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| W 0000<br><br>Bldg. 00 | This visit was for the investigation of complaint #IN00381799.<br><br>Complaint #IN00381799: Substantiated, federal/state deficiencies related to the allegation(s) are cited at W149 and W189.<br><br>Unrelated deficiencies cited.<br><br>Dates of Survey: June 8, 9, 10 and 13, 2022.<br><br>Facility Number: 000623<br>Provider Number: 15G080<br>AIMS Number: 100233870<br><br>These deficiencies also reflect state findings in accordance with 460 IAC 9.<br>Quality Review of this report completed by #15068 on 6/21/22. | W 0000 | | |
| W 0149<br><br>Bldg. 00 | 483.420(d)(1)<br>STAFF TREATMENT OF CLIENTS<br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br>Based on observation, record review and interview for 2 of 3 clients in the sample (former client A and client B), the facility failed to implement its written policy and procedures to prevent an incident of client to client aggression between former client A and client B which resulted in significant injuries to former client A.<br><br>Findings include:<br><br>On 6/9/22 at 12:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports | W 0149 | **W149:** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.<br><br>**Corrective Action:**<br>· All staff trained on the Abuse/Neglect Policy. **(Attachment A)**<br>· At any time there is an | 07/08/2022 |

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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| | and investigations were reviewed and indicated the following:<br><br>-A BDDS report dated 5/21/22 at 7:35 AM indicated, "This morning [former client A] was yelling and cussing at [client B] to stop bothering him. [Former client A] grabbed [client B's] shirt and [client B] shoved [former client A] away. [Former client A] fell back onto the couch. Staff came from the office, and separated the two men. Staff checked clients for injury finding no visual injuries. Staff walked with [former client A] to his bedroom to calm down and [client B] sat in the living room listening to music to calm down. No further issues. Plan to Resolve: [Former client A] and [client B] both have BSP's (sic) (behavior support plans) to address aggression. Staff intervened, separated client's (sic) and redirected to separate areas of the house. A client to client investigation will be completed to provide recommendations to avoid future incident".<br><br>-A BDDS report dated 5/23/22 at 11:20 AM indicated, "[Former client A] was involved in a client to client on Saturday 5/21/22. Another client pushed him onto the couch (followed under BDDS 1374844). Staff had checked him for injuries finding no visual injuries. This morning [former client A] was complaining of left sided rib pain. There are no visual marks. Staff took [former client A] to urgent care for evaluation. At urgent care an x-ray was completed showing 4 fractured ribs and a collapsed lung. He was ordered as a direct admit to [name of hospital]. He was admitted to the hospital and a chest tube was placed. An investigation is being completed for the client to client on 5/21/22 and the investigation will include inquiry of these injuries. Plan to Resolve: Investigation will be completed. Staff will remain in contact with the hospital for care and discharge | | allegation of abuse, neglect or mistreatment a reportable incident is completed and sent to the IDT, guardian, APS and BDDS.<br>· QIDP will complete 2 active treatment observations per week on varied shifts to ensure there is proper staffing and active treatment is occurring. **(Attachment B)**<br>· QIDP will ensure all staff are thoroughly trained on all Behavior Support Plans annually and as needed. **(Attachment B)**<br>· Rescare policy states with any allegation of abuse, neglect or mistreatment staff will be suspended immediately and an investigation is completed.<br>· Nurse will do an assessment within 24 hours following an allegation of abuse or neglect.<br><br>**Monitoring of Corrective Action:**<br>· The Area Supervisor will notify Human Resources immediately when an allegation is made.<br>· Human Resources will suspend the alleged staff immediately.<br>· Rescare Nurse will submit her assessment to the Nurse Manager, Program Manager, AED, ED and Quality Assurance upon completion.<br>· Rescare Management will do | |

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| | planning".<br><br>-A BDDS follow-up report dated 5/28/22 at 2:24 PM indicated, "[Former client A] remains admitted to [name of hospital]. There was some difficulty with the chest tube remaining in place and was stitched to keep in place. He continues on continues (sic) oxygen with nasal canula (sic) (device used to deliver supplemental oxygen through the nose). He has developed pneumonia during hospital stay. At admission to hospital he was receiving 5 liters oxygen but is no (sic) requiring 1 1/2 liters oxygen. He continues on IV (intravenous) antibiotic. A barium swallow evaluation (to examine the upper gastrointestinal tract) was ordered and completed. There were no new orders as a result of the barium swallow. He continues on a pureed diet with nectar thick fluids. Another chest x-ray will be completed on 5/29/22 and depending on x-ray results the chest tube may be discontinued. Staff will remain in contact with the hospital for care and discharge planning. Describe systemic actions being taken to assume health and safety issues: [Former client A] continues (sic) admitted to the hospital. He is improving and staff will remain in contact with the hospital for care and discharge planning. An investigation was completed to inquire about oirgin (sic) of the injuries. Investigation found the injures (sic) were a result of the client to client altercation on 5/21/22 (followed under BDDS 1374844). On 5/21/22 [former client A] had aggressed toward another client (client B). [Former client A] had grabbed the other clients (sic) (client B) shirt at the neck, the other client (client B) shoved and kicked [former client A] causing [former client A] to fall backward across the room about 8 feet. [Former client A] had no visual injuries. [Former client A] did not complain of pain until late Sunday evening 5/22/22 stating | | surprise visits to the facility 2 times weekly to ensure there are adequate staffing at the facility and report to the Program Manager, Program Director and Executive Director their findings.<br>· Quality Assurance will notify BDDS, APS and the IDT within 24 hours of the allegation.<br>· Quality Assurance will conduct an investigation and review with Program Managers, AED, Human Resource Manager and Executive Director.<br>· QIDP-D will review Abuse and Neglect Policy annually and as needed.<br><br>**Completion Date: 7/8/22** | |

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| | he only hurt a little and did not need a Tylenol (for pain relief). Staff will remain in contact with the hospital for care and discharge planning".<br><br>-A BDDS report dated 6/1/22 at 6:30 PM indicated, "[Former client A] was transferred from name of hospital] in [city] to [name of hospital] in [name of city/state]. The hospital spoke with [former client A's guardian] today to discuss a transfer to their hospital in [city/state]. The area/puncture on [former client A's] lung causing the lung to collapse is not improving/healing as doctor's (sic) had expected. The hospital told his sister/guardian that the [hospital city/state] facility could provide more intensive care if needed. He will be evaluated for possible need of surgery. Team will remain in contact with the hospital for care and discharge planning. Plan to Resolve: [Former client A] was transferred from [name of hospital] in [city] to [name of hospital] in [city/state] for evaluation to determine if surgery will be needed. Staff will remain in contact with the hospital for care and discharge planning. [Name of hospital/city] admission on 5/23/22 (followed under BDDS 1375332)".<br><br>- A BDDS follow-up report dated 6/3/22 at 4:36 PM indicated, "....Hospital reports today that [former client A] is doing well. They repeated his swallow study because of his coughing but no adjustment to diet needed - on purred (sic) nectar thick liquids. The pneumothorax (collapsed lung) appears to be closed as of today - lung is inflated per normal. A repeat chest -ray (sic) will be completed tomorrow and they do not feel he is going to require surgery. [Former client A] was up today working with physical therapy...."<br><br>A 5/26/22 Investigative Summary was reviewed and indicated: | | | |

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"On the morning of 5/21/22 [staff #4], staff reported [former client A] was yelling and cussing at [client B] to stop bothering him. [Former client A] grabbed [client B's] shirt and [client B] shoved [former client A] away. [Former client A] fell back onto the couch. Staff came from the office/med room and separated the two men. Staff checked clients for injury finding no visual injuries. Staff walked with [former client A] to his bedroom to calm down and [client B] sat in the living room listening to music to calm down. No further behavioral issues between the two men. On the morning of 5/23/22 [former client A] was complaining of left sided rib pain. [Staff #2], staff checked him for injury but found no visual marks. [Staff #2] took [former client A] to urgent care for evaluation. At urgent care an x-ray was completed showing 4 fractured ribs and a collapsed lung. He was ordered as a direct admit to [name of hospital]. He was admitted to the hospital and a chest tube was placed".

"[Client B] was interviewed at the group home on 5/25/22. [Client B] stated:
-Stated [former client A] 'pounced on me'.
-Stated [former client A] was calling him names and making fun of him.
- Stated [former client A] was following him around.
- Stated he was sitting on the couch. [Former client A] came over to him and was 'on top of me'.
- Stated 'I kicked him off me, hit him and knocked him to the floor'.
- Stated [staff #4] 'broke up the fight' and told [client B] to stop.
- Stated when [former client A] was on the floor, he didn't touch him.
- Stated he did call [former client A] a 'baby and a fool'.

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- Stated he 'crippled [former client A]' and he was 'sorry'...."

"[Staff #4] was interviewed at the group home on 5/25/22. [Staff #4] stated:
- Stated she was working Saturday morning 5/21/22 when the incident between [client B] and [former client A] occurred.
- Stated she was in the med (medication) room passing meds when the incident happened.
- Stated she had just passed [former client A's] meds and [former client A] had walked out of the med room.
- Stated [client B] was sitting on the couch by the window asking her who was coming in for the day.
- Stated [former client A] walked out of the med room yelling at [client B] to 'leave him alone'.
- Stated [client B] wasn't talking to [former client A].
- Stated she continued to get the next clients (sic) meds when she heard [client B] and [former client A] yelling.
- Stated she ran out into the living room and [former client A] had a hold of [client B's] shirt.
- Stated [client B] shoved [former client A] hard.
- Stated [former client A] landed on the other couch.
- Stated she helped [former client A] up from the couch, checked him for injuries and walked with him to his bedroom to separate the two men.
- Stated [client B] listened to music sitting on the couch to calm.
- Stated she asked [former client A] if he hurt anywhere, and he said no.
- Stated he had no visual injuries.
- Stated before she left that morning [former client A] was sitting next to her on the love seat, laughing and holding her hand.
- Stated she did not work Sunday 5/22/22.

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- Stated she did not see anything else that could have caused [former client A's] injuries.
- Stated she called [LPN/Licensed Practical Nurse #1] to report incident without injury - left message and [LPN #1] called back...."

"[Former client A] was interviewed at [name of hospital] on 5/26/22. [Former client A] stated:
- Stated he 'threw me'.
- Stated [client B] was the person that 'threw' him...."

Factual Findings from the 5/26/22 Investigative Summary:

"1. Staff working the morning of 5/21/22 was [staff #4].

