STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G157	A. BUILDING 00 B. WING	11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RES CARE COMMUNITY ALTERNATIVES SE IN	3011 APACHE DR JEFFERSONVILLE, IN 47130

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 0000 Bldg. 00	This visit was for an annual recertification and state licensure survey. This visit included the investigation of complaint #IN00233345. Complaint #IN00233345: Substantiated. Federal/state deficiencies related to the allegation are cited at W149, W157, W186, W227 and W249. Dates of Survey: November 6, 7, 8 and 9, 2017. Facility Number: 000693 Provider Number: 15G157 AIMS Number: 100234510 These deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review of this report completed by #15068 on 11/21/17.	W 0000		
W 0149 Bldg. 00	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.			

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

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	Based on record review and interview for 4 of 4 sampled clients (A, B, C and D), and one additional client (G), for 14 of 30 investigations and reportable incidents (Bureau of Developmental Disabilities Services/BDDS) reports of abuse/neglect reviewed, the facility failed to ensure the facility's neglect/abuse/mistreatment policy was implemented in regards to staff to client verbal/emotional abuse, client elopement, client to client aggression and client theft. Findings include: The facility's Bureau of Developmental Disabilities Services/BDDS reports, incident reports and investigations were reviewed on 11/06/17 at 2:00 PM, 11/07/17 at 12:21 PM and on 11/09/17 at 1:30 PM and indicated the following: 1. A BDDS report dated 11/08/17 indicated clients A and B engaged in a "fist fight" on 11/07/17 at 8:30 PM. Client A came to client B's bedroom and asked client B to return a pair of socks belonging to client A. Client B told client A to leave or she would make her leave and the fight erupted. The BDDS report indicated YSIS (You're Safe, I'm Safe/agency approved behavior management restraint techniques) was used according to the clients' Behavior	W 0149	**W149:** The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. **Corrective Action: (Specific):** The facility's policy has been updated to reflect notification of the administrator immediately upon an allegation of abuse, neglect, mistreatment, exploitation and injury of unknown source. Administrator will ensure an investigation is initiated and alleged employee is suspended for all allegations of abuse, neglect and mistreatment. All staff in the home will be trained on the operation standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment and violation of individual rights. **How others will be identified: (Systemic**): Quality Assurance will review all incidents daily to ensure that incidents of abuse and neglect are addressed and have preventative measures put in place per policy and will notify the team of any incidents that is reported that needs an investigation. They will then	12/09/2017

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	Support Plans. Client B had "minor bleeding from her nose piercing site with no other injuries noted...." 2. A BDDS report dated 10/21/17 indicated client A had eloped at 3:00 PM on 10/20/17 going toward an apartment house. She was out of line of sight of staff for an hour. Staff called her and she agreed to meet with staff at a gas station then had staff contact for "approximately 15 minutes." Client A left toward the apartments again and was out of staff's sight for two hours. Staff found her at "approximately 6:00 PM" and she ran again with two staff in pursuit. Police and EMS arrived at the scene and client A was taken to a local emergency room/ER for evaluation. A drug test indicated marijuana. Client A was released from the ER with the diagnosis of Cannabis Use Disorder. The facility indicated a court appointed guardian would be sought for client A. 3. An investigation dated 10/17-23/17 indicated client A eloped twice on 10/16/17. At 4:00 PM, client A went outside the facility and went through a hole in the fence. The investigation indicated it took 1-2 (one to two) minutes to get to the fence. Client A went to a boyfriend's apartment near the facility and returned between 4:30-5:15 PM.		submit the BDDS report and start an investigation. The Peer review team and the administrator will review the investigation within five days. The QA Manager will over see QA coordinator to ensure that all incidents of abuse and neglect are addressed and have preventative measures implemented. QA will maintain contact with Administrator throughout the investigation to ensure completion with in the 5 day requirement. It is facility's policy to suspend from duty any employee alleged of abuse, neglect, and exploitation. Administrator will ensure an investigation is initiated and alleged employee is suspended for all allegations of abuse, neglect and mistreatment. **Measures to be put in place:** All staff in the home will be trained on the operation standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment and violation of individual rights. **Monitoring of Corrective Action:** Quality Assurance will review all incidents daily to ensure incidents of abuse, neglect and exploitation are	

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	Client A eloped again at 8:00 PM and was gone 10-15 minutes. Client A said she went to the park to think and also to get her jacket. Client A did not tell staff either time. Staff did not document 5 minute checks. Client A's 9/5/17 Behavior Support Plan/BSP indicated the client was to be in staff's line of sight during waking hours, she was on 5 minute checks while sleeping, if the door to her bedroom was closed she was on automatic 1:1 (one staff to one client supervision) within 5 feet. The investigation determined staff was not neglectful in that no one was assigned the 5 minute checks at 8:00 PM, which staff #7 did not document. Only staff #8 was on duty at 4:00 PM when client A eloped and client A's BSP of line of sight and 5 minute checks were not implemented. 4. On 9/9/17 at 4:00 PM, client B and a peer were playing hide and seek in the facility's yard. Client B left the premises and walked to a nearby clothing store with staff following her on foot. Client B went into the store and tried to steal items (unknown), She refused to come with staff and was going to be charged with trespass. Police and EMS arrived and she was transported to a local ER where she was given literature on Bipolar disorder and a prescription for Celexa (anti-depressant).		followed per facility policy. The Peer review team and the administrator will review the investigation within five days and make recommendations'. The QA Manager will oversee QA coordinator to ensure that all incidents of abuse, neglect and exploitation are followed per facility policy. **Completion date: 12.09.17**	

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	5. An investigation on August 4-9, 2017 indicated an allegation that staff #9 cursed and threatened client G. It was substantiated staff #9 cursed, threatened and was verbally/mentally abusive to client G. Staff #9 was terminated. 6. On 8/8/17 a BDDS report indicated client B was on the facility's van after an appointment and got off and evaded the staff. The police found her and she was out of sight of staff for "10-15 minutes." 7. On 8/8/17 a BDDS report indicated client B eloped at 4:00 PM and was found in a local department store's parking lot where passersby called 911 when she had a tonic clonic seizure. 8. An investigation dated 6/19-22/17 indicated client A eloped through her bedroom window on 6/19/17 on third (night) shift. Staff #10 was new and did not know the client's BSP, so she did not do visual bed checks of client A.. The client was found to be gone at 7:20 AM on 6/19/17 when staff went to awaken her. Client A had locked her bedroom door and went through her window. She had made arrangements to be picked up by a boy she knew. They traveled to a town 92 miles north of the facility.			

