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	15G745	A. BUILDING 00 B. WING	05/11/2021

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

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W 0000 Bldg. 00	This visit was for the investigation of complaint #IN00349488. Complaint #IN00349488: Substantiated, no deficiencies related to the allegation(s) were cited. Unrelated deficiencies cited. Survey dates: 5/6/21, 5/7/21, 5/10/21 and 5/11/21 Facility Number: 011663 Provider Number: 15G745 AIMS Number: 200902020 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 5/26/21.	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 observation, record review and interview for 2 of 2 sampled clients (A and B) and 2 additional clients (C and D), the facility failed to implement its policy and procedures for prohibiting abuse, neglect, exploitation, mistreatment or violation of an individual's rights to prevent 1) alleged mistreatment of client A and client B, 2) a pattern of client-to-client physical aggression between clients A and C and clients B and D, and 3) appropriate staffing supports for clients A, B and C according to their program plans.	W 0149	1. The Program Manager will ensure the Area Supervisor and Residential Manager retrain staff on the Abuse, Neglect and Exploitation Policy and disciplinary action will be given if the policy is not followed. 2. Area Supervisor and Residential Manager will ensure that the Abuse, Neglect and Exploitation Policy is followed. 3. Monitoring of Corrective Action: The Program Manager,	06/10/2021

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Findings include: 1) On 5/7/21 at 7:47 AM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying Investigative Summaries was completed. The reports indicated: BDDS report dated 5/6/21 indicated, "It was reported that on an unknown date, staff observed other staff [staff #5] holding on to the front of [client B's] shirt with his face near [client B's] face. Reporting staff intervened and [staff #5] released [client B] and left the room. The review indicated the investigation was in process. BDDS report dated 5/5/21 indicated, "It was reported [client C] was talking to QIDP (Qualified Intellectual Disabilities Professional) when he told her that staff [staff #5] had hit him in the face near his left eye. [Client C] was unable to report the date of incident but said 'a couple of days ago'. No injuries were reported". The review indicated the investigation was in process. On 5/10/21 at 10:25 AM, staff #3 was interviewed. Staff #3 was asked about the allegations regarding client B and client C. Staff #3 stated, "It happened over Easter weekend, that Friday. [Staff #5] and [staff #4] picked up that weekend. [Staff #2] was still here and [client B] asked who was coming in. [Client B] went into his behaviors 'I don't want [staff #5]'. I think we got him to calm and [staff #2] left. One night he (client B) was wigging out. [Client B] threw himself on the floor. [Staff #5] said 'everybody out'. When I opened the door he		Area Supervisor and Residential Manager will ensure all incidents of possible abuse, neglect and exploitation are reported to the QA department. 4. The Behavior Clinician and QIDP will review ISP/BSP and train facility staff on updated plans to ensure appropriate supports are included. 5. A member of the review team will observe the Facility and report back to the IDT. 6. An IDT will meet weekly to review and report on issues and the team will discuss and implement improvements. 7. The Facility will ensure staffing is adequate to support the individuals and ensure proper implementation of plans. **Persons Responsible**: Executive Director, Program Manager, Quality Assurance, Area Supervisor, Director of Nursing, Nurse, Behavior Clinician, QIDP, Residential Manager, and DSP.	