2. Prior to the incident [staff #4] had passed [former client A's] meds (medications) and he walked out into the living room.

3. [Staff #4] stated [former client A] was saying 'leave me alone' as he walked out of the med room.

4. [Staff #4] stated [client B] was asking what staff was coming to work and not talking to [former client A].

5. [Staff #4] immediately went to the living room when she heard the two men yelling.

6. [Staff #4] intervened (sic) separated the two clients. [Staff #4] checked [former client A] over, found no visual injuries and walked with him to his bedroom. There were no further behavioral issues between the two men.

7. Individual [client B] does have a behavior support plan to address physical aggression as

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defined as becoming loud, cursing, threatening or yelling at others, throwing items, banging or hitting walls or objects.

8. Individual [former client A] does have a behavior support plan to address physical aggression as defined as slamming doors, hitting, kicking, scratching, shoving, throwing objects (walker) (sic) breaking items.

9. In interview, [staff #4] stated [client B] shoved [former client A] hard causing him to land on the couch 'sprawled out on his stomach'.

10. [Client B] was sitting on the couch next to the window, shoved [former client A] with him landing on the other couch across the room. The two couches are appropriately 8 steps apart.

11. [Staff #5] and [staff #1] worked Saturday 5/21/22 from 8am-8pm - report [former client A] did not complain of pain and participated in the normal routine.

12. [Staff #3] worked Saturday (5/21/22) overnight into Sunday (5/22/22) morning - reported [former client A] did not complain of pain. Normal overnight routine.

13. [Staff #2] worked Sunday 5/21/22 from 10am until Monday morning. Reported [former client A] complained of pain about 7:30pm. Stated [former client A] said his side hurt a little, that he had fought [client B]. He declined need for a Tylenol.

14. No one saw anything else happen that could have caused the injuries.

15. [Staff #4] implanted (sic) behavior plans separated clients (sic).

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16. Staff should have notified nurse on Sunday (5/22/22) evening that [former client A] was complaining of a small amount of pain".

Conclusion from the 5/26/22 Investigative Summary:

1. It was determined immediately prior to the physical aggression between individual [former client A] and individual [client B] that [former client A] was yelling at [client B] to leave him alone. [Client B] was asking staff who was coming in for the day and became anxious and agitated with [former client A's] comments.

2. It was determined that the circumstances of the physical aggression between individual [former client A] and individual [client B] on 5/21/22 was that [former client A] grabbed [client B] by the neck of his shirt. [Client B] retaliated with his own admission that he hit, kicked and shoved [former client A] down. [Client B] believed [former client A] was on the floor but may have perceived that with [former client A] 'sprawled' on his stomach on the couch across the room.

3. It was determined that staff stepped in between the individuals and verbally redirected for them to separate to prevent further physical aggression between the two men and this was effective in stopping in (sic) further aggression.

4. It is substantiated that both individuals have a behavior support plan to address aggression.

5. It is determined that staff implemented Behavior Support Plan as written.

6. Staff should have called the nurse on Sunday

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evening (5/22/22) to report small amount of pain".

Recommendations from the 5/26/22 Investigative Summary:

"*Possibly explore ideas to wait to pass meds when the morning/day shift staff arrive.

*IDT (interdisciplinary team) to discuss strategies to follow if [former client A] is saying 'leave me alone'.

*Team is contacting [client B's] psychiatrist to discuss his anxiousness.

*IDT to discuss proactive strategies to follow to decrease [client B's] anxiousness.

*Ensure proper documentation of behavior tracking sheets and incident reporting".

A review of the 5/26/22 Investigative Summary indicated former client A yelled at client B and told him to leave him alone as he was leaving the medication room and heading towards the living room. Staff #4 went back into the medication room and continued to prepare medication for the next client. Staff #4 heard former client A and client B yelling at each other so she went to intervene. When she exited the medication room, former client A had a hold of the neck area of client B's shirt. Staff #4 saw client B shove former client A which resulted in him landing on the couch on the other side of the living room. Both clients were checked for injuries and neither were injured. Client B reported he kicked, hit and knocked former client A to the floor. The clients were separated after the incident. On 5/22/22 at 7:30 PM, former client A complained of pain in the left rib area and the nurse wasn't called. Former

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client A was transported to Urgent Care on Monday, 5/23/22 after refusing to get out of bed. Former client A was diagnosed with 4 left rib fractures and a collapsed lung. He was admitted to the hospital and a chest tube was placed to inflate the lung. After the initial incident of verbal aggression where former client A yelled at client B to leave him alone, staff #4 did not separate former client A and client B which resulted in a physical altercation between the two clients.

Observations were conducted at the group home on 6/8/22 from 3:25 PM to 6:50 PM and on 6/9/22 from 4:00 PM to 6:15 PM. Client B was present at the group home throughout the observation periods. Former client A was not present at the group home.

On 6/8/22 at 2:45 PM, the QIDP-D (Qualified Intellectual Disabilities Professional- Designee) indicated former client A was discharged from the group home on 6/7/22. The QIDP-D indicated former client A was still in the hospital, but he was doing well and former client A's guardian reported former client A would be placed at a nursing home for rehabilitation upon release from the hospital.

On 6/9/22 at 3:40 PM and on 6/10/22 at 11:00 AM, former client A's record was reviewed and indicated the following:

Hospital medical records for former client A dated 5/23/22 indicated former client A was admitted to the hospital on 5/23/22 and transferred to another hospital on 6/1/22. "The patient is a [over age 70] male who presents to the emergency department out of concern for rib fractures and pneumothorax (collapsed lung). Patient has history of cognitive and neurobehavioral dysfunction. He currently resides at a nursing care facility. I am

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| RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL | 725 CARR ST<br>MILAN, IN 47031 |

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| | told that at the group home that he is at he got into an alleged altercation with another group home member (sic). I am told that the alleged altercation happened 2 days ago on Saturday. Patient reportedly got into a fight with this other resident. I am told that after the event the patient seem to be doing well but I am told that yesterday patient started to complain of pain in the left side of his back and ribs. Patient was seen today by caretaker and was brought to an urgent treatment center to be evaluated and to have chest x-ray performed. At the urgent treatment center I am told that he had signs of multiple rib fractures and pneumothorax and so he was brought to the emergency department for evaluation. Patient's caretaker states that his sister is his power of attorney. I am told that the patient has not had any signs of shortness of breath or increased respiratory labor.... There is a large left pneumothorax with periphery of left lower lobe showing dense passive collapse.... Posterior left seventh, eighth, ninth and 11th ribs are fractured. 10th rib appears spared. Posterior eighth rib has a segmental fracture.... ER (emergency room) physician placed a 28 French chest tube with resolution of the pneumothorax.... Primary significant finding was the multiple rib fractures and large left-sided pneumothorax.... At this current time patient appears stable. He is in no acute distress. At this current time patient is sedated with ketamine (anesthesia) and chest tube is placed without difficulty.... Patient has had chest tube for several days and unable to decrease the amount of suction as the patient has reaccumulation of his pneumothorax. I discussed with pulmonary and general surgery. General surgery is recommending transfer for thoracic (organs in the chest) surgery evaluation. They do not want to proceed with pleurodesis (procedure which sticks the lungs to the chest wall) here as | | | |

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they are concerned that thoracic surgery may prefer a different course of treatment.... The patient has been accepted to [same hospital in a different city/state] and is waiting for bed...."

Former client A's 5/7/21 BSP (Behavior Support Plan) indicated former client A had target behaviors of verbal aggression and physical aggression. "Proactive Strategies: 1. If [former client A's] voice, tone, or body language indicates that he is angry, ask [former client A] to identify his anger and provide [former client A] with opportunity to tell staff what is bothering him. 2. Staff will use visual reminders when possible to help [former client A] with repetitive questions such as a calendar, charts, etc. 3. Staff will assist [former client A] with identifying anger and help [former client A] cope with his emotions, ask [former client A] how he feels. If [former client A] is irritable, provide [former client A] with the opportunity to relax in his room or outside on the patio. 4. Staff will provide [former client A] with an activity of his choice as a mean of redirecting anger and encourage [former client A] to be constructive. 5. Staff will afford [former client A] the opportunity to use his bedroom to have personal space, while encouraging [former client A] to decrease anger.... Reactive Strategies: Verbal Aggression: 1. When [former client A] becomes verbally aggressive, staff will clear the area and keep [former client A] in eyesight. 2. Staff will attempt to provide solution to the issue, reassuring [former client A] and discussing options with [former client A] such as going to his room, a preferred activity, talking with staff. 3. If [former client A] chooses to go to his room, leave [former client A] alone for 5 minutes, staff will remain outside bedroom door until [former client A] has calmed. 4. Once [former client A] has calmed down, staff will discuss alternative ways

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of handling anxiety or frustration such as talking to someone, relaxing in his room, watching TV, listening to music, or going outside to the back patio...."

A review of the 5/7/21 BSP indicated staff did not implement the reactive strategies as indicated in the plan. Staff did not clear the area and keep former client A within eye sight after former client A left the medication room and was verbally aggressive towards client B. This resulted in a physical altercation which occurred between former client A and client B.

A review of the progress notes and behavior tracking from 5/21/22 through 5/23/22 indicated staff did not document the altercation between former client A and client B.

A review of the May 2022 nursing notes indicated staff #2 did not contact the nurse on 5/22/22 at 7:30 PM when former client A complained of rib pain.

A review of the May 2022 Skin Assessment form indicated from 5/21/22 through 5/23/22 staff documented no concerns.

A review of the May 2022 Pain Scale Assessment form indicated from 5/21/22 through 5/23/22 staff documented no concerns.

Discharge summary dated 6/7/22 indicated former client A was discharged from the group home on 6/7/22 due to, "Medical. Extended hospital stay (puncture of lung). Going to LTC (long term care)...."

On 6/10/22 at 8:00 AM, client B's record was reviewed.

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Client B's 11/6/21 BSP indicated client B had target behaviors of anxiousness and aggression. Reactive Strategies: "Anxiousness: Staff should watch for changes in [client B's] mood or behavior. In a calm voice ask [client B] what is bothering him, encouraging him to talk about what is bothering him or if he needs anything. Ensure [client B] that everything is okay. Give [client B] an answer to his question. If [client B] continues to ask the same question, have him answere (sic) the question by saying what was the answer I gave you. Give praise for following request/prompts related to [client B's] goals. Redirect to a favored activity such as drawing, games, favorite TV shows, going for a walk, etc.... Aggression: Immediately ensure [client B's] safety by: Redirecting him to a safe and calm area. Redirecting others away from him. If [client B] is continuing to place himself or others in jeopardy, use the You're Safe, I'm Safe (YSIS/behavioral intervention) procedures in the following order: One person YSIS, Two person YSIS. When using these techniques, be aware that [client B] may attempt to resist or struggle, position yourself so that you are safe. If you need help or need to be relieved, request another staff to assist/relieve you...."