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	Client A eloped at midnight on 6/19/17 and was picked up by the police at 3:00 PM 6/19/17. Assistant executive director staff picked her up and returned her to the facility on 6/19/17. It was determined the Area Supervisor had not trained staff #10 on the client's BSP and other on the job training new hires received regarding management of client needs/issues. 9. On 6/2/17 a BDDS report indicated client B eloped from workshop. 10. A BDDS report dated 5/17/17 indicated client A was found to have a boy hidden in her bedroom at 2:45 AM on 5/17/17. Staff called the police and the boy was escorted off the property. The client's bedroom was changed so client A slept upstairs and alarms were placed on the window and door of her new bedroom. 11. On 5/16/17 at 12:30 PM, client B eloped from her workshop, police found her and handcuffs were used. Client B was suspended from the workshop. 12. An investigation on 4/18-21/17 indicated client D alleged staff #11 threatened her, called her names, refused to give her a snack and made a rude gesture toward her. The allegations of with-holding a snack, making threats and			

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	verbal abuse were substantiated and staff #11 was terminated. 13. An investigation dated April 5 and 6, 2017 indicated client A had a boy in her room. The investigation indicated client A turned off door alarms and she had a bedroom downstairs. She had a boy hidden in her bedroom during bed checks but staff heard them and had the boy leave. The investigation indicated client A had visitors without staff knowledge on prior occasions. The investigation indicated staff would do checks through the night and door alarms that will sound upstairs would be installed. 14. 1/31-2/7/17 investigation indicated, client B possibly shoplifted (unable to substantiate), peers' items found in her bedroom and client C's money was gone. Client D was reimbursed $1.00 for lipstick and client C was reimbursed $10.00. It was substantiated items were missing and Client B was stealing from her housemates. Client door locks will be changed. Interview was conducted with the Quality Assurance Manager on 11/09/17 at 3:30 PM and indicated there had been two staff terminations for client verbal abuse (staff #9 and #11). The interview indicated clients A and B continued to			

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	exhibit inappropriate behaviors of non-compliance and elopement. The agency's revised policy dated 9/17/17 was reviewed on 11/07/17 at 2:30 PM and indicated, in part, the following: "Operation Standard Reporting and Investigating Abuse, Neglect, Exploitation, Mistreatment or Violation of an Individual's Rights ResCare staff actively advocate for the rights and safety of all individuals. All allegations or occurrences of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights shall be reported to the appropriate authorities through the appropriate supervisory channels and will be thoroughly investigated under the policies of ResCare, local, state and federal guidelines. Although ResCare staff are instructed and encouraged to use the internal reporting system outlined below, any staff has the right to contact Adult Protective Services directly, should they suspect abuse, neglect, exploitation, mistreatment or violation of an Individual's rights. ResCare strictly prohibits abuse, neglect, exploitation, mistreatment or violation of			

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	an Individual's rights. These include and are defined as any of the following: corporal punishment i.e. forced physical activity, hitting, pinching, the application of pain or noxious stimuli, the use of electric shock, the infliction of physical pain, seclusion in an area which exit is prohibited, verbal abuse including screaming, swearing, name-calling, belittling, damaging an individual's self-respect or dignity, failure to follow physician's orders, denial of sleep, shelter, food, drink, physical movement for prolonged periods of time, Medical treatment or care or use of bathroom facilities. Program Implementation/Intervention: Failure to provide goods and/or services necessary for the individual to avoid physical harm and /or intentional failure to implement a support plan, inappropriate application of intervention, etc. which may result in jeopardy without qualified person notification/review.... All employees receive training upon hire regarding definitions/causes of different types of, how to identify, prevent, document, remedial action to be taken, timely debriefing following the incident and how to report abuse, neglect, exploitation, mistreatment or violation of an Individual's rights, as well as what to expect from an investigation. All employees receive this training upon hire			

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	and annually, thereafter. Procedures: 1. Any ResCare staff person who suspects an individual is the victim of abuse, neglect, exploitation or mistreatment of an individual should immediately notify the Program Manager, and then complete an Incident Report. The Program Manager will then notify the Executive Director. This step should be done within 24 hours. 2. The Program Manager, or designee, will report the suspected abuse, neglect, exploitation, mistreatment or violations of Individual's rights within 24 hours of the initial report to the appropriate contacts.... 3. Any staff person who is suspected of abuse, neglect, exploitation, mistreatment or violation of an Individual's rights toward an individual will be immediately suspended until the allegation can be fully investigated. After the investigation, if the allegation is not substantiated, the employee will be paid for missed scheduled hours. 4. The Program Manager will assign an investigative team. A full investigation will be conducted by investigators who have received training from Labor			

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	Relations Association and ResCare's internal procedures on investigations. ResCare will not allow for nepotism during the conducting, directing, reviewing or other managerial activity of an investigation into an allegation of abuse, neglect, exploitation or mistreatment, by prohibiting friends and relatives of an alleged perpetrator from engaging in these managerial activities. One of the investigators will complete a detailed investigative case summary based on witness statements and other evidence collected. The report will be maintained in a confidential, secured file at the office. The investigation file will include the following components: a clear statement indicating why the investigation/review is being conducted along with the nature of the allegations/event (e.g., allegation of neglect, etc.), a clear statement of the event or alleged event in a time-line format including what, where, and when the event happened or is alleged to have happened, Identification by name and title of all involved parties or alleged involved parties including any victim(s) or alleged victim(s), all staff assigned to the victim(s) or alleged victim(s) at the time of the incident, all alleged perpetrators, when indicated; and all actual or potential witnesses to the event or alleged event, signed and dated			