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	(staff #5) had him like this (both hands clinching the front of her shirt). I told him (staff #5) enough". Staff #3 was asked where this occurred. Staff #3 stated, "In his (client B's) room. [Staff #5] had him by the shirt after shutting the door. I told him (staff #5) enough. [Staff #5] told me he spanked [client B] like he was his own kid. That was the first weekend when I worked with him (staff #5). [Client C] and [Client B] told me they were mean. He (staff #5) told me he poured water over [client B's] head. They took a cup of water or the sprayer from the sink. All I know was the couch was wet. They did that because he doesn't like it and to get him (client B) to do what they want. I talked with [area supervisor] and he didn't seem to care. I was so embarrassed when I talked with QA (Quality Assurance). I didn't report that. I told [staff #5] he was a bully. They make [client C] go ride his bike to keep him busy. [Client C] has stuck to [staff #5] hitting him. I've not seen that. I've talked with [client C] about telling the truth and not fabricating. [Client C] lies a lot. I'm not for sure on that. I just know they make him ride his bike. Sometimes for an hour if he's aggravating them. [Client D] said when I first started they called us tards like retards. I remember talking to [staff #5] about that. He said we might say that was retarded. I don't think this is the right job for him. He's rough around the edges. All of that happened literally over Easter weekend, the first weekend I had worked with them. [Staff #5] told me he spanked [client B] like he was 'my own son'. I told him he's not and a 40 something grown man. When I talked with QA, I was embarrassed that I did not report sooner. [Staff #5] and [staff #4] are like best friends. They will cover, I was stuttering (nervous) when I was talking with QA. [Client C] is dramatic. It's hit or miss (telling the truth) with him. Sometimes he tells the truth and sometimes he doesn't. I only know what I seen with [client B].			

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[Client C] doesn't really complain about [staff #4]. [Client D] doesn't say much. He's (client D) afraid they will retaliate against him".

On 5/10/21 at 10:45 AM, client D was interviewed. Client D was asked how he felt he was treated. Client D stated, "Well, pretty good when [staff #2] and [staff #3] are here, but [staff #5] and [staff #4] it's different". Client D was asked how it made him feel. Client D stated, "Like I'm being mistreated. After [client B] started hitting and spitting they pick him up under the arms and drag him into his room. Then they come back. Usually [staff #4] is on my side". Client D was asked if he was ever hit. Client D stated, "[client B] (hits him), but not staff". While asking about staff #4 and staff #5 working at the group home, client D interrupted the question by stating, "It's the issue. They say get, get. It's the attitude they have. With [client C] on his bike. When he (client C) comes out, they keep adding hours (to ride his bike)".

On 5/10/21 at 11:18 AM, the Area Supervisor was interviewed. The Area Supervisor was asked about alleged mistreatment of client B and client C. The Area Supervisor stated, "They told me he (staff #5) was being suspended. I didn't know about [client B]. I just know he (staff #5) is suspended, and it's being investigated." The Area Supervisor was asked if he was aware of any mistreatment. The Area Supervisor stated, "No, I would report it".

On 5/10/21 at 2:03 PM, the investigator was interviewed. The investigator was asked about the status of the investigations into client B and client C's alleged mistreatment. The investigator indicated each incident had a separate investigation ongoing and 4 people still needed to be interviewed. The investigator was asked about

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the timeline of events for the incidents. The investigator stated, "I'm not sure of the timeline for [client C]. He reported having a black eye. I have nursing notes and there was no black eye". The investigator was asked about the timeline of events for client B's incident. The investigator stated, "I can't say. I just spoke with someone who said two or three weeks ago. I talked with her (staff #3) the night she reported, on the 5th (May 2021). She did tell me the first day she worked with him that [staff #5] stated said he spanked him (client B) and treats him like he was his own son. She told me she took full responsibility for that (not reporting)". The investigator was asked if client A and client D were interviewed. The investigator stated, "I did interview [client D]. He saw [staff #5] smack [client B] on the butt". The investigator was asked about the use of water to get client B to comply to staff direction. The Investigator stated, "She (staff #3) told me the sofa was wet. She didn't see him do it. [Client C] said [staff #5] hit him multiple times with (open hand) over and over". The investigator was asked about client C being directed to ride his bike. The investigator stated, "[Staff #3] said they (staff #5) make him (client C) ride his bike. I've read narrative notes I've seen where they've noted he rides his bike. [Client A] said he hasn't seen anything. [Client D] did not say anything about it (bike)".