A review of the May 2022 progress notes and behavior tracking on 5/21/22 indicated staff did not document the altercation between former client A and client B.

On 6/8/22 at 2:00 PM, staff #2 was interviewed. Staff #2 indicated she wasn't present during the incident between former client A and client B. Staff #2 indicated staff #4 reported to her former client A grabbed client B by the shirt at the neck and was screaming in his face. Staff #2 stated,

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| | "[Client B] felt threatened and pushed him (former client A). [Client B] shoved [former client A] and he fell over on the couch. [Client B] went to the extreme. [Staff #4] didn't see anything. Typically, [client B] isn't aggressive. He's never had an incident (physical aggression). He got tired of getting screamed at so he reacted. There were no injuries at the time". Staff #2 indicated she worked third shift (7:00 PM Sunday to 8:00 AM Monday) Sunday evening (5/22/22). Staff #2 indicated former client A complained of rib pain once during her shift around 7:30 PM and she noticed a bump in the left rib area. Staff #2 indicated former client A didn't get up at all during the night which was unusual for him. Staff #2 stated, "I went to get him up in the morning and he was grunting and said it hurt. He didn't get up". Staff #2 indicated she called the Area Supervisor to tell him former client A needed to go to Urgent Care. Staff #2 indicated she took him to urgent care and and they found four fractured ribs on the left side and a collapsed lung so he was sent to the emergency room at the hospital. Staff #2 indicated upon arrival at the emergency room a chest tube was placed for the collapsed lung. Staff #2 stated, "He was in so much pain they put him on a morphine (for pain) drip". Staff #2 indicated former client A was admitted to the hospital. Staff #2 indicated after a period of time in the hospital former client A wasn't healing so he was transferred to a different hospital where specialists were in case he needed to have surgery. Staff #2 indicated former client A was still in the hospital, he didn't require surgery, he is doing well and will be discharged to a nursing home soon for rehabilitation. Staff #2 stated she did not contact the nurse after former client A initially complained of pain because he declined Tylenol and she "didn't think it was that bad". | | | |

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| | On 6/8/22 at 2:45 PM, the QIDP-D (Qualified Intellectual Disabilities Professional-Designee) was interviewed. The QIDP-D indicated client B did not have a history of physical aggression prior to the incident and he's lived at the group home for 2.5 years. The QIDP-D stated, "[Former client A] has officially been discharged effective today. He is still in the hospital at [city]. He didn't end up having surgery. The wound on the lung wasn't healing so he was transferred from [city] to [city/state]. Everything is healing well now. His [guardian] chose to move him to rehab (rehabilitation at a nursing home) then he will move to a different group home. [Client B's] BSP has been updated to include physical aggression as a target behavior instead of a component of another behavior".<br><br>On 6/8/22 at 5:15 PM, client B was interviewed. Client B stated, "I damaged him (former client A). I hurt his heart. We got in a fist fight. I thought he was making fun of me. He grabbed my shirt (puts both hands on collar of his shirt). It scared me. I pushed him down, punched him and jabbed him (made kicking motion with his foot). He was fine until a few days later. I picked my foot up and kicked him right here (points to chest area). I'm not a mean person. I'm sad about it. He was making fun of me".<br><br>On 6/10/22 at 12:40 PM, staff #3 was interviewed. Staff #3 indicated she came in at 8:00 PM on 5/21/22. Staff #3 stated, "He (former client A) was his normal self. He's an instigator. [Former client A] has gone after clients in the past and he throws his walker and takes off after them (clients). He shows new clients who is the boss, but it hasn't happened lately". When asked to define lately, staff #3 stated, "Not this year". Staff #3 indicated there were no complaints of pain | | | |

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throughout the night and he got up on Sunday morning and ate breakfast. Staff #3 stated, "No concerns at all". When asked if client B had a history of physical aggression, staff #3 stated, "No. He's only had a few issues with non-compliance. I just couldn't believe it. Never anything physical". Staff #3 stated former client A "would torment the clients all the time" but staff would intervene before it became physical. Staff #3 indicated she checked former client A from head to toe during her shift and he didn't have any injuries. Staff #3 indicated if a client has a behavior she would mark it in the book (behavior tracking). Staff #3 stated, "If I mark a behavior I will make a comment about what happened. If not, how do you know what happened?" Staff #3 indicated skin assessments were done daily during showers. Staff #3 indicated if a client complains of pain the nurse should be notified and it should be documented. Staff #3 indicated she works third shift (8:00 PM to 8:00 AM and she worked alone. Staff #3 stated, "We used to have 2 people, but we haven't for a while". Staff #3 indicated it wasn't possible to implement plans, cook, complete hygiene tasks and administer medication with the correct amount of supervision with one staff working. Staff #3 indicated she attempts to have all of the clients stay in the living room during medication administration and while she is cooking so she can supervise everyone.

On 6/13/22 at 1:44 PM, staff #4 was interviewed and indicated the following:
-Indicated she worked 3rd shift (morning) of 5/21/22 when the incident occurred.
-Indicated she was the only staff working.
-Indicated she was administering medication because it was almost time for her to leave.
-Stated during breakfast former client A "was being mean to everyone, throwing his walker

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| | around".<br>-When asked to define mean stated, "Verbal. He woke up in a bad mood. Grumpy".<br>-Indicated former client A calmed down briefly.<br>-Stated she administered former client A's medication and as he was walking out of the medication room he yelled "leave me alone" at client B several times.<br>-Indicated she went back into the medication room, pulled the door closed and started to prepare medication for another client.<br>-Indicated she heard client B and former client A yelling so she ran out of the medication room.<br>-Indicated client B was standing in front of the couch and former client A had a hold of client B's shirt at the collar.<br>-Stated, "[Client B] was yelling stop".<br>-Stated client B "shoved [former client A] pretty hard" and he landed on the couch across the room.<br>-Indicated she didn't see client B hit or kick former client A.<br>-Indicated former client A was still yelling at client B.<br>-Indicated client B was not injured and she checked former client A over and he also had no injuries or complaints of pain.<br>-Indicated she brought former client A into the office and called the nurse and Area Supervisor.<br>-Indicated the nurse said to check him (former client A) over, make sure he didn't hit his head and to keep an eye on him.<br>-Indicated she took former client A to his room to do a body check and he stayed in his room for a while.<br>-Stated before she left the group home former client A was back in the living room sitting on the couch "acting just fine".<br>-Indicated she had no concerns about former client A when she left the group home. | | | |

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| | -Indicated she should have separated former client A and client B when former client A was leaving the medication room and yelled at client B.<br><br>On 6/10/22 at 1:34 PM, the QIDP (Qualified Intellectual Disabilities Professional) and the QIDP-D were interviewed. The QIDP indicated one staff was working at the time of the incident. The QIDP indicated there should be at least two staff working in order to be able to implement plans. The QIDP indicated staff #2 should have called the nurse after former client A complained of pain on 5/22/22. The QIDP indicated client B hasn't displayed any incidents of physical aggression in the 2.5 years he has lived at the group home. The QIDP-D stated, "He (client B) reacted because he felt threatened when [former client A] grabbed the neck of his shirt". The QIDP indicated the two clients should have been separated after former client A yelled at client B to leave him alone as he was leaving the medication room. The QIDP indicated former client A's BSP wasn't implemented as written. The QIDP indicated the pain scale assessment and skin assessment forms for former client A were not completed accurately on 5/22/22 and there should have been documentation in the daily progress notes and behavior tracking about the incident. The QIDP-D stated, "They (staff) used to be in a good routine of documenting in the notes. We don't use an ABC (antecedent-behavior-consequence) form, but they should include what happened on the tracking form". The QIDP indicated client to client aggression was considered abuse, the facility should prevent abuse of the clients, the facility has an abuse/neglect policy and the policy should be implemented.<br>The agency's Abuse, Neglect and | | | |

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| | Exploitation Policy dated 11/14/18 was reviewed on 6/13/22 at 11:25 AM and indicated, "ResCare does not tolerate abuse, neglect, or exploitation of any persons served. All employees are required to report allegations or suspected incidents of abuse, neglect, and exploitation. Supervisors, managers, or employees are not permitted to engage in retaliation, retribution, or any form of harassment directed against any employee who, in good faith, reports allegations or suspected incidents or abuse, neglect or exploitation. All alleged or suspected abuse, neglect, and/or exploitation will be immediately investigated. Appropriate corrective action will be taken to ensure prevention of any further occurrence.... Investigation of Alleged or Suspected Abuse, Neglect or Exploitation: The supervisor receiving a report of alleged or suspected abuse, neglect or exploitation will ensure that an investigation is initiated immediately. All alleged or suspected abuse, neglect, and/or exploitation will actively and aggressively be investigated. ResCare Incident Management and Investigation procedures are to be followed...." This federal tag relates to complaint #IN00381799.9-3-2(a) | | | |
| W 0186<br>Bldg. 00 | 483.430(d)(1-2)<br>DIRECT CARE STAFF<br>The facility must provide sufficient direct care staff to manage and supervise clients in | | | |

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| | accordance with their individual program plans.<br><br>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 3 clients in the sample (B and C) and 4 additional clients (D, E, F and G), the facility failed to ensure there were sufficient staff present at the group home and during outings to meet the needs of clients B, C, D, E, F and G.<br><br>Findings include:<br><br>The surveyor arrived at the group home to open the survey on 6/8/22 at 2:00 PM. Upon arrival at the group home, staff #2 indicated she was working alone and clients B, C, D, F and G were home. Staff #2 indicated the clients usually attend day service but there were staffing issues this week and they weren't able to attend. Staff #2 indicated she was completing incident reports for clients B and C because there was an altercation between them earlier on the van during an outing. Staff #2 stated, "[Client C] attacked [client B]. [Client B] has scratches on his legs". Staff #2 indicated client C attacked her as well. Staff #2 stated, "I think I have a broken knuckle". Staff #2 showed the surveyor her hands and arms. Staff #2 had multiple scratch marks on both forearms and a knuckle on her left hand appeared bruised and swollen. Staff #2 stated, " I think it was because he (client C) was tired of being in the van. We went to the park then for a van ride for a couple hours". Staff #2 indicated they were driving on highway 50 and client C reached over the van seat and grabbed client B's leg. Staff #2 indicated she had to pull over on the highway and | W 0186 | **W186:** The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.<br><br>**Corrective action:**<br>· The Program Manager inserviced the Site Supervisor and Area Supervisor on staffing levels and the procedure for staffing the facility. (**Attachment C)**<br>· All staff trained to call the supervisor immediately if there is not a proper number of staff on shift. **(Attachment D)**<br>· QIDP will complete 2 active treatment observations per week on varied shifts to ensure there is proper staffing and active treatment is occurring. **(Attachment B)**<br>· Rescare Management will do surprise visits to the facility 2 times weekly to ensure there are adequate staffing at the facility.<br>· Multiple homes in the area travel to Happy Days day program where their transporting staff stay with them for the day. These homes meet and travel to the day program together to ensure there is additional staff available if there | 07/08/2022 |