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	statements from all involved parties, including all actual and potential witnesses to the event or alleged event, a statement describing all record and other document review associated with the event or alleged event, copies of all records and other documents reviewed that provide evidence supporting the finding of the investigation or review, if there are any discrepancies/conflicts between the evidence gathered, the discrepancy is resolved and/or explained, a determination if rights have been violated, if services and/or care were not provided or were not appropriately provided, if agency policies and/or procedures were not followed, and/or if any federal or state regulations were not followed, a clear statement of substantiation or non-substantiation of any allegation that includes a description/summary of the evidence that result in the finding, a definitive description of all corrective actions developed and implemented and/or to be implemented as a result of the investigation or review, including completion dates for each corrective action, the signature, name and title of the person completing the investigation and the date the investigation was completed. 5. An investigative peer review			

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	committee chosen by the Executive Director will meet to discuss the outcome of the investigation and to ensure that a thorough investigation has been completed. Members of the committee must include at least one of the investigators, the Executive Director or designee, Program Manager, QA representative and a Human Resources representative." This federal tag relates to Complaint #IN00233345. 9-3-2(a)			
W 0157 Bldg. 00	483.420(d)(4) STAFF TREATMENT OF CLIENTS If the alleged violation is verified, appropriate corrective action must be taken. Based on record review and interview for 4 of 4 sampled clients (A, B, C and D), for 12 of 30 investigations and reportable incidents (Bureau of Developmental Disabilities Services/BDDS) reports of abuse/neglect reviewed, the facility failed to ensure corrective measures were successfully implemented in regards to staff to client elopement, client to client aggression and client theft.	W 0157	**W157:** If alleged violation is verified, appropriate corrective action must be taken. **Corrective Action: (Specific):** The facility's policy has been updated to reflect notification of the administrator immediately upon an allegation of abuse, neglect, mistreatment, exploitation and injury of unknown source. Administrator will ensure an investigation is initiated and alleged employee is suspended	12/09/2017

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	Findings include: The facility's Bureau of Developmental Disabilities Services/BDDS reports, incident reports and investigations were reviewed on 11/06/17 at 2:00 PM, 11/07/17 at 12:21 PM and on 11/09/17 at 1:30 PM and indicated the following: 1. A BDDS report dated 11/08/17 indicated clients A and B engaged in a "fist fight" on 11/07/17 at 8:30 PM. Client A came to client B's bedroom and asked client B to return a pair of socks belonging to client A. Client B told client A to leave or she would make her leave and the fight erupted. The BDDS report indicated YSIS (You're Safe, I'm Safe/agency approved behavior management restraint techniques) was used according to the clients' Behavior Support Plans. Client B had "minor bleeding from her nose piercing site with no other injuries noted...." 2. A BDDS report dated 10/21/17 indicated client A had eloped at 3:00 PM on 10/20/17 going toward an apartment house. She was out of line of sight of staff for an hour. Staff called her and she agreed to meet with staff at a gas station and had staff contact for "approximately" 15 minutes. Client A left toward the apartments again and was out of staff's		for all allegations of abuse, neglect and mistreatment. All staff in the home will be trained on the operation standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment and violation of individual rights. **How others will be identified: (Systemic)**: Quality Assurance will review all incidents daily to ensure that incidents of abuse and neglect are addressed and have preventative measures put in place per policy and will notify the team of any incidents that is reported that needs an investigation. They will then submit the BDDS report and start an investigation. The Peer review team and the administrator will review the investigation within five days. The QA Manager will over see QA coordinator to ensure that all incidents of abuse and neglect are addressed and have preventative measures implemented. QA will maintain contact with Administrator throughout the investigation to ensure completion with in the 5 day requirement. It is facility's policy to suspend from duty any employee alleged of	

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	sight for two hours. Staff found her at "approximately 6:00 PM" and she ran again with two staff in pursuit. Police and EMS/Emergency Medical Services arrived at the scene and client A was taken to a local emergency room/ER for evaluation. A drug test indicated marijuana. Client A was released from the ER with the diagnosis of Cannabis Use Disorder. The facility indicated a court appointed guardian would be sought for client A. 3. An investigation dated 10/17-23/17 indicated client A eloped twice on 10/16/17. At 4:00 PM, client A went outside the facility and went through a hole in the fence. The investigation indicated it took 1-2 (one to two) minutes to get to the fence. Client A went to a boyfriend's apartment near the facility and returned between 4:30-5:15 PM. Client A eloped again at 8:00 PM and was gone 10-15 minutes. Client A said she went to the park to think and also to get her jacket. Client A did not tell staff either time. Staff did not document 5 minute checks. Client A's 9/5/17 Behavior Support Plan/BSP indicated the client was to be in staff's line of sight during waking hours, she was on 5 minute checks while sleeping, if the door to her bedroom was closed she was on automatic 1:1 (one staff to one client		abuse, neglect, and exploitation. Administrator will ensure an investigation is initiated and alleged employee is suspended for all allegations of abuse, neglect and mistreatment. **Measures to be put in place:** All staff in the home will be trained on the operation standard for reporting and investigating allegations of abuse, neglect, exploitation, mistreatment and violation of individual rights. **Monitoring of Corrective Action:** Quality Assurance will review all incidents daily to ensure incidents of abuse, neglect and exploitation are followed per facility policy. The Peer review team and the administrator will review the investigation within five days and make recommendations'. The QA Manager will oversee QA coordinator to ensure that all incidents of abuse, neglect and exploitation are followed per facility policy. **Completion date: 12.09.17**	

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	supervision) within 5 feet. The investigation determined staff was not neglectful in that no one was assigned the 5 minute checks at 8:00 PM, which staff #7 did not document. Only staff #8 was on duty at 4:00 PM when client A eloped and client A's BSP of line of sight and 5 minute checks were not implemented. 4. On 9/9/17 (BDDS report) at 4:00 PM, client B and a peer were playing hide and seek in the facility's yard. Client B left the premises and walked to a nearby clothing store with staff following her on foot. Client B went into the store and tried to steal items (unknown) She refused to come with staff and was going to be charged with trespass. Police and EMS arrived and she was transported to a local ER where she was given literature on Bipolar disorder and an prescription for Celexa (anti-depressant). 5. On 8/8/17 (BDDS report), client B was on the facility's van after an appointment and got off and evaded the staff. The police found her she was out of sight of staff for "10-15 minutes." 6. On 8/8/17 (BDDS report) at 4:00 PM, client B eloped and was found in a local department store's parking lot where passersby called 911 when she had a tonic clonic seizure.			