2) On 5/7/21 at 7:47 AM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying Investigative Summaries was completed. The reports indicated:

BDDS report dated 3/20/21 indicated, "It was reported [client A] became agitated with [client C]. [Client A] began to hit [client C] then bit [client C] on the left forearm. [Client C] scratched [client A] on the left side of the face. Police were called for

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	assistance. [Client A] then left the group home with staff following. [Client A] was running toward the highway when police arrived and picked [client A] and staff up and returned them to group home. [Client C] stated he wanted to press charges. Police took report and stated report would be sent to prosecutor. [Client C] sustained a bite that broke the skin with a 3 1/2 inch bruise on his left forearm and a 1/4 inch scratch on the left side of his chest. [Client A] sustained a 1 inch and a 4 1/2 inch scratch on the left side of his face. [Client C] was transported to ER (emergency room) for treatment of injuries. [Client C] (sic) released prescription for Amoxicillin/Clavulanate Potassium (antibiotic) 875 mg two times daily for 7 days". Investigation summary dated 3/20/21 indicated, "Briefly describe the incident:... [Client A] got up and started hitting [client C]. Staff intervened and clients sat back down in their seats. [Client A] jumped up again and started swinging at [client C] and biting him on the arm ...7. Is there a pattern of occurrences between these two clients? Yes ...Recommendations: The team will meet to discuss options. Staff will continue to follow the BSP/ISP (Behavior Support Plan/Individual Support Plan)...". BDDS report dated 3/23/21 indicated, "It was reported [client A] became agitated with [client C]. Staff attempted to verbally redirect the two men. [Client A] then approached [client C] and [client C] made a fist at [client A]. [Client A] then hit [client C] in the left side of the face. Staff attempted to verbally redirect the two men and contacted police for assistance. Police arrived and had [client A] go to a different room. Police spoke to both men and calmed them. No injuries were reported".			

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Investigation summary dated 3/22/21 indicated, "Briefly describe the incident: Staff was getting medications and redirected [client C] several times to stop speaking to [client A] in a disrespectful manner. [Client A] then confronted [client C] in his room and [client C] balled his fists up at [client A]. [Client A] then punched [client C] in the face. Staff redirected the clients and called 911...7. Is there a pattern of occurrences between these two clients? Yes, there is a pattern... Recommendations: Team met and discussed incidents. Team is going to seek transfer to another facility. The team is going to touch base with [name] and the psychiatric group [name] from [city] for assistance. There will be a third staff during medication times in the home".

BDDS report dated 3/24/21 indicated, "It was reported [client B] was taking a dish to the sink when [client D] got hold of [client B's] arm. [Client B] then hit [client D] in the chest. Staff was able to verbally redirect the two men. No injuries were reported".

Investigation summary dated 3/23/21 indicated, "Briefly describe the incident: [Client B] slapped [client D] in the chest after [client D] grabbed him by the arm. Staff immediately redirected [client B]... 7. Is there a pattern of occurrences between these two clients? Yes ...Recommendations: Team needs to meet to review pattern of client-to-client behaviors and discuss options to help reduce these occurrences".

BDDS report dated 4/15/21 indicated, "It was reported [client B] came out of his bedroom and [client D] told [client B] to go back in his bedroom. [Client B] hit [client D] on the right side of the face. Staff verbally redirected both men. No

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	injuries were reported". Investigation summary dated 4/14/21 indicated, "Briefly describe the incident: [Client B] came out of his room and [client D] told him to go back in his room. [Client B] slapped [client D] and walked away. Staff verbally (sic) there was no injury. Staff redirected [client B] back to his room. 7. Is there a pattern of occurrences between these two clients? Yes... Recommendations: Staff will continue to provide appropriate supervision of the clients to deter further opportunities for client-to-client incidents". BDDS report dated 5/6/21 indicated, "It was reported [client D] and [client B] were eating dinner when [client D] and [client B] reached for the milk at the same time. [Client B] became agitated and hit [client D] on the back. Staff was able to verbally redirect the two men. No injuries were reported". The review indicated the investigation was in process. 3) Observation was conducted on 5/10/21 from 10:09 AM to 11:31 AM. Staff #2 answered the door and completed the Covid-19 screening and took the surveyor's temperature. Clients A, B, C and D were in their rooms. While staff #2 completed the Covid-19 screening with the surveyor, staff #3 was verbally prompting client D about his morning snack and stated, "Are you ready for it"? Client D indicated he was not and returned to his room from the kitchen area. At 10:19 AM, staff #2 was asked about staffing supports present at the home. Staff #2 indicated only he and staff #3 were present at the home. At 10:25 AM, staff #3 was being interviewed about incident history noted above. During the			

