicated the staff involved seemed to be staff #1, who typically found the injuries, staff #5 and staff #6. He stated some of the injuries "were a little weird." He indicated he asked during the investigations if staff was doing the injuries and no one said anything. He indicated it was clear to him clients E and H were hitting each other. The QIDP Lead indicated there was no documentation the recommended pop ins on weekends were completed. He stated, regarding the injuries of unknown origin, "Some were indicative of abuse." He indicated the recommended observations were conducted although there was no documentation of them being done. He indicated the facility implemented a room change with clients E and H to split them up, audio monitors for both clients E and H, door alarm on client E's bedroom, daily body scans. The QIDP Lead indicated the			

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	corrective actions were implemented within the past month. When asked if the corrective actions were timely, he stated "seems like April and May (2022) were OK then implemented the safety measures." On 7/13/22 at 2:48 PM, the QIDP Lead although the recommended observations were conducted by administrative staff, there was no documentation to verify it. On 7/12/22 at 10:27 AM, the nurse indicated he noticed most of the injuries of unknown origin were found on the weekends. The nurse stated "sometimes seemed like it was when certain people worked. Usually around when [staff #5 and #6] worked. Could have been a coincidence." On 7/12/22 at 10:08 AM, staff #1 indicated since staff #6 had been suspended, there have been no issues with injuries of unknown origin. Staff #1 stated she was "not sure if there was a connection." She stated she "felt most were occurring during the weekends when [staff #6] worked (Thursday to Saturday). Seems suspicious. All the staff put it together that the bruises stopped since he's been suspended. No bruising found since he's been off." 9-3-2(a)			
W 0331 Bldg. 00	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview for 1 of 3 clients in the sample (A), the facility's nursing services failed to ensure client A had a physical therapy evaluation at his home as recommended by the Physical Therapist. Findings include:	W 0331	To correct the deficient practice staff responsible for appointments have been trained to ensure all recommendations are followed up on timely as well as documenting all conversations with doctors' offices. Additional monitoring will	08/14/2022

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	On 7/11/22 at 11:31 AM, a review of the facility's incident/investigative reports was conducted and indicated the following: 1) A 6/18/22 Bureau of Developmental Disabilities Services (BDDS) incident report indicated, "It was reported [client A] had been sleeping when he got up to use the restroom. While in the restroom [client A] fell out of his wheelchair. Staff contacted nurse and reported the incident, and that [client A] was alert. The nurse advised staff to complete 15-minute checks and [client A] became less alert. Nurse was contacted and advised staff to contact EMS (Emergency Medical Services). EMS arrived and pronounced [client A] deceased. Cause of death unknown currently. [Client A] had been ill and was scheduled to be evaluated for hospice services at the request of his guardian after having seen his physician the day prior to his death." 2) A 6/6/22 BDDS report indicated on 6/5/22 at 7:00 AM, "Staff reported [client A] became weak in his legs and dropped to the floor, on three occasions on 6/5. Staff assisted [client A] and helped him into a chair. Staff noted an abrasion to his right knee, dime sized, after the last incident...." 3) On 3/16/22 (no time indicated), the undated Consumer Falls Investigation indicated, "On 3-17-22 [staff #8] was assisting [client A] out of bed for morning routines. During the transfer [client A] sat down on the ground and refused to get up. [Staff #1] came in shortly after and assisted [staff #8] with getting [client A] off the floor. No injuries were sustained...."		be achieved by a weekly review of all appointments needed to be completed by the site nurse. To ensure no others were affected the nurse will review all appointments to ensure recommendations have been completed. Ongoing monitoring will be completed through quarterly review of all medical needs for each client.	

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	4) On 2/17/22 (no time indicated, the undated Consumer Falls Investigation indicated, "[Client A] was helped out of bed by staff and started to walk towards the bathroom. Staff then went to help another client while [client A] transitioned. When the staff came back [client A] had dropped to the ground from his walker...." The Recommendations section indicated, "Complete OT/PT (Occupational Therapy/Physical Therapy) evaluation per nurse and follow any recommendations...." 5) On 1/31/22 (no time indicated), the undated Consumer Falls Investigation indicated, "[Client A] sat in a chair in the dining room and slipped out and fell to the ground. He was assisted up and checked for injury. No injury was found...." On 7/11/22 at 12:33 PM, a focused review of client A's record was conducted. A 3/24/22 Medical Consult Record indicated, "Reason for Visit: Falling at home." The Results section indicated, "No obvious physical limitations. Can perform transfers/walking if following directions/cooperative." The Physician/Consultant Orders section indicated, "Recommend Home Health Physical Therapy evaluation. Feel therapy would be beneficial at home to determine if cause of falls is behavioral." A 4/26/22 Nurse Assessment and Review Report did not address the recommendations for an in home PT evaluation. On 7/13/22 at 3:23 PM, a 6/7/22 Interdisciplinary team meeting (IDT) indicated, "PT needs to schedule in home." On 7/13/22 at 2:49 PM, the Qualified Intellectual Disabilities Professional Lead (QIDP Lead) indicated the PT evaluation should have been			

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	completed. On 7/13/22 at 3:21 PM, the QIDP Lead indicated the staff attempted to schedule an appointment however the PT did not have enough staff to send to the home. The QIDP Lead stated there was "nothing documented" by staff indicating they attempted to schedule appointments. He indicated the staff who attempted to schedule an appointment did not document anything as well as the nurse. The QIDP Lead indicated it was documented on the programming quarterly about the need for the PT evaluation. On 7/14/22 at 8:23 AM, the nurse indicated client A had a PT evaluation at their office. The PT recommended an in home evaluation. When the RM called to schedule the appointment, she was told they did not have enough staff. The nurse indicated the RM called twice to schedule the appointment. The nurse indicated he did not document it. The nurse indicated he did not think the RM documented her attempts to schedule the appointment. The nurse stated, "I need to document everything." On 7/12/22 at 9:25 AM, the Quality Assurance Coordinator (QAC) indicated a PT evaluation was ordered but not completed. The QAC indicated he had an evaluation at the PT office and they recommended home health PT. She indicated when staff called to set up the appointment, the staff was told the PT was short staffed and did not have anyone to send. The QAC indicated she was not sure if there was documentation of ResCare staff calling to set up the appointment. She indicated staff should have documented their attempts to make an appointment. The QAC stated, "if it's not documented, it didn't happen." This federal tag relates to complaint #IN00383486.			

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