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	7. An investigation dated 6/19-22/17 indicated client A eloped through her bedroom window on 6/19/17 on third (night) shift. Staff #10 was new and did not know the client's BSP, so she did not do visual bed checks of client A. The client was found to be gone at 7:20 AM on 6/19/17 when staff went to awaken her. Client A had locked her bedroom door and went through her window. She had made arrangements to be picked up by a boy she knew. They traveled to a town 92 miles north of the facility. Client A eloped at midnight on 6/19/17 and was picked up by the police at 3:00 PM on 6/19/17. Assistant executive director staff picked her up and returned her to the facility on 6/19/17. It was determined the Area Supervisor had not trained staff #10 in the client's BSP and other on the job training new hires received regarding management of client needs/issues. 8. On 6/2/17 (BDDS report), client B eloped from workshop. 9. A BDDS report dated 5/17/17 indicated client A was found to have a boy hidden in her bedroom at 2:45 AM on 5/17/17. Staff called the police and the boy was escorted off the property. The client's bedroom was changed so client A			

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	slept upstairs and alarms were placed on the window and door of her new bedroom. 10. On 5/16/17 (BDDS report) at 12:30 PM, client B eloped from her workshop, police found her and handcuffs were used. Client B was suspended from the workshop. 11. An Investigation dated April 5 and 6, 2017 indicated client A had a boy in her room. The investigation indicated client A turned off door alarms and she had a bedroom downstairs. She had a boy hidden in her bedroom during bed checks but staff heard them and had the boy leave. The investigation indicated client A had visitors without staff knowledge on prior occasions. The investigation indicated staff would do checks through the night and door alarms that will sound upstairs would be installed. 12. An investigation dated 1/31-2/7/17 indicated client B possibly shoplifted (unable to substantiate), peers' items found in her bedroom and client C's money was gone. Client D was reimbursed $1.00 for lipstick and client C was reimbursed $10.00. It was substantiated items were missing and Client B was stealing from her housemates. Client door locks will be			

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	changed. Interview was conducted with the Quality Assurance Manager on 11/09/17 at 3:30 PM and indicated there had been two staff terminations for client verbal abuse (staff #9 and #11). The interview indicated clients A and B continued to exhibit inappropriate behaviors of non-compliance and elopement. This federal tag relates to Complaint #IN00233345. 9-3-2(a)			
W 0186 Bldg. 00	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. Based on observation, record review and interview for 4 of 4 sampled clients (A, B, C and D), and 3 additional clients (E, F and G), the facility failed to ensure sufficient staff to monitor clients' programs, behaviors and assistant with morning mealtime.	W 0186	**W186:** The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. **Corrective Action: (Specific):** The Residential	12/09/2017

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	Findings include: During observations at the facility on the morning of 11/07/17 from 6:10 AM until 8:22 AM, staff #12 was the only direct support professional (DSP) working with clients A, B, C, D, E, F, and G. Staff #12 was busy passing medications commencing at 6:19 AM. Staff #12 could not do line of sight visual observation of clients A and B according to their Behavior Support Plans. Staff #12 could not do monitoring of breakfast preparation or of dining for clients A, B, E and G. Staff #12 indicated on 11/07/17 at 6:30 AM, 2 to 3 DSPs worked the mornings (6:00 AM to 8:00 AM) when clients were getting ready for the day (dressing, hygiene, medications, breakfast). The interview indicated another DSP was expected at 6:00 AM, but did not arrive. The site supervisor (house manager) was on medical leave. The facility's Bureau of Developmental Disabilities Services/BDDS reports, incident reports and investigations were reviewed on 11/06/17 at 2:00 PM and indicated the following: An investigation dated 10/17-23/17 indicated client A eloped twice on		Manager will be re-trained on ensuring that the home is staffed according to the scheduled hours for the home. Staff will be trained on staffing needs and who to contact if not staffed accordingly for staffing assistance. **How others will be identified: (Systemic):** The Area Supervisor will review the schedule with the Residential Manager at least daily to ensure that the home is staffed according to the scheduled hours for the home. The area Supervisor will meet weekly with the Program Manager to review the scheduled hours for the home. **Measures to be put in place:** The Residential Manager will be re-trained on ensuring that the home is staffed according to the scheduled hours for the home. **Monitoring of Corrective Action:** The Area Supervisor will review the schedule with the Residential Manager at least daily to ensure that the home is staffed according to the scheduled hours for the home. The area Supervisor	

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	10/16/17. At 4:00 PM, client A went outside the facility and went through a hole in the fence. The investigation indicated it took 1-2 (one to two) minutes to get to the fence. Client A went to a boyfriend's apartment near the facility and returned between 4:30-5:15 PM. Client A eloped again at 8:00 PM and was gone 10-15 minutes. Client A said she went to the park to think and also to get her jacket. Client A did not tell staff either time. Staff did not document 5 minute checks. Client A's 9/5/17 Behavior Support Plan/BSP indicated the client was to be in staff's line of sight during waking hours, she was on 5 minute checks while sleeping, if the door to her bedroom was closed she was on automatic 1:1 (one staff to one client supervision) within 5 feet. The investigation determined staff was not neglectful in that no one was assigned the 5 minute checks at 8:00 PM, which staff #7 did not document. Only staff #8 was on duty at 4:00 PM when client A eloped and client A's BSP of line of sight and 5 minute checks were not implemented. Client A's record was reviewed on 11/07/17 at 7:55 AM and on 11/08/17 at 11:19 AM. Client A's 9/5/17 Behavior Support Plan/BSP indicated the client was to be in staff's line of sight during waking hours, she was on 5 minute		will meet weekly with the Program Manager to review the scheduled hours for the home. Review of schedules, staffing patterns, and needs will be on-going. **Completion date: 12.09.17**	