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	interview, the Area Supervisor entered the home and completed his Covid-19 screening at 10:35 AM. The group home was staffed with only staff #2 and staff #3 from 10:09 AM to 10:35 AM until the Area Supervisor entered. On 5/7/21 at 7:47 AM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports, internal incidents reports and accompanying Investigative Summaries was completed. The reports indicated: Internal incident report dated 2/7/21 indicated, "What happened during the incident? Client (client B) ran to basketball court. I called ESN 1 (neighboring home). [Staff #9] ran down to basketball court and got him back inside into his room because I had to stay with other clients. I was watching out the door". Investigation summary dated 2/7/21 indicated, "Briefly describe the incident and any sustained injury if any? Lead staff had given meds (medicines) and as this staff exited the home out the side door; a few minutes later [client B] ran out the door and onto the basketball court. Staff stood in the doorway watching [client B] and called another home and the Lead staff came back and got [client B] to come back inside... 10. Was there sufficient staff at the time of the incident? There was only one staff working at the time of the incident. Staff from ESN 1 assisted. Recommendations: Team needs to ensure required staffing ratios are in place. Team also needs to ensure the radio system for assistance is in place, functioning correctly and being used when needed". BDDS report dated 3/23/21 indicated, "It was reported [client A] became agitated with [client C].			

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Staff attempted to verbally redirect the two men. [Client A] then approached [client C] and [client C] made a fist at [client A]. [Client A] then hit [client C] in the left side of the face. Staff attempted to verbally redirect the two men and contacted police for assistance. Police arrived and had [client A] go to a different room. Police spoke to both men and calmed them. No injuries were reported".

Investigation summary dated 3/22/21 indicated, "Briefly describe the incident: Staff was getting medications and redirected [client C] several times to stop speaking to [client A] in a disrespectful manner. [Client A] then confronted [client C] in his room and [client C] balled his fists up at [client A]. [Client A] then punched [client C] in the face. Staff redirected the clients and called 911... 8. Was there sufficient staff at the time of the incident? No, two staff on duty. Recommendations: Team met and discussed incidents. Team is going to seek transfer to another facility. The team is going to touch base with [name] and the psychiatric group [name] from [city] for assistance. There will be a third staff during medication times in the home".

On 5/10/21 at 1:14 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about alleged mistreatment of clients B and C. The QAM stated, "Yes, [Quality Assurance Coordinator] is investigating". The QAM was asked about the pattern of client-to-client incident history in the home. The QAM stated, "With [client B] and [client D] staff have been instructed to stay between them as much as possible. For [client A], I believe they're (Interdisciplinary Team) is looking at different placement. As much as [client A] contributes, I think [client C] instigates as well. Staff have to keep them

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	separated, they're quick". The QAM indicated a pattern of client-to-client physical aggression had been identified. The QAM was asked about the staffing support levels at the home and the incidents that occurred on 2/7/21 and 3/22/21. The QAM stated, "There should be 3 staff during waking hours. We continue to question the ratio. We ask the staff (interview during investigation) and then check the timesheets". The QAM indicated staffing supports during the incidents on 2/7/21 and 3/22/21 were found through investigation to be not met. The QAM was asked about the implementation of the abuse, neglect, exploitation or mistreat and violation of an individual's rights (ANE) policy implementation during these above noted incidents. The QAM indicated the ANE policy should be implemented at all times and stated, "Yep". On 5/10/21 at 2:45 PM, the Interim Associate Director (IAD) was interviewed. The IAD was asked about the alleged mistreatment of clients B and C. The IAD stated, "I don't know the details on that". The IAD indicated an ongoing investigation into the allegations was being completed. The IAD was asked about the pattern of client-to-client physical aggression and staffing supports. The IAD indicated staffing supports were reviewed and changes in wage rate were forthcoming as way to attract and maintain staffing supports. The IAD stated, "It's 3 staff (during waking hours) and it's been a struggle". The IAD indicated staff supports were not met during the 2/7/21 and 3/22/21 incidents. The IAD indicated client A's placement was being reviewed and stated, "With [client A], we're looking at other services". The IAD indicated the client-to-client patten of physical aggression had been identified. The IAD indicated the ANE policy should be implemented at all times.			