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| | put her hazards on before she could intervene. Staff #2 indicated client C attacked her causing the injuries as she redirected the behavior. Staff #2 indicated client C grabbed her a couple days ago on an outing, but she thought it was because his incontinence brief was wet. Staff #2 indicated client C eventually calmed down and she was able to continue the drive back to the group home. Staff #2 indicated she worked by herself all day and she would be alone until 3:00 PM when staff #4 came to work. Staff #2 indicated she was scheduled to be off work at 3:00 PM when staff #4 arrived and staff #4 was scheduled to work by herself until 11:00 PM. At 3:00 PM, staff #4 arrived then left to go pick up client E from day program. Staff #4 arrived back to the group home with client E at 3:45 PM.<br><br>On 6/9/22 at 12:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed and indicated on 6/8/22 at 12:55 PM, "The home had went (sic) on an outing and was returning to the group home. [Client C] was sitting in front of [client B]. [Client C] began screaming for no apparent reason. [Client C] turned around, reached over the seat and began squeezing and scratching [client B's] right thigh. Staff pulled off the road to a safe area and separated the two men. [Client B] has 4 scratches to his inner right thigh with broken bleeding skin, one scratch to front knee and one scratch to his right elbow with broken kin (sic). Staff administered first aid. Plan to Resolve: [Client C] was admitted to the home in April (2022). This is first incident of aggression. A client to client investigation will be completed to provide recommendations to avoid future incident (sic)".<br><br>On 6/10/22 at 12:00 PM, staff schedules from | | should be a concern while traveling. Each van has a walkie talkie to utilize for assistance if needed during the trip to and from the day program.<br>· All BDDS reportable incidents are reviewed by Rescare Management during Peer Review.<br>· Quality Assurance Coordinator tracks all incident, BDDS and internal reports into a database. The database will be used to track patterns or trends with incidents and will be utilized during peer reviews and quarterly safety meetings.<br><br>**Monitoring of Corrective Action**:<br>· Human Resources monitor staff vacancies and hire staff based on this information.<br>· Active treatment observations will be sent to the Program Manager for review and to ensure completion.<br>· Rescare Management will do surprise visits to the facility 2 times weekly to ensure there are adequate staffing at the facility and report to the Program Manager, Program Director and Executive Director their findings<br>· Rescare Administration will have monthly meetings to discuss trends and patterns with individuals. | |

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| RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL | 725 CARR ST<br>MILAN, IN 47031 |

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| | 5/28/22 through 6/10/22 were reviewed and indicated the following:<br><br>5/28/22: 2 staff from 8:00 AM to 8:00 PM and 1 staff from 8:00 PM to 8:00 AM.<br>5/29/22: 2 staff from 8:00 AM to 8:00 PM and 1 staff from 8:00 PM to 8:00 AM.<br>5/30/22: 1 staff from 7:00 AM to 3:00 PM, 1 staff from 3:00 PM to 11:00 PM and 1 staff from 11:00 PM to 8:00 AM.<br>5/31/22: 1 staff from 7:00 AM to 3:00 PM, 1 staff from 3:00 PM to 11:00 PM and 1 staff from 11:00 PM to 8:00 AM.<br>6/1/22: 1 staff from 7:00 AM to 3:00 PM, 2 staff from 3:00 PM to 11:00 PM and 1 staff from 11:00 PM to 8:00 AM.<br>6/2/22: 1 staff from 7:00 AM to 3:00 PM, 2 staff from 3:00 PM to 11:00 PM and 1 staff from 11:00 PM to 8:00 AM.<br>6/3/22: 1 staff from 7:00 AM to 3:00 PM, 2 staff from 3:00 PM to 11:00 PM and 1 staff from 11:00 PM to 8:00 AM.<br>6/4/22: 2 staff from 8:00 AM to 8:00 PM and 1 staff from 8:00 PM to 8:00 AM.<br>6/5/22: 2 staff from 8:00 AM to 8:00 PM and 1 staff from 8:00 PM to 8:00 AM.<br>6/6/22: 1 staff from 6:00 AM to 2:00 PM, 1 staff from 3:00 PM to 11:00 PM and 1 staff from 11:00 PM to 8:00 AM.<br>6/7/22: 1 staff from 6:00 AM to 2:00 PM, 1 staff from 3:00 PM to 11:00 PM and 1 staff from 11:00 PM to 8:00 AM.<br>6/8/22: 1 staff from 6:00 AM to 2:00 PM, 3 staff from 3:00 PM to 11:00 PM and no staff scheduled from 11:00 PM to 8:00 AM.<br>6/9/22: 1 staff from 6:00 AM to 2:00 PM, 3 staff from 3:00 PM to 11:00 PM and no staff scheduled from 11:00 PM to 8:00 AM.<br>6/10/22: 1 staff from 6:00 AM to 2:00 PM, 3 staff from 3:00 PM to 11:00 PM and no staff scheduled | | **Completion Date: 7/8/22** | |

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from 11:00 PM to 8:00 AM.

On 6/10/22 at 8:00 AM, client B's record was reviewed. Client B's 6/9/22 BSP (Behavior Support Plan) indicated client B had target behaviors of non-compliance (Unwillingness to follow simple directions, requests, rules or prompts from staff or others such as chores, hygiene, goals, taking his medication, etc.), anxiousness, verbal aggression, physical aggression, insomnia, self-injurious behavior and suicide ideation.

On 6/10/22 at 9:00 AM, client C's record was reviewed. Client C's 5/6/22 BSP indicated client C had target behaviors of agitation, self-injurious behavior, physical aggression, personal space/boundary issues, wandering and insomnia.

On 6/10/22 at 10:35 AM, a focused review of client D's record was conducted. Client D's 6/14/21 BSP indicated client D had a target behavior of Psychosis which was defined as refusing to eat, staying in bed, refusing to answer when spoken to and fear of uneven surfaces.

On 6/10/22 at 10:50 AM, a focused review of client E's record was conducted. Client E's 5/28/22 Interaction Guidelines indicated client E had a target behavior of teasing/inappropriate comments. "[Client E] will at times will tease or make inappropriate comments usually towards staff- may make comments that a certain staff is his girlfriend, honey bunny, lover, etc. and make comments in sexual nature".

On 6/10/22 at 10:25 AM, a focused review of client F's record was conducted. Client F's 10/24/21 BSP indicated client F had target behaviors of intermittent explosive disorder, aggression, noncompliance (Unwillingness to follow simple

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directions, requests, or prompts from staff such has completing his chores, hygiene, goals, getting off the van, etc.), elopement, impulse control, disrobing (taking clothes off in public places), masturbation with injury, PICA (eating non-edible items) and insomnia.

On 6/10/22 at 11:05 AM, a focused review of client G's record was conducted. Client G's 2/9/22 BSP indicated client G had target behaviors of non-compliance (Unwillingness to follow simple directions, requests, or prompts from staff such has completing his chores, hygiene, goals, getting off the van, etc.), anxiousness, aggression and tantrums.

On 6/10/22 at 12:40 PM, staff #3 was interviewed. Staff #3 indicated she works third shift (8:00 PM to 8:00 AM) and she worked alone. Staff #3 stated, "We used to have 2 people, but we haven't for a while". Staff #3 indicated it wasn't possible to implement plans, cook, complete hygiene tasks and administer medication with the correct amount of supervision with one staff working. Staff #3 indicated she attempts to have all of the clients stay in the living room during medication administration and while she is cooking so she can supervise everyone.

On 6/13/22 at 1:44 PM, staff #4 was interviewed. Staff #4 indicated she typically works alone, especially on the overnight shift. Staff #4 indicated on Friday (6/10/22) two staff at all times was implemented so there should always be two staff working now. Staff #4 indicated the schedule was changed to include two staff on each shift due to the increase with client A's behaviors last week. Staff #4 indicated it wasn't possible to implement plans, assist with showers, cook and administer medication with only one

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| | staff present. Staff #4 stated, "It's not safe with only one staff. You can't be in seven places at one time".<br><br>On 6/10/22 at 1:34 PM, the QIDP (Qualified Intellectual Disabilities Professional) and the QIDP-D (Qualified Intellectual Disabilities Professional-Designee) were interviewed. The QIDP stated, "I think they normally do 2. Two staff for six clients. Saturday and Sunday 8:00 AM to 8:00 PM is two staff. Overnights (8:00 PM to 8:00 AM) it is one". The QIDP-D indicated staffing the group home has been a challenge and they have open positions. The QIDP indicated the AS (Area Supervisor) was in charge of the schedule. The QIDP-D stated, "Starting now there will be two staff at all times". The QIDP indicated the Team Lead updated the schedule last night to include two staff at all times.<br><br>9-3-3(a) | | | |
| W 0189<br><br>Bldg. 00 | 483.430(e)(1)<br>STAFF TRAINING PROGRAM<br>The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.<br>Based on observation, record review and interview for 3 of 3 clients in the sample (former client A and clients B and C) and 4 additional clients (D, E, F and G), the facility failed to ensure staff were competently trained to contact the nurse when a client complains of pain, complete thorough documentation for progress notes, behavior tracking, skin assessments and pain scale assessment forms and to ensure staff were trained to not go on outings without sufficient staff present. | W 0189 | **W189:** The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.<br><br>**Corrective action:**<br>· All staff trained on the protocol of when to notify the Nurse. (**Attachment E)**<br>· All staff trained to ensure all paperwork is thorough and | 07/08/2022 |