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	checks while sleeping, if the door to her bedroom was closed she was on automatic 1:1 (one staff to one client supervision) within 5 feet. Client B's record was reviewed on 11/07/17 at 1:15 PM and on 11/08/17 at 11:26 AM. Client B had a BSP dated 5/23/17 which indicated the client was to be in staff's line of sight during waking hours, she was on 5 minute checks while sleeping. An interview with Qualified Intellectual Disabilities Professional/QIDP #1 on 11/09/17 at 12:57 PM indicated clients should be supervised by staff. This federal tag relates to Complaint #IN00233345. 9-3-3(a)			
W 0227 Bldg. 00	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. Based on record review and interview for 1 of 4 sampled clients (A), the	W 0227	**W227:** The individual Program Plan states the specific	12/09/2017

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	QIDP/Qualified Intellectual Disabilities Professional failed to ensure client A's active treatment program/Individual Support Plan (ISP) training objectives or BSP/Behavior Support Plan included methods to address issues with avoiding instances of exploitation in social situations. Findings include: The facility's Bureau of Developmental Disabilities Services/BDDS reports, incident reports and investigations were reviewed on 11/06/17 at 2:00 PM, 11/07/17 at 12:21 PM and on 11/09/17 at 1:30 PM and indicated the following: 1. A BDDS report dated 10/21/17 indicated client A had eloped at 3:00 PM on 10/20/17 going toward an apartment house. She was out of line of sight of staff for an hour. Staff called her and she agreed to meet with staff at a gas station then had staff contact for "approximately 15 minutes." Client A left toward the apartments again and was out of staff's sight for two hours. Staff found her at "approximately 6:00 PM" and she ran again with two staff in pursuit. Police and EMS/Emergency Medical Services arrived at the scene and client A was taken to a local emergency room/ER for evaluation. A drug test indicated		objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c) (3) of section. **Corrective Action: (Specific):** The QIDP will be retrained on ensuring all Active Treatment Programs and Programming Plans include methods to address issues with avoiding instances of exploitation. Client A programming plans will be reviewed and updated and will include in-depth training methodology. **How others will be identified: (Systemic):** The QIDP lead will meet with the QIDP weekly for the next thirty days to ensure all programming plans are current and up to date with the correct information. The QIDP Lead will review all programming plans to ensure all programming plans are current and up to date with all correct information. Ongoing there will be site reviews completed bi-monthly by administrator whom will review plans for accuracy and being followed. **Measures to be put in place:** The QIDP lead will meet with	

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	marijuana. Client A was released from the ER with the diagnosis of Cannabis Use Disorder. The facility indicated a court appointed guardian would be sought for client A. 2. An investigation dated 10/17-23/17 indicated client A eloped twice on 10/16/17. At 4:00 PM, client A went outside the facility and went through a hole in the fence. The investigation indicated it took 1-2 (one to two) minutes to get to the fence. Client A went to a boyfriend's apartment near the facility and returned between 4:30-5:15 PM. Client A eloped again at 8:00 PM and was gone 10-15 minutes. Client A said she went to the park to think and also to get her jacket. Client A did not tell staff either time. Staff did not document 5 minute checks. Client A's 9/5/17 Behavior Support Plan/BSP indicated the client was to be in staff's line of sight during waking hours, she was on 5 minute checks while sleeping, if the door to her bedroom was closed she was on automatic 1:1 (one staff to one client supervision) within 5 feet. The investigation determined staff was not neglectful in that no one was assigned the 5 minutes checks at 8:00 PM, which staff #7 did not document. Only staff #8 was on duty at 4:00 PM when client A eloped and client A's BSP of line of sight and 5		the QIDP weekly for the next thirty days to ensure all programming plans are current and up to date with the correct information. The QIDP Lead will review all programming plans to ensure all programming plans are current and up to date with all correct information. Administrative site reviews will be conducted monthly. **Monitoring of Corrective Action:** The QIDP will be retrained on ensuring all Active Treatment Programs and Programming Plans include methods to address issues with avoiding instances of exploitation. Client A, B, C, D, E, F, and G programming plans will be reviewed and updated and will include in-depth training on methodology. **Completion date: 12.09.17**	

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	minute checks were not implemented. 3. An investigation 6/19-22/17 indicated client A eloped through her bedroom window on 6/19/17 on third (night) shift. Staff #10 was new and did not know the client's BSP, so she did not do visual bed checks of client A. The client was found to be gone at 7:20 AM on 6/19/17 when staff went to awaken her. Client A had locked her bedroom door and went through her window. She had made arrangements to be picked up by a boy she knew. They traveled to a town 92 miles north of the facility. Client A eloped at midnight on 6/19/17 and was picked up by the police at 3:00 PM 6/19/17. Assistant executive director staff picked her up and returned her to the facility on 6/19/17. It was determined the Area Supervisor had not trained staff #10 in the client's BSP and other on the job training new hires received regarding management of client needs/issues. 4. A BDDS report dated 5/17/17 indicated client A was found to have a boy hidden in her bedroom at 2:45 AM on 5/17/17. Staff called the police and the boy was escorted off the property. The client's bedroom was changed so client A slept upstairs and alarms were placed on the window and door of her new bedroom.			