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	On 5/10/21 at 3:15 PM, the 10/16/20 ANE policy was reviewed. The ANE policy indicated, "ResCare strictly prohibits abuse, neglect, exploitation, mistreatment, or violation of an Individual's rights". 9-3-2(a)			
W 0153 Bldg. 00	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. Based on interview and record review for 1 of 2 sampled clients, the facility failed to ensure alleged mistreatment of client B was immediately reported to the administrator. Findings include: 1) On 5/7/21 at 7:47 AM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports and accompanying Investigative Summaries was completed. The reports indicated: BDDS report dated 5/6/21 indicated, "It was reported that on an unknown date, staff observed other staff [staff #5] holding on to the front of [client B's] shirt with his face near [client B's] face. Reporting staff intervened and [staff #5] released [client B] and left the room. The review indicated the investigation was in process. On 5/10/21 at 10:25 AM, staff #3 was interviewed.	W 0153	1. The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. 2. The facility will retrain staff on the requirement of immediate reporting to ensure all alleged allegations of mistreatment are reported as required by state, federal and company policy. 3. The Area Supervisor will train all Facility Staff on the BDDS Reporting Standard. 4. Program Manager will ensure the Area Supervisor and Residential Manager retrain direct care staff on the Abuse, Neglect and Exploitation Policy. Failure to follow policy will result in	06/10/2021

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	15G745	A. BUILDING 00 B. WING	05/11/2021

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

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	Staff #3 was asked about mistreatment of client B. Staff #3 stated, "It happened over Easter weekend, that Friday. [Staff #5] and [staff #4] picked up that weekend. [Staff #2] was still here and [client B] asked who was coming in. [Client B] went into his behaviors 'I don't want [staff #5]'. I think we got him to calm and [staff #2] left. One night he (client B) was wigging out. [Client B] threw himself on the floor. [Staff #5] said 'everybody out'. When I opened the door he (staff #5) had him like this (both hands clinching the front of her shirt). I told him (staff #5) enough". Staff #3 was asked where this occurred. Staff #3 stated, "In his (client B's) room. [Staff #5] had him by the shirt after shutting the door. I told him (staff #5) enough. [Staff #5] told me he spanked [client B] like he was his own kid. That was the first weekend when I worked with him (staff #5). [Client C] and [Client B] told me they were mean. He (staff #5) told me he poured water over [client B's] head. They took a cup of water or the sprayer from the sink. All I know was the couch was wet. They did that so because he doesn't like it and to get him (client B) to do what they want. I talked with [area supervisor] and he didn't seem to care. I was so embarrassed when I talked with QA (Quality Assurance). I didn't report that". On 5/10/21 at 11:18 AM, the Area Supervisor was interviewed. The Area Supervisor was asked about the alleged mistreatment of client B and client C. The Area Supervisor stated, "They told me he (staff #5) was being suspended. I didn't know about [client B]. I just know he (staff #5) is suspended, and it's being investigated. The Area Supervisor was asked if he was aware of any mistreatment. The Area Supervisor stated, "No, I would report it". On 5/10/21 at 2:03 PM, the Investigator was		disciplinary action up to and including termination. **Persons Responsible**: QA Manager, QA Coordinator, QIDP, Residential Manager, Area Supervisor, DSP and Program Manager.	