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| | Findings include:<br><br>1. On 6/9/22 at 12:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed and indicated the following:<br><br>-A BDDS report dated 5/21/22 at 7:35 AM indicated, "This morning [former client A] was yelling and cussing at [client B] to stop bothering him. [Former client A] grabbed [client B's] shirt and [client B] shoved [former client A] away. [Former client A] fell back onto the couch. Staff came from the office, and separated the two men. Staff checked clients for injury finding no visual injuries. Staff walked with [former client A] to his bedroom to calm down and [client B] sat in the living room listening to music to calm down. No further issues. Plan to Resolve: [Former client A] and [client B] both have BSP's (sic) (behavior support plans) to address aggression. Staff intervened, separated client's (sic) and redirected to separate areas of the house. A client to client investigation will be completed to provide recommendations to avoid future incident".<br><br>-A BDDS report dated 5/23/22 at 11:20 AM indicated, "[Former client A] was involved in a client to client on Saturday 5/21/22. Another client pushed him onto the couch (followed under BDDS 1374844). Staff had checked him for injuries finding no visual injuries. This morning [former client A] was complaining of left sided rib pain. There are no visual marks. Staff took [former client A] to urgent care for evaluation. At urgent care an x-ray was completed showing 4 fractured ribs and a collapsed lung. He was ordered as a direct admit to [name of hospital]. He was admitted to the hospital and a chest tube was placed. An investigation is being completed for the client to | | complete including progress notes, behavior tracking, skin assessments and pain scale form. **(Attachment F)**<br>· Nurse completes weekly audit to ensure completion of all medical paperwork. **(Attachment G)**<br>· The Program Manager inserviced the Site Supervisor and Area Supervisor on staffing levels and the procedure for staffing the facility. (**Attachment C)**<br>· All staff trained to call the supervisor immediately if there is not a proper number of staff on shift. **(Attachment D)**<br>· QIDP will complete 2 active treatment observations per week on varied shifts to ensure there is proper staffing and active treatment is occurring. **(Attachment B)**<br>· Area Supervisor will complete 2 active treatment observations per week on varied shifts to ensure there is proper staffing and active treatment is occurring. **(Attachment H)**<br>· Rescare Management will do surprise visits to the facility 2 times weekly to ensure there are adequate staffing at the facility.<br>· All BDDS reportable incidents are reviewed by Rescare Management during Peer Review.<br>· Quality Assurance Coordinator tracks all incident, BDDS and internal reports into a database. The database will be | |

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| | client on 5/21/22 and the investigation will include inquiry of these injuries. Plan to Resolve: Investigation will be completed. Staff will remain in contact with the hospital for care and discharge planning".<br><br>-A BDDS follow-up report dated 5/28/22 at 2:24 PM indicated, "[Former client A] remains admitted to [name of hospital]. There was some difficulty with the chest tube remaining in place and was stitched to keep in place. He continues on continues (sic) oxygen with nasal canula (sic) (device used to deliver supplemental oxygen through the nose). He has developed pneumonia during hospital stay. At admission to hospital he was receiving 5 liters oxygen but is no (sic) requiring 1 1/2 liters oxygen. He continues on IV (intravenous) antibiotic. A barium swallow evaluation (to examine the upper gastrointestinal tract) was ordered and completed. There were no new orders as a result of the barium swallow. He continues on a pureed diet with nectar thick fluids. Another chest x-ray will be completed on 5/29/22 and depending on x-ray results the chest tube may be discontinued. Staff will remain in contact with the hospital for care and discharge planning. Describe systemic actions being taken to assume health and safety issues: [Former client A] continues (sic) admitted to the hospital. He is improving and staff will remain in contact with the hospital for care and discharge planning. An investigation was completed to inquire about oirgin (sic) of the injuries. Investigation found the injures (sic) were a result of the client to client altercation on 5/21/22 (followed under BDDS 1374844). On 5/21/22 [former client A] had aggressed toward another client (client B). [Former client A] had grabbed the other clients (sic) (client B) shirt at the neck, the other client (client B) shoved and kicked [former client A] | | used to track patterns or trends with incidents and will be utilized during peer reviews and quarterly safety meetings.<br><br>**Monitoring of Corrective Action**:<br>· Human Resources monitor staff vacancies and hire staff based on this information.<br>· Rescare Administration will have monthly meetings to discuss trends and patterns with individuals.<br>· Site reviews are completed monthly that includes checking documentation for completion.<br>· Rescare is implementing an electronic system for documentation that requires staff to document completely each shift.<br>· Active treatment observations will be sent to the Program Manager for review and to ensure completion.<br>· Rescare Management will do surprise visits to the facility 2 times weekly to ensure there are adequate staffing at the facility and report to the Program Manager, Program Director and Executive Director their findings<br>· Rescare Administration will have monthly meetings to discuss trends and patterns with individuals. | |

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| | causing [former client A] to fall backward across the room about 8 feet. [Former client A] had no visual injuries. [Former client A] did not complain of pain until late Sunday evening 5/22/22 stating he only hurt a little and did not need a Tylenol (for pain relief). Staff will remain in contact with the hospital for care and discharge planning".<br><br>-A BDDS report dated 6/1/22 at 6:30 PM indicated, "[Former client A] was transferred from name of hospital] in [city] to [name of hospital] in [name of city/state]. The hospital spoke with [former client A's guardian] today to discuss a transfer to their hospital in [city/state]. The area/puncture on [former client A's] lung causing the lung to collapse is not improving/healing as doctor's (sic) had expected. The hospital told his sister/guardian that the [hospital city/state] facility could provide more intensive care if needed. He will be evaluated for possible need of surgery. Team will remain in contact with the hospital for care and discharge planning. Plan to Resolve: [Former client A] was transferred from [name of hospital] in [city] to [name of hospital] in [city/state] for evaluation to determine if surgery will be needed. Staff will remain in contact with the hospital for care and discharge planning. [Name of hospital/city] admission on 5/23/22 (followed under BDDS 1375332)".<br><br>- A BDDS follow-up report dated 6/3/22 at 4:36 PM indicated, "....Hospital reports today that [former client A] is doing well. They repeated his swallow study because of his coughing but no adjustment to diet needed - on purred (sic) nectar thick liquids. The pneumothorax (collapsed lung) appears to be closed as of today - lung is inflated per normal. A repeat chest -ray (sic) will be completed tomorrow and they do not feel he is going to require surgery. [Former client A] was | | **Completion Date: 7/8/22** | |

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up today working with physical therapy...."

A 5/26/22 Investigative Summary was reviewed and indicated:

"On the morning of 5/21/22 [staff #4], staff reported [former client A] was yelling and cussing at [client B] to stop bothering him. [Former client A] grabbed [client B's] shirt and [client B] shoved [former client A] away. [Former client A] fell back onto the couch. Staff came from the office/med room and separated the two men. Staff checked clients for injury finding no visual injuries. Staff walked with [former client A] to his bedroom to calm down and [client B] sat in the living room listening to music to calm down. No further behavioral issues between the two men. On the morning of 5/23/22 [former client A] was complaining of left sided rib pain. [Staff #2], staff checked him for injury but found no visual marks. [Staff #2] took [former client A] to urgent care for evaluation. At urgent care an x-ray was completed showing 4 fractured ribs and a collapsed lung. He was ordered as a direct admit to [name of hospital]. He was admitted to the hospital and a chest tube was placed".

"[Client B] was interviewed at the group home on 5/25/22. [Client B] stated:
-Stated [former client A] 'pounced on me'.
-Stated [former client A] was calling him names and making fun of him.
- Stated [former client A] was following him around.
- Stated he was sitting on the couch. [Former client A] came over to him and was 'on top of me'.
- Stated 'I kicked him off me, hit him and knocked him to the floor'.
- Stated [staff #4] 'broke up the fight' and told [client B] to stop.

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- Stated when [former client A] was on the floor, he didn't touch him.
- Stated he did call [former client A] a 'baby and a fool'.
- Stated he 'crippled [former client A]' and he was 'sorry'...."

"[Staff #4] was interviewed at the group home on 5/25/22. [Staff #4] stated:
- Stated she was working Saturday morning 5/21/22 when the incident between [client B] and [former client A] occurred.
- Stated she was in the med (medication) room passing meds when the incident happened.
- Stated she had just passed [former client A's] meds and [former client A] had walked out of the med room.
- Stated [client B] was sitting on the couch by the window asking her who was coming in for the day.
- Stated [former client A] walked out of the med room yelling at [client B] to 'leave him alone'.
- Stated [client B] wasn't talking to [former client A].
- Stated she continued to get the next clients (sic) meds when she heard [client B] and [former client A] yelling.
- Stated she ran out into the living room and [former client A] had a hold of [client B's] shirt.
- Stated [client B] shoved [former client A] hard.
- Stated [former client A] landed on the other couch.
- Stated she helped [former client A] up from the couch, checked him for injuries and walked with him to his bedroom to separate the two men.
- Stated [client B] listened to music sitting on the couch to calm.
- Stated she asked [former client A] if he hurt anywhere, and he said no.
- Stated he had no visual injuries.

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- Stated before she left that morning [former client A] was sitting next to her on the love seat, laughing and holding her hand.
- Stated she did not work Sunday 5/22/22.
- Stated she did not see anything else that could have caused [former client A's] injuries.
- Stated she called [LPN/Licensed Practical Nurse #1] to report incident without injury - left message and [LPN #1] called back...."

"[Former client A] was interviewed at [name of hospital] on 5/26/22. [Former client A] stated:

- Stated he 'threw me'.

- Stated [client B] was the person that 'threw' him...."

Factual Findings from the 5/26/22 Investigative Summary:

"1. Staff working the morning of 5/21/22 was [staff #4].

2. Prior to the incident [staff #4] had passed [former client A's] meds (medications) and he walked out into the living room.

3. [Staff #4] stated [former client A] was saying 'leave me alone' as he walked out of the med room.

4. [Staff #4] stated [client B] was asking what staff was coming to work and not talking to [former client A].

5. [Staff #4] immediately went to the living room when she heard the two men yelling.