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	5. An Investigation dated April 5 and 6, 2017 indicated client A had a boy in her room. The investigation indicated client A turned off door alarms and she had a bedroom downstairs. She had a boy hidden in her bedroom during bed checks but staff heard them and had the boy leave. The investigation indicated client A had visitors without staff knowledge on prior occasions. The investigation indicated staff would do checks through the night and door alarms that will sound upstairs would be installed. Client A's record was reviewed on 11/07/17 at 7:55 AM and on 11/08/17 at 11:19 AM. The review indicated an ISP dated 2/1/17 and a 9/5/17 BSP which indicated the client had the inappropriate behaviors of elopement and was vulnerable to sexual exploitation by men. The client's BSP indicated client A was to be in staff's line of sight during waking hours, she was on 5 minute checks while sleeping, if the door to her bedroom was closed she was on automatic 1:1 (one staff to one client supervision) within 5 feet. The ISP/BSP had no indepth training methodology to assist client A in learning social awareness skills in regards to sexual exploitation and making good life			

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	choices. An interview with QIDP #1 on 11/09/17 at 12:57 PM indicated client A's ISP/BSP should address how to avoid sexual exploitation and making good life choices. This federal tag relates to Complaint #IN00233345. 9-3-4(a)			
W 0249 Bldg. 00	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. Based on observation, record review and interview for 2 of 4 sampled clients (A and B), the facility failed to ensure staff implemented clients' programs. Findings include:	W 0249	**W249 :** Program Implementation **Corrective Action: (Specific):** All staff working at the home will be re-trained on client Programming Plans and Active	12/09/2017

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	During observations at the facility on the morning of 11/07/17 from 6:10 AM until 8:22 AM, staff #12 was the only direct support professional (DSP) working with clients A, B, C, D, E, F, and G. Staff #12 was busy passing medications commencing at 6:19 AM. Staff #12 could not do line of sight visual observation of clients A and B according to their Behavior Support Plans. Staff #12 could not do monitoring of breakfast preparation or of dining for clients A, B, E and G. Staff #12 indicated on 11/07/17 at 6:30 AM, 2 to 3 DSPs worked the mornings (6:00 AM to 8:00 AM) when clients were getting ready for the day (dressing, hygiene, medications, breakfast). The interview indicated another DSP was expected at 6:00 AM, but did not arrive. The site supervisor (house manager) was on medical leave. The facility's Bureau of Developmental Disabilities Services/BDDS reports, incident reports and investigations were reviewed on 11/06/17 at 2:00 PM and indicated the following: An investigation dated 10/17-23/17 indicated client A eloped twice on 10/16/17. At 4:00 PM, client A went outside the facility and went through a hole in the fence. The investigation		Treatment Plans. **How others will be identified: (Systemic):** All staff at the home will be re-trained on all individuals BSP's to ensure full understanding. The QIDP will be at the home at least twice weekly to conduct observations, to ensure that all individual program plans are implemented as written and that changes are made based in individual need. The QIDP will meet weekly with the Lead QIDP to ensure all that Programming plans meets the individual's needs. The Site Supervisor will be in the home at least five times weekly to ensure all client Program Plans are being implemented. The Area Supervisor will be in the home at least weekly to ensure the Programming Plans are being implemented. **Measures to be put in place:** All staff working at the home will be re-trained on client Programming Plans and Active Treatment Plans. **Monitoring of Corrective Action :)** All staff at the home will be re-trained on all individuals BSP's to ensure full understanding. The QIDP will be at the home at least twice weekly to conduct observations which will be documented and turned into QIDP Lead to ensure that all individual program plans are	

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	indicated it took 1-2 (one to two) minutes to get to the fence. Client A went to a boyfriend's apartment near the facility and returned between 4:30-5:15 PM. Client A eloped again at 8:00 PM and was gone 10-15 minutes. Client A said she went to the park to think and also to get her jacket. Client A did not tell staff either time. Staff did not document 5 minute checks. Client A's 9/5/17 Behavior Support Plan/BSP indicated the client was to be in staff's line of sight during waking hours, she was on 5 minute checks while sleeping, if the door to her bedroom was closed she was on automatic 1:1 (one staff to one client supervision) within 5 feet. The investigation determined staff was not neglectful in that no one was assigned the 5 minute checks at 8:00 PM, which staff #7 did not document. Only staff #8 was on duty at 4:00 PM when client A eloped and client A's BSP of line of sight and 5 minute checks were not implemented. Client A's record was reviewed on 11/07/17 at 7:55 AM and on 11/08/17 at 11:19 AM. Client A's 9/5/17 Behavior Support Plan/BSP indicated the client was to be in staff's line of sight during waking hours, she was on 5 minute checks while sleeping, if the door to her bedroom was closed she was on automatic 1:1 (one staff to one client		implemented as written and that changes are made based in individual need. The QIDP will meet weekly with the Lead QIDP to ensure all that Programming plans meets the individual's needs. The Site Supervisor will be in the home at least five times weekly to ensure all client Program Plans are being implemented. The Area Supervisor will be in the home at twice weekly for 30 days and ongoing weekly to ensure the Programming Plans are being implemented. **Completion date: 12.09.17**	

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	supervision) within 5 feet. Client B's record was reviewed on 11/07/17 at 1:15 PM and on 11/08/17 at 11:26 AM. Client B had a BSP dated 5/23/17 which indicated the client was to be in staff's line of sight during waking hours, she was on 5 minute checks while sleeping. QIDP/Qualified Intellectual Disabilities Professional #1 was interviewed on 11/09/17 at 12:57 PM. The interview indicated staff should implement clients' program plans. This federal tag relates to Complaint #IN00233345. 9-3-4(a)			
W 0368 Bldg. 00	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on observation, record review and interview for 1 additional client (E) the facility failed to ensure client E received only medications prescribed for her use. Findings include:	W 0368	**W368:** Drug Administration, The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. **Corrective Action:**	12/09/2017