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	interviewed. The investigator was asked about the status of the investigations into client B's alleged mistreatment and timeline of events. The investigator stated, "I can't say. I just spoke with someone who said two or three weeks ago. I talked with her (staff #3) the night she reported, on the 5th (May 2021). She did tell me the first day she worked with him that [staff #5] stated said he spanked him (client B) and treats him like he was his own son. She told me she took full responsibility for that (not reporting)". On 5/10/21 at 1:14 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the reporting of the alleged mistreatment of client B. The QAM indicated suspected abuse, neglect, mistreatment should be reported immediately to the administrator. The QAM indicated staff have been trained and further follow up was needed. On 5/10/21 at 2:45 PM, the Interim Associate Director (IAD) was interviewed. The IAD was asked about the reporting of the alleged mistreatment of client B. The IAD stated, "We've done a lot of training on reporting. They've seen the repercussions of that". The IAD indicated the alleged mistreatment of client B should have been immediately reported to the administrator and further follow up was needed. 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.			

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	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), and 1 additional client (C), the facility failed to ensure there was sufficient direct care staff to manage and supervise clients A, B and C according to their program plans. Findings include: Observation was conducted on 5/10/21 from 10:09 AM to 11:31 AM. Staff #2 answered the door and completed the Covid-19 screening and took the surveyor's temperature. Clients A, B, C and D were in their rooms. While staff #2 completed the Covid-19 screening with the surveyor, staff #3 was verbally prompting client D about his morning snack and stated, "Are you ready for it"? Client D indicated he was not and returned to his room from the kitchen area. At 10:19 AM, staff #2 was asked about staffing supports present at the home. Staff #2 indicated only he and staff #3 were present at the home. At 10:25 AM, staff #3 was being interviewed about incident history noted above. During the interview, the Area Supervisor entered the home and completed his Covid-19 screening at 10:35 AM. The group home was staffed with only staff #2 and staff #3 from 10:09 AM to 10:35 AM until the Area Supervisor entered. On 5/7/21 at 7:47 AM, a review of the Bureau of Developmental Disabilities Services (BDDS) incident reports, internal incidents reports and accompanying Investigative Summaries was completed. The reports indicated:	W 0186	1. The Program Manager will conduct a weekly meeting to project needs and plan coverage for open shifts. All Area Supervisors in the New Albany Program and All ESN Direct Support Leads, will attend if available. 2. ResCare New Albany Operation has brought in staff from out of town and, increased wages for DSPs outside of the ESN System including paid travel time bonuses, and mileage. 3. ResCare New Albany has increased DSP hourly base wages to $15.00 and $15.60 based on DSP selection of benefits. A $2000.00 sign on bonus is being offered to all new hires effective June 1, 2021 and a $2000.00 referral bonus is being offered to existing staff to assist in recruiting qualified DSPs. 4. Human Resources has made filling ESN Open shifts a priority, this will continue until vacancies are filled. 5. The Area Supervisor will coordinate with ESN Direct Support Leads to ensure shift coverage. All unfilled shift will be reported to the Program Manager. 6. DSP Base pay has been increased for all ESN Staff hour to help fill staffing vacancies,	06/10/2021

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	Internal incident report dated 2/7/21 indicated, "What happened during the incident? Client (client B) ran to basketball court. I called ESN 1 (neighboring home). [Staff #9] ran down to basketball court and got him back inside into his room because I had to stay with other clients. I was watching out the door". Investigation summary dated 2/7/21 indicated, "Briefly describe the incident and any sustained injury if any? Lead staff had given meds (medicines) and as this staff exited the home out the side door; a few minutes later [client B] ran out the door and onto the basketball court. Staff stood in the doorway watching [client B] and called another home and the Lead staff came back and got [client B] to come back inside... 10. Was there sufficient staff at the time of the incident? There was only one staff working at the time of the incident. Staff from ESN 1 assisted. Recommendations: Team needs to ensure required staffing ratios are in place. Team also needs to ensure the radio system for assistance is in place, functioning correctly and being used when needed". BDDS report dated 3/23/21 indicated, "It was reported [client A] became agitated with [client C]. Staff attempted to verbally redirect the two men. [Client A] then approached [client C] and [client C] made a fist at [client A]. [Client A] then hit [client C] in the left side of the face. Staff attempted to verbally redirect the two men and contacted police for assistance. Police arrived and had [client A] go to a different room. Police spoke to both men and calmed them. No injuries were reported". Investigation summary dated 3/22/21 indicated, "Briefly describe the incident: Staff was getting		additional bonuses are being provided for qualified staff. 7. A weekly report is being provided to the hiring manager that will identify open positions and forecast staff gains and losses. Persons Responsible: Program Manager, Human Resource, Quality Assurance, Area Supervisor, Behavior Clinician, QIDP, Residential Manager, and DSP.	