6. [Staff #4] intervened (sic) separated the two clients. [Staff #4] checked [former client A] over,

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| | found no visual injuries and walked with him to his bedroom. There were no further behavioral issues between the two men.<br><br>7. Individual [client B] does have a behavior support plan to address physical aggression as defined as becoming loud, cursing, threatening or yelling at others, throwing items, banging or hitting walls or objects.<br><br>8. Individual [former client A] does have a behavior support plan to address physical aggression as defined as slamming doors, hitting, kicking, scratching, shoving, (sic) throwing objects (walker) breaking items.<br><br>9. In interview, [staff #4] stated [client B] shoved [former client A] hard causing him to land on the couch 'sprawled out on his stomach'.<br><br>10. [Client B] was sitting on the couch next to the window, shoved [former client A] with him landing on the other couch across the room. The two couches are appropriately 8 steps apart.<br><br>11. [Staff #5] and [staff #1] worked Saturday 5/21/22 from 8am-8pm - report [former client A] did not complain of pain and participated in the normal routine.<br><br>12. [Staff #3] worked Saturday (5/21/22) overnight into Sunday (5/22/22) morning - reported [former client A] did not complain of pain. Normal overnight routine.<br><br>13. [Staff #2] worked Sunday 5/21/22 from 10am until Monday morning. Reported [former client A] complained of pain about 7:30pm. Stated [former client A] said his side hurt a little, that he had fought [client B]. He declined need for a Tylenol. | | | |

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14. No one saw anything else happen that could have caused the injuries.

15. [Staff #4] implanted (sic) behavior plans separated clients (sic).

16. Staff should have notified nurse on Sunday (5/22/22) evening that [former client A] was complaining of a small amount of pain".

Conclusion from the 5/26/22 Investigative Summary:

1. It was determined immediately prior to the physical aggression between individual [former client A] and individual [client B] that [former client A] was yelling at [client B] to leave him alone. [Client B] was asking staff who was coming in for the day and became anxious and agitated with [former client A's] comments.

2. It was determined that the circumstances of the physical aggression between individual [former client A] and individual [client B] on 5/21/22 was that [former client A] grabbed [client B] by the neck of his shirt. [Client B] retaliated with his own admission that he hit, kicked and shoved [former client A] down. [Client B] believed [former client A] was on the floor but may have perceived that with [former client A] 'sprawled' on his stomach on the couch across the room.

3. It was determined that staff stepped in between the individuals and verbally redirected for them to separate to prevent further physical aggression between the two men and this was effective in stopping in (sic) further aggression.

4. It is substantiated that both individuals have a

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behavior support plan to address aggression.

5. It is determined that staff implemented Behavior Support Plan as written.

6. Staff should have called the nurse on Sunday evening (5/22/22) to report small amount of pain".

Recommendations from the 5/26/22 Investigative Summary:

"*Possibly explore ideas to wait to pass meds when the morning/day shift staff arrive.

*IDT (interdisciplinary team) to discuss strategies to follow if [former client A] is saying 'leave me alone'.

*Team is contacting [client B's] psychiatrist to discuss his anxiousness.

*IDT to discuss proactive strategies to follow to decrease [client B's] anxiousness.

*Ensure proper documentation of behavior tracking sheets and incident reporting".

A review of the 5/26/22 Investigative Summary indicated former client A yelled at client B and told him to leave him alone as he was leaving the medication room and heading towards the living room. Staff #4 went back into the medication room and continued to prepare medication for the next client. Staff #4 heard former client A and client B yelling at each other so she went to intervene. When she exited the medication room, former client A had a hold of the neck area of client B's shirt. Staff #4 saw client B shove former client A which resulted in him landing on the couch on the other side of the living room. Both

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clients were checked for injuries and neither were injured. Client B reported he kicked, hit and knocked former client A to the floor. The clients were separated after the incident. On 5/22/22 at 7:30 PM, former client A complained of pain in the left rib area and the nurse wasn't called. Former client A was transported to Urgent Care on Monday, 5/23/22 after refusing to get out of bed. Former client A was diagnosed with 4 left rib fractures and a collapsed lung. He was admitted to the hospital and a chest tube was placed to inflate the lung. After the initial incident of verbal aggression where former client A yelled at client B to leave him alone, staff #4 did not separate former client A and client B which resulted in a physical altercation between the two clients.

Observations were conducted at the group home on 6/8/22 from 3:25 PM to 6:50 PM and on 6/9/22 from 4:00 PM to 6:15 PM. Client B was present at the group home throughout the observation periods. Former client A was not present at the group home.

On 6/8/22 at 2:45 PM, the QIDP-D (Qualified Intellectual Disabilities Professional- Designee) indicated former client A was discharged from the group home on 6/7/22. The QIDP-D indicated former client A was still in the hospital, but he was doing well and former client A's guardian reported former client A would be placed at a nursing home for rehabilitation upon release from the hospital.

On 6/9/22 at 3:40 PM and on 6/10/22 at 11:00 AM, former client A's record was reviewed and indicated the following:

Hospital medical records for former client A dated 5/23/22 indicated former client A was admitted to the hospital on 5/23/22 and transferred to another

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| | hospital on 6/1/22. "The patient is a [over age 70] male who presents to the emergency department out of concern for rib fractures and pneumothorax (collapsed lung). Patient has history of cognitive and neurobehavioral dysfunction. He currently resides at a nursing care facility. I am told that at the group home that he is at he got into an alleged altercation with another group home member (sic). I am told that the alleged altercation happened 2 days ago on Saturday. Patient reportedly got into a fight with this other resident. I am told that after the event the patient seem to be doing well but I am told that yesterday patient started to complain of pain in the left side of his back and ribs. Patient was seen today by caretaker and was brought to an urgent treatment center to be evaluated and to have chest x-ray performed. At the urgent treatment center I am told that he had signs of multiple rib fractures and pneumothorax and so he was brought to the emergency department for evaluation. Patient's caretaker states that his sister is his power of attorney. I am told that the patient has not had any signs of shortness of breath or increased respiratory labor.... There is a large left pneumothorax with periphery of left lower lobe showing dense passive collapse.... Posterior left seventh, eighth, ninth and 11th ribs are fractured. 10th rib appears spared. Posterior eighth rib has a segmental fracture.... ER (emergency room) physician placed a 28 French chest tube with resolution of the pneumothorax.... Primary significant finding was the multiple rib fractures and large left-sided pneumothorax.... At this current time patient appears stable. He is in no acute distress. At this current time patient is sedated with ketamine (anesthesia) and chest tube is placed without difficulty.... Patient has had chest tube for several days and unable to decrease the amount of suction as the patient has | | | |

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reaccumulation of his pneumothorax. I discussed with pulmonary and general surgery. General surgery is recommending transfer for thoracic (organs in the chest) surgery evaluation. They do not want to proceed with pleurodesis (procedure which sticks the lungs to the chest wall) here as they are concerned that thoracic surgery may prefer a different course of treatment.... The patient has been accepted to [same hospital in a different city/state] and is waiting for bed...."

A review of the progress notes and behavior tracking from 5/21/22 through 5/23/22 indicated staff did not document the altercation between former client A and client B.

A review of the May 2022 nursing notes indicated staff #2 did not contact the nurse on 5/22/22 at 7:30 PM when former client A complained of rib pain.

A review of the May 2022 Skin Assessment form indicated from 5/21/22 through 5/23/22 staff documented "no concerns".

A review of the May 2022 Pain Scale Assessment form indicated from 5/21/22 through 5/23/22 staff documented no concerns.

On 6/10/22 at 8:00 AM, client B's record was reviewed.

A review of the May 2022 progress notes and behavior tracking on 5/21/22 indicated staff did not document the altercation between former client A and client B.

On 6/8/22 at 2:00 PM, staff #2 was interviewed. Staff #2 indicated she worked third shift (8:00 PM Sunday to 8:00 AM Monday) Sunday evening

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(5/22/22). Staff #2 indicated former client A complained of rib pain once during her shift around 7:30 PM and she noticed a bump in the left rib area. Staff #2 indicated former client A didn't get up at all during the night which was unusual for him. Staff #2 stated, "I went to get him up in the morning and he was grunting and said it hurt. He didn't get up". Staff #2 indicated she called the Area Supervisor to tell him former client A needed to be seen. Staff #2 indicated she took him to urgent care and and they found four fractured ribs on the left side and a collapsed lung so he was sent to the emergency room at the hospital. Staff #2 indicated upon arrival at the emergency room a chest tube was placed for the collapsed lung. Staff #2 stated, "He was in so much pain they put him on a morphine drip". Staff #2 indicated former client A was admitted to the hospital. Staff #2 stated she did not contact the nurse after former client A initially complained of pain because he declined Tylenol and she "didn't think it was that bad".

On 6/8/22 at 5:15 PM, client B was interviewed. Client B stated, "I damaged him (former client A). I hurt his heart. We got in a fist fight. I thought he was making fun of me. He grabbed my shirt (puts both hands on collar of his shirt). It scared me. I pushed him down, punched him and jabbed him (made kicking motion with his foot). He was fine until a few days later. I picked my foot up and kicked him right here (points to chest area). I'm not a mean person. I'm sad about it. He was making fun of me".

On 6/10/22 at 12:40 PM, staff #3 was interviewed. Staff #3 indicated if a client has a behavior she would mark it in the book (behavior tracking). Staff #3 stated, "If I mark a behavior I will make a comment about what happened. If not, how do

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you know what happened?" Staff #3 indicated skin assessments were done daily during showers and they should be accurate.

On 6/13/22 at 1:44 PM, staff #4 was interviewed and indicated the following:
-Indicated she worked 3rd shift (morning) of 5/21/22 when the incident occurred.
-Indicated she was the only staff working.
-Indicated she was administering medication because it was almost time for her to leave.
-Stated during breakfast former client A "was being mean to everyone, throwing his walker around".
-When asked to define mean stated, "Verbal. He woke up in a bad mood. Grumpy".
-Indicated former client A calmed down briefly.
-Stated she administered former client A's medication and as he was walking out of the medication room he yelled "leave me alone" at client B several times.
-Indicated she went back into the medication room, pulled the door closed and started to prepare medication for another client.
-Indicated she heard client B and former client A yelling so she ran out of the medication room.
-Indicated client B was standing in front of the couch and former client A had a hold of client B's shirt at the collar.
-Stated, "[Client B] was yelling stop".
-Stated client B "shoved [former client A] pretty hard" and he landed on the couch across the room.
-Indicated she didn't see client B hit or kick former client A.
-Indicated former client A was still yelling at client B.
-Indicated client B was not injured and she checked former client A over and he also had no injuries or complaints of pain.

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-Indicated she brought former client A into the office and called the nurse and Area Supervisor.
-Indicated the nurse said to check him (former client A) over, make sure he didn't hit his head and to keep an eye on him.
-Indicated she took former client A to his room to do a body check and he stayed in his room for a while.
-Stated before she left the group home former client A was back in the living room sitting on the couch "acting just fine".
-Indicated she had no concerns about former client A when she left the group home.
-Indicated she should have separated former client A and client B when former client A was leaving the medication room and yelled at client B.
-Indicated the incident should have been documented in the progress notes and in the behavior tracking.