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	The facility's Bureau of Developmental Disabilities Services/BDDS reports, incident reports and investigations were reviewed on 11/06/17 at 2:00 PM, 11/07/17 at 12:21 PM and on 11/09/17 at 1:30 PM and indicated the following: A BDDS report dated 7/25/17 indicated on 7/24/17 at 7:00 PM client E was administered another client's medications in error by staff #9. The medications were gabapentin 600 mg/milligrams (behavior), Onfi 20 mg., oxcarbazepine (anticonvulsant) 900 mg., Vitamin D 2000 IU/international units (supplement), and trazodone 150 mg (anti-depressant). The BDDS report indicated client E was taken to a local ER/emergency room and was there 4 hours for observation/evaluation. She was instructed to follow up with her primary care physician on 8/1/17. Interview with the LPN was conducted on 11/07/17 at 7:10 A.M. The LPN indicated all medications should be labeled with each client's name and instructions for administration to avoid errors. Interview with QIDP/Qualified Intellectual Disabilities Professional staff on 11/09/17 at 12:57 PM indicated		**(Specific):** The staff will be retrained on the operation standards for reporting and investigating abuse, neglect, exploration, mistreatment or violation of an individual's rights. Staff that made the error will be retrained on medication administration by the nurse and will be observed by the nurse on passing medications. **How others will be identified: (Systemic):** The nurse assigned to the location will do medication observations at least once weekly for the next sixty days to ensure the medication administration policy is being followed. The Site Supervisor will do medication observations at weekly and the Area Supervisor will do medication observations at least weekly for the next 30 days and monthly thereafter. The Quality Assurance Manager will review all incident reports to ensure no investigations need to be completed. **Measures to be put in place:** The staff will be retrained on the operation standards for reporting and investigating	

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	medications should be administered without error. 9-3-6(a)		abuse, neglect, exploration, mistreatment or violation of an individual's rights. **Monitoring of Corrective Action:)** The nurse assigned to the location will do medication observations at least once weekly for the next sixty days to ensure the medication administration policy is being followed. The Site Supervisor will do medication observations at least twice monthly and the Area Supervisor will do medication observations at least monthly. The Quality Assurance Manager will review all incident reports to ensure no investigations need to be completed. **Completion date: 12.09.17**	
W 0388 Bldg. 00	483.460(m)(1)(i) DRUG LABELING Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. Based on observation, record review, and interview, for 1 of 3 clients (E) observed during the morning medication administration, the facility failed to have the client's topical (ammonium lactate) cream medication labeled.	W 0388	**W388:** Drug Labeling. Labeling Drugs and biological must be based on currently accepted professional principles and practices. **Corrective Action: (Specific):**	12/09/2017

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	Findings include: An observation of the morning medication administration was conducted at the group home on 11/07/17 at 6:19 A.M. Staff #12 prepared and administered client E her medications. Client E's medication caddy contained an unlabeled box with a tube of ammonium lactate (generic Lachydrin cream). Review of client E's record on 11/07/17 at 6:25 AM indicated a physician's order dated 10/20/17 for client E to receive ammonium lactate cream to her feet twice daily. Interview with the LPN was conducted on 11/07/17 at 7:10 A.M. The LPN indicated all medications should be labeled with each client's name and instructions for administration. 9-3-6(a)		All staff at the home will be retrained on the medication administration policy and procedure and following all physicians 'orders as written. **How others will be identified: (Systemic):** The area supervisor will be in the home at least weekly and will complete medication observations at least once weekly for the next thirty days with staff to ensure that all medications are being administered without error and are correctly labeled. The nurse will be in the home at least weekly and will complete medication observations at least once weekly for the next thirty days with staff to ensure that all medications are being administered without error and will do an audit on all medications to ensure that all medications are correctly labeled and match the physician's orders. Medication Administration Observations that are completed will be turned into the Program Manager. **Measures to be put in place:** All staff at the home will be retrained on the medication administration policy and procedure and following all physicians' orders as written. **Monitoring of Corrective Action:** The area supervisor will be in the home at least weekly and will complete medication observations at least once weekly	

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			for the next thirty days with staff to ensure that all medications are being administered without error and are correctly labeled. The nurse will be in the home at least weekly and will complete medication observations at least once weekly for the next thirty days with staff to ensure that all medications are being administered without error and will do an audit on all medications to ensure that all medications are correctly labeled and match the physician's orders. Medication Administration Observations that are completed will be turned into the Program Manager. **Completion date: 12.09.17**	
W 0460 Bldg. 00	483.480(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. Based on observation, record review and interview for 2 of 4 sampled clients (A and B), and 2 additional clients (E and G), the facility failed to ensure the total menued diet was offered to clients. Findings include: During observations at the facility on the morning of 11/07/17 from 6:10 AM until 8:22 AM, staff #12 was the only direct	W 0460	**W460:** Each client must receive a nourishing well balanced diet including modified and specially prescribed diets. **Corrective Action: (Specific):** All staff in the home will be retrained on all clients' dining plans, following the menu, serving the correct portion sizes and offering substitutions.	12/09/2017

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	support professional (DSP) working with clients A, B, C, D, E, F, and G. Staff #12 was busy passing medications commencing at 6:19 AM. Client E had her medications administered on 11/07/17 at 6:19 AM. Client E was given a Boost supplement drink at 6:30 AM and staff #12 asked client F to open the boxed drink for client E. Staff did not encourage client E to have cereal, cranberry juice, or raisin toast or substitutes for the meal items. Client A was observed at 7:00 AM to eat a serving of oatmeal without milk, juice or toast. Clients G and B were observed to make two packets each of instant oatmeal for breakfast at 7:10 AM on 11/07/17. Staff was not available to monitor clients A, B, E or G's breakfast. The 11/07/17 breakfast menu (reviewed at 8:00 AM on 11/07/17) consisted of 1/2 cup cranberry juice, 1/2 cup hot or 3/4 cup cold cereal, 1 cup milk, and raisin toast. Staff #12 indicated on 11/07/17 at 6:30 AM, 2 to 3 DSPs worked the mornings (6:00 AM to 8:00 AM) when clients were getting ready for the day (dressing, medications, breakfast). The interview indicated another DSP was expected at 6:00 AM, but did not arrive.		**How others will be identified: (Systemic):** The residential manager will be in the home at least five times weekly and observe a meal at least weekly to ensure that all client dining plans are being followed as written, that the menu is being followed, the correct portion sizes are being served and that substitutions are being offered. The Area Supervisor will be in the home at least once weekly to observe a meal to ensure that all client dining plans are being followed as written, that the menu is being followed, the correct portion sizes are being served and that substitutions are being offered. The observations will be turned into the program manager weekly. Ongoing there will be site reviews completed bi-monthly by administrator whom will review plans for accuracy and being followed. **Measures to be put in place:** All staff in the home will be retrained on all clients' dining plans, following the menu, serving the correct portion sizes and offering substitutions. **Monitoring of Corrective Action:** The residential manager will be in the home at least five times weekly and observe a meal at least weekly to ensure that all client dining plans are being	