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	medications and redirected [client C] several times to stop speaking to [client A] in a disrespectful manner. [Client A] then confronted [client C] in his room and [client C] balled his fists up at [client A]. [Client A] then punched [client C] in the face. Staff redirected the clients and called 911... 8. Was there sufficient staff at the time of the incident? No, two staff on duty. Recommendations: Team met and discussed incidents. Team is going to seek transfer to another facility. The team is going to touch base with [name] and the psychiatric group [name] from [city] for assistance. There will be a third staff during medication times in the home". On 5/7/21 at 11:29 AM, client A's record was reviewed. The record indicated the following: -Individual Support Plan (ISP) dated 10/2/20 indicated, "Discharge Plan: The interdisciplinary team recommends that he (client A) have supervision while participating in community activities, as he has not acquired safe pedestrian skills. [Client A] requires structure for leisure time activities. The interdisciplinary team has reviewed the comprehensive assessments and determined that (sic) this time, due to the level of needs and training required and his inability to transfer some skills to other environments or setting, [Client A] needs continued placement and active treatment services...". On 5/7/21 at 11:55 AM, client B's record was reviewed. The record indicated the following: -Individual Support Plan (ISP) dated 3/25/21 indicated, "Discharge Plan: [Client B] requires supervision to ensure basic ADL's (adult daily living skills) are completed ... The interdisciplinary team recommends that [client B] have supervision			

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while participating in community activities... The interdisciplinary team has reviewed the comprehensive assessments and determined that at this time, due to the level of needs and training required and inability to transfer some skills to other environments or setting, [client B] is in need of continued ICF/MR (Intermediate Care Facility for Individuals with Intellectual Disabilities) placement and active treatment services...".

On 5/7/21 at 12:15 PM, client C's record was reviewed. The record indicated the following:

-Individual Support Plan (ISP) dated 2/25/21 indicated, "Discharge Plan: The interdisciplinary team recommends that he (client C) have supervision while participating in community activities, as he has not acquired safe pedestrian skills. [Client C] requires structure for leisure time activities. The interdisciplinary team has reviewed the comprehensive assessments and determined that currently, due to the level of needs and training required and his unwillingness to transfer some skills to other environments or settings. [Client C] needs continued placement and active treatment services...".

On 5/10/21 at 1:14 PM, the Quality Assurance Manager (QAM) was interviewed. The QAM was asked about the staffing support levels at the home and the incidents that occurred on 2/7/21 and 3/22/21. The QAM stated, "There should be 3 staff during waking hours. We continue to question the ratio. We ask the staff (interviews during investigations) and then check the timesheets". The QAM indicated staffing supports during the incidents on 2/7/21 and 3/22/21 were found through investigation to not be met.

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	On 5/10/21 at 2:45 PM, the Interim Associate Director (IAD) was interviewed. The IAD was asked about the alleged mistreatment of clients B and C. The IAD stated, "I don't know the details on that". The IAD indicated an ongoing investigation into the allegations was being completed. The IAD was asked about staffing supports. The IAD indicated staffing supports were reviewed and changes in wage rate were forthcoming as way to attract and maintain staffing supports. The IAD stated, "It's 3 staff (during waking hours) and it's been a struggle". The IAD indicated staff supports were not met during the 2/7/21 and 3/22/21 incidents. On 5/10/21 at 3:20 PM, the undated Reimbursement Guidelines for the 24 hour Extensive Support Needs Residences were reviewed. The record indicated, "Individuals living in residences under this category must be supervised at all times and the staffing pattern at full capacity should be a minimum of: three (3) staff on the day shift; three (3) staff on the evening shift; and two (2) staff on the night shift". 9-3-3(a)			