On 6/10/22 at 1:34 PM, the QIDP (Qualified Intellectual Disabilities Professional) and the QIDP-D were interviewed. The QIDP indicated staff #2 should have called the nurse after former client A complained of pain on 5/22/22. The QIDP indicated the pain scale assessment and skin assessment for former client A were not completed accurately on 5/22/22 and there should have been documentation in the daily progress notes and behavior tracking about the incident. The QIDP-D stated, "They (staff) used to be in a good routine of documenting in the notes. We don't use an ABC (antecedent-behavior-consequence) form, but they should include what happened on the tracking form". The QIDP indicated staff needed to be retrained on documentation.

2. The surveyor arrived at the group home to open the survey on 6/8/22 at 2:00 PM. Upon

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| | arrival at the group home, staff #2 indicated she was working alone and clients B, C, D, F and G were home. Staff #2 indicated the clients usually attend day service but there were staffing issues this week and they weren't able to attend. Staff #2 indicated she was completing incident reports for clients B and C because there was an altercation between them earlier on the van during an outing. Staff #2 stated, "[Client C] attacked [client B]. [Client B] has scratches on his legs". Staff #2 indicated client C attacked her as well. Staff #2 stated, "I think I have a broken knuckle". Staff #2 showed the surveyor her hands and arms. Staff #2 had multiple scratch marks on both forearms and a knuckle on her left hand appeared bruised and swollen. Staff #2 stated, " I think it was because he (client C) was tired of being in the van. We went to the park then for a van ride for a couple hours". Staff #2 indicated they were driving on highway 50 and client C reached over the van seat and grabbed client B's leg. Staff #2 indicated she had to pull over on the highway and put her hazards on before she could intervene. Staff #2 indicated client C attacked her causing the injuries as she redirected the behavior. Staff #2 indicated client C grabbed her a couple days ago on an outing, but she thought it was because his incontinence brief was wet. Staff #2 indicated client C eventually calmed down and she was able to continue the drive back to the group home. Staff #2 indicated she worked by herself all day and she would be alone until 3:00 PM when staff #4 came to work. Staff #2 indicated she was scheduled to be off work at 3:00 PM when staff #4 arrived and staff #4 was scheduled to work by herself until 11:00 PM. At 3:00 PM, staff #4 arrived then left to go pick up client E from day program. Staff #4 arrived back to the group home with client E at 3:45 PM. | | | |

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On 6/9/22 at 12:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed and indicated on 6/8/22 at 12:55 PM, "The home had went (sic) on an outing and was returning to the group home. [Client C] was sitting in front of [client B]. [Client C] began screaming for no apparent reason. [Client C] turned around, reached over the seat and began squeezing and scratching [client B's] right thigh. Staff pulled off the road to a safe area and separated the two men. [Client B] has 4 scratches to his inner right thigh with broken bleeding skin, one scratch to front knee and one scratch to his right elbow with broken kin (sic). Staff administered first aid. Plan to Resolve: [Client C] was admitted to the home in April (2022). This is first incident of aggression. A client to client investigation will be completed to provide recommendations to avoid future incident (sic)".

On 6/10/22 at 8:00 AM, client B's record was reviewed. Client B's 6/9/22 BSP (Behavior Support Plan) indicated client B had target behaviors of non-compliance (Unwillingness to follow simple directions, requests, rules or prompts from staff or others such as chores, hygiene, goals, taking his medication, etc.), anxiousness, verbal aggression, physical aggression, insomnia, self-injurious behavior and suicide ideation.

On 6/10/22 at 9:00 AM, client C's record was reviewed. Client C's 5/6/22 BSP indicated client C had target behaviors of agitation, self-injurious behavior, physical aggression, personal space/boundary issues, wandering and insomnia.

On 6/10/22 at 10:35 AM, a focused review of client D's record was conducted. Client D's 6/14/21 BSP indicated client D had a target behavior of

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Psychosis which was defined as refusing to eat, staying in bed, refusing to answer when spoken to and fear of uneven surfaces.

On 6/10/22 at 10:50 AM, a focused review of client E's record was conducted. Client E's 5/28/22 Interaction Guidelines indicated client E had a target behavior of teasing/inappropriate comments. "[Client E] will at times will tease or make inappropriate comments usually towards staff- may make comments that a certain staff is his girlfriend, honey bunny, lover, etc. and make comments in sexual nature".

On 6/10/22 at 10:25 AM, a focused review of client F's record was conducted. Client F's 10/24/21 BSP indicated client F had target behaviors of intermittent explosive disorder, aggression, noncompliance (Unwillingness to follow simple directions, requests, or prompts from staff such has completing his chores, hygiene, goals, getting off the van, etc.), elopement, impulse control, disrobing (taking clothes off in public places), masturbation with injury, PICA (eating non-edible items) and insomnia.

On 6/10/22 at 11:05 AM, a focused review of client G's record was conducted. Client G's 2/9/22 BSP indicated client G had target behaviors of non-compliance (Unwillingness to follow simple directions, requests, or prompts from staff such has completing his chores, hygiene, goals, getting off the van, etc.), anxiousness, aggression and tantrums.

On 6/10/22 at 1:34 PM, the QIDP (Qualified Intellectual Disabilities Professional) and the QIDP-D (Qualified Intellectual Disabilities Professional-Designee) were interviewed. When asked why there was only one staff on an outing

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| RES CARE COMMUNITY ALTERNATIVES SOUTH CENTRAL | 725 CARR ST<br>MILAN, IN 47031 |

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| | with 5 clients, the QIDP stated, "That, I can't answer. With the ratio (5 clients to 1 staff), I think they can, but it was not a safe situation. Not to have just one person (staff). Should have more than one person due to safety concerns". The QIDP indicated there should always be more than one staff on the van if more than one client is being transported.<br><br>This federal tag relates to complaint #IN00381799.<br><br>9-3-3(a) | | | |
| W 0249<br><br>Bldg. 00 | 483.440(d)(1)<br>PROGRAM IMPLEMENTATION<br>As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. | | | |
| | Based on observation, record review and interview for 1 of 3 clients in the sample (C) and 1 additional client (F), the facility failed to implement client C's BSP (Behavior Support Plan) to prevent an incident of client to client aggression between client C and client F.<br><br>Findings include:<br><br>The surveyor arrived at the group home to open the survey on 6/8/22 at 2:00 PM. Upon arrival at the group home, staff #2 indicated she was working alone and clients B, C, D, F and G were home. Staff #2 indicated the clients usually attend day service but there were staffing issues this week and they weren't able to attend. Staff #2 indicated she was completing incident reports for | W 0249 | **W249:** As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.<br><br>**Corrective Action:**<br>· The Program Manager inserviced the Site Supervisor and Area Supervisor on staffing levels | 07/08/2022 |

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| | clients B and C because there was an altercation between them earlier on the van during an outing. Staff #2 stated, "[Client C] attacked [client B]. [Client B] has scratches on his legs". Staff #2 indicated client C attacked her as well. Staff #2 stated, "I think I have a broken knuckle". Staff #2 showed the surveyor her hands and arms. Staff #2 had multiple scratch marks on both forearms and a knuckle on her left hand appeared bruised and swollen. Staff #2 stated, " I think it was because he (client C) was tired of being in the van. We went to the park then for a van ride for a couple hours". Staff #2 indicated they were driving on highway 50 and client C reached over the van seat and grabbed client B's leg. Staff #2 indicated she had to pull over on the highway and put her hazards on before she could intervene. Staff #2 indicated client C attacked her causing the injuries as she redirected the behavior. Staff # 2 indicated client C grabbed her a couple days ago on an outing, but she thought it was because his incontinence brief was wet. Staff #2 indicated client C eventually calmed down and she was able to continue the drive back to the group home. Staff #2 indicated she worked by herself all day and she would be alone until 3:00 PM when staff #4 came to work. Staff #2 indicated she was scheduled to be off work at 3:00 PM when staff #4 arrived and staff #4 was scheduled to work by herself until 11:00 PM. At 3:00 PM, staff #4 arrived then left to go pick up client E from day program.<br><br>An observation was conducted at the group home on 6/8/22 from 3:25 PM to 6:50 PM. From 3:25 PM to 3:50 PM, client C was in his room listening to music and singing. Staff #4 arrived back to the group home with client E at 3:45 PM. Staff #2, staff #4 and the QIDP-D (Qualified Intellectual Disabilities Professional-Designee) were present | | and the procedure for staffing the facility. (**Attachment C)**<br>· All staff trained to call the supervisor immediately if there is not a proper number of staff on shift. **(Attachment D)**<br>· QIDP will ensure all staff are thoroughly trained on all Behavior Support Plans annually and as needed. **(Attachment B)**<br>· QIDP will complete 2 active treatment observations per week on varied shifts to ensure there is proper staffing and active treatment is occurring. **(Attachment B)**<br>· Area Supervisor will complete 2 active treatment observations per week on varied shifts to ensure there is proper staffing and active treatment is occurring. **(Attachment H)**<br>· Rescare Management will do surprise visits to the facility 2 times weekly to ensure there are adequate staffing at the facility.<br>· Multiple homes in the area travel to Happy Days day program where their transporting staff stay with them for the day. These homes meet and travel to the day program together to ensure there is additional staff available if there should be a concern while traveling. Each van has a walkie talkie to utilize for assistance if needed during the trip to and from the day program. | |