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	QIDP/Qualified Intellectual Disabilities Professional #1 was interviewed on 11/09/17 at 12:57 PM. The interview indicated staff should supervise clients during mealtime and ensure they received menued foods or substitutions. 9-3-8(a)		followed as written, that the menu is being followed, the correct portion sizes are being served and that substitutions are being offered. The Area Supervisor will be in the home at least once weekly to observe a meal to ensure that all client dining plans are being followed as written, that the menu is being followed, the correct portion sizes are being served and that substitutions are being offered. The observations will be turned into the program manager weekly. **Completion date: 12.09.17**	
W 0484 Bldg. 00	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. Based on observation and interview for 4 of 4 sampled clients (A, B, C and D), and 3 additional clients (E, F and G), the facility failed to ensure clients used appropriate table service for the evening meal. Findings include: During observations at the facility on the evening of 11/06/17 from 4:10 PM until 5:45 PM, staff #5 and #7 were working with clients A, B, C, D, E, F, and G. The	W 0484	**W484:** The facility must equip areas with tables, chairs, eating utensils and dishes designed to meet the developmental needs of each client. **Corrective Action: (Specific):** All staff in the home will be retrained ensuring that all the appropriate utensils are used for each table service. The home has been provided with all new utensils, dishes and pot and pans. **How others will be identified:**	12/09/2017

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	evening meal was observed consisting of lasagna, garlic bread, beverages, green beans, and combination salad with dressing. The table was observed to be set by client C at 4:45 PM using plastic forks as the table service. Clients A, B, C, D, E, F, and G used the plastic forks to consume their evening meal. Interview with Assistance Executive Director staff #1 on 11/09/17 at 10:30 AM indicated the facility should have all necessary tableware and cutlery for mealtime for all individuals living in the facility. It was unknown why staff allowed client C to set the table on 11/06/17 using plastic forks. 9-3-8(a)		**(Systemic):** The residential manager will be in the home at least three times weekly for the next thirty days and will observe the meal to ensure all clients are participating in all aspects of meal preparation, serving themselves, and ensuring the appropriate utensils are being used for each table service. The Area Supervisor will be in the home at least weekly for the next thirty days and will observe the meal to ensure all clients are participating in all aspects of meal preparation, serving themselves, and ensuring the appropriate utensils are being used for each table service. The observations will be turned into the program manager weekly. . **Measures to be put in place:** All staff in the home will be retrained ensuring that all the appropriate utensils are used for each table service. The home has been provided with all new utensils, dishes and pot and pans. **Monitoring of Corrective Action:** The residential manager will be in the home at least three times weekly for the next thirty days and will observe the meal to ensure all clients are participating in all aspects of meal preparation, serving themselves, and ensuring the appropriate utensils are being used for each table service. The Area Supervisor will be in the	

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			home at least weekly for the next thirty days and will observe the meal to ensure all clients are participating in all aspects of meal preparation, serving themselves, and ensuring the appropriate utensils are being used for each table service. The observations will be turned into the program manager weekly. **Completion date: 12.09.17**	
W 9999 Bldg. 00	State Findings: The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met: 460 IAC 9-3-4 Active Treatment Services. (b) The provider shall obtain day services for each resident which: (1) meet the criteria and certification requirements established by the division of aging and rehabilitative services for all day service providers; (2) meet the resident's active treatment needs set forth in the resident's individual program plan as determined by the interdisciplinary team conference with preference for services in the least	W 9999	**W9999:** The facility must obtain day services for each resident which: (1) meet criteria and certification requirements established by the divisions of aging and rehabilitative services for all service providers. **Corrective Action: (Specific):** The QIDP will be retrained on ensuring that all clients are involved in an active day program or involved in an active treatment activity in the community. Client B has refused to attend the ResCare program and the QIDP will work with Client B to find a day services that meets client B's needs. **How others will be identified: (Systemic):** The QIDP Lead will meet with the QIDP at least weekly for the next thirty days to	12/09/2017

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	restrictive environment. This state rule was not met as evidenced by: Based on observation, record review and interview, the facility failed to meet the active treatment needs pertaining to day services programming for 1 of 4 sampled clients (B). Findings include: Client B was observed at the facility on 11/06/17 from 4:10 PM until 5:45 PM and on 11/07/17 from 6:10 AM until 8:22 AM. Client B was at the facility and did not attend a day program. An observation was done at the local workshop (11/07/17 9:07 AM) and client B did not attend the workshop. At 4:45 PM on 11/06/17, client B indicated she no longer attended day program/workshop because of something she had done in the past. She did not explain what had happened. Review of client B's record on 11/08/17 at 11:26 AM indicated no contraindication to attending a day program. Interview with Assistant Executive		ensure that all clients are involved in a day service or involved in an active treatment program out in the community. **Measures to be put in place:** The QIDP will be retrained on ensuring that all clients are involved in an active day program or involved in an active treatment activity in the community. Client B has refused to attend the ResCare program and the QIDP will work with Client B to find a day services that meets client B's needs. **Monitoring of Corrective Action:** The QIDP Lead will meet with the QIDP at least weekly for the next thirty days to ensure that all clients are involved in a day service or involved in an active treatment program out in the community. **Completion date: 12.09.17**	

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	Director #1 on 11/06/17 at 1:36 PM indicated client B was supposed to attend the facility's day program adjacent to the agency's office. The interview indicated client B refused to attend the alternate day program. 9-3-4(b)(1)(2)			