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| | at the group home. At 3:55 PM, staff #4 was in the kitchen talking with staff #2 about dinner and client C came out of his bedroom, walked straight towards staff #4 and attempted to grab her arms. Staff #2 intervened and client C grabbed her by the shoulder and her hair. The QIDP-D attempted to intervene and client C attacked her by grabbing her wrists and squeezing. Clients B, D, E, F and G were prompted to leave the kitchen area for their safety. At 3:58 PM, the QIDP-D gave client C some potato chips and he calmed down long enough to eat the chips. At 3:59 PM, the QIDP-D got client C's tablet and placed it on the table next to him. The QIDP-D grabbed client C's communication board off the kitchen counter and attempted to have client C indicate what he wanted. Client C ignored the prompts. The QIDP-D stated, "This is totally new. We've not seen this until today. He usually will grab your wrist to take you somewhere he wants to be or to what he wants". At 4:02 PM, staff #2 was able to get client C to go to his room and listen to his music. At 4:09 PM, client C came out of his bedroom, opened the front door and looked outside while yelling. QIDP-D offered to sit with him outside. Client C sat down for two minutes then came back inside grabbing at staff #2 and the QIDP-D. Staff #4 avoided client C and went the opposite direction he went. At 4:15 PM, client C was offered a shower by staff #2. Client C continued to attack staff #2 and the QIDP-D by grabbing their arms and hands. Staff #2 had scratches with a red substance on various spots on her arms so she went to the bathroom to cover the scratches. The QIDP-D stated, "He knows the majority of his body parts" and asked client C if something hurt. Client C did not respond and continued to attack the QIDP-D. At 4:19 PM, staff #2 returned to the kitchen and stated, "He might be constipated. I'm trying to think of everything". | | **Monitoring of Corrective Action:**<br><br>· Human Resources monitor staff vacancies and hire staff based on this information.<br>· Active treatment observations will be sent to the Program Manager for review and to ensure completion.<br>· QIDP trains all staff annually and as needed on all client behavior plans.<br>· QIDP includes in the monthly summary all data from behavior tracking to track patterns of behavior or significant changes in behaviors.<br>· Rescare Management will do surprise visits to the facility 2 times weekly to ensure there are adequate staffing at the facility and report to the Program Manager, Program Director and Executive Director their findings<br>· Rescare Administration will have monthly meetings to discuss trends and patterns with individuals.<br><br>**Completion Date: 7/8/22** | |

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| | Staff #4 was passing medication and staff #2 had her prepare of dose of milk of magnesia (for constipation) for client C. At 4:20 PM, staff #2 was able to get client C into the shower. Staff #2 assisted client C with his shower and administered the milk of magnesia while he was in the shower. Client C was calm during his shower. At 4:27 PM, client C was done in the shower and went out front to sit with the QIDP-D. At 4:31 PM, client C came back inside and began attacking staff #2 and the QIDP-D by grabbing their arms, wrists and hands. Staff #2 attempted to redirect client C, but she was unsuccessful. Staff #2 stated, "I'm taking him for a psych (psychiatric) eval (evaluation) at the hospital". Client C was outside on the front porch with the QIDP-D. The surveyor stated, "By yourself?" Staff #2 stated, "Yes ma'am, I am. It's part of my job". The surveyor stated, "It's not safe is it?" Staff #2 stated, "It's part of my job". Staff #2 grabbed a red folder off of the desk in the office and walked out the front door. Staff #2 assisted client C into the van and buckled his seatbelt. The surveyor asked staff #4 if it was safe for her (staff #2) to transport him and staff #4 stated, "No, absolutely not. It's ridiculous". Staff #4 then went to the medication room/office and closed the door. At 4:35 PM, the surveyor asked the QIDP-D if it was safe for staff #2 to transport client C by herself and the QIDP-D stated, "No, it's not a good idea for her to go alone. I'm stopping her. She can't go alone". The QIDP-D instructed staff #2 she couldn't go by herself. Client C was calm sitting on the van so they let him sit there with staff #2. At 4:44 PM, client C went back inside.<br><br>At 4:45 PM, staff #2 spoke with the surveyor outside. Staff #2 had pinch marks, scratches and bruises up and down both of her arms. Staff #2 indicated the behavior started earlier today on the | | | |

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| | van as she was driving down highway 50 and client C reached over the back seat of the van and grabbed client B's leg and scratched him. Staff #2 indicated she wasn't able to intervene until she was able to pull over. Staff #2 indicated as she was redirecting client C he attacked her multiple times. At 4:49 PM, client C became loud again so staff #2 went back inside to assist. Client C was offered several things to assist with calming and he declined everything. At 4:50 PM, staff #4 grabbed her belongings from the office and walked out the front door. Staff #4 didn't say anything on the way out the door. Clients B, D, E, F and G were prompted to wash their hands for dinner. Client C was in his room listening to music. At 4:55 PM, the QIDP (Qualified Intellectual Disabilities Professional) arrived at the group home. Clients B, D, E, F and G were sitting at the kitchen table passing the food around the table. The clients started eating. At 4:59 PM, client C came out of his bedroom yelling loudly. He attacked the QIDP and staff #2 by grabbing their arms and wrists. Client C walked around the kitchen table where the other clients were trying to eat dinner. At 5:05 PM, client C went behind client F and smacked him on the back and shoulder. Client F was not injured. The QIDP intervened to prevent further incidents. The QIDP and the QIDP-D escorted client C to his room and stayed with him while the clients ate dinner. At 5:11 PM, staff #2 indicated staff #4 told her to call her when client C calmed down and she would return to work. At 5:15 PM, client B was done eating and was interviewed by the surveyor on the front porch. Client B had multiple scratches on his right leg above the knee. Client B indicated client C caused the scratches on the van ride today. Client B indicated they were driving down the road and client C reached over the van seat and grabbed his leg. Client B stated, "He got | | | |

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| | [staff #2] too. She broke her wrist I think". Client B indicated it made him sad and he didn't want client C to sit near him on the van anymore. At 5:30 PM, the clients were done eating so client C came to the kitchen to eat dinner. Client C sat down and bit his arm. Client C was calm while he ate his dinner. At 5:40 PM, staff #6 came to the home to work. The QIDP-D stated, "I've never seen him like this before. I'm not sure what is wrong with him. He has grabbed wrists before, but not with aggression". The QIDP-D was asked at what point they should consider a psych eval. The QIDP-D stated, "We are at that point. We have a call in to the nurse to see about an emergency psych eval. He calmed in his room for a good while. I just can't figure it out. He's still in his honeymoon period. We are still learning him. We tried a psych eval earlier but it wasn't safe to transport him". Client C continued to come in and out of his room yelling and going after staff with his hands. Client C was blocked and guided back to his room each time. At 6:00 PM, staff #6 came out of client C's room and stated, "I am going to call 911 to transport him to the ER (emergency room) for a psych eval". Client C continued to come to the living room and staff would redirect him back to his bedroom. At 6:03 PM, a police officer arrived. From 6:03 PM to 6:20 PM, client C continued to go in and out of his room yelling. At 6:20 PM, the ambulance arrived to assess client C. At 6:25 PM, client C walked with assistance from staff #2 and the QIDP out to the ambulance. At 6:35 PM, the ambulance left the group home with client C.<br><br>On 6/9/22 from 4:00 PM to 6:15 PM, an observation was conducted at the group home. At 4:20 PM, client C arrived back at the group home with staff #2. Staff #2 indicated the hospital administered Ativan (for behavior) to client C and | | | |

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| | he was calm while he was at the emergency room. Staff #2 indicated there were no beds open at any of the psychiatric hospitals so the hospital emergency room discharged him back to the group home. Client C was prescribed .5 mg (milligrams) of Ativan twice a day and he has an appointment with the psychiatrist on 6/16/22. Throughout the observation period, client C wandered throughout the group home, smiled at staff, listened to music in his bedroom, interacted with staff, watched TV in his bedroom, served himself dinner, ate dinner and remained calm. Client C did not display physical aggression and he did not yell throughout the observation.<br><br>On 6/9/22 at 12:45 PM, the facility's BDDS (Bureau of Developmental Disabilities Services) reports and investigations were reviewed and indicated the following:<br><br>-On 6/8/22 at 12:55 PM, "The home had went (sic) on an outing and was returning to the group home. [Client C] was sitting in front of [client B]. [Client C] began screaming for no apparent reason. [Client C] turned around, reached over the seat and began squeezing and scratching [client B's] right thigh. Staff pulled off the road to a safe area and separated the two men. [Client B] has 4 scratches to his inner right thigh with broken bleeding skin, one scratch to front knee and one scratch to his right elbow with broken kin (sic). Staff administered first aid. Plan to Resolve: [Client C] was admitted to the home in April (2022). This is first incident of aggression. A client to client investigation will be completed to provide recommendations to avoid future incident (sic)".<br><br>-On 6/8/22 at 3:45 PM, "Staff had returned from an outing. Staff had went (sic) to the kitchen to start | | | |

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| | dinner. [Client C] came into the kitchen and began grabbing at staff. Staff attempted to redirect asked if he wanted a snack, he continued to grab at staff's wrist. [Client C] continued to grab at all staff, walked past [client F] sitting at the table and attempted to grab him. Staff did a two person escort down the hallway and into his room. Staff remained with [client C] attempting to calm him offering choice of activities. [Client C] continued aggression grabbing staff, walking out of his bedroom and down the hall, staff completed the two person escort to his room and again remained with him attempting to calm him. When the other clients finished dinner staff walked with [client C] to the table and he ate all his dinner with periodically grabbing at staff assisting him at the table. Staff called 911 to have him evaluated in the ER (emergency room) for a psychiatric consult and possible in-patient. He was taken to [name of hospital] ER via EMS (emergency medical services). At the ER a psychiatric consult was obtained. He is currently at the ER and will remain in the ER awaiting transport to a psychiatric hospital. One taff (sic) did receive injury to her right hand knuckle and will seek x-ray. Plan to Resolve: The hospital is working on finding a psychiatric in-patient. [Client C] will remain at [name of hospital] ER until a psychiatric inpatient can be obtained".<br><br>On 6/10/22 at 9:00 AM, client C's record was reviewed. Client C's 5/6/22 BSP indicated client C had target behaviors of agitation, self-injurious behavior, physical aggression, personal space/boundary issues, wandering and insomnia. "Reactive Strategies: Agitation: When [client C] becomes agitated, staff will clear the area of other clients and keep [client C] in line of sight. Assess immediate situation for an agitating factor or a reasonable way to provide [client C] with what he | | | |

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is wanting/needing. If calmed, refer to communication board and say 'Show me' in an attempt to see if he is wanting/needing something. Physical Aggression: If [client C] displays aggression: Immediately ensure [client C's] safety by: Redirecting him to a safe and calm area. Redirecting others away from him. If [client C] is continuing to place himself or others in jeopardy, use the You're Safe, I'm Safe (YSIS/behavioral intervention) procedures in the following order: One person YSIS then Two person YSIS...."

A review of client C's 5/6/22 BSP indicated staff did not implement the BSP as written. Staff did not redirect client C to a safe or calm area and he was able to strike client E on the shoulder and back.

On 6/10/22 at 1:34 PM, the QIDP and the QIDP-D were interviewed. The QIDP stated, "We should intervene and make sure the other clients are safe and move him to a safe area. I just didn't get to him quick enough. He barely touched him then he was escorted to his room". The QIDP indicated based on client C's aggressive behavior throughout the day, client C shouldn't have been around the other clients and the incident of client to client aggression would have been prevented. The QIDP indicated client C's BSP should have been implemented as written.

9-3-4(a)